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ANALYSIS OF KENYA'S LEGAL FRAMEWORK FOR UNIVERSAL HEALTH COVERAGE (UHC)

A Review of the Social Health Insurance Act, Primary Healthcare Act, Digital Health Act, and Facilities Improvement Financing Act

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Disclaimer

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Abbreviations

BETA	Bottom-up Economic Transformation Agenda
CHUs	Community Health Units
CoG	Council of Governors
CoK	Constitution of Kenya
COVID	Coronavirus Disease
CRA	Commission on Revenue Allocation
CRC	Convention on the Rights of the Child
CRPD	Convention on the Rights of Persons with Disabilities
CSO	Civil Society Organization
DANIDA	Danish International Development Agency
DHA	Digital Health Act
eCHIS	Electronic Community Health Information System
EMC	Emergency Medical Care
FIFA	Facilities Improvement Financing Act
KHIS	Kenya Health Information System
KII	Key Informant Interview
MoH	Ministry of Health
NHIF	National Health Insurance Fund
OOP	Out-of-pocket payments
PFM	Public Financial Management
PHCA	Primary Healthcare Act (PHCA)
PHCF	Primary Health Care Fund
PWD	Persons with Disabilities
SHA	Social Health Authority
SHIA	Social Health Insurance Act
SHIF	Social Health Insurance Fund
SDG	Sustainable Development Goals
SocHI	Social Health Insurance
UHC	Universal Health Coverage
WHO	World Health Organization

Acknowledgement

The Kenyan Section of the International Commission of Jurists (ICJ Kenya) recognises that every resident and citizen in Kenya deserves certainty in healthcare infrastructure and the ability to receive adequate, effective, and quality services when needed. Everyone's lived experiences and expectations are important in this context. With this in mind, we employed innovative approaches to promote inclusivity and conducted research to identify and understand the challenges that hinder access to healthcare services in Kenya. This research provides evidence to support informed recommendations for improving healthcare access.

The publication consolidates concerns, proposals, opportunities, and recommendations from a diverse group of stakeholders engaged with the healthcare system in our country. As part of our right to health project, it is a knowledge product among many others.

This document reviews the health laws enacted in 2023, which aim to strengthen the legal framework for universal health coverage and health financing. These laws include the Social Health Insurance Act 2023, the Primary Healthcare Act 2023, the Digital Health Act 2023, and the Facilities Improvement Financing Act 2023.

The legal analysis presented will be utilized to engage stakeholders in the health sector and advocate for a more progressive rights framework.

ICJ Kenya extends its heartfelt gratitude to everyone who contributed to this report's successful review and preparation. We especially thank Dr. Charles Oyaya, the consultant who provided expert research and analysis and compiled the report.

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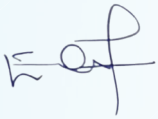

Eric Mukoya
Executive Director
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EXECUTIVE SUMMARY

The objective of this review was to identify gaps in the Social Health Insurance Act 2023, Primary Healthcare Act 2023, Digital Health Act 2023 and the Facilities Improvement Financing Act 2023 that were enacted by Parliament to strengthen the legal framework for UHC and health financing. This report also highlights challenges and areas of improvement with respect to the enacted health laws. These included issues related to alignment of the laws with constitutional principles and human rights norms, distribution of functions between national and county governments, institutional capacity, equity, gender and social inclusion among others. It is intended to lead to solutions to the identified gaps and challenges through law reforms.

Key findings and recommendations

1. **Declaration of the enacted laws unconstitutional but the breaches are redeemable:** The implementation of the enacted laws faced legal challenges with the High Court in July 2024 declaring the Social Health Insurance Act, Primary Healthcare Act and the Digital Health Act unconstitutional due to what the court considered "redeemable breaches", and which it gave Parliament 120 days to redress. The Court of Appeal however, lifted the conservatory orders suspending the implementation of the Social Health Insurance Act paving the way for its implementation from 1st October 2024.

2. **Lack of harmony between the Social Health Insurance Act and its own stated universal health coverage objective.**

3. **Potential conflicts between legislation and constitutionally guaranteed health rights:** The implementation of the Social Health Insurance Act revealed significant equity concerns, and potential conflicts between legislation and constitutionally guaranteed health rights. For example, Sections 26(5) and 47(3) of SHIA set preconditions for accessing services both at county and national government level limiting access only to active and up to date contributors and their dependents. This poses a threat to the constitutional right of citizens to access basic and emergency health care. In addition, the mandatory registration and contribution requirements raise concerns of potentially violating constitutional rights and restricting emergency healthcare access especially for poor households and vulnerable groups.

4. **The exclusion criteria is potentially in conflict with constitutional principles of equity, inclusion and affirmative action:** The definition of beneficiaries, vulnerable persons and the exclusion criteria under Sections 26 and 27 of the SHIA are in contradiction with principles of gender and social inclusion and affirmative action envisioned under Articles 10(2)(b), 21(3), 27 and 56(e) of the Constitution, potentially excluding indigent persons, casually employed and unemployed individuals from accessing healthcare services. This misalignment may therefore reduce or limit the enjoyment of healthcare rights for the most vulnerable and marginalized groups such as persons with disabilities, older individuals, children, women, older members of society and marginalized communities.

   In addition, although Section 2 of the SHIA indicates that 'vulnerable person(s)' shall be identified as such by the relevant government body, but it does clearly state who the relevant government body is or should be. This leads to ambiguity in applying the provisions to ensure transparent and accountable process of identifying, registration and enrolling the genuine vulnerable persons to the social health insurance scheme.

5. **The role of county governments appears largely ignored in the administration and delivery structure of the three funds established by the Social Health Insurance Act:** The administration and delivery structure of the Social Health Insurance Act including the Social Health Insurance Fund (SHIF), Primary Healthcare Fund (PHCF) and the Emergency, Chronic and Critical Illness Fund (ECCIF) appear to ignore or disregard or undermine the role of county governments in the implementation and delivery of healthcare services as constitutionally outlined under the Fourth Schedule.

   Furthermore, the delivery structure of the social health insurance scheme is functionally disconnected from the health system at Level 1 – Community Health Service and appears to be administratively in direct conflict with the devolved structure and principles of governance. The role of the county governments and county health system is also not clearly defined as well as the parameters for intergovernmental relations within the delivery structure between the Social Health Authority (SHA) and county governments in the financing and delivery of health services.

6. **The social health insurance mandatory character is supported by a heavily punitive system for contributors and beneficiaries:** Individuals who are not registered, or who are not up-to-date and active contributors, or who are not wholly dependent on up-to-date and active contributors, may be excluded from accessing healthcare, including emergency medical treatment through SHIF, PHCF, and ECCIF. Section 27(6) creates a strict punitive system for households and individuals who fail to pay contributions and penalties accrued, which are recoverable debts to the SHIF under Section 49(2) and (4). Section 27(7) requires that a person must pay all outstanding contributions and penalties before resuming access to healthcare under the SHIA. This is unlike the voluntary model of the defunct NHIF, where contributors could rejoin anytime they were able.

   The exclusion criteria under Sections 26 and 27 of SHIA will most likely put vulnerable and marginalized groups, including unemployed individuals, informal sector workers, and poor households in a precarious position where they risk losing access to essential healthcare services as well as their valuable assets. Essentially, under the SHIA those unable to fulfill their monthly or annual payment obligations, and to pay all outstanding contributions and penalties accrued are at risk of being permanently locked out of accessing public healthcare and loss of their assets with potential catastrophic impact on the vulnerable and marginalized populations, driving them further into poverty.

7. **Implications of registration and specific contribution criteria for households and informal sector contributors:** Individuals who are not registered under specific provisions or not meeting specific contribution criteria set by the SHIA may face significant challenges in accessing healthcare services. Collecting annual contributions from households and individuals in the informal sector as well as those struggling with monthly payments may be challenging due to irregular incomes, casualization of labour and competing financial burdens. This will not only pose challenges for effective financial planning but also significantly limit or exclude the poor household and informal sector contributors from accessing essential healthcare services through the three funds established under SHIA. This will also most likely drive the poor, vulnerable, indigents, casually employed and the unemployed into poverty and destitution minus access to health care.

   To address the foregoing gaps and issues, the analysis gives recommendations emphasizing the need for a comprehensive review and amendment to the Social Health Insurance Act as the main legal instrument for achieving universal health coverage objectives and the right to health including ensuring its effective administrative functionality.

INTRODUCTION

The Constitution of Kenya 2010 guarantees every person the right to the highest attainable standard of health, which includes the right to health care services, including reproductive health care under Article 43(1)(a). Further, Article 43(2) of the Constitution provides that a person shall not be denied emergency medical treatment while Article 43(3) provides that state shall provide appropriate social security to persons who are unable to support themselves and their dependents.

Under Article 53(c), every child has a right to healthcare and the best interests of a child shall always be paramount. Minorities and the marginalized are also assured of the enjoyment of their rights through affirmative action programmes that ensure they have reasonable access to water, health services and infrastructure under Article 56 (e).

Articles 20 and 21 vests in the state a constitutional obligation to take legislative, policy and other measures, including setting of standards to achieve the progressive realization of the rights guaranteed in Article 43, to domesticate the provisions of any relevant international treaty and convention that Kenya has ratified; and to address the needs of the vulnerable groups in society when allocating resources. The State has a further constitutional obligation under Article 46 of the Constitution to protect consumer rights, including the protection of their health, safety, and economic interests.

Background

To support the realization of the right to health and delivery of Universal Health Coverage (UHC), Parliament enacted the Social Health Insurance Act 2023, the Primary Healthcare Act 2023 and the Digital Health Act, 2023 to strengthen the legal framework for UHC and health financing on 19th October 2023.

These laws together with the Facility Improvement Financing Act 2023 aimed at the ensuring equitable financing and provision of all essential services from preventive, promotive, curative, palliative and rehabilitative health care services. To this end, the Social Health Insurance Act 2023 establishes three funds, namely, the Social Health Insurance Fund and two publicly financed funds, that is, the Primary Health Fund, and Chronic, Emergency and Critical Illness Fund.

While the new laws promise comprehensive benefits, they have faced fair share of challenges with their implementation facing a setback when the High Court (Mabea, Limo and Muganbi, JJ.) on 12th July 2024 declared all the three laws unconstitutional. The Court however, lifted the conservatory orders suspending the implementation of the Social Health Insurance Act paving the way for its implementation from 1st October 2024.

The Court of Appeal stayed the execution of the High Court's judgement declaring the Social Health Insurance Act (SHIA) unconstitutional until the case is heard and determined. In arriving at this determination, the Court considered the fact that the SHIA had been in effect for 9 months and that the National Health Insurance Fund (NHIF) was technically inoperable and could not be revived by a simple revocation of Section 54 of SHIA, which repealed the NHIF Act.

Denying the stay would, in the Court's view, leave Kenya without a national health insurance framework. To mitigate irreversible government action towards implementing the SHIA on account of the stay, the Court has ordered that the hearing of the matter be expedited.

Against this backdrop, ICJ Kenya undertook a review of the enacted laws with the view of strengthening the legal framework for UHC and health financing through engagement of stakeholders in the health sector to agitate for a more progressive rights framework. On the basis of the review, ICJ Kenya also expected to propose amendments to the impugned legislation and make recommendations to legislators and policymakers to improve health law and policy reforms towards enhancing the right to health.

Review goal and objectives

The goal of the review was to undertake an analysis of the recently enacted health laws and regulations that seek to strengthen the legal framework for Universal Health Coverage (UHC) and health financing in Kenya. On the basis of the review, ICJ Kenya would engage stakeholders in the health sector on the laws; agitate for a more progressive rights framework; propose amendments to the legislations; and make recommendations to policymakers to improve health policy and legislative reforms towards enhancing the right to health. Specifically, the review aimed to:

1. Review and produce an overview of the Social Health Insurance Act 2023, Primary Healthcare Act 2023, Facility Improvement Financing Act 2023, Digital Health Act 2023, and the Social Health Insurance (General) Regulations 2024

2. Assess the consistency of the Social Health Insurance Act 2023, Primary Healthcare Act 2023, Facility Improvement Financing Act 2023, Digital Health Act 2023, and the Social Health Insurance (General) Regulations 2024 with human rights norms, standards, principles and the capacity of institutional mechanisms put in place to ensure the implementation and enforcement of the right to health as guaranteed in the Constitution of Kenya.

3. Interrogate provisions within the laws and regulations that undermine or have the potential to undermine human rights norms, standards, and principles; distribution of health functions between the national and county governments; and gender and social equity in health.

4. Interrogate gaps in the laws and regulations and potential challenges that might be faced during their implementation and highlight the implications of the above-mentioned laws and regulations to the general public.

5. Give recommendations and propose amendments to the laws and regulations.

6. Enhance public awareness of the implications of the laws and regulations.

7. Engage relevant stakeholders in the health sector on the laws and regulations, to agitate for a more progressive right to health legal and policy framework in Kenya.

Methodology

The review adopted a qualitative approach involving mainly literature review and participatory stakeholder workshops. The literature review involved a critical analysis of relevant literature including the recently enacted health laws (the Social Health Insurance Act 2023, Primary Healthcare Act 2023, Facility Improvement Financing Act 2023, Digital Health Act 2023, and the Social Health Insurance (General) Regulations 2024) and other relevant policy and legal documents, reports, case studies, journal articles, books, and other secondary information

from multiple sources including databases, open sources, websites, and targeted web browser searches. Evidence synthesis and policy analysis techniques were used to establish evidence on the emerging gaps, challenges or issues of concern with the enacted health laws.

Participatory stakeholder workshops were used to facilitate health sector stakeholder engagement workshops and forums on the findings and recommendations of the review and to agitate for a more progressive right to health. The forums were also used to enhance public awareness of the implications of the laws and regulations. The comments and feedback received from the stakeholder workshops and forums fed into the revision and finalization of the report and proposals for amendments to the legislation and policy reforms.

The qualitative information gathered from secondary sources and workshop deliberations was organized, summarized and categorized according to source themes and objectives of the review. At the interpretation stage, the findings derived from various data sources was packaged into a comprehensive report including findings, recommendations and proposals for amendments presented to key stakeholders.

UNIVERSAL HEALTH COVERAGE (UHC)

The concept of Universal Health Coverage (UHC) has gained widespread political support as part of the global Sustainable Development Goals (SDG) agenda. The World Health Organization (WHO) describes UHC as *"all people have access to the full range of quality health services they need, when and where they need them, without financial hardship."* [1]

Both the Social Health Insurance Act, No. 16 of 2023 and Primary Healthcare Act No. 13 of 2023 define UHC as "all individuals and communities receive the health services they need including the full spectrum of essential, quality health services from health promotion to prevention, treatment, rehabilitation, and palliative care without suffering financial hardship."

UHC has three dimensions: population coverage; services covered; and financial protection. UHC programs seeks to ensure that all individuals and communities can access the essential services they need for their health and wellbeing through a single unified benefit package, without suffering financial hardship and the risk of financial catastrophe or hardship.[2]

Broadly Kenya has evolved a supportive constitutional, legal and policy environment for the pursuit of the universal health coverage agenda. In this regard, the Constitution of Kenya (CoK) 2010, the Health Act 2017, the Social Health Insurance Act 2023, the Primary Health Care Act 2023 and the Digital Health Act 2023 provide the basic legal framework for UHC.

These instruments aim to ensure that all individuals and communities receive the health services they need through the health system. The SDG 3, which aims to ensure healthy lives and promote well-being for all at all ages by reducing the burden of priority diseases, reducing mortality, ensuring universal access to sexual and reproductive health care services is to be tracked using two indicators, namely coverage of essential health services (SDG 3.8.1); and catastrophic health spending (and related indicators) (SDG 3.8.2).

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[1] WHO (2024), Universal health coverage (UHC). Geneva: World Health Organization; 2024 (https://www.who.int/news-room/fact-sheets/detail/universal-health-coverage-(uhc))

[2] The UHC Policy Brief, available at https://www.health.go.ke/wp-content/uploads/2019/01/UHC-QI-Policy-Brief.pdf (accessed 23.04.2022)

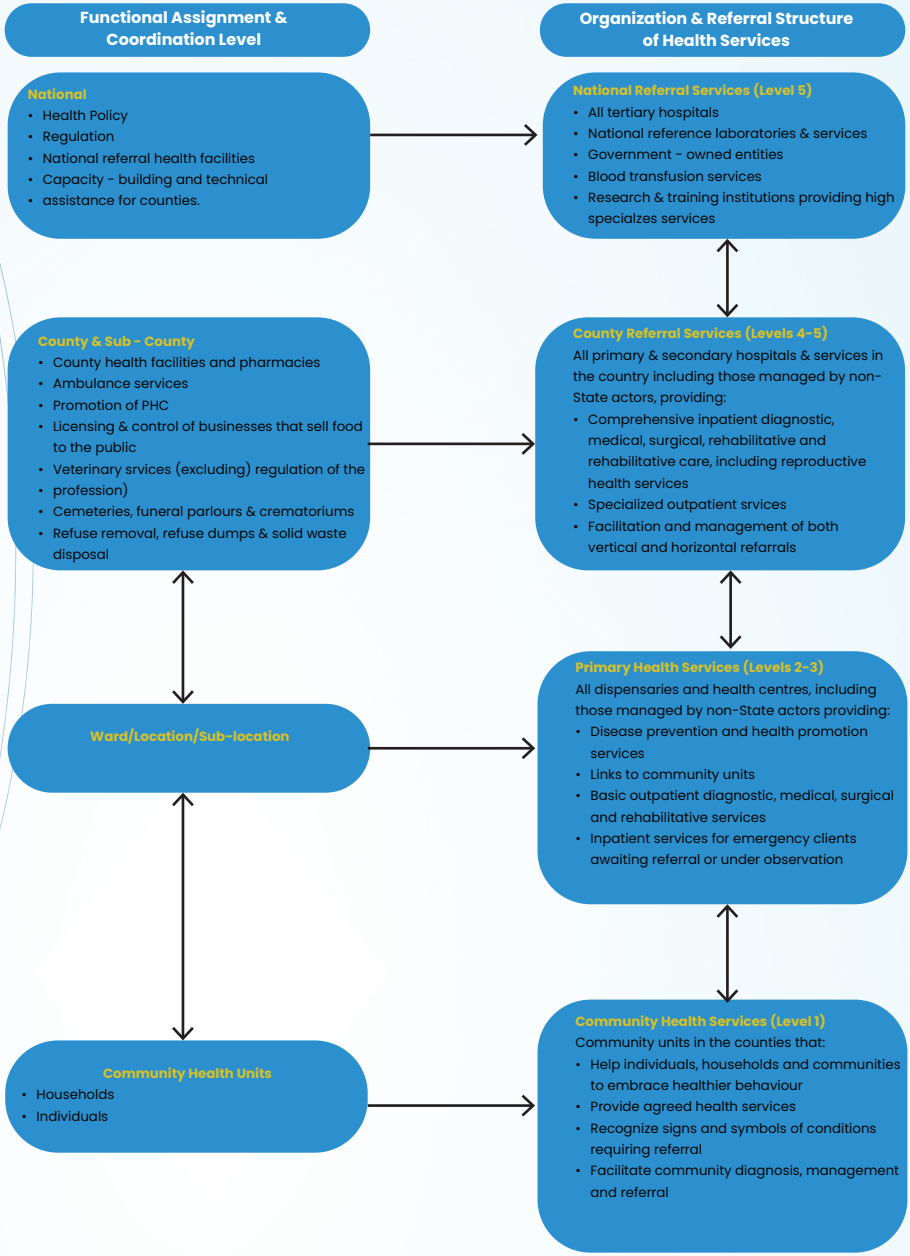
The Kenya Health Policy 2014 – 2030 goal is to ensure universal coverage of critical essential packages of services that positively contribute to the progressive realisation of the right to the highest attainable standards of health including health care, reproductive health and emergency medical services guaranteed under Article 43 of the Constitution of Kenya.

Despite enabling policy and legal environment, the key threats to achieving universal health coverage remain poverty, inequality, unemployment, job insecurity, inadequate human resources and financing against the triple burden of neonatal, communicable and non-communicable diseases.

Health Service Delivery Framework for UHC

The Health Act 2017 establishes a unified health system which encompasses public and private health service providers. Health services in Kenya are provided across the six levels of service delivery structure technically classified under the First Schedule to the Health Act, 2017. These include Level 1: Community Health Services; Level 2: Dispensary/Clinic; Level 3: Health Centre; Level 4: Primary Hospital; Level 5: Secondary Hospital; and Level 6: Tertiary Hospital. The first five levels (Levels 1-5) are managed within the county health system while the sixth level is managed by the national government within the national health system. Within the health service delivery system, the patients may move from one level to the next by using a referral letter.

Figure 1: Organization and function structure of health service delivery in Kenya



Source: Adapted from Kenya Health Policy 2014–2030

ACHIEVING UNIVERSAL HEALTH COVERAGE THROUGH SOCIAL HEALTH INSURANCE

The Government of Kenya has committed to accelerating attainment of Universal Health Coverage (UHC). UHC aims at ensuring that all Kenyans access and receive essential quality health services without suffering financial hardship. These services include promotive, preventive, curative, rehabilitative and palliative health services.

Attaining UHC is thus considered critical to addressing the high burden of communicable conditions, a rising burden of non-communicable conditions, and cushioning the health system from emerging and re-emerging disease outbreaks and changing demographic patterns. Out-of-pocket payments (OOP) for health services also remain a major financial barrier to accessing health services and exposes households to catastrophic health expenditure.

To address these challenges and accelerate progress towards UHC, there is a general consensus that social health insurance offers an organisational mechanism for raising and pooling funds to finance health services, along with tax-financing, private health insurance, community insurance, and others.[3] Besides health financing, UHC implies putting in place efficient health service delivery systems, adequate health facilities and human resources, information systems, good governance and enabling legislation.

According to WHO health systems framework, the objectives of social health insurance include:

- Improving health and reducing health inequalities;
- Being responsive to people's expectations;
- Ensuring fairness of financing; and renewing Primary Health Care, of which the search for universal coverage is one of the core principles.[4]

In addition, SHI is considered to:

- Be a way of mobilizing additional domestic resources for health;
- Allow organizational change for improved health system quality and efficiency (e.g. purchaser-provider splits, new provider payment mechanisms); and
- Extend financial risk protection to more people, or provide greater levels of protection to those already with coverage (e.g. replacing out-of-pocket spending with some form of prepayment, switching from private health insurance to SHI, at least for a basic package of health services). This is seen as a way of allowing more people to use needed services without incurring high out-of-pocket payments, effectively moving closer to universal coverage.[5]

In Kenya, the government has since 2017 made a strong commitment to achieve universal health coverage. Universal Health Coverage (UHC) is particularly an integral part of the Bottom-up Economic Transformation Agenda (BETA), which underscores the significance of social health insurance in achieving the UHC goals.

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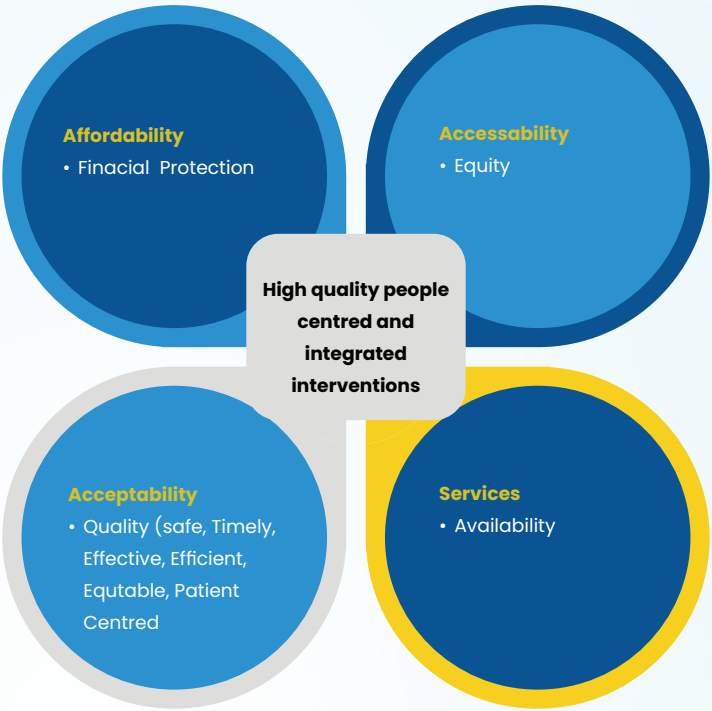
[3] World Health Organization. The World Health Report 2008. Primary health care: now more than ever. Geneva: WHO, 2008

[4] World Health Organization. The World Health Report 2008. Primary health care: now more than ever. Geneva: WHO, 2008

[5] Ole Doetinchem, Guy Carrin and David Evans (2010), Thinking of introducing social health insurance? Ten questions, World Health Report (2010) Background Paper, No 26, WHO. https://cdn.who.int/media/docs/default-source/health-financing/technical-briefs-background-papers/26_10q.pdf?sfvrsn=bbee2c2c_3&download=true

The goal of the Kenya UHC Policy 2020 - 2030 is "to ensure all Kenyans have access to essential quality health services without suffering financial hardship as shown in Figure 2 below.

Figure 2: Aspiration of Universal Health Coverage



Source: MOH, Kenya UHC Policy 2020-2030

Towards social health insurance scheme

Kenya's attempts to implement UHC dates back to early 2000s, when the government considered mandatory health insurance with a package of care defined in 2004, but it was never adopted (Künzler 2016). Building on the earlier efforts, the government started in earnest in 2017 designing and implementing priority health financing reforms to accelerate progress towards UHC. These reforms included:

a. Increasing the share of (mandatory) pooled resources through a health insurance-based mechanism built on the existing National Health Insurance Fund (NHIF);
b. Enhancing the capacity of the NHIF to function as a strategic purchaser of health services;
c. Expanding coverage of health services equitably through an emphasis on primary healthcare; and
d. Improving public financial management arrangements to enhance effectiveness of public funds in the devolved health sector.

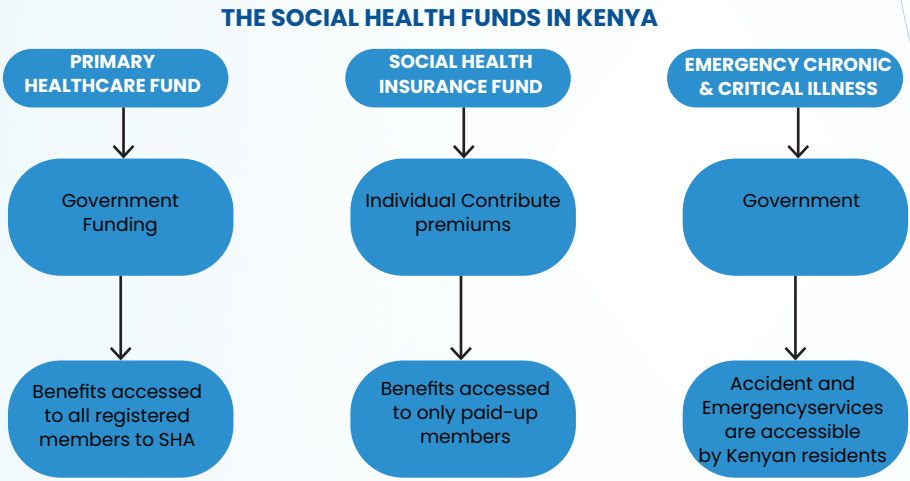
Specifically, the National Hospital Insurance Fund (NHIF) Act, 1998 (now repealed) was amended to provide for the establishment of the National Health Insurance Fund (the Fund); the National Health Insurance Fund Management Board (the Board); and mechanisms of contributions to and

the payment of benefits out of the Fund. Section 5(1) (g) of the NHIF Act provided that one of the objects of the National Health Insurance Fund Management Board was to facilitate attainment of universal health coverage with respect to health insurance.

Section 15 (1B) of the NHIF Act as amended made the national government liable as a contributor to the Fund on behalf of the indigent and vulnerable persons identified as such by the relevant government body. The NHIF Act defined "indigent" as a person who is poor and needy to the extent that the person cannot meet their basic necessities of life. It also defined vulnerable person as a person who is in need of special care, support or protection, including the orphaned and vulnerable children, widows or widowers, person with disability, elderly persons or indigent due to a risk of abuse or neglect and who has been identified as such by the relevant government body. The NHIF Act made contributions mandatory for citizens aged 18 years and above, except those listed as dependents.

Although the National Health Insurance Fund (NHIF) originally established in 1966 played a pivotal role in financing healthcare in the country, it was designed to cover citizens with a regular income. Consequently, it excluded a significant portion of the population from obtaining health insurance and even when it expanded coverage to the informal sector, there was low uptake. In 2022, only three (3) out of every ten (10) citizens were covered under NHIF.[6] To overcome the implied gaps and to accelerate progress towards UHC, Parliament enacted the Social Health Insurance Act 2023, the Primary Healthcare Act 2023 and the Digital Health Act, 2023 to strengthen the legal framework for universal health coverage. These laws together with the Facility Improvement Financing Act 2023 aimed at ensuring equitable financing and provision of all essential services from preventive, promotive, curative, palliative and rehabilitative health care services. To this end, the Social Health Insurance Act 2023 establishes three funds, namely, the Social Health Insurance Fund, the Primary Health Fund, and Chronic, Emergency and Critical Illness Fund as shown figure 3 below.

Figure 3: Health funds established under the Social Health Insurance Act, 2023



Source: MOH and Social Health Authority (SHA), Optimized Benefits Package Tariffs, September 2024

[6] KIPPRA (2024), Implementing Social Health Insurance in Kenya, June 30, 2024. https://kippra.or.ke/Implementing Social Health Insurance in Kenya – KIPPRA

The Social Health Insurance (General) Regulations 2024 were published to operationalize the Social Health Insurance Act and the Funds.

The object of these Regulations is to give effect to the provisions of the Social Health Insurance Act by facilitating the enforcement of mandatory registration of every person resident in Kenya pursuant to section 26(1) of the Act, and access to the highest attainable standard of health care. The Regulations apply to –

- Implementation of the Primary Healthcare Fund;
- Implementation of the Social Health Insurance Fund;
- Implementation of the Emergency, Chronic and Critical Illness Fund;
- Empanelment and contracting of healthcare providers and health facilities;
- Benefits accruing to contributors and their beneficiaries;
- Determination of the tariffs applicable;
- Procedures for settlement of claims; and
- Processes and services under the Act.

The Social Health Insurance legislation aims at ensuring all individuals and communities receive the health services they need, including the full spectrum of essential, quality health services from health promotion to prevention, treatment, rehabilitation, and palliative care without suffering financial hardship, and improving the quality of life for all citizens by providing equitable, accessible, affordable, and high-standard healthcare.

Implementation challenges of the social health insurance legislation

The implementation of Social Health Insurance Act 2023 enacted in October 2023 faced a setback when the High Court declared the Act unconstitutional following a petition dated 24/11/2023. In the case of Aura v Cabinet Secretary, Ministry of Health & 11 others [2024] eKLR,[7] the Petitioner, Joseph Enock Aura, challenged the constitutionality of the Social Health Insurance Act, 2023 alongside the Primary Health Care Act, 2023 and the Digital Health Act, 2023 and sought various reliefs, including a declaration of their unconstitutionality and nullification. The Petitioner: -

a. Challenged the constitutionality of sections 26(5) and 27(4) of Social Health Insurance Act (SHIA) on grounds that the impugned provisions locked out people from accessing emergency medical treatment contrary to Article 43 (2) of the Constitution; that section 26(5) would limit the right of citizens to access public services as provided for under Articles 6(3) and 12(1) of the Constitution and that withholding public services at both national and county levels from unregistered and unpaid members would infringe upon Article 174 of the Constitution; that Section 26(5) making registration of people a prerequisite to accessing public services infringed on the economic and social rights to those unregistered under Article 43 of the Constitution; that section 26(5) of SHIA violated the right to life protected under Article 26(1) of the Constitution; and that section 27(4) of SHIA breached Article 43(2) by restricting access to health services solely to registered and paid-up members

[7] Aura v Cabinet Secretary, Ministry of Health & 11 others; Kenya Medical Practitioners & Dentist Council & another (Interested Parties) (Constitutional Petition E473 of 2023) [2024] KEHC 8255 (KLR) (Constitutional and Human Rights) (12 July 2024) (Judgment), [2024] KEHC 8255 (KLR)

b. Argued that the requirement of Section 47(3) of SHIA for active and up to date contribution as a precondition to access health care services posed a threat to the constitutional right of citizens to access emergency health care; that it violated the right to health by requiring every Kenyan to be uniquely identified using biometrics for provision of health services; and that it was unconstitutional because it required Kenyans to undergo digitization through unique biometrics and that the provision relied on sections 5(1)(g) and 5(1)(ha) of the Registration of Persons Act, which had since been declared unconstitutional by the Court.

c. Contended that section 38 of SHIA, as currently enacted and significantly amended from the original Bill, violated the principles of public finance as enunciated in Article 201 of the Constitution. These guiding principles of public finance encompassed openness, accountability, public participation in financial matters, the promotion of an equitable society, the prudent and responsible use of public funds and clear, responsible financial management and fiscal reporting.

d. Raised concerns about section 26(3) of SHIA, alleging it could facilitate the exploitation of children by requiring digital registration for those born after the legislation's enactment.

e. Objected to additional provisions introduced into the Act without undergoing public participation, specifically highlighting sections 26(6), 26(7), and section 38 thereof.

f. Criticized the Primary Health Care Act (PHCA), 2023 for being overly prescriptive towards counties and for assigning healthcare responsibilities to untrained Community Health Promoters.

g. Decried the process of enactment of the impugned Acts for being in contravention with sections 5,6,8,9 and 11 of the Statutory Instruments Act. Section 5 of the Act provides for consultation before making statutory instruments in certain cases; section 6 for regulatory impact statements; section 8 for notification of regulatory impact statements; section 9 where regulatory impact statements may be unnecessary and section 11 requires laying of statutory instruments before Parliament.

h. Decried the inadequate time allocated for public participation and the short notice provided for submission of memoranda by the National Assembly and the Senate with regards to the Primary Health Care Act (PHCA) and Digital Health Act (DHA), and not conducting any public participation engagements in the national language, that is, Kiswahili, contrary to Article 7(1) of the Constitution.

The Council of Governors (COG) in support of the petition submitted that sections 26(5), 27(1)(a) and 47(3) of SHIA were unconstitutional and unlawful and that Section 26(5) required proof of compliance with the Act as a precondition to access public services from the government which jeopardizes fundamental rights. The COG also submitted that the provision was an affront to the Fourth Schedule of the Constitution which assigns functions to the National and County Governments.

The Commission on Revenue Allocation acknowledged that the impugned Acts, specifically under section 27(1)(d) and 27(2) of SHIA, as well as section 16(c) of the PHCA, contained provisions concerning financial matters affecting counties yet the Commission was not consulted to provide recommendations for consideration by both houses of Parliament.

The petitioner therefore sought a declaration of Sections 26(5), 27(1)(a), 27(4), 38, and 47(3) of the Social Health Insurance Act, 2023 as unconstitutional, null and void to the stated extent; and the entire Social Health Insurance Fund Act, 2023, the entire Digital Health Act, 2023 and the entire Primary Health Act, 2023 invalid having been enacted without complying with the mandatory requirements of the Statutory Instruments Act and effective, tangible and mandatory public participation as prescribed and required under Articles 10(2) (b) and 118(b) of the Constitution of Kenya and are all therefore null and void.

The Respondents, in turn, argued that the enactment of the impugned statutes was necessary by citing the overarching need to breathe life to Article 43(1)(a). They also argued that Article 24 of the Constitution pertaining to limitations of rights and fundamental freedoms was justified. The Respondents took the position that:

a. The state is obligated to take progressive measures to realize the rights under Article 43.

b. SHIA was enacted to establish the framework for managing social health insurance, providing for the establishment of the Social Health Authority, and giving effect to Article 43(1)(a) of the Constitution of Kenya and that UHC cannot be realized through voluntary contribution and that with that realization, legislative measures to sanction or compel compliance was necessary.

c. The limitation of rights was justified citing the provisions of Article 24 of the Constitution on the limitation of rights and fundamental freedoms.

d. Public participation was thoroughly conducted in the enactment of the 3 impugned Acts, involving the Ministry of Health, the National Assembly, and the Senate, with a focused engagement on targeted stakeholders, thereby ensuring robustness in the engagements

e. The concept of mandatory health insurance for all citizens is rooted in the principles of solidarity and universality. These are aimed at spreading risks across the entire population to enable access to essential healthcare services and prevent "free riding." Thus, a mandatory health insurance scheme would ensure stable funding, promote preventive care, reduce public financial burdens, and provide equitable access to medical care.

f. Despite concerns over section 26(5) of SHIA, no constitutional rights would be violated, supporting the unique identifier's role in enhancing privacy, confidentiality, and fraud prevention.

g. Regarding the PHCA, community health promoters are vital in supporting healthcare workers to implement preventive and promotive health strategies.

From the foregoing, the Court (A Mabeya, RK Limo & FG Mugambi, JJ) held as follows: -

a. That it was clear that some rights would be limited and their enjoyment pegged on compliance with the impugned Acts. In particular section 26(5) set compliance with the Act as a precondition to accessing services both at county and national government. The section provides that a person not compliant could be denied access to public services.

b. That considering the primary objective of the 3 legislations, which is to give effect to Article 43(1)(a) of the Constitution, there was evidence that the former legal framework (NHIF) failed to realize those rights and in any event, continued voluntary contribution was unsustainable.

c. That the former legal framework under NHIF based on the evidence on record showed lack in the principle of solidarity. It was therefore evident that unless some sort of compulsion or sanction is applied, then the realization of the rights under Article 43(1)(a) will be a mirage. In this regard the objectives of Sections 26(5) and 27 of SHIA are noble aimed at bringing solidarity and equity in terms of subscription and contribution to the Social Health Insurance Fund (SHIF) and at the same time ensuring that the benefits are spread across the population, which is both sustainable and a reality.

d. That applying the principles for limitation under Article 24 on the reasonableness, the nature of the right, the extent of the limit and the proportionality as proposed limitation under Article 6(3) and 12(1) is reasonable, justifiable and proportionate.

e. That to the extent that section 26(5) and 27(4) of SHIA have not made exception to the right to emergency medical services, the same cannot stand the test of constitutionality. They offend Article 43(2) of the Constitution because the precondition set out in those 2 provisions infringe on the right to access to emergency services on one hand while it is the same right that the state aspires to realize with the impugned Acts.

The import of the impugned provisions would mean that if a person is rushed to hospital in whatever state, including an unconscious state, he/she will only access emergency treatment upon proof of compliance. The right to life and emergency services should have and ought to have been shielded and to the extent that the provisions did not shield or exempt the right to emergency treatment set out in article 43(2) they are unconstitutional.

f. That the Social Health Insurance Fund, the Primary Health Fund and Emergency Care Insurance Fund are all clearly and unambiguously established under sections 25, 20 and 28 of the Act respectively.

g. That the current section 38 of SHIA was introduced without the benefit of public participation and ignored a key principle under Article 201(a) which emphasizes on the need for openness, accountability and public participation in financial matters. The provisions of Article 201 of the Constitution must be understood and interpreted against a histography of the Kenyan society.

The drafters of the Constitution were certainly intent in representing a departure from a past where public financial matters were a preserve of closed dialogue in opaque rooms only rubberstamped by Parliament. Section 38 in our view therefore fails the test under Article 201(a) of the Constitution and is therefore unconstitutional.

h. That although the objectives and purpose of the impugned legislations were to have progressive, transformative and a huge impact in the realization of universal healthcare for this country, the haste with which they were enacted infringed on the national values and principles of the Constitution.

In as much as we appreciate the noble intention, we cannot disregard the clear constitutional tenets which bind us. Article 20 requires us to promote and protect the values that underlie an open and democratic society and the spirit, purports and objects of the bill of rights.

Overall, the Court being cognizant of the importance of the impugned Laws and the input that went into their enactments and recognizing the purport of the enactments as far as realization of the rights under Article 43 of the Constitution is concerned, decided to give Parliament an opportunity to redeem itself and save the Laws.

The Court found that the breaches that tainted the Laws were redeemable and therefore could be corrected. Accordingly, the court found the petition meritorious and allowed it under the following terms: -

a. That Parliament undertakes sensitization, adequate, reasonable, sufficient and inclusive public participation in accordance with the Constitution before enacting the said Acts and amending the unconstitutional provisions in terms of the Court's judgment.

b. That compliance with (a) above be undertaken within 120 days of the date of the judgment.

c. That within that period, the Acts shall remain suspended.

d. That in default of (a) and (b) above, on 10/11/2024, the following relief shall take effect forthwith - i. A declaration is hereby issued that the entire Social Health Insurance Fund Act, 2023; the entire Digital Health Act, 2023 and the entire Primary Health Act, 2023 are all unconstitutional for the reasons set out in this Judgment and therefore invalid, null and void.

The Court (A Mabeya, RK Limo & FG Mugambi, JJ)[8] on 12th July 2024, however, lifted the conservatory orders suspending the implementation of the Act, paving way for the rollout of the Social Health Insurance Fund from 1st October 2024. implementation.

In allowing a temporary stay of the suspension for 45 days as requested, the Court appreciated the concerns raised by the respondents with the order for suspension which may create a lacuna on matters health in this country even as parties seek to comply with the judgment. The stay granted however did not affect the suspension of sections 26 (5) and 27 (4) of SHIA in light of the Court's finding on their unconstitutionality.

REVIEW OF THE ENACTED LAWS FOR UNIVERSAL HEALTH COVERAGE AND HEALTH FINANCING

The goal of the review was to analyze the recently enacted health laws and regulations that seek to strengthen the legal framework for Universal Health Coverage (UHC) and health financing in Kenya. Specifically, the review aimed to review and produce an overview of the Social Health Insurance Act 2023, Primary Healthcare Act 2023, Facility Improvement Financing Act 2023, Digital Health Act 2023, and the Social Health Insurance (General) Regulations 2024. This also involved assessment of the consistency of the laws with human rights norms, standards, principles and the capacity of institutional mechanisms put in place to ensure the implementation and enforcement of the right to health as guaranteed in the Constitution of Kenya. In addition, the review has looked at the Court findings in the Aura v Cabinet Secretary, Ministry of Health & 11 others [2024] eKLR Petition.[9]

[8] Aura v Cabinet Secretary, Ministry of Health & 11 others; Kenya Medical Practitioners & Dentist Council & another (Interested Parties) (Constitutional Petition E473 of 2023) [2024] KEHC 8255 (KLR) (Constitutional and Human Rights) (12 July 2024) (Judgment), [2024] KEHC 8255 (KLR)

[9] Aura v Cabinet Secretary, Ministry of Health & 11 others; Kenya Medical Practitioners & Dentist Council & another (Interested Parties) (Constitutional Petition E473 of 2023) [2024] KEHC 8255 (KLR) (Constitutional and Human Rights) (12 July 2024) (Judgment), [2024] KEHC 8255 (KLR)

Review of the Social Health Insurance Act, 2023

The Social Health Insurance Act No. 16 of 2023 ("SHIA") establishes the framework for the management of social health insurance; provides for the establishment of the Social Health Authority; and gives effect to Article 43(1)(a) of the Constitution of Kenya. The Social Health Insurance Act, 2023 repealed the longstanding 58-year-old National Hospital Insurance Fund (NHIF) to introduce Social Health Insurance. The primary aim of the Act is to promote the implementation of universal health coverage by ensuring all individuals and communities receive the health services they need, including the full spectrum of essential, quality health services from health promotion to prevention, treatment, rehabilitation, and palliative care without suffering financial hardship.

The objectives of the Social Health Insurance Act, 2023 are to:

- Provide a framework for improved health outcomes and financial protection in line with the right to health and universal health coverage;
- Realign healthcare systems, processes and programs for responsiveness, reliability and sustainability of health care in Kenya;
- Enhance the pooling of resources and risks based on the principles of solidarity, equity and efficiency so as to guarantee access to health care services to all; and
- Promote strategic purchasing of healthcare services.

General Comment

The SHIF Act is well intended to provide the means for attaining universal health coverage and ensuring that all Kenyans have access to affordable and comprehensive quality health services towards realization of the right health guaranteed under Article 43 (1) (a) and (2) of the Constitution of Kenya.

The right to health is closely connected to other human rights such as access to safe and clean drinking water, a clean and healthy environment, access to education, access to information, adequate housing and reasonable standards of sanitation, social security and protection and safe working conditions. Hence the social determinants of health must be addressed as well to guarantee health rights.

Broadly the three funds established by the SHIA 2023 are intended to enhance benefits and services covering a broader spectrum of treatments and medical interventions and to respond to beneficiaries' diverse healthcare needs.

The funds include the Primary Healthcare Fund, the Social Health Insurance Fund (SHIF), and the Emergency, Chronic, and Critical Illness Fund.

- Primary Healthcare Fund: covering services like screening for common health issues, routine physical examinations and education that promotes health and health seeking behavior.
- Social Health Insurance Fund: the core fund with mandatory registration and contributions covering most disease areas based on established tariffs; and

- Emergency, Chronic and Critical Illness Fund: covering the cost of management of chronic illnesses, once the SocHI cover is exhausted.

Table 1 below presents the assessment of the issues, gaps, implications and recommendations for improvement of the Social Health Insurance Act, 2023.

Table 1: Assessment of the issues, gaps, implications and recommendations for improvement of the Social Health Insurance Act, 2023

Provisions of the SHIA	KEY ISSUES AND GAPS			Comments on implications for implementation	Recommendations & proposals for amendments
	Human rights norms, standards and principles	Distribution of functions, between National and county governments institutional capacity	Gender and social equity		
Section 2 (d) "beneficiary" means a person who - is a person with disability and is wholly dependent on and living with the contributor	As a mandatory scheme, this definition will potentially violate the rights of PWDs guaranteed under Article 43 and 56 of the Constitution by excluding the PWDs who - are neither wholly dependent on nor living with the contributor who are not up to date or active; who are not registered by the National Council for Persons with Disabilities; or who by themselves are not up to date with their own contributions or are not active from accessing health care including emergency medical treatment under SHIF, PHCF and/or ECCIF from the national government, county government or a national or county government entities.	The limitation or exclusion clauses under Sections 26, 27 and 28 apply to both national and county governments and entities in exercising their powers and functions under the Fourth schedule and their duties/obligations under Articles 43, 56, 20 and 21 of the Constitution • 26 (5) states that any person who is registerable as a member under this Act shall produce proof of compliance with the provisions of this Act on registration and contribution as a precondition of dealing with or accessing public services from the national government, county government or a national or county government entities	The definition of beneficiaries, vulnerable persons and the exclusion criteria provided under Sections 26 and 27 of the SHIA are potentially in contradiction with principles of gender and social inclusion and affirmative action envisioned under Articles 10 (2)(b), 21(3), 27 and 56 (e).	Given the mandatory nature of the SHIF and the liability assigned to failure to contribute and keep up to date (section 27), the application of the definitions is potentially problematic especially with regards to enabling or protecting the rights of PWDs and vulnerable persons/groups who are either not wholly dependent on or are not living with up to date or active contributors to accessing health care including emergency medical treatment they need	The definition of the beneficiaries including persons with disabilities and vulnerable persons should be aligned with Articles 21 (3), 27, 56, 54, and 260 of the Constitution to ensure PWDs and the vulnerable persons/groups enjoy to the greatest possible extent, their rights to highest attainable standards of health care and emergency treatment guaranteed under Articles 43 (1) (a) and (2) and 56(e) of the Constitution.

		• Section 27 (4) - A person shall only access healthcare services under this Act where their contributions to the Social Health Insurance Fund are up to date and active • Section 28(a) (b) - There is established a Fund be known as the Emergency, Chronic and Critical Illness Fund to— (a) defray the costs of management of chronic illnesses after depletion of the social health insurance cover and (b) to cover the costs of emergency treatment		under SHIF, PHCF and/or ECCIF.	
Section 2 defines "vulnerable person" as a person who needs special care, support or protection, including the orphaned and vulnerable children, widows or widowers, person with disability, elderly persons or indigent due to a risk of abuse or neglect and who has been identified as	As a mandatory scheme, this definition will potentially violate the rights of vulnerable and marginalized groups (Articles 21 (3) and 27 and 260 of the Constitution) guaranteed under Article 43, 27 and 56 of the Constitution by excluding the vulnerable and marginalized groups who - are neither wholly	• Article 21 (3) which provides that "All State organs and all public officers have the duty to address the needs of vulnerable groups within society, including women, older members of society, persons with disabilities, children, youth, members of minority or marginalised communities, and			

such by the relevant government body	dependent on nor living with the contributor who are not up to date or active from accessing health care including emergency medical treatment under SHIF, PHCF and/or ECCIF from the national government, county government or a national or county government entities. • Article 21(3) provides that "All State organs and all public officers have the duty to address the needs of vulnerable groups within society, including women, older members of society, persons with disabilities, children, youth, members of minority or marginalised communities, and members of particular ethnic, religious or cultural communities". • **Article 260** defines "marginalised group" as a group of people who, because of laws or practices before, on, or after the effective date, were or are disadvantaged by	members of particular ethnic, religious or cultural communities" • Article 27(6) vests in the State the duty to take legislative and other measures, including affirmative action programmes and policies designed to redress any disadvantage suffered by individuals or groups because of past discrimination • Article 56 (e) - the State shall put in place affirmative action programmes designed to ensure that minorities and marginalised groups—(e) have reasonable access to water, health services and infrastructure			

	discrimination on one or more of the grounds in Article 27 (4). • Article 27 (4) provides that the State shall not discriminate directly or indirectly against any person on any ground, including race, sex, pregnancy, marital status, health status, ethnic or social origin, colour, age, disability, religion, conscience, belief, culture, dress, language or birth.				
Sections 5 and 6 on the functions and powers of the Social Health Authority		• The Section 5&6 provisions do not provide for the Social Health Authority's engagement and consultation with the county governments even though 26 (5) identifies county governments and county government entities as public service providers. • The mere representation of the county governments through the representatives from the County Executive Committee Health Caucus and COG in the SHA Board doesn't		The non-alignment of the SHA with the constitutional principles, objects and structure of devolved government presents a potential risk of conflict between the County Governments and SHA in the implementation of the Act.	• The powers and functions of SHA need to be aligned with the constitutional principles of governance and functional assignment between national and county governments under Articles 6, 10, 174, 186 and 189 and the Fourth Schedule of the Constitution

		health care" as essential health care based on practical, scientifically sound and socially acceptable methods and technology that is made universally accessible to individuals and families in the community at levels 1, 2 and 3 of health services, to meet their health needs at every stage of the life cycle, with their full participation and at an affordable cost to the community and the county		system, structure of the PHCF excludes Level 1 services. This undermine access to provision of promotive, preventive, rehabilitative and palliative care services	palliative care including family and home-based care and rehabilitation and referrals • Section 21 (c) should be amended to make clear that the fees or levies contemplated refer to purchase of services by SHIF from Levels 2 and 3 and that it does not imply that patients will be required to pay the said levies or fees. • The Act should be amended to clearly state who is eligible to access primary health care services (Levels 2 &3) given the fact that hitherto to the SHIA, services at this level were free.
Section 25 on sources of the Social Health Insurance Fund. Section 25 (2)(b) provides that there shall be paid into the Fund among others - monies appropriated by the National Assembly for indigent and vulnerable persons.	As a mandatory scheme, the issues is how the indigents and vulnerable persons will be accurately identified to access the cover provided through National Assembly appropriation (Section 25(2)(b). If the system of identification is not gender, socially and disability inclusive, the	• Although Section 2 of the SHIA indicates that "vulnerable person (s)" shall be identified as such by the relevant government body, it does clearly state who the relevant government body is or should be. • The Act does explicitly state the role of CGs including Level Community Health	The appropriateness of the means, criteria and structures used to identify the indigents and vulnerable persons will determine the extent to which the gender and social inclusion and equity objective is achieved through the SHIF	The non-alignment of the SHIF administration with the constitutional principles, objects and structure of devolved government presents a potential risk of conflict between the County Governments and	• The Act should be amended to provide for the role of county governments and community health units in the identification of indigent and vulnerable peoples within the counties for purposes of accessing SHIF. • The identification and targeting of indigents or vulnerable persons to access the funds

	rights of the indigents and vulnerable individuals/persons guaranteed under Article 43, 27 and 56 of the Constitution are likely to be violated or infringed upon especially those who - are neither wholly dependent on nor living with the contributor but who are not up to date or active from accessing health care including emergency medical treatment under SHIF, PHCF and/or ECCIF from the national government, county government or a national or county government entities.	Units in the identification of indigents and vulnerable persons to benefit from SHIF.		SHA in the implementation of the Act.	appropriated by National Assembly should be tested against the provision of sections 27 (1) (a), 26 (5) and 27 (2) (b) of the Act to prevent the exclusion of the indigents and vulnerable persons from accessing healthcare services through SHIF.
Section 26 (1) (5) on registration as a member of the Social Health Insurance Fund.	While section 26 (1) of the Act makes it mandatory for every Kenyan to register as a member of the Social Health Insurance Fund, section 26 (5) states that any person who is registerable as a member under this Act shall produce proof of			The implementation of this provision may pose special challenges to certain vulnerable persons such as those who are of unsound mind, PWDs, street families, child headed households	The Act needs to make clear provision on who is registrable or not registrable under the Act and what constitutes proof of compliance with the provisions of the Act on registration and contribution as a pre-condition of dealing with or accessing public

	compliance with the provisions of this Act on registration and contribution as a precondition of dealing with or accessing public services from the national government, county government or a national or county government entities. Section 26 (5) is potentially discriminatory to those who may not be deemed as registerable or may not be able to produce proof of compliance with the provisions of the Act on registration and contribution			and marginalized communities who may not be able produce proof of compliance with the provisions of the Act on registration and contribution.	services from the national government, county government or a national or county government entities.
Sections 27, 49(2)(4) and 53 on contributions, liability to SHIF. recovery of accrued contributions and penalties as debt and penalty.	• While the objectives of Sections 26(5) and 27 of SHIA appear to be well intended to ensure solidarity and equity in terms of contributions to the Social Health Insurance Fund (SHIF) and spread of benefits across the population, making access to healthcare a liability to households and conditional without exception would	Although Section 27 (5) states that the government shall ensure that premium financing products are provided for non-salaried persons for the payment of social health insurance, it does clearly state who the government is or should be, is it National government, county governments or both.	• Section 27 (1) (a) of SHIA makes every Kenyan household liable contributors to SHIF. Section 27 (6) specifically provides that any person who fails to pay any contribution in respect of any period on or before the day on which payment is due shall be liable to a penalty equal to two percent (2%) of the	• Although section 27 (2) (b) provides that contributions under the Act shall be paid in the case of a household whose income is not derived from salaried employment, by an annual contribution of a proportion of	• The Act should define what government means under the Act • Section 27 should be amended to align with its objective of giving effect to Article 43 and providing a framework for improved health outcomes and financial protection in line with the right to health and universal health coverage (Section 3(a) of the Act.)

	potentially infringe on the indigents and vulnerable persons' right to health care, emergency medical treatment and life guaranteed under Articles 43 and 26 of the Constitution. • Section 27 (4) is unequivocal that a person shall only access healthcare services under the Act where their contributions to the Social Health Insurance Fund are up to date and active. This provision will potentially have the effect of locking out millions of vulnerable Kenyans from accessing healthcare especially in the context of high levels of poverty, dependency, unemployment, casualization of labor and seasonality of incomes, which may impact on households and contributors' ability remain up to date and active with contributions.		amount due for contribution for the period which the contribution remains unpaid and the total annual contributions. Section 27 (7) further provides that a person shall pay all outstanding contributions and penalties accrued before resuming access to the healthcare services provided under this Act. The implications of these punitive provisions are far reaching for poor households, marginalized and vulnerable persons and groups who for some reasons are not able to keep up to date with contributions and cannot immediately access financial assistance contemplated under section 27 (2) (c) of the Act. • The implications of the penalty under Section 27(6) for the poor, vulnerable,	household income as determined by the means testing instrument in the manner prescribed by the Act, it does not define income. This potentially makes administration of the testing instrument a challenge given the fact that there are many households especially in marginalized communities without formal financial income. • The penalty prescribed under section 53 may be too heavy and unrealistic for the unemployed, informal sector workers, low income and poor household contributors, and the vulnerable who may not be able to keep up to date with	• The Act should define what income means under the Act • Review the inclusivity, sensitivity and applicability of the testing instruments in the context of human rights norms and standards in the Bill of Rights. • The means testing should be preceded by risk and vulnerability analysis contemplated by Articles 20 & 21 against Article 43 (1) (a) and (2) • The Act should be amended to provide for the minimum standards of healthcare accessible to all Kenyans irrespective of whether a person is a registered, active or up to date with contributor e.g. emergency medical treatment and primary healthcare services at level 2 and 3. • Amend Section 27 (1) (a) of SHIA to define households and informal sector contributors as eligible rather than liable contributors to SHIF.

	• The means testing may not align with the human rights norms and standards prescribed in the Bill of rights		marginalized, unemployed informal sector and those who may lose income or employment in the course of the year and therefore not able to contribute on a monthly basis or renew their annual contributions resulting in loss of cover and financial catastrophe in accessing healthcare, potential loss of assets and pushing more households and workers in poverty as the accrued penalties and unpaid contributions are recoverable debts to the Fund under Section 49 (2) (4). • Section 27(6) is potentially a killer clause compared a voluntary scheme such as the defunct NHIF where the worst could be just loss of cover but contributors were allowed to rejoin at any time. However, under the SHIF those unable to pay all outstanding	contributions to the fund, or remain active. Section 53 on general penalty A person convicted of an offence under this Act for which no other penalty is prescribed shall be liable to a fine not exceeding 1 million shilling or in the case of a natural person, to imprisonment for a term not exceeding two years, or to both.	Exempt households and informal sector workers from the liability and penalty clauses of the Act.

			contributions and penalties accrued are at risk being permanently locked out of accessing healthcare with potential catastrophic effects impact on the vulnerable and marginalized groups.		
Sections 28, 29, 30, 31 and 32 on the sources and use of Emergency, Chronic and Critical Illness Fund to defray the costs of management of chronic illnesses after depletion of the social health insurance cover and to cover the costs of emergency treatment and regulation.	This provision read together with Sections 27(6)(7) of the Act potentially offends the right of every person to emergency medical treatment guaranteed under Article 43 (2) of the Constitution.	• The Fund does not provide for ambulance services which is presumed to be the responsibility of county governments. This may have the effect of denying those in need access to emergency medical care under the funds. • The role of county governments including county assemblies' appropriation is not identified as sources of funds for the Emergency, Chronic and Critical Illness Fund • Sections 30, 31 and 32 do not require the Cabinet Secretary to consult with COG/county governments in making regulations for	This provision read together with Sections 27(6)(7) of the Act potentially offend the right of pregnant mothers in need of emergency obstetric care.	The fund is only accessible after the exhaustion of the SHIF cover but does not provide a clear mechanism for seamless transition from SHIF to ECCIF.	• The Act or regulations should provide an efficient mechanism to ensure seamless transition from the exhaustion of SHI cover to the onset of ECCIF without requiring prior or further approval. • The SHIF, PHCF and ECCIF should be aligned with the constitutional principles of governance and functional assignment between national and county governments under Articles 6, 10, 174, 186 and 189 and the Fourth Schedule of the Constitution • The Act should provide for inter-governmental mechanism or framework for coordination, cooperation or

		the implementation of the Emergency, Chronic and Critical Illness Fund, defining essential healthcare package and prescribing the tariffs applicable to the benefits package. This offends the principles and objects of devolved government under Articles 6, 174, 186 and the Fourth Schedule and189 of the Constitution			collaboration between SHIF, PHCF and ECCIF and county government specific health funds or health financing mechanisms established within their powers. • Section 30, 31 and 32 of the Act should be amended to provide for the Cabinet Secretary to consult with the COG/county governments in making regulations for the implementation of the Emergency, Chronic and Critical Illness Fund (section 30), defining essential healthcare package (section 31) and prescribing the tariffs applicable to the benefits (section 32)
Sections 33 and 34 on empanelment and contracting		Although county governments are responsible for levels 1-5 health facilities, the Act does not provide a framework for cooperation between SHA and county governments and the role of county governments in the		Ensuring efficient implementation and operations of the SHIF, PHCF and ECCIF without involvement of the county governments will remain a challenge.	Sections 33 and 34 should be amended to provide for the role of county governments and cooperation between SHA and each county government in monitoring and overseeing contract performance

		empanelment and contracting processes			
Section 38 - All receipts, earnings and accruals to the Authority and the balance of the Funds at the close of each financial year shall be retained by the Authority for the purposes of the Funds				The Act does define how and for what the funds retained each financial year by the Authority will be used or applied. This potentially opens avenues of abuse and corruption	Section 38 of the Act should amended to introduce a limitation clause and to provide for the use of the retained funds to waive outstanding contributions and penalties accrued by the household and informal sector contributors unable to clear their outstanding contributions and debts under Section 27(7)) of the Act

The Social Health Insurance Regulations, 2024

The Social Health Insurance (General) Regulations, 2024 ("the Regulations") published on 8th March, 2024 but annulled by the Senate aimed to give effect to and operationalize the Social Health Insurance Act No. 16 of 2023. The objectives of the Regulations were to facilitate the enforcement of mandatory registration of every person resident in Kenya pursuant to section 26(1) of the Act; and access to the highest attainable standard of health care. The Regulations applied in respect to –

- Implementation of the Primary Healthcare Fund; and
- Implementation of the Social Health Insurance Fund;
- Implementation of the Emergency, Chronic and Critical Illness Fund;
- Empanelment and contracting of healthcare providers and health facilities;
- Benefits accruing to contributors and their beneficiaries;
- Determination of the tariffs applicable;
- Procedures for settlement of claims; and
- Processes and services under the Act.

Broadly the issues and gaps identified in relation to the principal Act, the Social Security Act, 2023 apply to the Regulations. In addition, the FIRST SCHEDULE FORM 1 on application for registration under employment type (only provides for four types of employment EMPLOYED, SELF-EMPLOYED, SPONSORED & ORGANISED GROUP).

The form does not provide a choice on unemployed. It would otherwise appear that the unemployed should not apply for registration or are barred from applying for registration for Social Health Insurance. This potentially discriminates the unemployed contrary to Article 10 of the Constitution. The applicants are also only identified with the primary healthcare network and not existing community health units.

The primary healthcare networks are not functionally linked to the established Level 1 community health units (First Schedule to the Health Act, 2017). The administration of the Social Health Insurance Act therefore appears to be functionally delinked from the county health system especially at the community level contrary to the objects of the devolved government Articles 10, 174, 189 (1) and the Fourth Schedule Part 2 (2) (14) of the CoK and the County Government Act Section 48.

It is also curious that under Regulation 69 on Public Engagement, SHA is to, at least every five years, convene fora through meetings, colloquiums, webinars, workshops or such other consultative platforms for purposes of;

a. Facilitating consultations, co-ordination and collaboration in the implementation of the Act and these Regulations;

b. Making recommendations aimed at improving the furtherance of the objects of the Act and these Regulations;

c. Creating awareness on any matter under the Act and these Regulations; and

d. Promoting data and information sharing including sharing of experiences, best practice or emerging issues on matters of social health insurance.

However, five years is rather such a long time to engage the public on such an important matter of public interest.

The Primary Health Care Act No. 13 of 2023

The Primary Health Care Act No. 13 of 2023 ("PHCA") aims to provide a framework for the delivery of, access to and management of primary health care.

The objects of PHCA, 2023 are to, among other things, promote and fulfill the rights of all persons in Kenya towards the progressive realization of their right to the highest attainable standards of health care; ensure provision of primary health care through a systemic approach and clear delineation of roles of all stakeholders towards realization of universal health coverage; and provide for the establishment of primary health care networks, community health units and other stakeholder centered engagement forums for sustainable provision of primary health care services.

Although section 20 of the SHIA 2023 establishes the Primary Healthcare Fund (PHCF) whose object shall be to purchase primary health care services from health facilities vested in county governments under Part 2 (2)(c) of Fourth Schedule of the Constitution, the Primary Health Care Act, 2023 and the First Schedule of the Health Act 2017, the administration and delivery structure of the Fund appears to ignore or disregard the role of county governments in the delivery of primary healthcare services.

The Digital Health Act No. 15 of 2023

The Digital Health Act No. 15 of 2023 ("DHA") provides for the establishment of the Digital Health Agency; a framework for provision of digital health services; and establishment a comprehensive integrated digital health information system.

Section 3 of the Digital Health Act 2023 provides that the objects of the Act are among other things to—establish and maintain a comprehensive integrated health information system; promote innovation and the safe, efficient and effective use of technology for healthcare, including for continuity of care, emergency and disaster preparedness and disease surveillance; and provide for the safe and secure transfer of personal, identifiable health data and client's medical records to and from health facilities within and outside Kenya.

Although section 47 of the Social Health Insurance Act provides for digitization of all processes and services including interoperability through an information system, it does not define the information system including health information system and integrated health information system as provided in the Digital Health Act 2023. Section 47 (1) of the Social Health Insurance Act provides that all processes and services under this Act shall continue to be digitized using appropriate, reliable, secure, inter-operable, verifiable and responsive technology through an information system.

The Social Heath Insurance Act does not also provide for the linkages and interoperability of the Social Health Insurance information system and the Kenya Health Information system (KHIS).

Section 3 (h) of the Digital Health Act 2023 provides that the object of the Act is to provide for the safe and secure transfer of personal, identifiable health data and client's medical records to and from health facilities within and outside Kenya.

Facilities Improvement Financing Act No 14 of 2023

The Facilities Improvement Fund Act No 14 of 2023 provides for public health facility improvement financing; and the management and administration of facility improvement financing. The Act applies from level 1 to level 5 public health facilities.

The objectives the Act are to, among other things, provide for an efficient, secure and accountable mechanism for the collection, retention and management of revenue derived from health services rendered at public health facilities; provide for the appropriation, management and use of budgeted health services revenue to supplement operations and facilitate quality service delivery in public health facilities; promote equitable health facilities improvement financing including benefit sharing in accordance with the relevant laws of Kenya; and provide for a unified system to guide financial management in public health facilities, improving efficiency and effectiveness and ultimately quality health service delivery.

Despite the FIFA 2023 providing a framework for efficient, secure and accountable mechanism for the collection, retention, management and utilization of revenue derived from health services rendered at public health facilities from level 1 to level 5 public health facilities, Section 21 (c) of the Social Health Insurance Act 2023 provides that one of the sources of funds for the Primary Health Care Fund include monies allocated for that purposes from fees or levies administered.

The Social Health Insurance Act 2023 does not however, indicate from where the fees or levies will be charged or sourced. If the intention is to derive the fees and levies from the monies received as user fees, charges and monies paid as reimbursement for services received from insurance firms or other relevant entities by health facilities at Level 2-5, then Section 21(c) of the Social Health Insurance Act will be in conflict with the provisions of the Facility Improvement Fund Act, 2023.

Section 51 of the Social Health Insurance Act 2023 on conflict with other laws however, appears to suggest that the Act shall prevail in the case of any inconsistency between this Act and any other legislation on matters related to provision of social health insurance.

Discussion

All the impugned healthcare laws share a common purpose of promoting the implementation of universal health care, and ensuring that all Kenyans have access to affordable, equitable and comprehensive quality health services towards the realization of the right to health guaranteed under Article 43 of the Constitution.

The objectives and purpose of the legislations appear progressive and transformative and intended to improve health outcomes and financial protection.

However, whereas the Social Health Insurance Act 2023 seeks to address the structural, normative and systemic challenges inherent in the now defunct National Health Insurance Fund (NHIF), the design and spirit of the three social health insurance funds, remain fundamentally similar to NHIF and its hospital based focus and operational structure except the fact the NHIF was voluntary and Social Health Insurance is mandatory.

Each of the funds established by the Social Health Insurance Act are structured to do exactly what NHIF used to do – enable access to facility based services. The Social Health Insurance Act has also to some extent inadequately specified how the three Funds would interact and provide for separation of premium collection and funds vis-a-vis reimbursement and payment

and to comprehensively address community health services and other key building blocks of the health system such as leadership, governance, health information systems, health workers, and technologies and products.

While monthly self-payments posed challenges under NHIF, a one-off annual payment for individuals in the informal sector has been introduced by the Act to address this. However, collecting annual contributions from those struggling with monthly payments may be challenging due to competing financial burdens. This will pose challenges for effective financial planning. In addition, although the deductions from salaried employees are now equivalent to 2.75% of the gross monthly income, up from the previous capped amount of KES 1,700 and this adjustment is considered necessary to fund the expansion of healthcare coverage, it's important to find a middle ground where the financial impact on individuals does not outweigh the expected benefits. Capping the deductions is advisable to minimize the impact on disposable income for low and middle-income earners and prevent an adverse effect on the economy.

The SHIF's mandatory character and application although well intended, is supported by a heavily punitive system for contributors and beneficiaries. Since any outstanding contributions and penalties accrued are recoverable debts to the SHIF, the administration of the fund will most likely drive the poor, vulnerable, indigents, casually employed and the unemployed into poverty and destitution minus access to health care.

All the three funds do not also make provisions for community and family based healthcare services including promotive, preventive, rehabilitation and palliative care. Functionally, the delivery and administrative structure of the social health insurance system establish by the Act is disconnected from the health system at the Level – Community Health Service and appears to be administratively in direct conflict with the devolved structure and principles of governance. The role of the county governments and county health system is therefore not clearly defined as well as the parameters for intergovernmental relations within the delivery structure between the SHA and the county governments in the financing and delivery of the health services.

In addition, there is lack of harmony between the SHIA and its own stated universal health coverage objectives as well as the other related health laws such as Primary Healthcare Act, 2023, Digital Health Act 2023 and the Facilities Improvement Financing Act. The Act has not provided foundational principles such as inclusivity, interdependence, participation, solidarity, acceptability, affordability, accessibility, equity, transparency, accountability, efficiency and sustainability. In particular, there are concerns that the new health laws neither comprehensively addressed critical governance and service delivery challenges of the health system[10] nor reflect the needs and socio-economic realities of the people of Kenya.

[10] National Assembly, Report on the Consideration of the Estimates of Revenue and Expenditure FY 2024 2025 http://www.parliament.go.ke/sites/default/files/2024-06/Report%20on%20the%20Consideration%20of%20the%20Estimates%20of%20Revenue%20and%20Expenditure%20FY%202024%202025.pdf_0.pdf

CONCLUSION AND RECOMMENDATIONS

Conclusion

The enacted laws were well intended to provide the means for attaining universal health coverage and ensuring that all Kenyans have access to affordable and comprehensive quality health services towards the realization of the right health guaranteed under Article 43 (1) (a) and (2) of the Constitution of Kenya.

However, while the current legal framework for UHC appears robust, there still remains many challenges and barriers to the realization of the UHC objectives and the right to health in Kenya through the SHIA as currently enacted. The main legal vehicle, SHIA, 2023 was not only impugned but continued to face various implementation and transitional challenges since inception in October 2024.

In summary, the review has revealed that SHIA has gaps and issues related to its constitutional alignment, lack of clarity on vulnerable populations, neglect of county government responsibilities, and discrepancies in human rights and equity considerations.

Thus, as the transition to the new social health insurance supported UHC era unfolds, careful consideration and necessary adjustments will be required to address the constitutional, governance, human rights, equity and inclusion issues and concerns that have arisen from SHIA and UHC implementation. If the gaps are not addressed, SHIA, 2023 risks limiting access to quality healthcare services and excluding vulnerable populations even more.

Practically, to advance towards universal healthcare coverage and improve the health outcomes, the implementation of the universal health coverage and sustainable health financing strategy through the new Social Health Insurance system will require a comprehensive approach, inclusive, affirmative action and participatory strategy involving both national and county governments.

Recommendations

To address the foregoing gaps and issues, the following recommendations are made. The recommendations emphasize the need for comprehensive review and amendments to the SHIA as the main legal instrument for achieving UHC objectives and the right to health including ensuring its effective administrative functionality.

a. To mitigate the legal barriers to achieving the UHC and the right to health, amendments to the SHIA 2023 and the Regulations should be made in order to, among other things:

- Align the definition of beneficiaries with constitutional provisions such as Articles 21(3), 27, 54, 56, and 260 to ensure Persons with Disabilities (PWDs) and the vulnerable persons/ groups enjoy to the greatest possible extent, their rights to highest attainable standards of health care.
- Redefine households and informal sector contributors as eligible rather than liable contributors to SHIF under Section 27 (1) (a) of SHIA.
- Exempt households, vulnerable groups and informal sector contributors from penalties.
- Define what "government" means under the Social Health Insurance Act.

- Define what "income" means under the Social Health Insurance Act.
- Make clear provision on who is registrable or not registrable under the Social Health Insurance Act and what constitutes the minimum requirement to access primary and emergency healthcare services from the public entities.
- Provide clear guiding principles in the Social Health Insurance Act such as inclusivity, interdependence, participation, solidarity, acceptability, affordability, accessibility, equity, transparency, accountability, efficiency and sustainability.
- Provide for the minimum and essential package of healthcare accessible to all Kenyans irrespective of whether a person is a registered, active or up to date contributor e.g. emergency medical treatment and primary healthcare services at level 2 and 3.
- Make Section 21 (c) clear that the fees or levies contemplated refer to purchase of services by SHIF from Levels 2 and 3 and that it does not imply that patients will be required to pay the said levies or fees.
- Clearly state who is eligible to access primary health care services (Levels 2 &3) given the fact that services at the primary healthcare level were free before the Social Health Insurance Act.
- Provide for the role of county governments and community health units in the identification of indigent and vulnerable peoples within the counties for purposes of accessing SHIF.
- Provide for the role of county governments and the relationship between SHA and each county government in monitoring and overseeing contract performance under sections 33 and 34 of the SHIA.
- Align SHIF, PHCF and ECCIF with the constitutional principles of devolved governance and functional assignment between national and county governments under Articles 6, 10, 174, 186 and 189 and the Fourth Schedule of the Constitution.
- Provide for inter-governmental coordination, cooperation or collaboration between SHA in the administration of SHIF, PHCF and ECCIF, and county governments.
- Provide for the Cabinet Secretary to consult with the Council of Governors and county governments in making regulations for the implementation of the Emergency, Chronic and Critical Illness Fund (section 30), defining essential healthcare package (section 31) and prescribing the tariffs applicable to the benefits (section 32).
- Align SHIA with the PHCA 2023, FIFA2023 and DHA 2023.
- Provide for the linkages and interoperability of the Social Health Insurance information system, the Kenya Health Information system (KHIS) and Electronic Community Health Information System (eCHIS).
- Introduce a limitation clause under section 38 to provide for the use of the retained funds to waive outstanding contributions and penalties accrued by the households and informal sector contributors unable to clear their outstanding contributions and debts under Section 27(7)) of the Act thereby being denied access to healthcare services through the three social health insurance funds.

b. Review the inclusivity of the testing instruments in the context of human rights norms and standards in the Bill of Rights. The administration of the means testing instrument should be preceded by risk and vulnerability analysis contemplated by Articles 20 & 21 against Article 43 (1) (a) and (2).

c. The Social Health Insurance Fund (SHIF), Primary Healthcare Financing Fund (PHCF), and Emergency, Chronic and Critical Illnesses Fund (ECCIF) should respectively allocate a proportion of their funds as program grants to support primary healthcare networks, Community Health Services at Level 1, and support health system capacity development.

This is imperative if the Social Health Insurance Act 2023 is to achieve the objectives of universal health coverage and the right to health. The expenditure to be made out of PHC Fund should include expenditure for Level 1 Community Health Services and system, primary healthcare networks and provision of promotive, preventive, rehabilitative and palliative care including family and home-based care and rehabilitation and referrals.

d. The SHIA Regulations should be amended to

- Include a category on the unemployed in the registration application form (FIRST SCHEDULE FORM 1 on application for registration). The Form only provides for four types of occupation/employment, namely EMPLOYED, SELF-EMPLOYED, SPONSORED & ORGANISED GROUP).
- Provide an efficient mechanism to ensure seamless transition from the exhaustion of SHI cover to the onset of ECCIF without requiring prior or further approval; and
- Provide engage with the public regularly, either annually or biennially to enhance transparency and accountability.

e. Conduct further research to provide critical insights in relation to effectiveness of the enacted health laws. Some of the research areas that can underpin future reforms and ensure the enacted laws fulfill their intended objectives effectively include investigating:

- The extent to which the UHC related laws are achieving their intended objectives, such as universal health coverage, digital health integration, and financing improvements.
- The effects on healthcare services, patient outcomes, and financial sustainability.
- Barriers (e.g., resource allocation, governance inefficiencies, regional differences) affecting the achievement of universal health coverage
- The effects of SHIA funds in improving service delivery and coverage, especially in underserved areas and vulnerable populations

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