

## Effectiveness of Public Health Insurance in the Treatment of COVID-19 during the First Year of the Pandemic in Kenya

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Accepted: 12 May 2026 || Published: 22 June 2026

### Abstract

Since 2004, the Government of Kenya has used the public health insurance as a strategic tool to implement Universal Health Care, seeking to lower inequality in access to health care. To date, the fund covers only 16% of the population. Public health insurance has an enhanced scheme that covers those in formal employment, with beneficiaries paying up to US\$15 per month, while the super cover for those in the informal sector pays US\$4. Worth noting is that 83% of Kenya's workforce is in the informal sector, the majority of whom cannot afford this premium. While the cost of treatment for COVID-19 was estimated at US\$18 to US\$599 per day, at the onset of the pandemic, the public health insurance announced that it would not cover COVID-19 treatment for all its beneficiaries. As the Pandemic progressed, the Fund limited treatment to health facilities designated by the Ministry of Health, thereby excluding private hospitals, which were better equipped and had greater capacity to treat COVID-19. The objectives of this study were to assess the affordability and accessibility of public health insurance as a tool of primary health care scheme in Kenya; to determine the effectiveness of public health insurance coverage in the treatment of COVID 19 during the first year of the pandemic; and to establish mechanisms that can inform comprehensive future responses to pandemics and epidemics. The study employed a qualitative research method. Specifically, the desktop research method was used to collect data. The study showed that although public health insurance is a form of social protection, it was ineffective in treating COVID-19, especially for those in the informal sector. Further, the Fund remained unaffordable and inaccessible to the majority of Kenyans.

**Keywords:** *Effectiveness, Treatment of COVID-19, Public health insurance*

**How to Cite:** Mwangi, L. M. (2026). Effectiveness of Public Health Insurance in the Treatment of COVID-19 during the First Year of the Pandemic in Kenya. *Journal of Medicine, Nursing and Public Health*, 6(6), 66-72.

### 1. Introduction

In December 2019, the World Health Organization (WHO) reported an outbreak that later became a global pandemic, now known as COVID-19. The pandemic was uniquely driven by globalization and the high mobility of people (Ayenew et al., 2020). While the whole world was caught unprepared at the outset, there were fears about Africa's ability to manage the

pandemic. This was due to her weak health infrastructure and a high disease prevalence, resulting in an immunocompromised population (Lone & Ahmad, 2020).

Kenya was rated as high risk for COVID-19 importation, with a low infectious disease index (Jaguga & Kwobah, 2020). The country reported its first case on 13<sup>th</sup> March 2020. The Government of Kenya initiated a rapid response following the ground-zero patient by locking down all its international airports, closing all learning institutions, banning public gatherings and entertainment joints, and limiting inter-county travel, while encouraging people to work from home. These measures were effective in slowing down the rate of infections. While the preventive measures were commendable, the treatment of COVID-19 posed a challenge to both the government (which had limited health infrastructure) and the population (as treatment was inaccessible and unaffordable to most Kenyans) (Ouma et al., 2020).

### **1.1 Public Health Insurance as a Tool of Social Protection**

Social protection in Kenya is hinged on three pillars: social security, social assistance, and health insurance (Doyle & Ikutwa, 2021). Public health insurance was established in 1966 as mandatory for those in the formal sector. In 1998, it extended its mandate to include those in the informal sector (Barasa et al., 2018). Thus, all Kenyan citizens aged 18 and above with a monthly income of US\$10 are eligible for the cover.

Contributions for those in formal employment are mandatory, through a monthly statutory deduction ranging from KShs.150-1700 (US\$1.5-17), while for the informal sector, contributions are voluntary at a fixed sum of Kshs 500 (US\$5) under the National Scheme (NS) (Mbau et al., 2020). Civil Servants and disciplined services are covered under the Civil Servants Scheme (CSS), which is funded by the Government and managed as a separate fund. Further, Public Health Insurance has a Health Insurance Subsidy Program (HISP) which provides free insurance to vulnerable groups identified as the elderly, orphans, those living in extreme poverty, and those living with extreme disabilities. Other programs include Edu Afya, which covers students, and Linda Mama, which offers free maternity care to all mothers (ibid).

### **1.2 Objectives of the Study**

The objectives of this study are to assess the affordability and accessibility of public health insurance as a tool of primary health care scheme in Kenya; to determine the effectiveness of public health insurance coverage in the treatment of COVID 19 during the first year of the pandemic; and to establish mechanisms that can inform comprehensive future responses to pandemics and epidemics.

## **2. Methodology**

The study was carried out in Kenya. Kenya is an East African country that is bordered by Tanzania, Uganda, Somalia, Ethiopia, South Sudan, and the Indian Ocean. Its total area is 582,646 square Kilometers and has a population of 53.8 million. The Country is ranked as a lower-middle-income country (LMIC). The Data for this study were collected through a review of peer-reviewed publications and grey literature on public health insurance. The papers were obtained through Google searches and Google Scholar searches. Keywords used in the search engines were ‘public health insurance’, ‘COVID-19’, and ‘Social Protection in Kenya’. A total of 18 published papers and grey literature were reviewed. Furthermore, data were obtained from the websites of the Kenya Ministry of Health and the Kenya Parliament.

### 3. Findings

#### 3.1 Affordability and Accessibility of Public Health Insurance

Article 43 of the Kenyan constitution stipulates that every person has the right to the highest attainable standard of health. Further, it defines health as a “state of complete physical, mental, and social well-being and not merely the absence of disease and infirmity.” (GoK, 2010).

Public Health Insurance, as a state corporation, has a mandate to provide accessible, affordable, sustainable, and quality social health to all Kenyans. The Fund remains the largest health insurance provider in the country, covering only 16% of the population, while private insurance companies cover 1%. This leaves 83% of Kenyans without any health insurance (WHO, 2019).

The Government of Kenya (GoK) had envisioned that universal health care for all citizens would be in place by 2022. It therefore embarked on various reforms to public health insurance to increase coverage and reduce inequalities in access to health services. Between 2010 and 2017, the fund increased from 2.7 million to 6.6 million members in the formal sector, and from 2 million to 2.5 million in the informal sector (Barasa et al., 2018). Worth noting is that Kenya’s informal sector comprises 83% of its workforce (KNBS, 2019). It can therefore be deduced that the 17% of Kenyan citizens with health coverage closely mirrors the share of Kenyans in the formal sector. While the informal sector comprises of 83% of the Kenyan workforce, it accounts for 35% of public health insurance membership. From 2015, when public health insurance revised its premium for the informal sector from KShs.160 (US\$1.6) to Kshs. At 500 (US\$5), it has continued to record low enrolment from this sector and a high attrition rate. Notably, 75% of those in the informal sector cannot afford the insurance premium (Kazungu & Barasa, 2017). Moreover, at its peak in 2017, the attrition rate was reported at 73%.



Figure 1: NHIF membership

It is commendable that the Fund places no age or pre-existing conditions limitations; it limits its members to using only one designated health facility for outpatient care. This is discouraging given the country's spatial space. Thus, if one falls ill outside the designated health facility, the cover becomes inaccessible. Furthermore, the US\$ 14-per-family-per-month utilization limit for outpatient cover is quite low, given that the average Kenyan family has 3.9 members. It is worth noting that these limitations do not apply to CSS. Table 1 shows the per-person, per-month capitation rate for the three schemes offered by the Fund.

**Table 1: Public Health Insurance Capitation rate per person enrolled per year**

Contract	Capitation in Private Facilities	Capitation in Public Facilities
National scheme	Kshs.1,400 (US\$14)	Kshs.1,200 (US\$ 12)
Civil Servants Scheme	Kshs.2,800 (US\$28)	Kshs.1,500 (US\$15)
HISP	Kshs. 1,400 (US\$14)	Kshs. 1,200 (US\$12)

The table shows that CSS has better access to healthcare compared to NS and HISP. CSS are therefore seen as lucrative patients who are preferred by health care providers over others, thereby bringing about inequality, which the Fund was mandated to bridge (WHO, 2019). Analysis of benefits paid by public health insurance shows that CSS members receive more benefits than those of NS and HISP members. This perception of preference, or actual preference, acts as a barrier for members of the informal sector. The GoK's offer of superior cover for its civil service may indicate its awareness of inadequacies of NS and HISP cover, which covers the majority of its citizens.

Finally, the Fund engages large hospitals to provide services to its members, while neglecting small facilities such as dispensaries. Unfortunately, large health facilities are mainly found in urban centers, while the primary health care providers in rural areas are lower-level clinics and dispensaries. Access to this Fund, therefore, becomes difficult for Kenyans living in rural areas, as small clinics and dispensaries are not covered by the Fund. Worth noting is that 60% of Kenyans live in rural areas.

### **3.2 Public Health Insurance Response to the COVID-19 Pandemic in the First Year of the Pandemic**

At the onset of the pandemic, private companies declared that COVID-19 was a pandemic, and did not qualify for medical insurance coverage. Unfortunately, public health insurance responded in like manner to private insurance. Initially, the Fund stated that it would not cover COVID-19 as it was a pandemic (NMG, 2020). Later on, this position changed, and the Fund committed to covering patients from Ministry of Health (MoH)- designated facilities only, thereby effectively locking out private hospitals (Ministry of Health, 2020). The move raised the question of the public facilities' capacity to handle a pandemic without supplementary help from private facilities. Thus, unlike countries such as Spain, which nationalized all private hospitals, the GoK alienates them.

Moreover, reports from major news outlets in Kenya reported that the Fund was only offsetting bills for civil servants under CSS. In response, the Fund stated that, due to the enormous financial burden of treating COVID-19, it was unable to cover the NS and HISP. This decision effectively locked out the entire informal sector. In Kenya, it was estimated that the cost of treating COVID-19 was US\$18 per day for home-based care, US\$63 for mild-to-moderate patients, and US\$124-US\$599 for critical patients (Barasa et al., 2021). Without insurance coverage, treatment for COVID-19 was unaffordable and inaccessible not only to the poor in the country but also to the middle class. The pandemic itself had created 2 million “new poor” in the country (Beazley et al., 2021). Alienation of NS by the Fund, therefore, meant that its members could not afford or access treatment for COVID-19.

#### **4. Conclusion**

The resilience and sustainability of public health insurance as a national health cover came into question in the way it handled the pandemic. The GoK's vision to provide Universal Health Care to all its citizens by the year 2022 through public health insurance remained just that: a vision. Although Kenya signed the Abuja Declaration, which requires a 15% budgetary allocation to health, the country's average allocation has been 6% of the total budget. The health sector, therefore, remains underfunded compared with other sectors, such as infrastructure development and security. With only 17% of the Kenyan citizens able to afford health insurance, access to adequate health care remains out of reach for the majority of Kenyans. Public health insurance membership remains biased towards the formal sector and urban areas.

The GoK offer of a superior cover to civil servants only confirms its awareness of the National Scheme's ineffectiveness, which covers the rest of the citizens. Moreover, the Fund's biased response to the COVID-19 pandemic, which covered only CSS members, underscores the need to reformulate its policies to encourage a more inclusive response in the future.

#### **5. Recommendations**

Public health insurance continues to struggle to enroll new members from the informal sector and to retain existing members. The informal sector accounts for 35% of its membership and 0.04% of the country's insured population. A major barrier cited is the high premium. Studies suggest that 75% of workers in the informal sector cannot afford the cost of Kshs.500 (US\$5) premium. A reduced premium rate of Kshs.300 (US\$3) is more preferred. (Kazungu & Baraza, 2017).

Moreover, because the informal sector is not a unified bloc, it becomes difficult for the Fund to identify potential members. As targeted marketing strategies of its products may prove hard, the Fund may consider broad interventions that cut across the entire informal sector. General approaches, for instance, may require simplified communication strategies. A customer care help line would help ensure that information and assistance are accessible when needed.

The Fund may also simplify its registration process to encourage even the semi-illiterate population to access the Fund. For instance, the requirement of a National Identification card and a birth certificate is unnecessary duplication, as both are forms of identification, and either would suffice.

Further, it is important for the Fund to increase access by accrediting lower-level health facilities in rural areas. These facilities serve the poorest in marginalized communities and reduce the distance they must travel to access healthcare.

Finally, there is a need to reduce administrative costs, which currently stand at 45% of the total Fund. Streamlining its operations and automating processes may reduce administrative expenditure. As this is a public fund, there is a need for a legislative mechanism to limit administrative expenditures and ensure the fund's sustainability.

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