2025

RUPHA
RURAL & URBAN PRIVATE HOSPITALS ASSOCIATION OF KENYA

Facility Payment and Financial Wellbeing Report

A Survey of SHA-Contracted Healthcare Providers for the JAN-APRIL 2025 Period

Prepared by the Rural & Urban Private Hospitals Association of Kenya (RUPHA)

with support from

kaph

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CHRISTIAN HEALTH ASSOCIATION OF KENYA

YOU SHALL BE MY WITNESSES
K.C.C.B

Kenya Healthcare Federation
The Health Sector Board of KEPSA

Executive Summary

The April–May 2025 Facility Payment Survey, conducted by the Rural & Urban Private Hospitals Association of Kenya (RUPHA) in collaboration with other national provider associations from **23rd April to 6th May 2025**, assesses the evolving provider reimbursement landscape under the Social Health Authority (SHA). The survey is part of a continuous monitoring initiative launched at the start of Kenya's transition from the National Health Insurance Fund (NHIF) to SHA. It aims to provide timely, evidence-based feedback from healthcare providers to inform national policy, programmatic adjustments, and financing reforms.

This edition of the survey received responses from 477 facilities across all levels of care and ownership types—including public, private, and faith-based institutions. The survey sheds light on SHA contracting, PHC accreditation, reimbursement patterns, claim bottlenecks, and the underlying financial health of healthcare facilities.

SHA Contracting and PHC Accreditation

- **High Contracting Coverage:** 96% of facilities surveyed received SHA contracts.
- **Extensive PHC Accreditation:** 86% were accredited for Primary Health Care (PHC), including a small but significant number of Level 5 FBO hospitals, likely an adaptation to service gaps in underserved areas.

PHC Reimbursements: Inconsistent and Inadequate

- **Irregular Payments:** Only 20% of PHC-accredited facilities received payments for each month in the quarter January–March 2025; 45% received no payments at all.
- **Perceived Inadequacy:** 63% of PHC-contracted facilities said the payments were "less than expected," with dissatisfaction highest among FBOs (83%).
- **Payment Ambiguity:** Level 4 facilities—particularly public ones—struggled to distinguish PHC payments from other disbursement streams, complicating budget planning.

Trends in PHC Reimbursement Amounts

- **Divergent Ownership Experiences:** 54% of public facilities reported increased reimbursements, while 50% of private and 38% of FBO facilities saw declining trends, highlighting unequal adjustment to the global budget model.

SHIF Reimbursements: Widespread But Shallow

- **Widespread Payouts, Low Coverage:** 75% of Level 3–5 facilities had received SHIF payments, but 83% said less than 50% of their submitted claims had been paid.
- **Private Sector Disadvantage:** Private facilities reported that on average only 27% of their claims had been settled compared to 36% reported by FBO facilities and 40% for public facilities.

Surgical Claims: High Risk, Slow Processing

- **Disproportionate Concern:** While only a third of SHIF claims were surgical, 39% of facilities identified surgical claims as the most problematic, pointing to high claim value and complexity.
- **Extended Processing Timelines:** Over half of surgical claims remained unprocessed after three months, particularly in private and FBO hospitals offering higher-tier services.

Financial Distress: Systemic and Deepening

- **91% of Facilities in Financial Distress:**
    - 100% of FBOs
    - 95% of private facilities
    - 84% of public facilities
- **Common Challenges:** Difficulties paying suppliers, covering operating costs, and coping with cash flow volatility were near-universal.

Root Causes of Financial Distress by Level

- **Level 2 Facilities:** Dominated by unpaid PHC claims (87%); NHIF arrears and SHIF liabilities play a smaller role.
- **Level 3 Facilities:** Heavily burdened by legacy NHIF debts (45%), with PHC and SHIF liabilities also contributing.
- **Level 4 Facilities:** Faced a dual threat of unpaid NHIF claims (67%) and SHIF backlog (31%), with PHC issues largely irrelevant.
- **Level 5 Facilities:** Almost entirely affected by NHIF arrears (88%) and SHIF delays (12%), with no PHC contracting for most.

Policy and System-Level Recommendations

- **Stabilize PHC Disbursements:** Clear, predictable, and traceable PHC reimbursements are vital to safeguarding primary care continuity, especially at Levels 2 and 3.
- **Resolve Surgical Claims Bottlenecks:** Dedicated processing lanes and verification protocols for surgical claims are needed to avoid collapse of high-cost services.
- **Clear NHIF Arrears:** Addressing historical debts is urgent for financial recovery, especially in FBO and private sectors.
- **Strengthen Claim Management Systems:** Reduce SHIF delays by automating claim adjudication, providing feedback dashboards, and maintaining open provider–payer communication.
- **Enhance Financial Risk Mitigation:** Expand emergency liquidity solutions or bridging mechanisms for distressed facilities.

Final Remark

Without timely and coordinated interventions, Kenya's health system risks systemic disinvestment from critical service areas—especially surgery, PHC, and inpatient care. This report provides an evidence-based roadmap to restore provider's confidence and ensure the financial viability of the sector as SHA's rollout matures.

Table of Contents

1 Introduction 1

1.1 Background 1

1.2 Objectives of the Survey 1

1.3 Methodology 2

1.3.1 Sampling Strategy and Representativeness 2

1.3.2 Skew and Sample Bias Observations 3

2 Facility Profiles 4

2.1 Ownership Categories of Participating Facilities 4

2.2 KEPH Level Distribution of Participating Facilities 5

2.3 Ownership Composition Within KEPH Levels 5

3 SHA Contracting and PHC Accreditation 7

3.1 Contracting Status under SHA 7

3.2 PHC Accreditation Status 7

3.3 Accreditation Gaps and Observations 8

4 PHC Payment Consistency and Predictability 9

4.1 Monthly Payment Trends 9

4.2 Consistency of PHC Payments by KEPH Level & Ownership 10

4.2.1 Public Facilities 10

4.2.2 Private Facilities 11

4.2.3 Faith-Based (FBO) Facilities 11

5 PHC Payment Adequacy 13

5.1 Overall Perceptions of Adequacy 13

5.2 Adequacy Ratings by Ownership and KEPH Level 14

5.2.1 Faith-Based Organizations (FBOs) 14

5.2.2 Private Facilities 14

5.2.3 Public Facilities 15

5.3 Trends in PHC Reimbursement Amounts 16

5.3.1 Overall Trend (All Facilities) 16

5.3.2 Ownership-Based Trends 17

5.4 Emerging PHC Reimbursement Patterns and Implications 18

5.4.1 Key Observations 18
5.4.2 Implications 18
6 SHIF Payment Performance 19
6.1 SHIF Reimbursement Levels 19
6.1.1 Level 3 Facilities – SHIF Reimbursements: 19
6.1.2 Level 4 Facilities - SHIF Reimbursements: 20
6.1.3 Level 5 Facilities - SHIF Reimbursements 21
6.2 SHIF Reimbursement Patterns 22
6.3 Month-on-Month Analysis of SHIF Payments (Dec 2024 – Apr 2025) 24
6.3.1 Ownership Disaggregation: 24
7 Surgical Claims and High-Value SHIF Reimbursements 26
7.1 Prevalence of Surgical Claims in Facility Portfolios 26
7.2 Surgical Claims Held in Review 28
7.3 Duration of Surgical Claims in Review 29
7.4 Implications 30
8 Facility Financial Wellbeing 31
8.1 Overview of Financial Distress Among Facilities 31
8.2 Key Drivers of Financial Distress 32
8.2.1 KEPH-Level Insights 33
8.2.2 Ownership-specific insights: 34
8.3 Specific Financial Challenges 35
8.4 Financial Wellbeing by KEPH Level 36
8.5 Financial Challenges by Ownership Category 37
9 Key Insights from the Survey 39

1 Introduction

1.1 Background

The April–May 2025 Payments Survey was conducted by the **Rural & Urban Private Hospitals Association of Kenya** (RUPHA) from **23rd April to 6th May 2025**. This survey is the latest in a series of structured assessments undertaken since the transition from the National Health Insurance Fund (NHIF) to the Social Health Authority (SHA). These surveys aim to document the experiences of healthcare providers as SHA rolls out the Social Health Insurance Fund (SHIF) and the Primary Health Care (PHC) global budget reimbursement models.

This effort reflects a broader goal to close the feedback loop between healthcare providers, policymakers, and payers. The survey was implemented in partnership with other national provider associations—including **the Kenya Association of Private Hospitals (KAPH), the Christian Health Association of Kenya (CHAK), the Catholic Health Commission of Kenya (CHCK) under the Kenya Conference of Catholic Bishops, and the Kenya Healthcare Federation (KHF)**—as well as with the support of **County Health Departments.**

1.2 Objectives of the Survey

The April–May 2025 survey set out to:

- Track the consistency, adequacy, and timeliness of PHC and SHIF payments to healthcare facilities;
- Assess the extent of financial distress and operational disruption among providers;
- Identify which claim categories and facility types are most affected by delays or underpayments;
- Understand surgical claims dynamics and the impact of delayed reviews on hospital cash flows;
- Monitor the effectiveness of SHA's facility accreditation, contracting, and claims systems;
- Provide actionable feedback to the Ministry of Health and SHA to improve provider engagement, reimbursement systems, and service delivery under UHC.

1.3 Methodology

This was an online survey conducted via a structured 28-item questionnaire, divided into seven thematic sections:

1. Contracting and Accreditation
2. PHC Payment Consistency
3. PHC Payment Adequacy
4. SHIF Claims and Settlement Trends
5. Surgical Claims Management
6. Facility Financial Wellbeing
7. Underlying Causes of Financial Distress

A total of **477** healthcare facilities responded to the survey. Respondents represented diverse ownership models and service levels across Kenya, from primary to tertiary care.

1.3.1 Sampling Strategy and Representativeness

To ensure proportionality and reduce sampling bias, the target distribution was based on the 2023 Master Facility List (N = 14,378). The desired sample (n = 384) was stratified by KEPH level and ownership as shown below:

KEPH Level	Public	Private	FBO	NGO	Total
Level 2	130	128	19	9	286
Level 3	32	27	6	2	67
Level 4	11	12	3	1	27
Level 5	1	1	1	0	3
Level 6	1	0	0	0	1
Total	**175**	**168**	**29**	**12**	**384**

The actual distribution achieved was:

KEPH Level	Public	Private	FBO	NGO	Total
Level 2	128	53	4	–	185
Level 3	70	107	8	1	186
Level 4	10	69	10	1	90
Level 5	–	10	5	1	16
Total	**208**	**239**	**27**	**3**	**477**

1.3.2 Skew and Sample Bias Observations

Compared to the ideal stratified sample:

- **Level 2 public and private facilities** are underrepresented (especially Level 2 private), while **Level 3 and 4 private facilities** are overrepresented.
- **NGO-owned facilities** were under-sampled (only 3 vs. a target of 12).
- **Level 5 facilities**, though a small fraction nationally, had relatively higher-than-expected representation (16 vs. 3).
- **Faith-Based Organizations (FBOs)** were nearly proportional in total count but skewed toward Level 4 and 5.

These variations imply that while the sample is sufficiently diverse for disaggregated insights, results should be interpreted with caution for underrepresented groups—particularly NGOs, Level 2 FBOs, and higher-tier public hospitals.

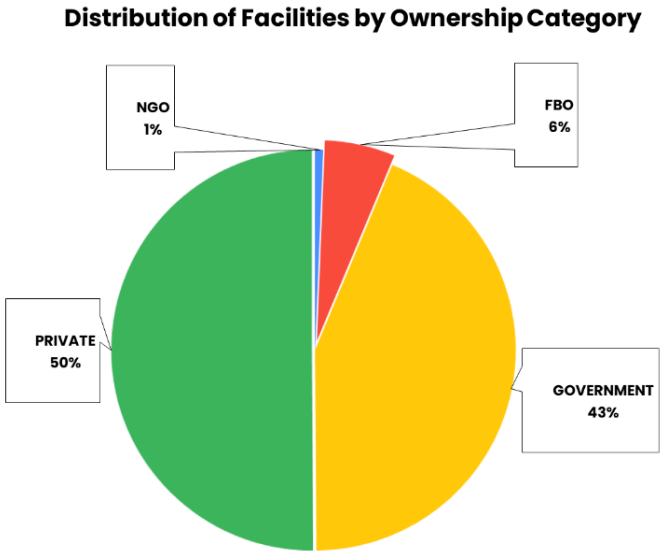
2 Facility Profiles

This section describes the composition of participating facilities in the April–May 2025 Payments Survey, organized by ownership category and KEPH level. A comparative analysis with the Kenya Health Facility Census (2023) is provided to assess the representativeness of the sample.

2.1 Ownership Categories of Participating Facilities

A total of 477 healthcare facilities participated in the survey. By ownership:

- **Private facilities** accounted for **239 facilities (50%)**
- **Government (public) facilities** comprised **208 facilities (43%)**
- **Faith-based organizations (FBOs)** made up **27 facilities (6%)**
- **Non-governmental organizations (NGOs)** comprised **3 facilities (1%)**

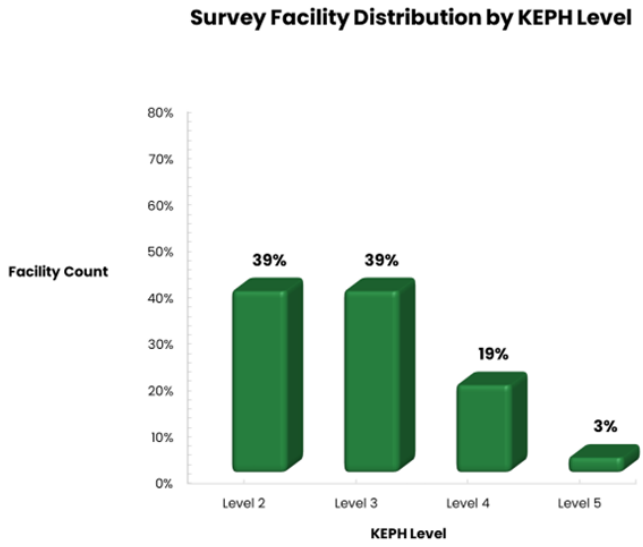


This distribution is broadly aligned with the national composition of facilities as reported in the Health Facility Census (2023), which found that 47% of facilities were public, 46% were privately owned, and 8% were FBO/NGO-operated. The slightly lower FBO representation in the survey sample (6% vs. 8%) reflects their limited footprint in the overall system.

2.2 KEPH Level Distribution of Participating Facilities

Survey respondents were drawn primarily from the primary care tiers of the Kenyan Essential Package for Health (KEPH):

- **Level 2 facilities: 185 facilities (39%)**
- **Level 3 facilities: 186 facilities (39%)**
- **Level 4 facilities: 90 facilities (19%)**
- **Level 5 facilities: 16 facilities (3%)**

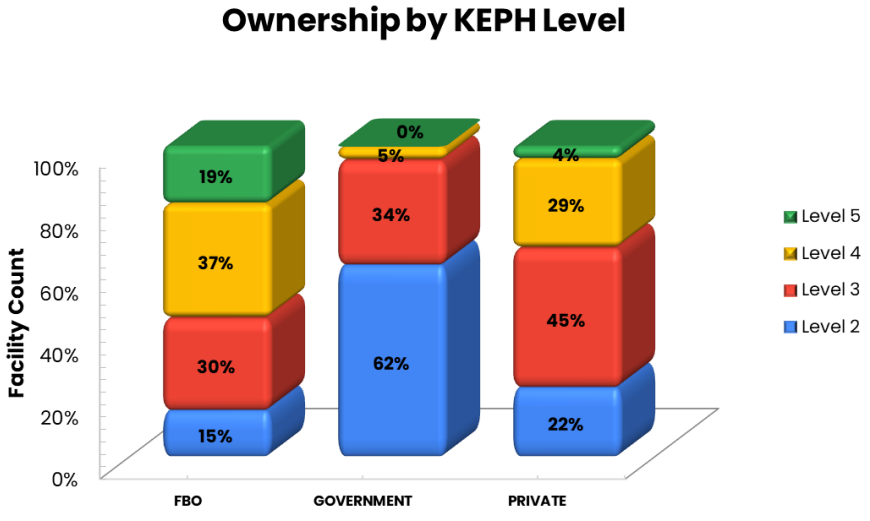


This mirrors the national distribution of KEPH levels, where Level 2 facilities constitute 71% of all licensed facilities (n = 8,806), followed by Level 3 (21%), Level 4 (8%), and Level 5/6 (less than 1%). While the survey slightly over-represents higher-level facilities (particularly Level 3 and 4), this is consistent with the operational scope of payment reforms, which more directly impact service delivery at Level 3 and above.

2.3 Ownership Composition Within KEPH Levels

An ownership breakdown within each KEPH level shows important patterns:

- **Public facilities**: The sample is heavily weighted toward **Level 2 (62%)**, followed by **Level 3 (34%)**, and a small share of **Level 4 (5%)**. This aligns with national data showing that most public facilities are concentrated at Level 2 (72% nationally).



- **Private facilities**: Include **45% Level 3**, **29% Level 4**, **22% Level 2**, and **4% Level 5**, reflecting their broader scope across multiple tiers and stronger presence at Level 3 and Level 4 relative to public facilities.
- **FBO facilities**: Skewed toward higher-level care. In this sample, **37% are Level 4**, **30% Level 3**, **19% Level 5**, and **15% Level 2**, consistent with national data showing a concentration of FBOs in referral-level care.

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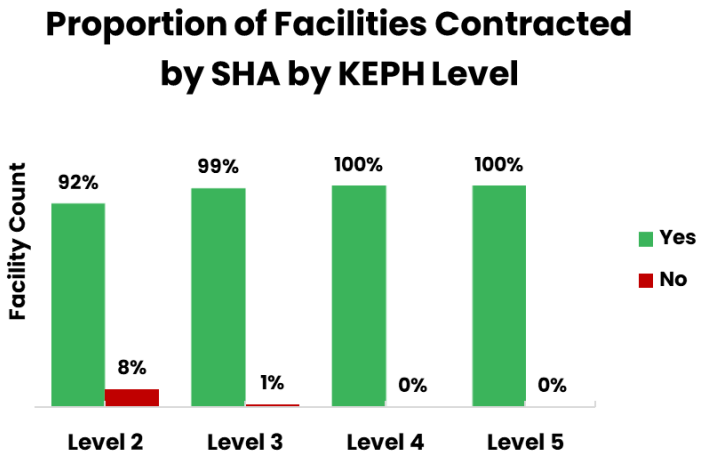
3 SHA Contracting and PHC Accreditation

3.1 Contracting Status under SHA

As of May 2025, **96%** of the 477 surveyed facilities reported that they had been **contracted by the Social Health Authority (SHA)**, while **4%** had not yet been contracted. This marks an improvement from the **October–December 2024 survey, where 93% of surveyed facilities were contracted**.

The near-universal contracting reflects progress in SHA's provider onboarding efforts, particularly among public and higher-level private hospitals. However, several uncontracted facilities—particularly **Level 2 private and recently established clinics**—reported delays related to:



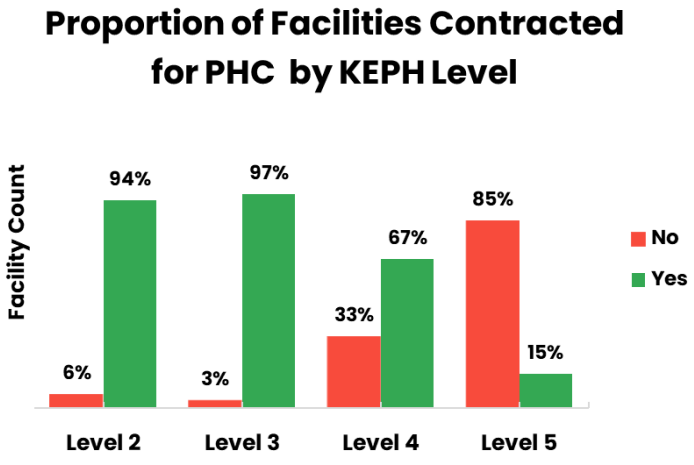
- Incomplete documentation and verification steps
- Unclear accreditation procedures
- Delays in facility inspections

These barriers may delay the onboarding of new entrants and constrain equitable access to services under SHA in underserved areas.

3.2 PHC Accreditation Status

The SHA requires **all Level 2 and Level 3 facilities** to be accredited for **Primary Healthcare (PHC)** services under the SHIF Act 2023 and PHC Act 2023. Level 4 facilities may also offer PHC services based on designation.

The survey found that **86%** of all responding facilities had received PHC accreditation. Disaggregation by KEPH level revealed the following:



- **Level 2:** 94% reported PHC accreditation
- **Level 3:** 97% accredited
- **Level 4:** 67% accredited
- **Level 5:** 15% accredited

These results are consistent with the policy expectation of full PHC accreditation for lower-tier facilities. The presence of PHC-accredited Level 5 facilities, although uncommon, suggests selective authorizations in high-need areas or dual-role operations in referral hospitals.

3.3 Accreditation Gaps and Observations

Despite high levels of accreditation overall, several gaps and inconsistencies remain:

- Some **Level 4 facilities** expressed uncertainty over their eligibility for PHC accreditation.
- A few **Level 2 private clinics** reported **delays in receiving formal accreditation certificates** despite completing all application steps and actively offering PHC services.
- Notably, **15% of Level 5 facilities** reported having PHC accreditation—an unexpected outcome given that these are typically referral facilities. This is likely explained by the **selective approval of certain Level 5 hospitals**, particularly those **run by Faith-Based Organizations (FBOs)**, to provide PHC services in areas **with limited access to lower-tier facilities**. These facilities may operate **community-linked outpatient departments** functioning as de facto primary care units.

Facilities without PHC accreditation are **ineligible for PHC-related capitation payments**, excluding them from a potentially stable funding stream. For many Level 2 and 3 providers, this poses a significant risk to operational sustainability.

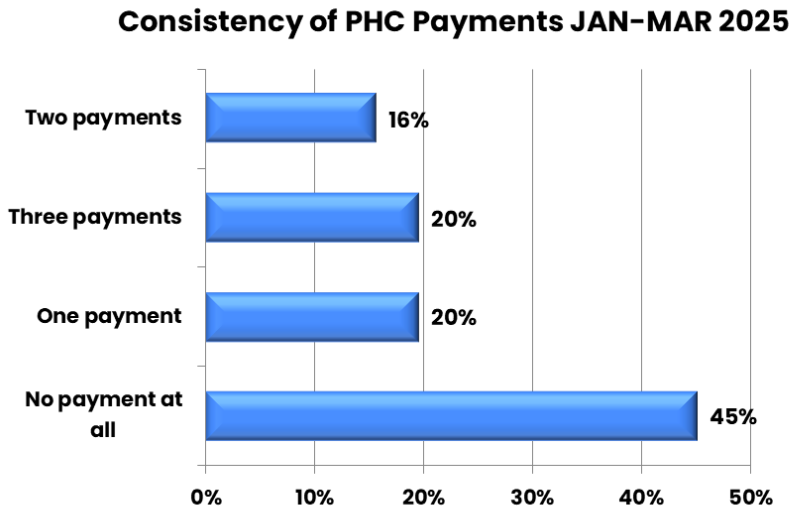
Implication: SHA should **clarify eligibility criteria** for PHC accreditation, particularly for hybrid or higher-level facilities, and **accelerate processing** for providers meeting basic standards.

4 PHC Payment Consistency and Predictability

The survey assessed whether healthcare facilities were receiving PHC payments consistently since January 2025, when the Social Health Authority (SHA) began disbursing funds under the Primary Health Care (PHC) global budget model. This model allocates funds monthly to contracted facilities based on actual utilization, disease complexity, and relative demand in each Primary Care Network (PCN), replacing the previous capitation system.

4.1 Monthly Payment Trends

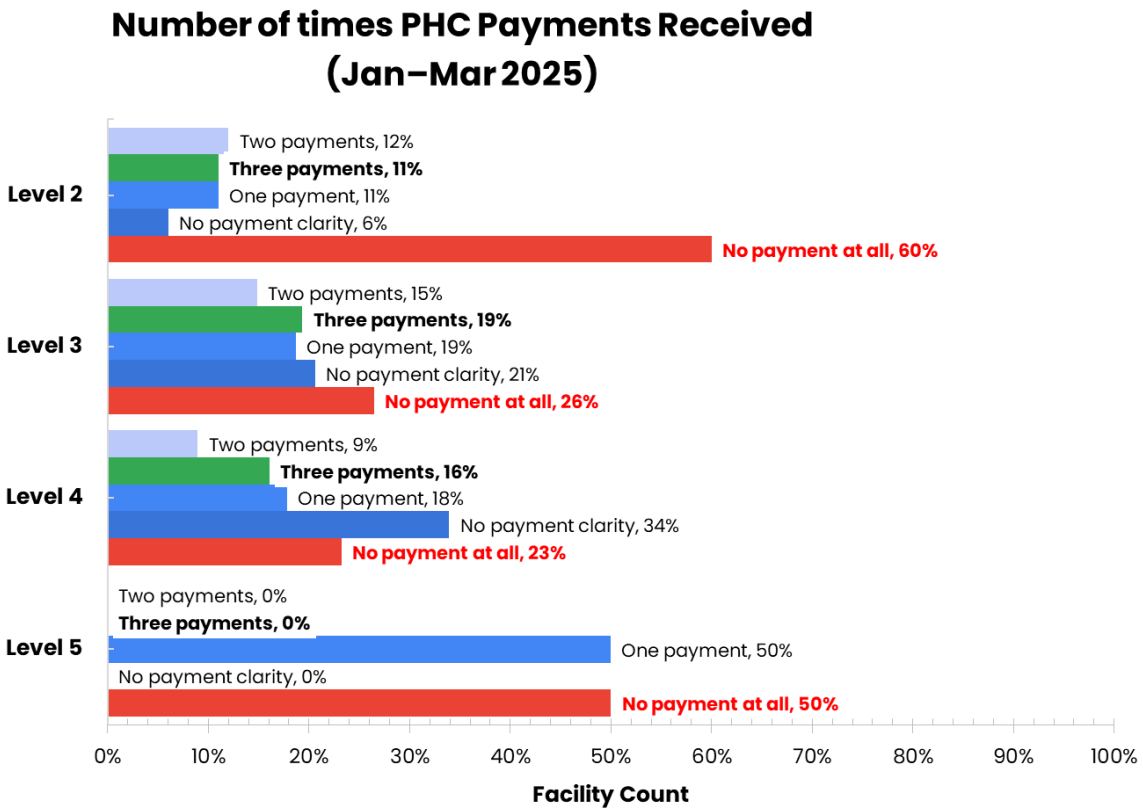
Out of the **332 facilities** (representing **86%** of total respondents) that reported being contracted for PHC, only a minority reported predictable monthly payments:



- **20%** of contracted facilities received PHC reimbursements in **all three months** (January–March 2025).
- **15%** received payments in **two of the three months**.
- **20%** reported receiving payment for **only one month**.
- **45%** received **no PHC payment at all**, despite being accredited and actively offering services.

These findings suggest inconsistencies in the disbursement of PHC funds, affecting a significant number of accredited providers.

4.2 Consistency of PHC Payments by KEPH Level & Ownership



The patterns varied significantly across facility types and levels of care:

4.2.1 Public Facilities

46% of PHC accredited public facilities reported receiving no payments in the Jan – Mar 2025 quarter while only 15% received a payment every single month.

- **Level 2**: 60% reported receiving **no PHC payment**, while 5% were unclear about their payment status. Only 14% confirmed receiving all three months of PHC reimbursements.
- **Level 3**: 15% received full payments for the three-month period, another 15% received only March payments, 38% received no payment, and 17% lacked clarity on their payment status.

- **Level 4**: 63% of respondents were **uncertain** whether payments received were related to PHC or other claim categories. Of the remainder, 13% had received only January payments, while 25% reported full payments for all three months.

4.2.2 Private Facilities

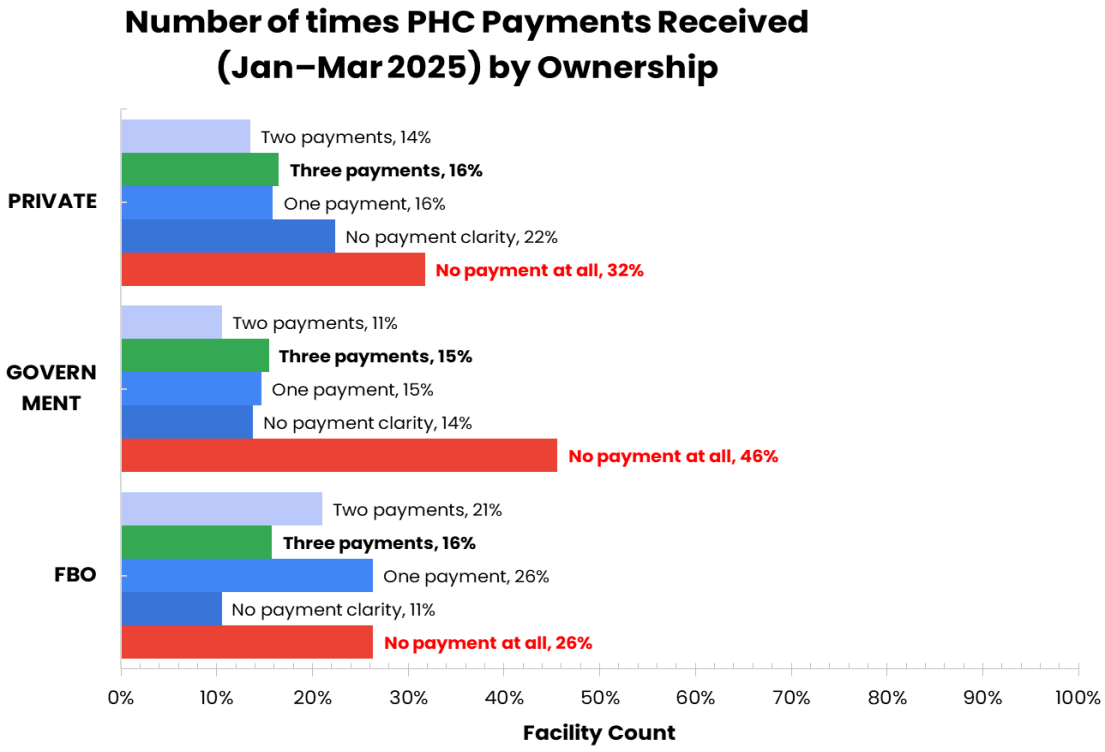
32% of PHC accredited private facilities reported receiving no payments in the Jan – Mar 2025 quarter while only 16% received a payment every single month

- **Level 2**: Similar to public facilities, 60% reported **no payments**, and 12% were unclear about payment status. Only 14% received all three months' reimbursements.
- **Level 3**: 21% confirmed full reimbursements, 31% cited unclear payment status, and 18% reported no payment.
- **Level 4**: Mixed results, with 30% reporting no payments, 33% uncertain whether payments were for PHC, and only 12% receiving full quarterly reimbursements.

4.2.3 Faith-Based (FBO) Facilities

26% of PHC accredited private facilities reported receiving no payments in the Jan – Mar 2025 quarter while only 16% received a payment every single month

- **Level 2**: 50% had not been paid, while the remaining 50% were evenly split between receiving payments for January–February and March.
- **Level 3**: A balanced spread—25% received no payment; the remaining facilities were evenly divided across various payment months and clarity levels (each 13%).
- **Level 4**: A more favorable trend was observed—29% received full quarterly



payments, 29% received payments for February–March, and the remaining responses were evenly distributed among no payment, March-only payment, and payment uncertainty (each 14%).

These findings reveal persistent **delays and inconsistencies** in PHC reimbursements across all sectors, with Level 2 facilities—particularly public and private—experiencing the highest rates of non-payment. The **lack of clarity on the purpose of payments**, especially among Level 4 public facilities, further complicates efforts to track and manage cash flows at the facility level.

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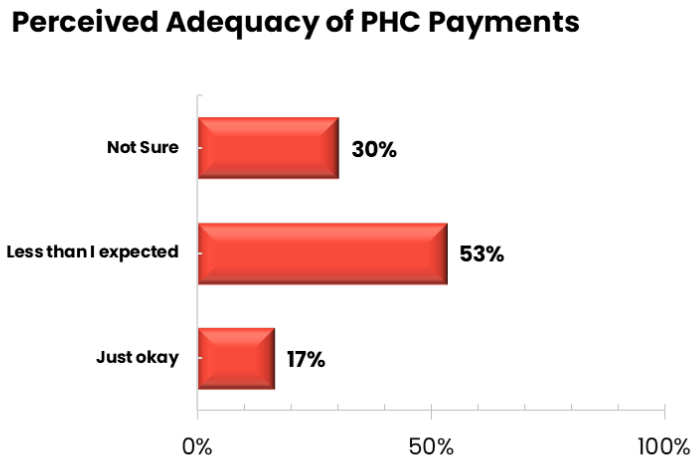
5 PHC Payment Adequacy

The survey assessed how healthcare facilities **perceived the adequacy of reimbursements** received for Primary Healthcare (PHC) services under the Social Health Authority's global budget model. Facilities were asked whether the amounts received were **"just okay," "less than expected," or whether they were unsure of the appropriateness of the payments**. These responses provide insight into the alignment—or misalignment—between actual reimbursements and the operational expectations of providers.

5.1 Overall Perceptions of Adequacy

Among the 332 facilities accredited and contracted for PHC services:

- **53%** reported that the payments received were **less than expected**.
- **17%** considered the reimbursements to be **just okay**.
- **30%** were **unsure** how to rate the adequacy of the payments.



These findings indicate that a clear majority of PHC-contracted facilities found the reimbursement levels unsatisfactory, suggesting systemic underfunding or mismatched expectations relative to service delivery costs.

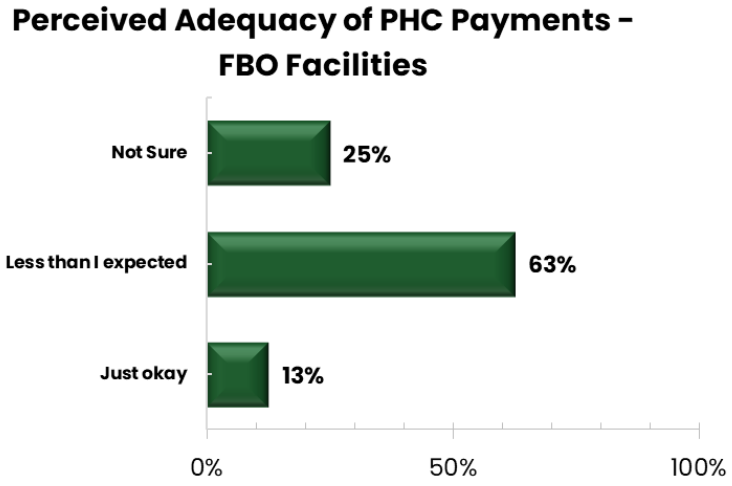
5.2 Adequacy Ratings by Ownership and KEPH Level

The perceived adequacy of PHC payments varies significantly by facility ownership and KEPH level, reflecting different cost structures, service volumes, and levels of dependency on SHA reimbursements.

5.2.1 Faith-Based Organizations (FBOs)

FBO facilities expressed the highest dissatisfaction overall, with **63%** reporting that payments were less than expected.

- **Level 2 FBOs:** Evenly split—50% found payments just okay, 50% less than expected.
- **Level 3 FBOs:** 79% said payments were less than expected; 21% said "just okay."
- **Level 4 FBOs:** 67% less than expected; 17% just okay; 17% unsure.

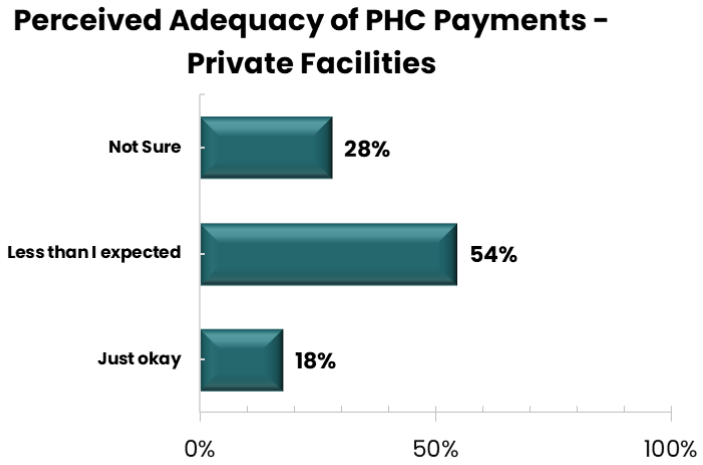


The data suggest that higher-tier FBOs—many of which act as referral centers—face a pronounced gap between their service delivery costs and the reimbursements received under the PHC model.

5.2.2 Private Facilities

Private sector facilities were moderately less critical than FBOs, but a majority still expressed dissatisfaction:

- **54%** reported payments were less than expected.
- **18%** rated them as just okay.



- **24%** were unsure.

Disaggregated by level:

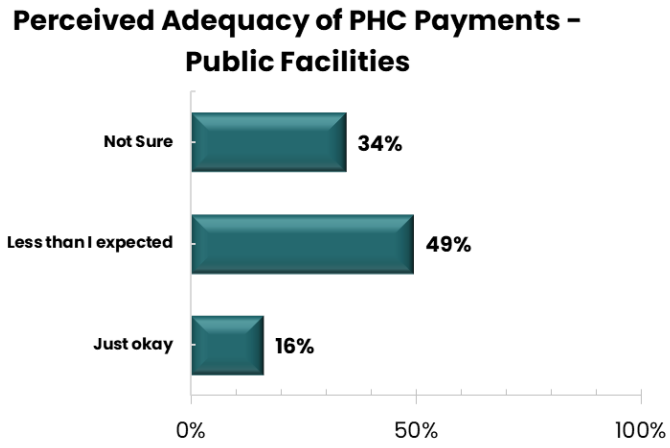
- **Level 2 Private:** 64% less than expected; 21% just okay; 14% unsure.
- **Level 3 Private:** 59% less than expected; 18% just okay; 23% unsure.
- **Level 4 Private:** 38% less than expected; 15% just okay; 47% unsure.

Private Level 4 facilities showed the highest level of uncertainty regarding the adequacy of PHC payments, with nearly half unable to assess whether the amounts received were appropriate. This ambiguity likely stems from difficulties in distinguishing PHC reimbursements from other payment streams, a challenge compounded by the broader service portfolios and complex billing environments typical of higher-level private hospitals.

5.2.3 Public Facilities

Despite having a slightly more favourable outlook, public sector facilities demonstrated continued concern over PHC payment adequacy, with **nearly half (49%)** reporting that the payments received were less than expected. In addition, **over a third (34%)** were unsure about the adequacy of the amounts, reflecting persistent challenges in understanding payment attribution or reconciling disbursements with services delivered. Only **16%** of public facilities rated the payments as just okay, highlighting ongoing uncertainty even within the public health system.

- **49%** said payments were less than expected.
- **16%** rated them as just okay.
- **34%** were unsure.



Breakdown by KEPH level:

- **Level 2 Public:** 55% less than expected; 19% just okay; 26% unsure.
- **Level 3 Public:** 48% less than expected; 17% just okay; 35% unsure.
- **Level 4 Public:** 37% less than expected; 0% just okay; 63% unsure.

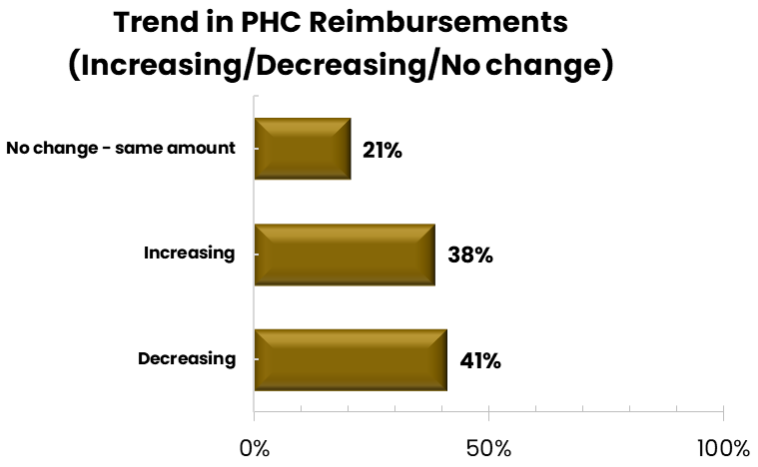
The high level of uncertainty, particularly among Level 4 public facilities, where 63% were unsure about the adequacy of PHC payments and none rated the payments as just okay, reflects persistent challenges in distinguishing PHC reimbursements from other funding streams such as SHIF or ECCI. Similarly, the notable uncertainty at Levels 2 and 3 suggests ongoing gaps in communication, reconciliation, or documentation of payment sources within the public sector.

5.3 Trends in PHC Reimbursement Amounts

To assess changes in PHC reimbursements over time, facilities were asked whether their reimbursement amounts had increased, decreased, or remained the same since SHA implementation. This offers a dynamic view of how payment adequacy has evolved under the new system.

5.3.1 Overall Trend (All Facilities)

- **41%** of facilities reported a **decrease** in PHC reimbursement amounts.
- **38%** observed an **increase**.
- **21%** stated that amounts had **remained unchanged**.



This mixed outcome indicates that while some facilities have experienced improvement, the higher share of those reporting decreased reimbursements suggests a deterioration in PHC payment reliability for a substantial number of providers. This raises concern about the long-term viability of PHC service delivery under the current funding framework.

5.3.2 Ownership-Based Trends

Ownership Category	Decreasing (%)	Increasing (%)	No Change (%)
Private	51%	28%	21%
FBO	38%	38%	23%
Public	26%	54%	20%

- **Private facilities** were the most likely to report declining reimbursements, with half of all respondents noting decreases.
- **Public facilities** saw the most favorable trends, with over half indicating increasing reimbursements.
- **FBOs** were evenly split, with no dominant trend in either direction.

These differences highlight uneven implementation outcomes, with private and FBO sectors facing more financial instability.

5.4 Emerging PHC Reimbursement Patterns and Implications

5.4.1 Key Observations

- **Facility Level Matters:** Level 4 facilities across all ownership types consistently expressed the greatest dissatisfaction and reported the highest uncertainty regarding PHC reimbursements—both in terms of amount and predictability.
- **Public Facilities Show Slight Edge:** Public Level 2 and 3 facilities showed somewhat more positive trends, indicating better integration into SHA's payment systems or stronger support from county health departments.
- **Complexity Grows with Facility Level:** The uncertainty among Level 4 facilities likely reflects the complexity of managing multiple reimbursement streams (PHC, SHIF, and ECCI), making it difficult to isolate and assess PHC-specific payments.

5.4.2 Implications

- **Private Sector Pressures:** The high incidence of declining reimbursement amounts among private facilities could intensify existing financial challenges, particularly for Level 3 and 4 providers with broader service mandates and higher operational costs. This threatens continuity of care in areas heavily served by the private sector.
- **FBO Concerns:** Faith-based facilities, which serve a significant referral and surgical care role, may face compounded financial pressure given their higher exposure to NHIF arrears, unpredictable PHC reimbursements, and slower SHIF settlements.
- **Public Sector Improvements:** Positive trends in public facilities may reflect improved SHA contract management or readiness in the public health system to implement PHC service delivery. However, uncertainties at Level 4 show that progress is still uneven.

Overall, the trends underscore the need for more predictable, transparent, and equitably distributed PHC reimbursements to ensure sustainability of primary care services—especially under a universal health coverage (UHC) agenda.

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6 SHIF Payment Performance

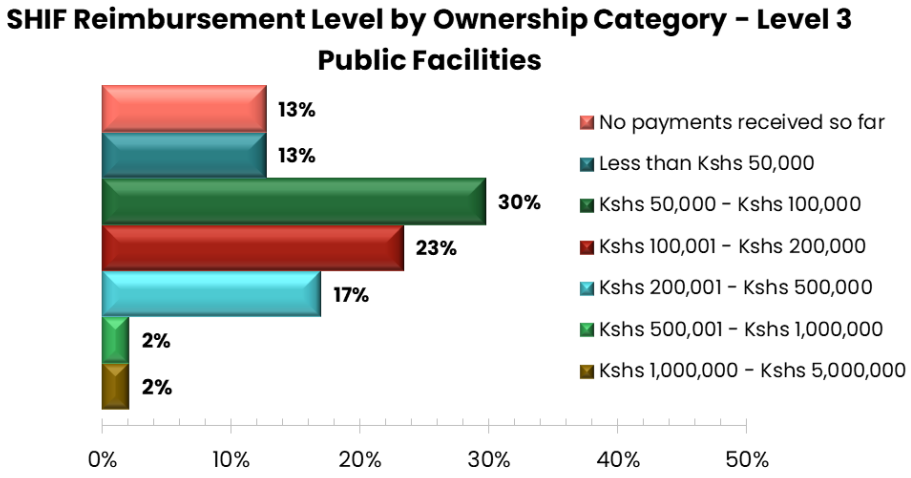
This section evaluates how healthcare facilities are experiencing the Social Health Insurance Fund (SHIF) reimbursement system under SHA. The analysis draws from monthly payment levels, claims settlement patterns, and facility-level variations from December 2024 to April 2025. It covers three thematic areas: (1) SHIF Reimbursement Levels, (2) SHIF Reimbursement Patterns, and (3) Month-on-Month Analysis of SHIF Payments.

6.1 SHIF Reimbursement Levels

To understand the scale and equity of SHIF reimbursements, facilities were asked to indicate the total amounts received monthly, disaggregated by KEPH level and ownership. This approach provides a clearer view of fund distribution trends while minimizing distortions caused by facility size or service mix.

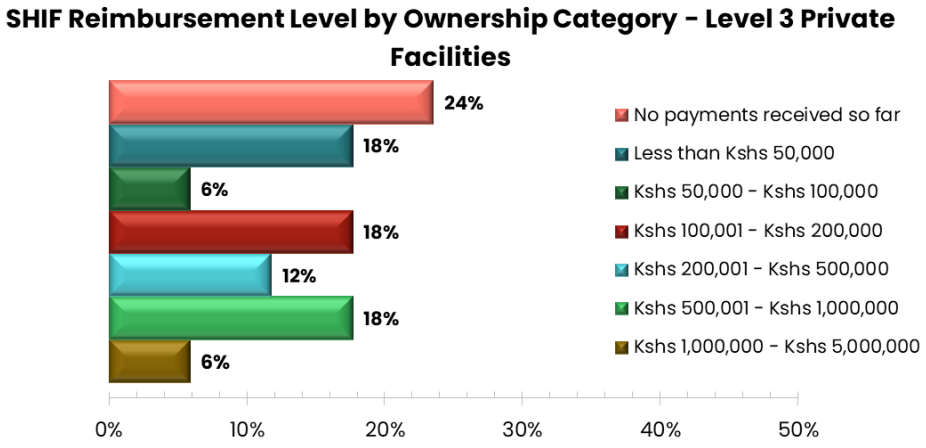
6.1.1 Level 3 Facilities – SHIF Reimbursements:

At Level 3, Faith-Based Organizations (FBOs) reported the lowest reimbursement ranges, with 50% receiving less than Kshs 50,000 monthly. **Public Level 3 facilities** fared slightly better, with 53% receiving Kshs 50,000–200,000.



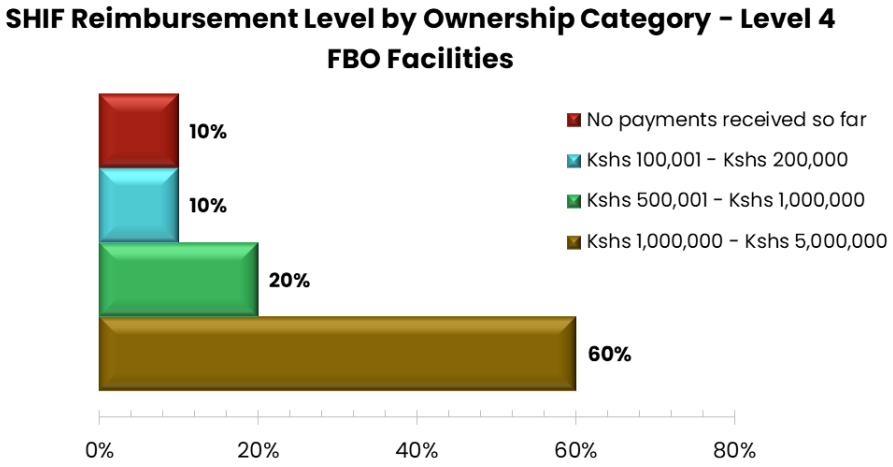
Private facilities presented a polarized profile: 24% reported receiving no payment, while 18% reported monthly reimbursements exceeding Kshs 500,000—higher than any other category at this level. This suggests that private Level 3 facilities may be both more selectively contracted on one hand and more efficient in claim submission or handle more

high value claims on the other hand , though the exclusion of a quarter of facilities signals coverage gaps.

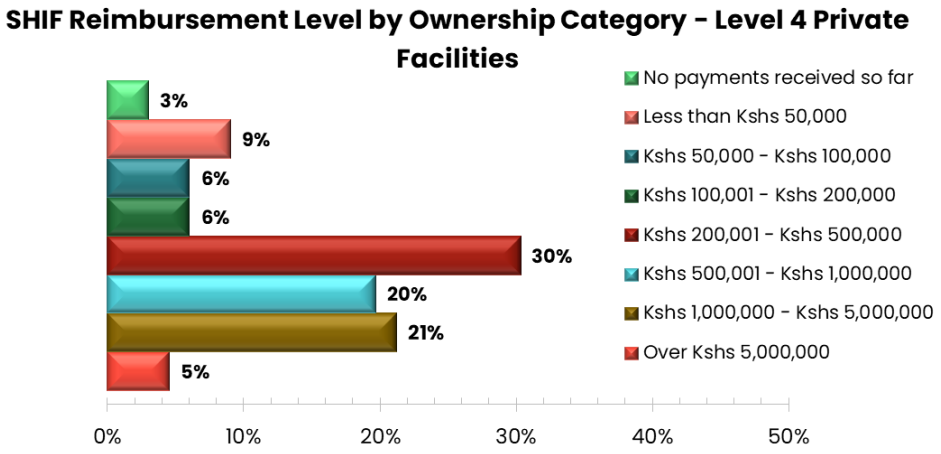


6.1.2 Level 4 Facilities - SHIF Reimbursements:

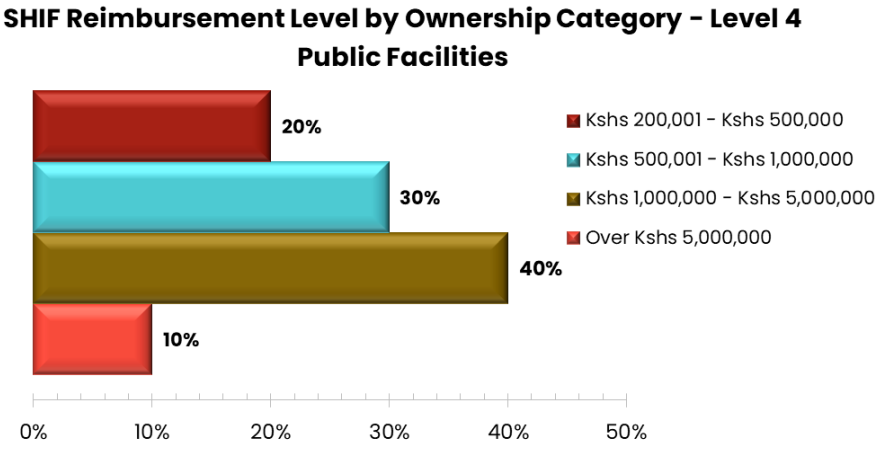
Reimbursement patterns at Level 4 were higher. FBO facilities reported the most favorable profiles—60% received between Kshs 1–5 million monthly, and another 20% received Kshs 500,001–1 million.



In contrast, 51% of private Level 4 facilities received less than Kshs 500,000, while only 21% crossed the Kshs 1 million threshold.



Public facilities showed a more balanced spread: 40% received Kshs 1–5 million, 30% received Kshs 500,001–1 million, and 20% received Kshs 200,001–500,000.



These figures highlight a relative advantage for FBOs at this level, potentially due to their referral functions or more established contracting terms.

6.1.3 Level 5 Facilities - SHIF Reimbursements

Only FBO and private Level 5 facilities participated in the survey. Among FBOs, 60% received more than Kshs 5 million monthly, with the remainder receiving Kshs 1–5 million. Private Level 5 facilities had a broader range: 20% received more than Kshs 5 million, 30% between Kshs 1–5 million, and others clustered in lower brackets. These high

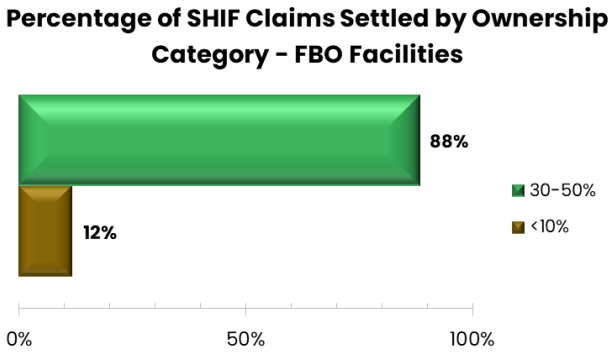
reimbursement levels suggest that Level 5 contracting is operational and generating substantial payments—particularly for FBOs—though sample sizes were small.

6.2 SHIF Reimbursement Patterns

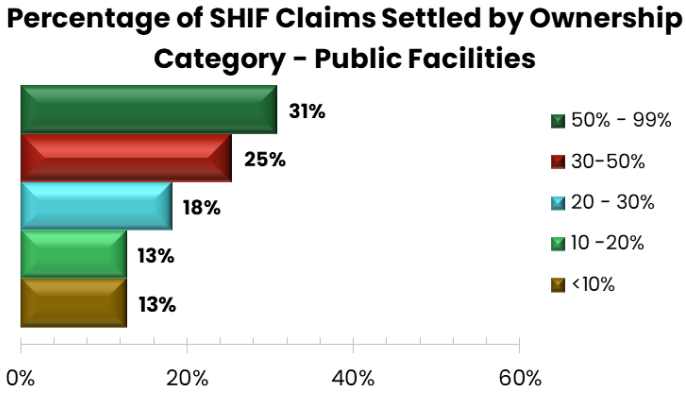
Facilities were asked to report what proportion of their submitted SHIF claims had been paid since the transition from NHIF to SHA in October 2024. This metric provides a more nuanced picture of the effectiveness of the SHIF reimbursement process.

Across all facilities, the average SHIF claims settlement rate was **34%**.

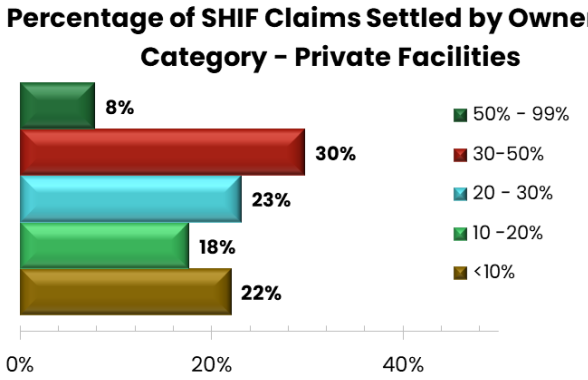
- **FBO Facilities**: 88% reported that 30–50% of their claims had been settled. None reported settlement above 50%. The average settlement rate was estimated at 36%.



- **Public Facilities**: A more even distribution was observed. While 30% had received 50–99% of their claims, another 25% were in the 30–50% band. The estimated average settlement was 40%.



- **Private Facilities**: These showed the weakest performance. Only 8% had received over 50% of their claims. Nearly a quarter (22%) reported that less than 10% had been paid. The average settlement was just 27%.

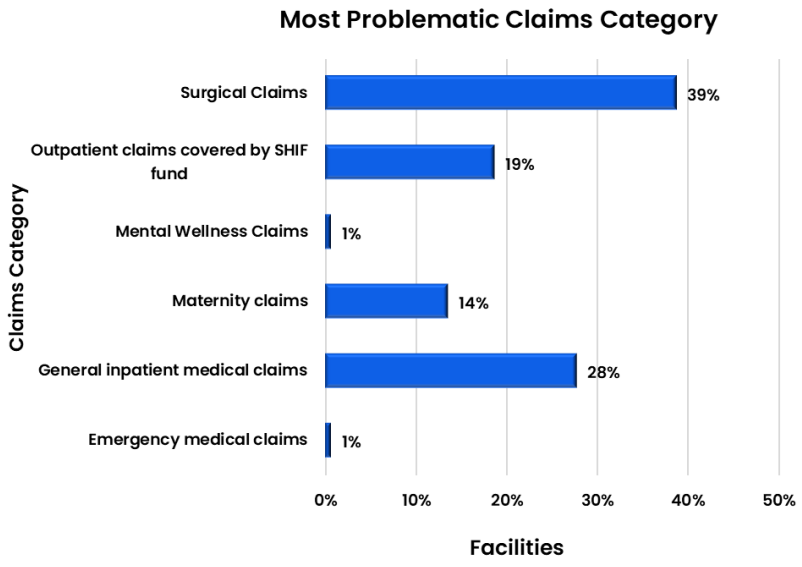


This analysis reveals persistent inefficiencies in SHIF claim settlement, with private facilities particularly disadvantaged. While public facilities had relatively better outcomes, significant proportions of claims remain unpaid across all categories.

In addition, the most problematic claim categories were identified as follows:

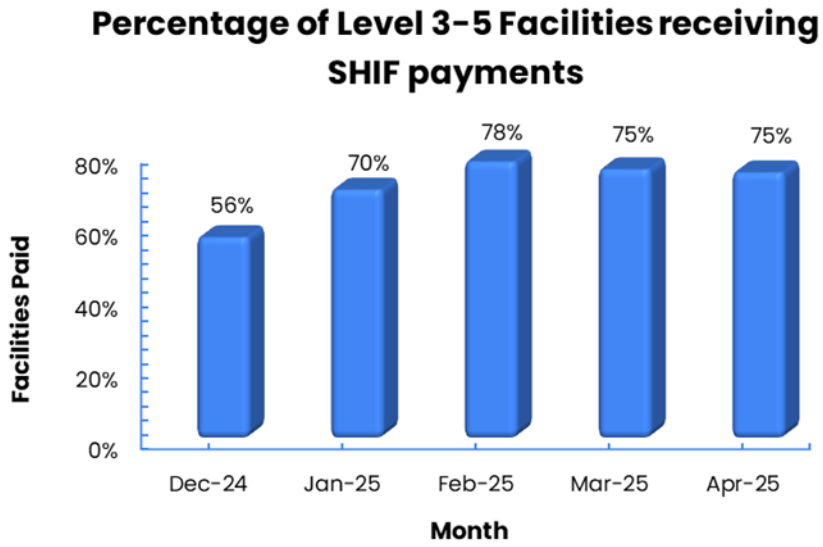
- **Surgical Claims (39%)**
- **Inpatient Medical Claims (28%)**
- **Outpatient SHIF Claims (19%)**
- **Maternity Claims (14%)**

The dominance of surgical claims as a bottleneck reflects the complexity, higher value, and documentation intensity of these claims—factors that often result in extended review periods and disputes.



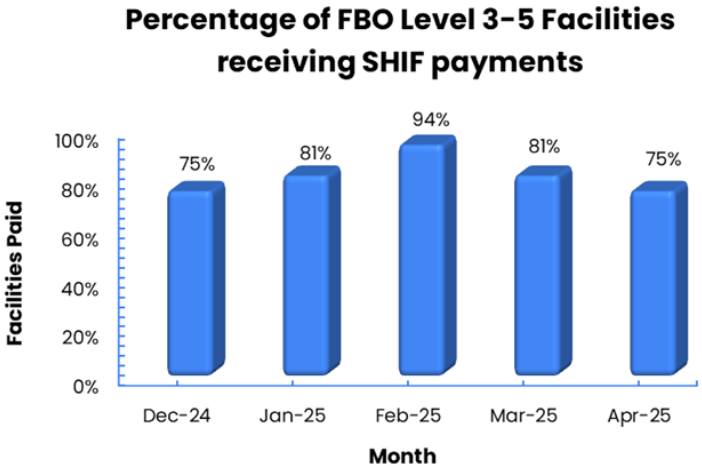
6.3 Month-on-Month Analysis of SHIF Payments (Dec 2024 – Apr 2025)

The survey examined SHIF disbursement trends across Level 3 to 5 facilities over a five-month period. The percentage of facilities reporting receipt of SHIF payments increased from **56% in December 2024** to a high of **78% in February 2025**, before settling at **75% in both March and April**.

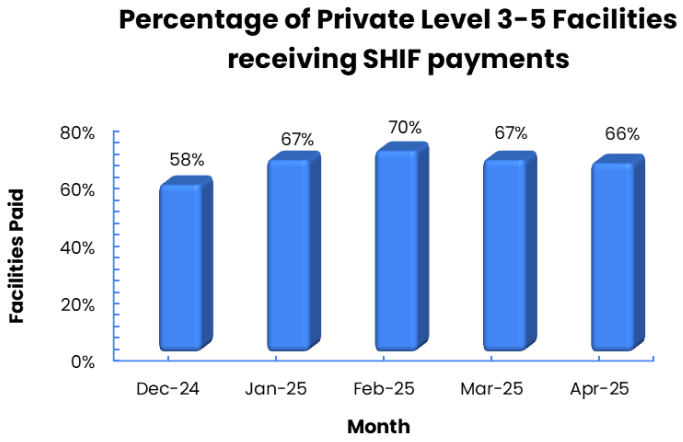


6.3.1 Ownership Disaggregation:

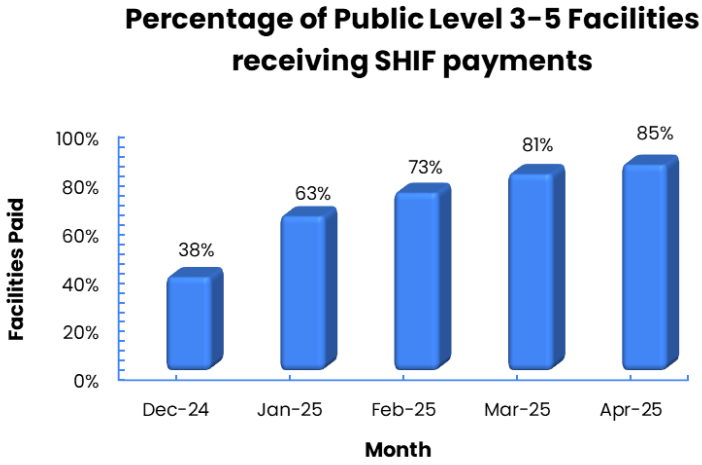
- **FBO Facilities:** Consistently reported the highest SHIF payment coverage, peaking at 94% in February before declining to 75% in April.



- **Private Facilities:** Showed the least improvement, hovering between 58–70% across the entire period. The stagnation suggests unresolved systemic issues in processing or prioritization.



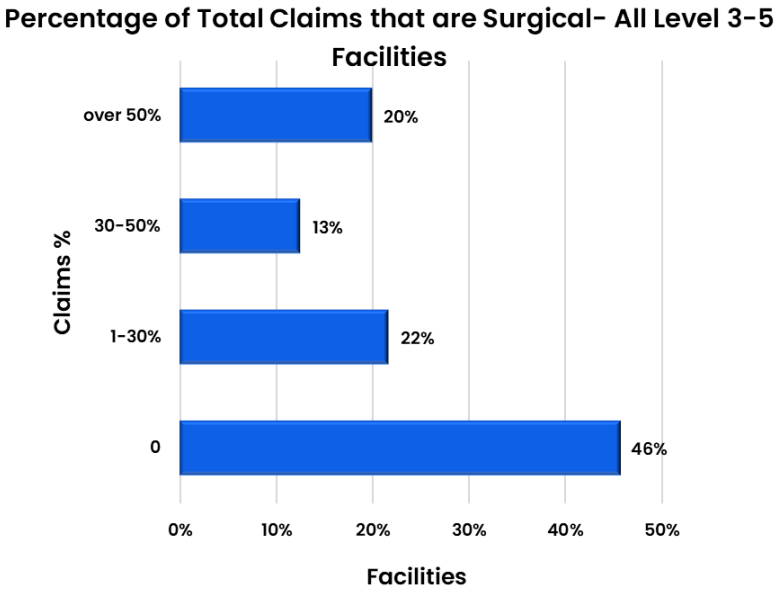
- **Public Facilities:** Demonstrated the sharpest improvement, with payment receipt jumping from 38% in December to 85% by April—an indication of improved alignment between public facilities and SHA's reimbursement systems.



These trends confirm a general improvement in SHIF disbursement, albeit with continued challenges in coverage, especially for private facilities. The strong performance among public providers and FBOs points to either greater administrative alignment or prioritization.

7 Surgical Claims and High-Value SHIF Reimbursements

Surgical claims are a significant subset of SHIF reimbursements due to their high cost, documentation intensity, and clinical complexity. The April–May 2025 Payments Survey explored the profile, volume, and review duration of surgical claims to assess how their delayed processing is affecting the financial position of referral-level facilities.



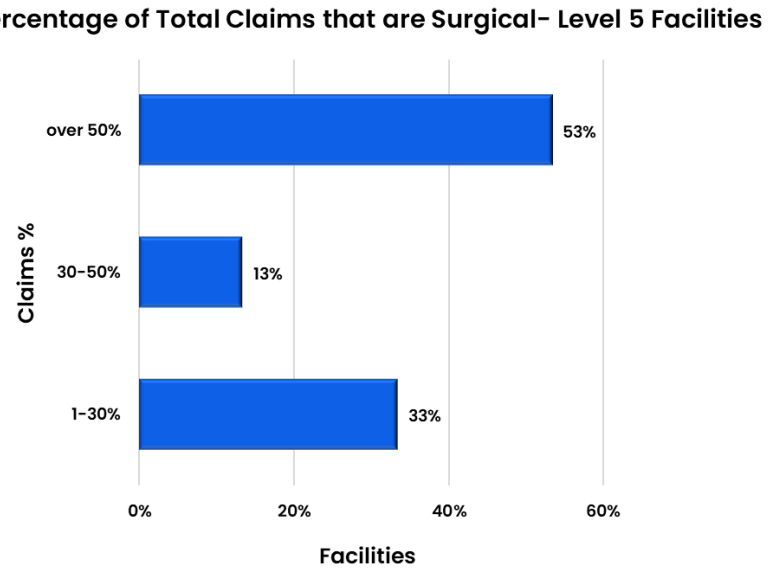
7.1 Prevalence of Surgical Claims in Facility Portfolios

Surgical procedures constituted a major share of submitted claims for many facilities, particularly among higher-level providers. Of the Level 3–5 facilities surveyed:

- **33%** reported that surgical procedures comprised over **30%** of their submitted claims.
- **20%** indicated that **over half** of all claims submitted were surgical in nature.

These figures are strongly tier-dependent:

By KEPH level:

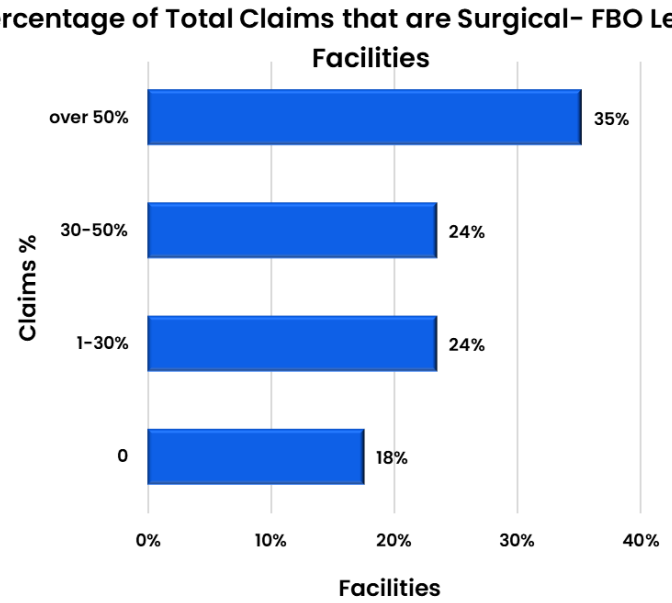


- **Only 2%** of Level 3 facilities had surgical-heavy claim volumes.
- At Level 4, **52%** reported that over 30% of their claims were surgical.
- At Level 5, this rose to **67%**, consistent with their role as surgical referral centers.

By ownership:

- **59%** of FBOs with Level 3–5 facilities submitted surgical-heavy claims (30%+).
- **45%** of private facilities reported the same.
- **No** public facilities in the survey fell into this category (30%+).

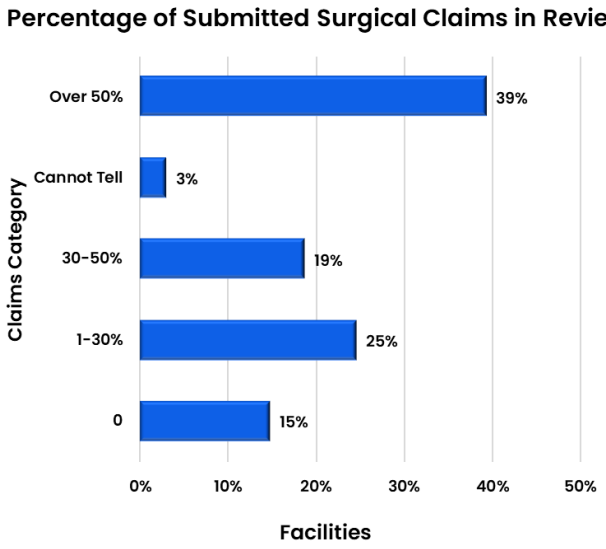
This aligns with earlier findings that FBOs in the survey were more likely to operate high-level hospitals offering specialized surgical care.



7.2 Surgical Claims Held in Review

A striking proportion of surgical claims remain in prolonged review:

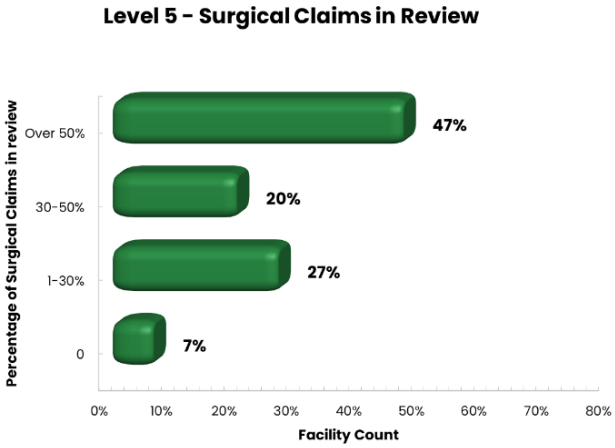
- **39%** of facilities reported that **more than half** of their surgical claims were still under review by SHA.
- Another **19%** indicated that **30–50%** of their surgical claims were pending review.
- Only **15%** reported that all surgical claims had been processed and cleared.



KEPH-level analysis revealed that:

- **89%** of Level 3 facilities had no surgical claims under review (reflecting their limited volume).
- At Level 4, **38%** had over 50% of surgical claims in review.
- At Level 5, **47%** of facilities reported that more than half of their surgical claims were yet to be settled.

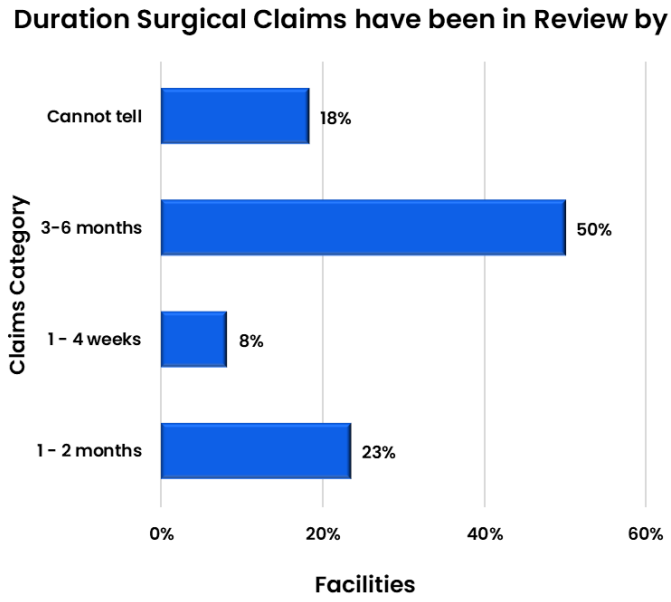
These trends suggest that the higher the level of care—and the greater the surgical load—the more likely it is that surgical claims remain stuck in the SHA review pipeline.



7.3 Duration of Surgical Claims in Review

Facilities were asked to indicate how long their surgical claims had remained in review:

- **50%** had claims that had been in review for **3–6 months**.
- **23%** had waited **1–2 months**.
- **8%** reported a wait of **1–4 weeks**.
- **18%** could not estimate how long their claims had been in review, suggesting poor communication or limited tracking capabilities.



The 3–6 month delay window is of particular concern, given the high upfront costs of surgical services—covering theater supplies, equipment use, anesthesia, personnel, and post-operative care. Facilities face severe cash flow pressures when these high-value claims remain unsettled for extended periods.

7.4 Implications

The findings reveal a critical chokepoint in SHA's reimbursement system. **Facilities offering surgery—particularly FBOs and Level 4–5 hospitals—are carrying a disproportionate burden of delayed payment. These delays:**

- Strain working capital and compromise the continuity of surgical services.
- Increase the risk of stock-outs of surgical consumables and theater supplies.
- Undermine provider confidence in SHIF's ability to support complex care under UHC.

A targeted SHA response is necessary, including:

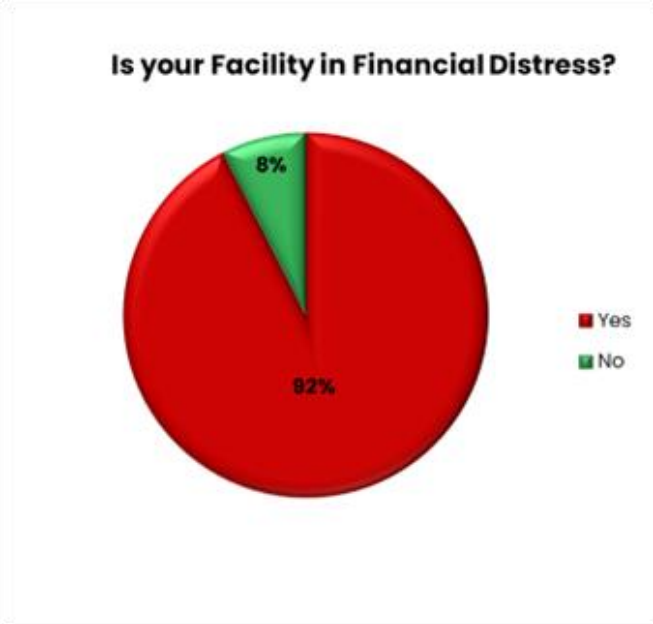
- Strengthening review capacity for surgical claims.
- Developing fast-track adjudication pathways for urgent or high-volume facilities.
- Improving feedback loops and transparency on claim statuses.

Unless these bottlenecks are addressed, the goal of equitable access to essential surgical care under SHIF will remain aspirational.

8 Facility Financial Wellbeing

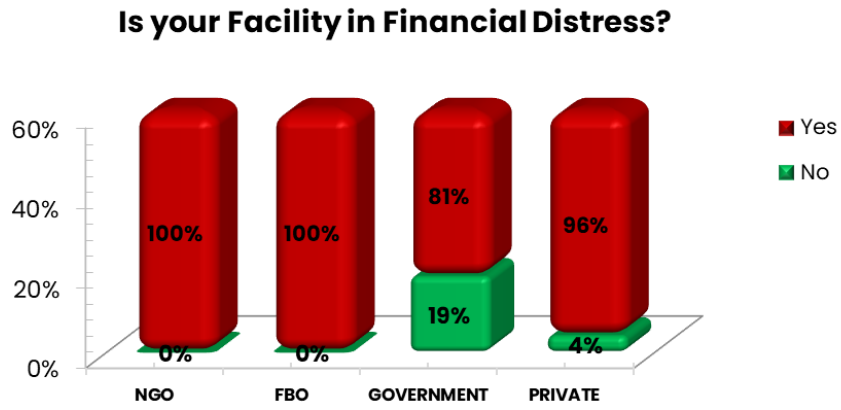
8.1 Overview of Financial Distress Among Facilities

Despite some progress in SHIF disbursements, healthcare facilities across Kenya continue to operate under intense financial pressure. In the April–May 2025 survey, **92% of all facilities** reported being in financial distress, with sharp variation across ownership types:



- **100% of faith-based (FBO) facilities** reported financial distress.
- **95% of private facilities** reported similar distress.
- **84% of public facilities** indicated financial strain.

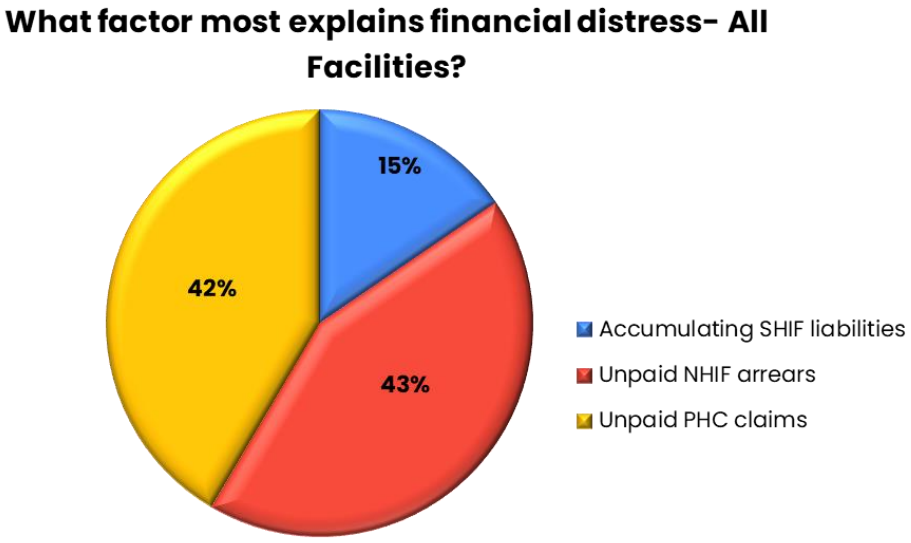
These findings suggest that recent improvements in contracting, and payment frequency have not yet translated into financial sustainability, especially for providers heavily dependent on reimbursements from the Social Health Authority (SHA).



8.2 Key Drivers of Financial Distress

Facilities were asked to identify the primary cause of their financial distress. Two issues stood out as most frequently cited, outstanding NHIF arrears and PHC-related cashflow challenges:

- **Unpaid NHIF arrears** – 43%
- **Unpaid PHC claims** – 42%
- **Unpaid SHIF claims** – 15%



These overlapping liabilities—spanning past NHIF obligations and current SHA reimbursements—underscore the structural fragility facing facilities and the compounding effect of multiple unsettled claims.

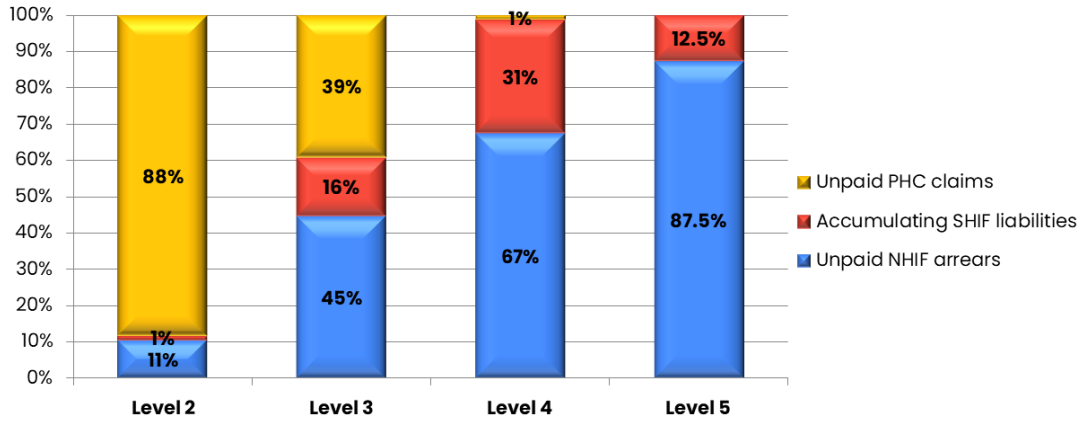
8.2.1 KEPH-Level Insights

Financial distress drivers varied significantly across KEPH levels, shaped by the degree of PHC reliance, exposure to legacy NHIF debts, and levels of contracting under SHA:

8.2.1.1 Level 2 Facilities:

PHC payment gaps were the dominant concern. A striking **88%** of Level 2 facilities attributed their financial distress to **unpaid PHC claims**, reflecting their high dependency on primary care reimbursements under the global budget model. In contrast, **11%** cited **accumulating SHIF liabilities**, and only **1%** identified **NHIF arrears**, highlighting the limited historical exposure of these lower-tier facilities to inpatient or surgical reimbursement backlogs.

What factor most explains financial distress?- Based on KEPH Level



8.2.1.2 Level 3 Facilities:

The sources of distress were more diversified. **45%** of Level 3 facilities pointed to **unpaid NHIF arrears,** indicating residual pressure from legacy inpatient or maternity claims however a significant **39%** also reported **unpaid PHC claims** emanating from the new SHA contracts. **16%** identified **SHIF delays**, signaling early signs of emerging strain as SHIF becomes more prominent in their service mix.

8.2.1.3 Level 4 Facilities:

Higher-tier facilities showed a sharp departure from primary care concerns. Only **1%** cited **PHC reimbursements** as a concern, reflecting reduced dependence on PHC payments or lack of accreditation for PHC. Instead, **67%** of facilities cited **unpaid NHIF arrears**, and **31%** reported **accumulating SHIF liabilities**. This reinforces the importance of timely inpatient and surgical reimbursement to this category of providers.

8.2.1.4 Level 5 Facilities:

Among Level 5 hospitals, financial distress was overwhelmingly linked to **legacy NHIF arrears**, cited by **88%** of facilities. **12%** pointed to **SHIF reimbursement delays**, and **none** reported PHC payments as a concern, consistent with their low participation in SHA's PHC contracting framework. These facilities are high-volume referral centers whose operational stability is closely tied to resolution of large, complex claims under both NHIF and SHIF.

8.2.2 Ownership-specific insights:

8.2.2.1 FBO facilities:

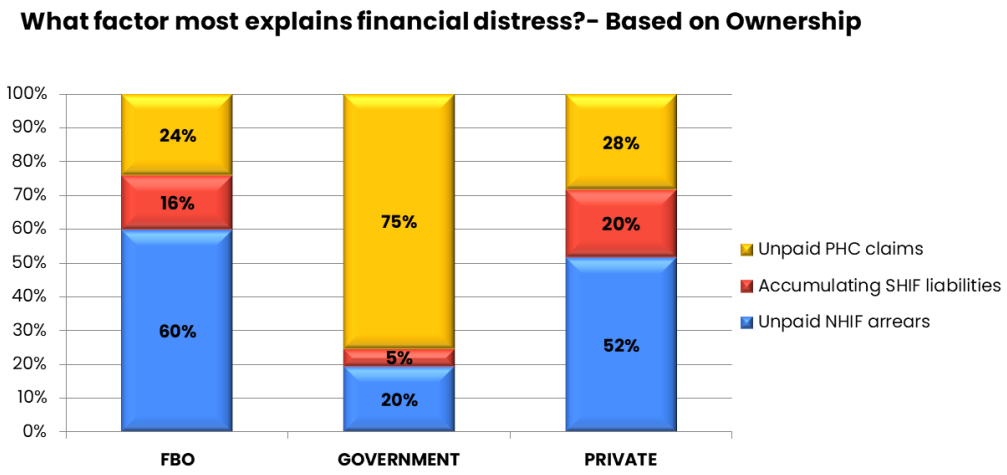
The main distress driver was **unpaid NHIF arrears** (60%), followed by **unpaid PHC claims** (24%) and **accumulating SHIF liabilities** (16%). These facilities, often operating as referral centers, carried significant legacy debts under NHIF.

8.2.2.2 Private facilities:

The top driver was **NHIF arrears** (52%), followed by **PHC delays** (28%) and **accumulating SHIF liabilities** (21%). Their exposure to surgical and inpatient services makes them particularly sensitive to SHIF payment backlogs.

8.2.2.3 Public facilities:

Here, **unpaid PHC claims** dominated (75%), reflecting the heavy reliance of public Level 2 and 3 facilities on timely PHC reimbursements.



8.3 Specific Financial Challenges

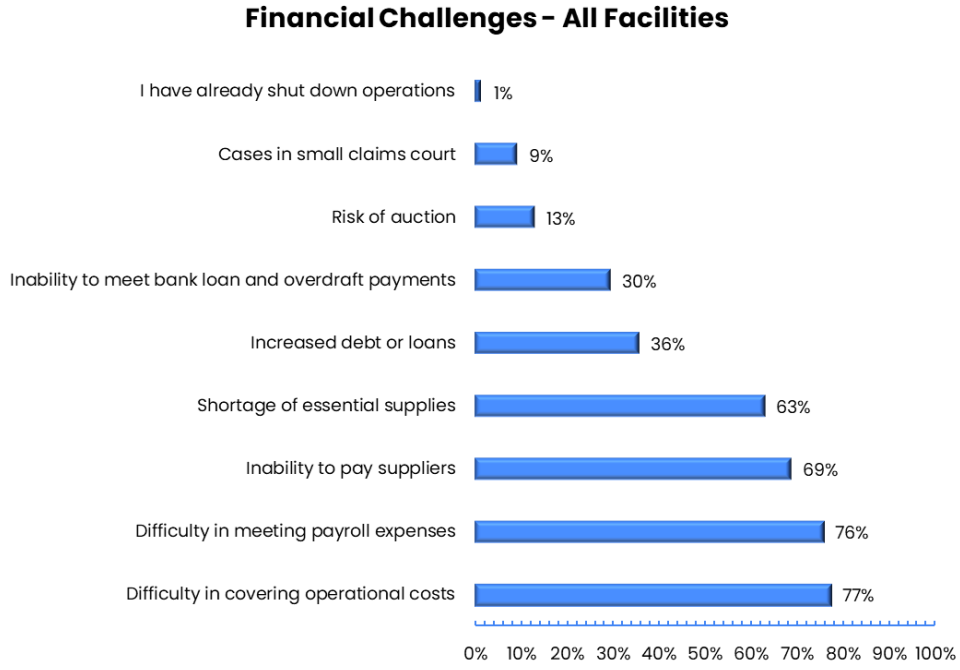
The survey examined the particular financial challenges experienced by facilities. The most widespread issues across all ownership and KEPH levels were:

- **77%** had difficulty covering operational costs
- **76%** struggled to meet payroll obligations
- **69%** could not pay suppliers
- **63%** experienced shortages of essential supplies

Other notable issues included:

- **36%** had increased their loan or debt burdens
- **30%** were defaulting on bank loans or overdrafts
- **13%** were at risk of auction
- **9%** faced small claims court cases
- **1%** had already shut down operations

These patterns reflect a sector under severe liquidity stress, with many facilities resorting to credit to keep operations afloat.



8.4 Financial Wellbeing by KEPH Level

Level 2 Facilities were the most financially vulnerable:

- **88%** struggled with payroll
- **85%** lacked essential supplies
- **80%** could not cover operational costs
- **71%** were unable to pay suppliers

This reflects persistent undercapitalization in Kenya's primary care tier.

Level 3 Facilities were also heavily affected:

- **75%** faced payroll challenges
- **72%** could not meet operational expenses
- **57%** experienced stockouts of essential supplies

Level 4 Facilities, while reporting slightly better liquidity, were more exposed to credit risks:

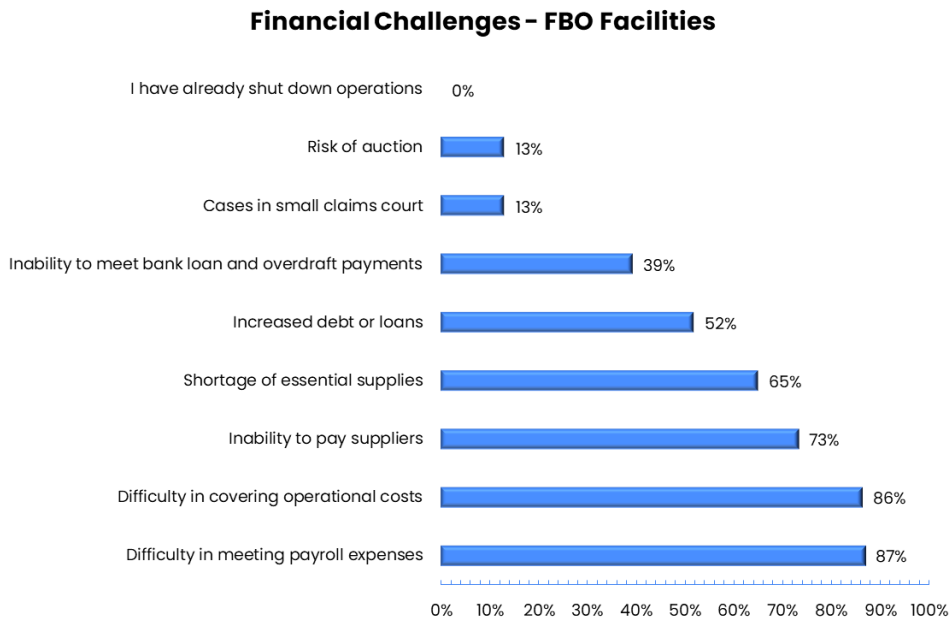
- **78%** had supplier payment backlogs
- **80%** struggled with operational costs
- **35%** defaulted on loan repayments
- **16%** faced auction risk

These findings point to higher fixed costs and accumulated liabilities in referral-level hospitals.

8.5 Financial Challenges by Ownership Category

FBO Facilities reported the highest levels of stress:

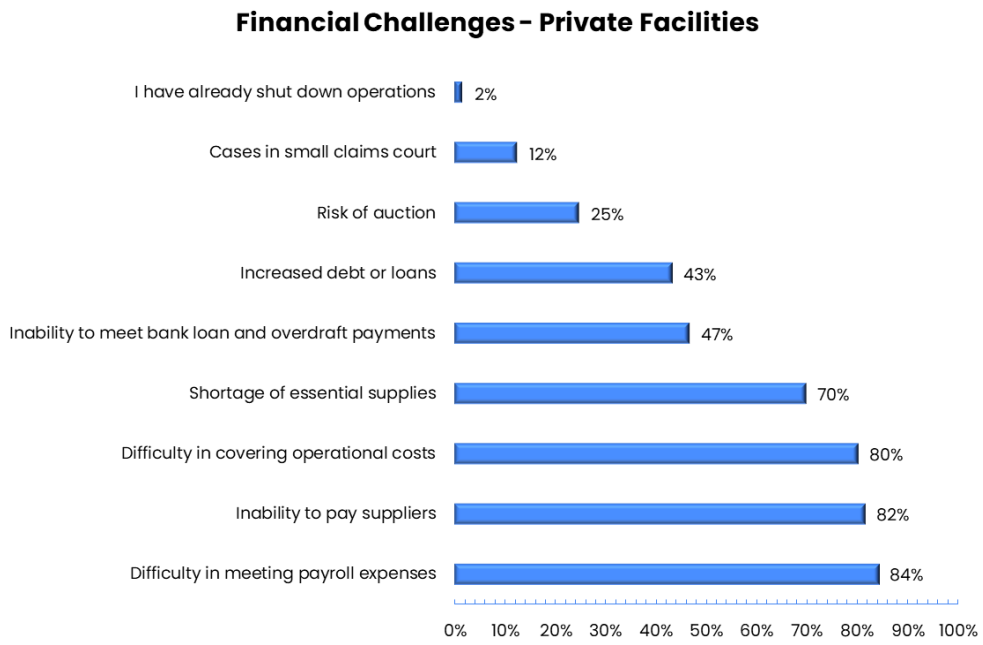
- **87%** struggled with payroll
- **86%** with operational costs
- **73%** could not pay suppliers
- **52%** had taken on new loans
- **39%** defaulted on bank obligations



While no FBO facilities reported closure, **13%** were at risk of auction or court proceedings.

Private Facilities displayed acute liquidity stress:

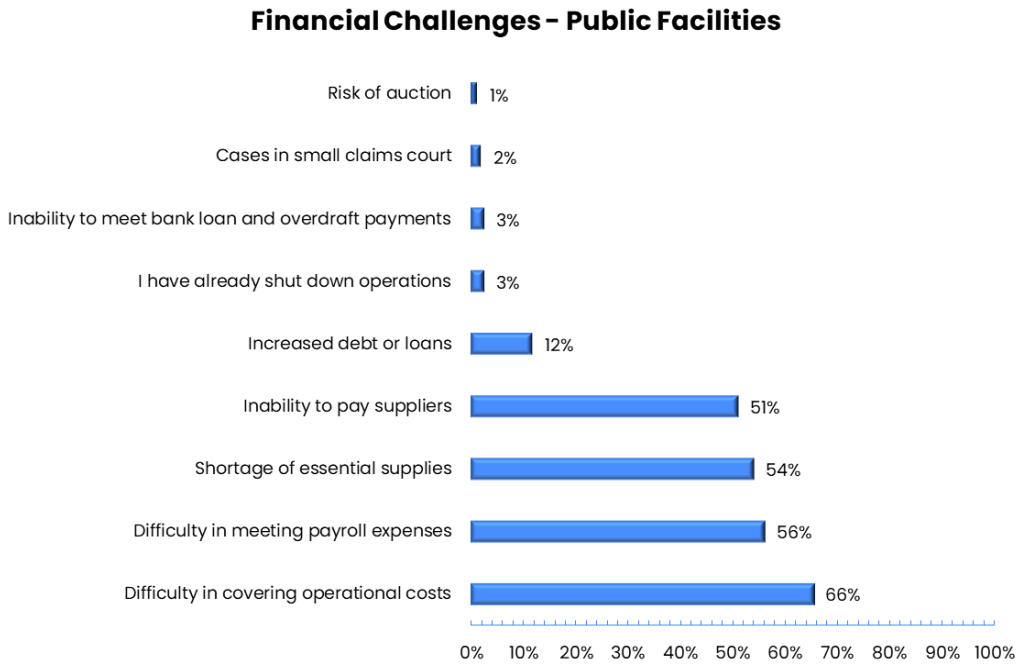
- **84%** had payroll challenges
- **82%** could not pay suppliers
- **80%** struggled with operational costs
- **47%** defaulted on bank loans
- **25%** faced risk of auction
- **2%** had already shut down



Public Facilities showed relatively lower, yet still concerning, levels of strain:

- **66%** had difficulty with operational costs
- **56%** faced payroll challenges
- **51%** could not pay suppliers
- Only **3% or less** faced auction or legal risks

While subventions and government flexibility may cushion public facilities, unpaid PHC claims remain a persistent threat to their financial sustainability.



9 Key Insights from the Survey

1. Broad SHA PHC Accreditation with Selective Adaptations

- **Widespread PHC Accreditation**: 86% of all surveyed facilities reported being accredited to provide PHC under the SHA framework. This high coverage was consistent across ownership types and KEPH levels—except for Level 5 hospitals, which typically do not provide routine PHC.
- **Targeted PHC Accreditation at Level 5**: About 15% of Level 5 facilities—primarily faith-based—were accredited for PHC. These hospitals serve remote populations lacking lower-level alternatives. Their inclusion illustrates SHA's pragmatic approach to adapting PHC contracting to local care access gaps.

2. PHC Reimbursements: Inconsistent, Delayed, and Frequently Inadequate

- **Low Payment Consistency**: Only 15% of PHC-accredited facilities received payments for all three months of the January–March 2025 period. Among Level 2 public and private facilities—core PHC providers—60% received no payment at all.
- **Payment Ambiguity Undermines Planning**: A significant number of Level 4 public and private facilities reported difficulty identifying whether received payments were for PHC, SHIF, or ECCI claims—hindering budget tracking and operational decisions.
- **Majority View Payments as Inadequate**: 63% of PHC-accredited facilities found reimbursements to be "less than expected." FBOs reported the highest dissatisfaction (83%), particularly at Level 4, where service intensity and costs are higher. This reflects misalignment between the global budget allocations and actual costs of sustained PHC delivery.

3. PHC Reimbursement Trends Are Uneven and Ownership-Dependent

- **Diverging Experiences**: While 54% of public facilities saw PHC reimbursement amounts increase, half of private facilities reported a decline. Among FBOs, 38% saw increases while an equal proportion reported decreases. These mixed patterns suggest variability in SHA portal usage, claims tracking efficiency, and internal administrative capacity.

4. SHIF Reimbursements Are Broad-Based But Often Shallow

- **Widespread but Partial Coverage**: 75% of Level 3–5 facilities received some SHIF reimbursements, but only 17% reported having more than half of their SHIF claims settled. In fact, 43% of facilities received less than 30% of what they invoiced.
- **Financial Risk Persists Despite Reimbursements**: 91% of Level 3–5 facilities still report financial distress, underscoring that partial payments are not enough to stabilize operations. Facilities remain exposed to a combination of unpaid NHIF legacy claims, erratic PHC reimbursements, and high-cost SHIF surgical claims.

5. Surgical Claims: Low Volume, High Value, and Systemically Risky

- **High-Risk Category**: Although only 33% of Level 3–5 facilities reported that surgical claims accounted for over 30% of their SHIF invoices, 39% identified surgical claims as the most problematic. The issue lies not in volume but in high value, complexity, and long processing times.
- **Verification Bottlenecks**: Private and FBO facilities reported that many surgical claims had been pending for over 90 days. Delays in verifying and settling these claims have cascading effects, threatening cash flow in service lines like maternity, emergency surgery, and specialist care.

6. Persistent Financial Distress Across the Health System

- **Distress Is Widespread**: Over 90% of all facilities surveyed—across all ownership categories and levels—reported experiencing financial strain. The most common challenges included inability to pay suppliers, rent arrears, and difficulties covering utility bills.
- **Public Payroll Shielded, But Operations Not**: Public sector facilities, especially Level 4, reported fewer payroll concerns due to exchequer-supported salaries and union protections. However, these facilities still face acute operational funding gaps, with 80% of public Level 4 hospitals unable to pay suppliers or sustain core utilities.

7. Root Causes of Distress Vary by Level and Ownership

- **Primary Care Tier (Levels 2–3)**: PHC claims were the top source of distress for Level 2 (88%) and Level 3 (39%) facilities, particularly private and FBOs. The unpredictability of global budget disbursements has left these frontline providers financially vulnerable.
- **Higher-Tier Facilities (Levels 4–5)**: At Level 4 and 5, the primary source of distress was **legacy NHIF arrears**—cited by 67% and 88% of facilities, respectively. These hospitals bear the backlog of unpaid surgical and inpatient claims from the NHIF era. SHIF delays are emerging as an additional pressure point.
- **Multifactorial Financial Strain**: The interplay between historical debts (NHIF), transitional bottlenecks (SHA), and current underfunding (PHC) reveals a complex landscape that cannot be solved by addressing only one reimbursement stream.