Universal Health Coverage in Kenya: The Financing, Governance, and Institutional Dynamics of a Decentralized Policy Environment.

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ABSTRACT

The research focuses on the mechanisms, challenges, and consequences that UHC reform in Kenya has, conceptualizing UHC as a long-term government policy project that cuts across the governance, financing, and state capacity nexus. Based on theoretical frameworks of policy learning, incrementalism, and institutional capacity, the article evaluates the effects of Kenya's devolved system of health and strategic purchasing mechanism on UHC implementation and equity outcomes. Using qualitative policy analysis of government reports and academic publications, the research unveils structural constraints of the social health insurance program over time, the presence of inequalities in the delivery of services, and constraints of governance that mitigate the effects of reforms. These results bring into focus the necessity to strengthen the institutional capacity, strategic purchasing, and intergovernmental mobilization to achieve equitable and sustainable UHC. The article is a policy theory contribution to intricate social reforms through the way in which iterative policy learning and governance structure frame reform paths in a lower- and middle-income setting.

INTRODUCTION

UHC has become a key public policy goal in Kenya, and it represents the global normative commitments as well as national state priorities in social protection and service delivery. UHC is integrated at the global level in the Sustainable Development Goals as a tool of promoting fair access to vital services alongside protecting households against economic vulnerability (World Health Organization, 2010; United Nations, 2015). In Kenya, UHC is not only embraced as a health-sector initiative but as a state-led policy reform, which is interested in financing, governance, and institutional coordination at the governmental levels (Ministry of Health, 2014). UHC is framed by official policy frameworks, which associate health system reform with productivity, development of human capital, and the promotion of social equity (Government of Kenya, 2007; Ministry of Health, 2014). This status UHC above technical intervention and brings it above the company of a redistributive public policy tool and thus, deserves the scholarly attention as a reform of the public policy with governance, state capacity, and policy sustainability implications.

The commitment of UHC in Kenya is clearly expressed in official policy documents that lay a legal and strategic base for the implementation of reforms. According to the Kenya Health Policy 2014-2030, UHC is one of the guiding principles in developing the health system, and the policy further emphasizes equitable access, protection of financial risks, and improvement of quality as one of the policy objectives (Ministry of Health, 2014). The policy makes UHC an ongoing process of reforms that should ultimately be achieved by gradual realization and not by providing universal coverage at once, based on the fiscal and organizational limitations of the state (World Bank, 2019). The policy document on the development of the Ministry of Health supports this orientation by describing the steps to be implemented in stages and the necessity of institutional preparedness. The framing of this kind is consistent with the international policy recommendations to achieve incremental growth of coverage in lower- and middle-income countries (World Health Organization, 2010). As a result, UHC in Kenya is integrated into a consistent policy framework, but not pursued in standalone programmes.

UHC has maintained a place in the public policy agenda in Kenya due to political prioritisation that has spanned across the successive administrations. The inclusion of UHC in government planning reports and Ministry of Health policy statements continues to recognize it as one of the flagship reforms in line with national

development strategies, such as Vision 2030, and other medium-term plans (Government of Kenya, 2007; Ministry of Health, 2020). This stability implies that UHC has reached a level of agenda stability that is not confined to electoral periods, which is a characteristic that has commonly been linked with long-term social policy changes (Pierson, 2004). According to the reports of the Ministry of Health, coordination among the national government, county governments, and financing institutions has been easy through the high-level political support (Ministry of Health, 2020). This kind of coordination is primarily involved in the devolved governance situation of Kenya, where the power of implementation is distributed among the levels of government (Bossert & Beauvais, 2002). Political commitment is hence a facilitating institutional state of affairs and not rhetoric. At this, long-term prioritisation has helped to make UHC part of the Kenya policy machinery.

The Kenyan approach to the implementation of UHC is an indication of conscious dependence on gradual reform and policy learning. Policy documents on the Ministry of Health state that pilot initiatives and rolled-out plans are approaches to testing policy tools and administrative provisions before they can be applied on a larger national level (Ministry of Health, 2020). Such types of pilots allow policymakers to understand the existing operational limitations and modify plans of implementation according to the observed results, thus being consistent with theories of incrementalism in the field of public policy (Lindblom, 1959). Instead of trying to achieve a more holistic reform formative, the Kenyan state employs an adaptive strategy, which focuses on feedback and changes as time goes by (Howlett & Ramesh, 2014). These types of strategies are usually suggested in more complicated policy areas that are marked by uncertainties and limits of capacity (Pressman & Wildavsky, 1984). Incremental implementation here can thus be considered a strategic adaptation and not policy indecision. In line with this, the UHC trend in Kenya represents policy learning in the context of reforms.

The other characteristic feature of the UHC policy agenda in Kenya is institutional restructuring. Policies of the Ministry of Health focus on the need to transform health financing systems to enhance pooling, purchasing, and accountability operations in the system (Ministry of Health, 2014; World Bank, 2019). These reforms are defined as conditions to sustainability as opposed to simple technical changes, highlighting the institutional orientation of the policy. Policy documents also emphasize the need to define institutional roles and reinforce regulatory control in order to promote fair access to services (Ministry of Health, 2014). This emphasis is consistent with the larger body of public policy research that attributes the effectiveness of social policies to the capacity and quality of governance in the state (Fukuyama, 2013). UHC can be considered a governance reform and not a service-delivery programme through foregrounding institutional design. Therefore, institutional restructuring is considered to be one of the fundamental pillars of the UHC public policy in Kenya.

Finally, the inclusion of the Universal Health Coverage (UHC) in Kenya's devolved governance structure is part of the policy design process. The guidance that was released by the Ministry of Health recognizes the county authorities as the leading implementers of health services, while providing stewardship and coordination responsibilities to the national government (Ministry of Health, 2014). This setup reflects an effort to balance the national needs of spheres of policy coherence with local spheres of local responsiveness, which is a significant difficulty in decentralized systems (Bossert, 2016). Policy documents frame devolution as a pathway for adapting to the specific context and innovating instead of being seen as a structural constraint to the implementation of UHC (Ministry of Health, 2020). Mechanisms for intergovernmental coordination are stressed as being the key to coordinating actions at the county level with national goals. Viewed through this prism, devolution is cemented as a conscious choice of governance as part of the UHC policy architecture. Consequently, Kenya's UHC reform is a multi-level public policy experiment that is built on cooperative governance.

LITERATURE REVIEW AND CONCEPTUAL FRAMEWORK

UHC Implementation and Service Utilisation

The UHC pilot programme in Kenya, which started in select counties in 2018, was designed to increase access to essential health services and to help reduce financial burdens on the population through the lowincome and the informal sector (Barasa et al., 2021). Data from these pilot counties show increased utilisation of outpatient services, which is a result of the reduction of user fees and improved coverage, increasing demand for healthcare (MoH, 2020). Nevertheless, operational challenges, such as a shortage of staff, supply chain interruptions, and

irregular observance of the referral protocols, hindered the realization of the expected health outcome to the fullest (Langat et al, 2025). Moreover, inequalities emerged across the counties: the level of uptake of services provided and quality of services improved in counties with better fiscal and administrative capacities than resource-poor or remote areas (EquityHealthJ, 2024). These findings convey the concern that although UHC reforms have helped to stimulate service utilisation, the reality is that they are still influenced by local governance, institutional capacity, and operational readiness. Accordingly, Kenya's experience shows that increasing coverage is not sufficient to make the health system equitable.

The pilot also revealed persistent gaps in financial protection, especially in the informal sector populations facing impediments to enrolment in the benefits of a National Hospital Insurance Fund (NHIF) and a lack of awareness of entitlements (Mugo et al, 2022). These gaps show that despite the existence of provisions in formal policy, coverage expansion does not necessarily translate to the meaning of financial protection for or universal coverage. Regional imbalances in facility locations and resource percentages, along with other inequities such as rural people facing longer travel times, indirect costs to patients, and fluctuating quality of services, etc. (EquityHealthJ, 2024), also cause higher inequities in access to health services. Such evidence argues for the need to evaluate the results of UHC based on the systemic constraints and implementation capacity, rather than just on nominal figures with the implementation of enrolment. In conclusion, Kenya's pilot shows that policy houses must come with focused operational and governance approaches in order to achieve equitable access to services.

Incremental Reform and Policy Learning

Kenya's UHC trajectory is a good example of the use of incrementalism and policy learning to guide complex health system reforms (Kiendrébéogo et al., 2020). Feedback from pilot activities in some selected counties provided operational feedback on utilisation of services, supply chain performance, and patient satisfaction, which informed subsequent changes in benefit packages and delivery arrangements (Langat et al., 2025; MoH, 2020). This approach provides an example of a more engineered learning process whereby empirical learning from implementation feeds back into policy evolution (as opposed to the expectation that they can immediately be covered nationally). Nonetheless, persisting limitations include passive purchasing practices and monitoring gaps; therefore, lessons from the pilot are not translated equally in terms of equitable outcomes among all counties: EquityHealthJ (2019). These observations lead to the following suggestions: Incrementalism and learning processes are successful only where institutional mechanisms exist to bring feedback into coherent adjustments of policies and operations.

The conditional form of policy learning is also emphasized in comparative evidence, where the main components of effective incremental reforms in Rwanda and Thailand have been the use of well-organized feedback mechanisms, strong political commitment, and the ability to implement standardized implementation protocols (Kiendrébéogo et al., 2020). In Kenya, though experiences from pilot projects have been used to design Primary Care Networks and the revision of NHIF benefits, there has been a gap in consistent adoption of approaches, due to disparities in county levels of administrative and technical capacity. As well, use of pilot lessons in national UHC policy has been patchy in line with differences in political priority and local implementation readiness (Mugo et al., 2022). Thus, one of its central implications is the institutionalization of incremental learning into governance structures in order to convert the policy experimentation effects into measurable improvements in coverage and equity.

Policy Capacity, Governance, and Equity Outcomes

Policy capacity, including administrative, technical, and operational, but also performance and management skills, experience, and technical know-how, and qualifications, has been a decisive determinant of UHC outcomes in Kenya (Wu, Ramesh & Howlett, 2015). Counties with an effective financial plan and administrative structure constantly fared better in terms of coverage, on-time reimbursement to the providers, and better alignment with national goals (EquityHealthJ, 2024). On the other hand, counties that have limited capacity struggled with delays in the disbursement of funds, stock outages, and inconsistencies in the delivery of service, leading to inequities despite formal policy commitments (MoH, 2020). Structural features of NHIF financing and provider payment mechanisms also generate differential incentives, which are often biased towards

resource-rich locations, leaving informal sector populations uninsured (Mugo et al., 2022). These trends show that the policy capacity is an intermediate in turning reforms in UHC into equitable service access and financial protection.

Devolution adds to the confusion in the equity arena. While county governments are a key implementer of health services, there are variations in the local level of government on issues of local governance, fiscal space, and administrative capacity that affect the effectiveness of UHC reforms (EquityHealthJ, 2024). Initiatives like the Social Health Authority focus on harmonizing the purchasing functions and enhancing accountability, but, to the best of our information, there are challenges persisting in areas such as staffing, digital infrastructure, and stakeholder coordination (MoH, 2020). These findings illustrate how good governance is the key to closing the gap between designing policies and improving health, and in which equity is born out as an outcome of coordinated capacity, institution building, and oversight systems. Consequently, Kenya's UHC reforms demonstrate that incremental learning, institutional capacity, and governance structures are interlinked as determinant factors in the success or failure of policy.

The experience of Kenyan universal health coverage shows that expansion of coverage, learning from pilots, and following policy adjustments are interdependent in terms of institutional capacity and governance structure in determining concrete outcomes (Mugo et al., 2022). Although the pilot programmes have complemented utilisation and improved policy refinements, there are systemic barriers, including uneven facilities distribution, poor coverage of the informal sector, and gaps in administrative capacity that limit the ability to achieve equitable and comprehensive health coverage (Barasa et al., 2021). These observations contextualise Kenya's UHC reforms as experiments in multi-level governance where incremental reforms, learning by doing, and capacity building have collective influence on the outcomes. The conceptual framework behind this study highlights the processes that connect the three elements of policy design, governance arrangements, and equity outcomes to provide a foundation for an empirical study to determine under what circumstances UHC works in some counties and fails in others. Consequently, a holistic knowledge about the trajectory of UHC in Kenya requires combining policy learning, incrementalistic methods, and studies of institutional capacity to explain differences in health access and financial protection.

METHODOLOGY

Research Design and Data Sources

This study uses a qualitative policy analysis design, which is based on a systematic analysis of secondary policy and institutional documents relating to Universal Health Coverage reforms in Kenya. The decision to choose this design is justified because UHC in Kenya has been conceived, governed, and revised in the form of dominant formal policy instruments and institutional arrangements as opposed to a single discrete intervention (Ministry of Health, 2020). In this work, UHC is seen as a long-term reform strategy, public policy institutionalised within the context of governance architecture in Kenya, shaped by fiscal limits, intergovernmental relations, and institutional capacity development. Consistent with contemporary health policy scholarship, official policy documents are considered as empirical artefacts which reflect how states define problems, justify reform options, and adjust strategies over time (Gilson et al, 2020). The methodological emphasis is therefore on policy processes and institutional design, and not so much on service coverage or health outcomes. Coherence between the research questions, the theoretical framework, and the analytical approach is thus ensured in this orientation.

The article uses publicly available policy documents and institutional reports that have been published between 2019 and 2024 and thus covers a period of strengthened development and implementation of UHC policy in Kenya. Core materials include the policy frameworks of the Ministry of Health, UHC implementation, health financing, and progress and evaluation tools researched by national government institutions (Ministry of Health, 2021). Documents were identified where they explicitly referred to issues of governance of UHC, financing arrangements, responsibilities of implementation of UHC, intergovernmental coordination, and where such documents were formally issued or endorsed by public authorities. Materials that were purely descriptive, promotional, or that did not relate to institutional reform were excluded in order to maintain analytical focus. Peer-reviewed studies that have been published in the same period have been used selectively to contextualise and critically interrogate the policy record, particularly those on UHC reform in the context of the devolved

health system in Kenya (Barasa et al., 2021). Kenya is approached not in terms of being a national context, but as an analytically salient intervention in which ambitious social policy reform coincides with decentralised authority and fiscal limit.

Analytical Strategy, Reflexivity, and Contribution

The analysis uses a theoretically informed qualitative content approach informed by concepts of policy learning, incremental reform, and state capacity. Policy documents were reviewed in terms of framing and framing of reform problems, institutional roles, and recognition and resolution of implementation challenges over time in the official policy document record (Ministry of Health, 2021). Interpretive rigor was ensured by following patterns of continuity and accommodation between successive documents instead of looking at isolated utterances. Where an indicator of the framing or institutional change was found, it was checked in connection to reported implementation difficulties and thus brought an analytical argument to bear not on the putative intention but explicitly on the observed policy adjustment. This approach is inspired by recent uses of policy learning theory that emphasise the use of iterative decision-making in conditions of uncertainty and constraint (Dunlop & Radaelli, 2020). Accordingly, the analytical strategy gives precedence to mechanisms of reform evolution over static policy description.

The study is only based on secondary data and does not include primary data from frontline actors and service users, a border that is the result of a deliberate methodological choice rather than a lack of access. The research is concerned with the issues of how UHC is conceptualised, governed, and revised within the formal policy system, for which official policy documents comprise a critical empirical site (World Health Organization, 2021). While recognizing that policy texts reflect formalised positions, and may not reflect informal political negotiation or the local practice, for the analysis, policy coherence and success are not taken for granted. Instead, it focuses on how constraints, tradeoffs, and institutional tensions are expressed within the reform process itself. This reflex position of the analytical is a more credible way of presenting an analytical work, since the claimed results are brought into congruence with the definition of the analyzed empirical material.

By focusing primarily on the policy record of UHC in Kenya, the proposed methodological approach makes possible an analysis of reform as conceived and managed by the state rather than viewed as a normative aspiration or outcome measure. The focus on governance mechanisms, learning processes, and institutional capacity brings into focus dimensions of UHC reform that are often hidden in performance- and outcomeoriented evaluations (World Bank, 2020). The case of Kenya provides the analytically valid lessons on other developing countries with low- to middle-income status, aiming to achieve the UHC by decentralised regimes, specifically in terms of the order in which the reforms are implemented and the functions of the other tiers. While in itself the study does not argue for the statistical generalisation of the results, it adds value to the larger

academic debates on policy learning and state capacity in complex social policy reforms. Thus, the methodology offers a strong basis for analysing UHC as a dynamic public policy process and not a static policy objective.

Governance and implementation of UHC in Kenya.

Kenya's Universal Health Coverage (UHC) reform has seen a well-tuned process of reform that has occurred through a negotiated approach in decentralized governance, which demonstrates an equilibrium between national-level regulation and county-level implementation. Counties are responsible for the provision of primary health services. At the same time, the national government provides guidance, sets policy frameworks, and provides strategic support, which determines the operationalization of UHC in a range of contexts. The phased introduction of Primary Care Networks (PCNs) and mandatory social insurance mechanisms are examples of the implementation nature of reforming by allowing counties to take on new roles gradually (Langat et al., 2025). These measures were not homogeneous, but rather varied, in line with the local administrative capacity, resources, and existing health infrastructure, pointing out the need for flexibility of governance. Overall, it can be seen from Kenya's decentralized system that context-oriented, incremental reform can make national goals consistent with local operational realities. It can help maintain progress toward achieving universal coverage.

Policy learning is a key element of the process of UHC in Kenya, showing the iterative nature in which policy learning from experience informs reform. Counties have interpreted the national guidance within their local capacities, leadership structure, and fiscal resources, leading to different but contextually adapted approaches to service delivery (Karimi et al., 2025). Some counties succeeded in integrating PCNs into existing health structures, while others faced administrative and financial bottlenecks and had to constantly adjust and discuss the program with national authorities. These interactions helped transfer and share knowledge between counties and the national government so that policies can be refined through practical knowledge gained rather than focusing on theoretical design alone. Consequently, Kenya's approach is a testament to the fact that learning is woven into operational practice and intergovernmental coordination and makes adaptation both an intention and a strategy in the implementation of UHC.

Equity and access issues remain as defining characteristics of the reform efforts in Kenya, underlining the need to tackle geographic and structural imbalances. Analyses have shown that the people who live in remote or underserved counties are receiving inadequate access to NHIF contracted facilities, hence engendering unequal progress towards achieving universal coverage (Kazungu et al., 2024). These inequities are shaped by differences in the county-level governance, resource allocation, and infrastructure capacity, which demonstrate that decentralization is not a sufficient ingredient for equitable outcomes. Efforts to control disparities have focused on addressing local needs through interventions that are focused on low-income populations, such as prioritizing underserved areas for the development of PCNs and the deployment of the health workforce. Within this context, the fear of exclusion issues is central to examining the effectiveness and inclusivity of UHC reforms and adds to the need for targeted strategies adaptive to local realities.

Institutional capacity and financing reforms are key determinants of the success of the UHC implementation. NHIF purchasing reforms, including changes to the contribution rates, benefit packages, and provider payment mechanisms, have aimed to improve efficiency, service quality, and financial protection (Mbau et al., 2020). Counties with strong administrative and financial management arrangements were more successful at implementing these reforms, proving that capacity is a prerequisite as well as an outcome of the successful implementation of policies. National initiatives to strengthen capacity have included, among others, technical guidance and training programs, as well as supporting data and supply chain systems, in a coordinated approach to addressing institutional strengthening These dynamics underscore the fact that the reforms in Kenya are not structural in nature but are closely embedded with governance capability and fiscal stewardship issues, which places institutional capability at the centre of reform success.

Political commitment and leadership have an impact on the sustainability and direction of UHC reforms in Kenya. The overt inclusion of UHC goals in national planning documents, quality-improving initiatives, and strategic priorities of NHIs signifies high-level policy prioritisation (Barasa et al., 2018). Nonetheless, differences in local political will, leadership turnover, and competing county priorities have impacted this pace and consistency of implementation, underscoring that it is not enough just to make the formal commitment. High-quality UHC proposals require a long-term partnership between the national and county actors and depend on the existence of the institutional mechanisms that turn the political goodwill into action. So far, the experience of Kenya shows that political buy-in, coupled with structures of governance and institutional ability, helps achieve meaningful progress on the way to universal health coverage and gives scope for local adaptation and innovation.

In sum, Kenya's UHC reform reflects the interplay between the institutional elements of governance, policy learning, institutional capacity, and political commitment on the evolution of a complex health system. Incremental adaptation helps countries respond to the contextual constraint and stay in line with national goals. Learning comes from hands-on experience and from interaction with other governments, not just through topdown orders, so that reforms are developed according to real-world experience. Equity and capacity issues highlight the need for context-specific planning and interventions in order to achieve meaningful coverage results. Collectively, these dynamics show that the approach to UHC in Kenya represents a strategic, adaptive, and evidence-informed model of decentralized health policy reform.

DISCUSSION

The financing reforms of the UHC across Kenya reveal the amplified structural limitations within the social health insurance (SHI) scheme that are both simultaneously correlated with their coverage efficacy and equity. Retrospective analysis of the country's National Hospital Insurance Fund (NHIF) policy coverage and effectiveness shows that even before the implementation of the Social Health Insurance Fund (SHIF), only a small percentage of the population was effectively covered especially in the informal sector, with the coverage still at only 17 percent and informal sector uptake at 27 percent as at July 2023 (Nungo et al, 2024). This trend is consistent with larger evidence that SHI models based on the principle of payroll or contributory schemes do not scale up to cover the situations when formal employment is limited, which highlights a conflict between intentions of creating SHI models and labor-market facts common in most low- and middle-income economies (Nungo et al., 2024). Limited enrolment undermines financial protection and the risk pooling ability of SHI, and therefore the financing arrangements tend to disproportionately favour the already covered populations at the cost of rendering large portions vulnerable to catastrophic health spending. In turn, the SHI experience in Kenya highlights the need to finance the mechanism that would cope with the structural labour-market exclusions and equitably increase the risk pools.

The equity implications of the health financing architecture in Kenya are enhanced by inefficiencies and poor strategic purchasing functions in the SHI system. Analysis of NHIF purchasing reforms shows persistent weaknesses regarding delayed reimbursements, poor communications for benefit packages, uneven distribution of contracted providers, and infrastructural gaps compromising access and quality of services (Mbau et al., 2020). Herein, strategic purchasing, which is a paper-based experience on dividing pooled funds with the ultimate aim to maximise health, acts as a gateway to health systems research, wherein financing is connected to service delivery goals (Sumankuuro et al., 2022). However, as Kenya's experience indicates, the buying environment is passive mainly, as the purchasing mechanism is not able to offer resources according to the population's health and provide incentives to providers in a practical way. This inactive buying erodes the effectiveness as well as fairness continuously, with the resultant differences in access to services across the county and population lines. Accordingly, although UHC relies on financing inputs to operate, they would not suffice without the other institutional capacity and strategic purchasing structures in devising the pooled resources into equitable and high-quality services.

There are also guides to governance and poor institutional capacity, which continue to influence how financing mechanisms are being practiced. The NHIF case study provides evidence that the bureaucratic nature of delays, weak accountability systems, and inconsistent provider payment rates has undermined the credibility and operational effectiveness of the SHI system, leading to loss of public trust and a reduction in participation (Nungo et al., 2024; Mbau et al., 2020). There is evidence suggesting that proper governance frameworks, health technology evaluation, and successful provider involvement are conditions that precede the establishment of the alignment between purchasing and the larger UHC (Sumankuuro et al., 2022). Without this capacity, even well-crafted financing reforms have a high risk of stifling fragmentation and inequity since resources cannot be used in underserved populations or to hold up quality improvements. The case of reform addressed in Kenya demonstrates that institutional capacity needs to be seen as part and parcel of financing reform and not an Incidental factor in order to enable pooled funds to fund equitable access and quality outcomes of the services.

The analytical importance of such views of the effects of financing effectiveness upon strategic purchasing is supported with comparative LMIC evidence, respectively. A systematic review of strategic purchasing in nine middle-income countries found that schemes characterised by strong governance structures, health technology assessment, and rigorous provider performance monitoring had the capacity to harness financing to improve UHC outcomes (Sumankuuro et al, 2022). On the other hand, countries with delayed payments, poor purchaser-provider relationships, and insufficient performance incentives had higher out-ofpocket payments and low coverage gains. The different global trends echo these developments in Kenya, which is why insufficient purchasing power may hinder UHC developments regardless of the coverage of pooled funds. In this regard, Kenya's reforms point to a vital intersection between financing design and governance capacity that needs to be navigated in order to achieve sustainable UHC.

The international benchmarking against high-income nations also proves that financing models are not sufficient in assuring UHC results that lack sound institutional ecosystems and flexible governance systems. Since Germany and Switzerland, among others, record their analyses of healthcare systems that are marked with compulsory tax or regulated risk pools, have offered equitable access, it appears partly due to that being entrenched in long-standing regulatory, administrative, and accountability frameworks (Hurst & Siciliani, 2024). These systems offer reliable risk pooling, cost control, and benefit standardization mechanisms, which stand in stark contrast to the beginning design of SHIF in Kenya, where the factor of inclusion of the informal sector is still important, and the administrative capacity is a key constraint. This comparative insight highlights the point that the maturity of the institution and the embedded financing, service delivery, and governance are at least as important as the mode of financing.

Finally, the case in Kenya informs the general theory about financing UHC by clarifying the interactions between policy structure, governance, and the political economy. Political affiliations, administrative practices, and patterns of stakeholder engagement have influenced the NHIF reforms, such as those regarding the premium rates and benefit packages, which often do not follow the technical advice (Nungo et al., 2024). These policies are good examples of the complexity of adaptive health financing reforms in LMICs, where the interaction of governance arrangements and economic constraints drives the reform agenda. Evidence on strategic purchasing puts the need to surmount these challenges for not only institutional reform and capacity building, but mechanisms for transparent stakeholder engagement to align interests among government, providers, and citizens (Sumankuuro et al., 2022). Consequently, Kenya's UHC financing reforms provide a model that shows that advances towards universal coverage represent a non-linear exercise in the adoption of financing models but a multi-level governance challenge demanding coordination between technical design, institutional capacity, and political accountability.

CONCLUSION AND POLICY IMPLICATIONS

The case of the Universal Health Coverage (UHC) reforms of Kenya depicts a complex interaction among financing design, institutional capacity, and governance structures that are required in the achievement of equitable health access services. Empirical evidence obtained from the National Hospital Insurance Fund (NHIF) suggests that the growth in coverage and accessibility of financial protection is hindered by low participation from the informal sector (Nongo, 2024). This finding highlights that one solution, pooled financing, does not guarantee universal coverage (David, 2022). Administrative inefficiencies and lengthy delays in provider remuneration are further undermining public trust and reducing the number of people who enrol in social health insurance (Mbau, 2020). Taken together, these facts imply that to be effective, UHC reform should be focused on financing, governance, and institutional capacity simultaneously.

Equity is one of the key challenges in Kenya's SHI system. Analyses point out that the SHI coverage disproportionately favors the formal sector employees, resulting in the rural and informal populations remaining unprotected (David, 2022). Persistent out-of-pocket spending adds to the fragility of the finances of these populations (Nungo, 2024). Verifications of LMIC situations prove that mandatory pools and standardization of benefits are necessary to achieve equal accessibility (Sumankuuro, 2022). In Kenya, this fact highlights the importance of aligning redistributive financing institutions and initiatives based on institutional capacity building (Hurst, 2024). Without this kind of integration, an increase in coverage risk will not be sustainable.

Institutional capacity is an important factor in determining policy effectiveness. Deficiencies in accountability structures along with inconsistencies in provider payments are decreasing the credibility and operational efficacy of SHI systems (Mbau, 2020). Health systems research study highlights that governance systems, targeted buying, and participation of providers cannot be ignored in transforming the pooled funds to reach high-quality and accessible services (Sumankuuro, 2022). The history of the reform process in Kenya proves that institutional capacity should be viewed as one of the key elements of financing reform (Nungo, 2024). Failure to govern can encourage inequities and inefficiency.

From a policy perspective, the promotion of UHC in Kenya requires the extension of compulsory pooling mechanisms, especially for people in the informal sector (David, 2022). Reforms to purposeful purchasing should ensure that resources are directed in an efficient way and tied to provider performance indicators

(Sumankuuro, 2022). Strengthening governance through stakeholder engagement and intergovernmental coordination in a transparent manner is also essential (Mbau, 2020). All these measures will help to make sure that financing reforms will result in balanced access to services and the improvement of quality (Hurst, 2024).

Lastly, the lesson of Kenya provides a more general implication to LMICs. There is empirical evidence that universal coverage requires as much to be persistently adapted, learned, and harmonized between technical design and political-economic realities as it relies upon financing models (Nungo, 2024). The interconnection of strategic purchasing, governance, and financing design is one of the key dimensions along which fair and sustainable UHC can be achieved (Sumankuuro, 2022). Kenya's reforms show that multilevel coordination and integrated reforms need to be attained, hence focusing on both technical and institutional dimensions (David, 2022).

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