# NATIONAL HEALTH INSURANCE & COVERAGE OF NCDS

This brief describes how national health insurance (NHI) arrangements in **Ghana, Kenya, and Rwanda** provide coverage for NCD services. For insurance schemes to be sustainable, they should aim to have large pools that encompass individuals with varying health risks and income levels to maximize cross-subsidization. The brief summarizes how countries use prepaid public resources to subsidize NCD care, and the extent to which purchasing arrangements support prevention, early diagnosis, and continuity of care.

## MAIN LEVER: WHERE YOU CAN HAVE THE MOST IMPACT

Use NCD evidence to shape what pooled funds pay for, who can access covered benefits, and how providers are paid to deliver prevention, follow-up, and chronic care.

## RISKS: TWO FINANCING RISKS TO MANAGE

1. When enrollment is voluntary in practice, people who need care are most likely to join, raising costs and weakening sustainability.
2. Even when services are covered, people may not receive them if facilities cannot deliver benefit package entitlements.

## WHAT GOOD LOOKS LIKE: WHAT TO AIM FOR

Prepaid public financing channeled through insurance schemes, paired with purchasing arrangements that prioritize prevention, continuity of care, and financial protection.

## SIGNALS TO WATCH ACROSS THE TABLES

- **Coverage and entitlement:** Who is enrolled and who is automatically entitled?
- **Redistribution capacity:** How much prepaid funding flows through the scheme, and are public revenues used to subsidize vulnerable populations?
- **Benefit design and access rules:** Which NCD services, medicines, diagnostics, and referral services are covered, and under what conditions?
- **Provider readiness and accreditation:** Can contracted facilities deliver covered NCD services, or do supply gaps result in out-of-pocket spending?
- **Payment incentives:** Do payment methods incentivize prevention, case management, quality, and continuity of care?

## KEY TAKEAWAYS: WHAT THIS SNAPSHOT SUGGESTS ABOUT THE THREE COUNTRIES

- **Countries finance NHI through different models, with implications for coverage and sustainability.** Rwanda pairs high coverage with large contribution financing and subsidization, while Ghana's scheme relies mainly on an earmarked levy; Kenya's new Taifa Care model combines contributions with government subsidies.
- **Some conditions are more clearly defined in benefits packages than others.** Across all three countries, primary care and basic screening services are clearly articulated and included, while services for renal disease, mental health, and rehabilitation are limited or excluded.
- **Where data exist (Ghana and Kenya), facility readiness is a binding constraint for NCD services such as mental health and cancer.** Even where benefits exist, service availability varies widely, with gaps in diagnostics, medicines, and specialized services.
- **Most provider payment mechanisms remain passive,** with limited incentives for prevention, quality, or continuity of NCD care. Rwanda, however, is transitioning to a more strategic set of payment mechanisms.
- **Rwanda's high PHC and prevention spending provides a strong base for NCD care.** With ~70% of health spending directed to PHC and ~33% to prevention/promotion, Rwanda is well placed to strengthen NCD screening, diagnosis, and continuity of care.

FINANCING ACCELERATOR NETWORK for NCDs

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**Audience**
Ministry of Health NCD, planning, budgeting, and PHC staff; Ministry of Finance staff

**Countries**
**FAN members:** Ghana, Kenya, Rwanda

**Data**
Scheme documents, NHA / GHED, surveys

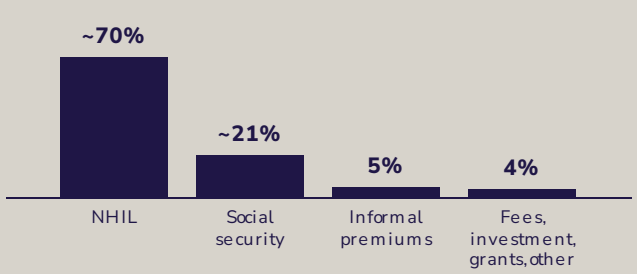
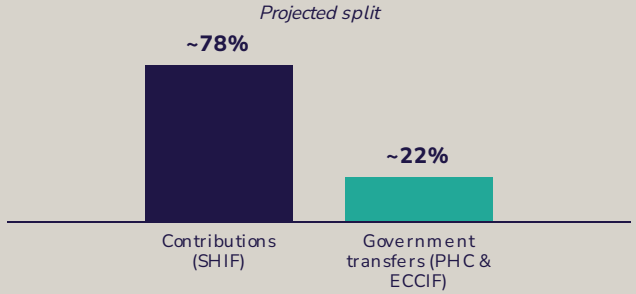
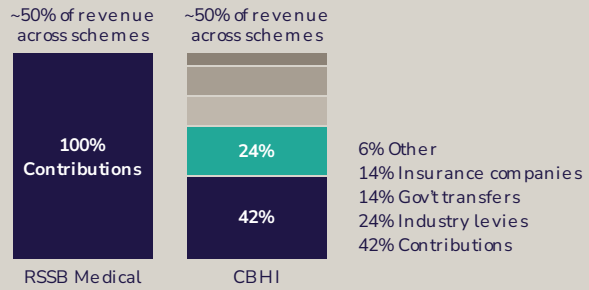
# LEVEL OF POOLING

| | GHANA<br>National Health Insurance Scheme (NHIS) | KENYA<br>Taifa Care ★ New in 2024, scaling | RWANDA<br>Mutuelle de Santé (CBHI) & RSSB Medical Insurance |
|---|---|---|---|
| **Size** | 54% Population coverage (2025)<br>23% CHE channeled through scheme (2023) | ~50% Population coverage (2025)<br>TBD CHE channeled through scheme (not yet reported) | 85% Population coverage (2023–24)<br>20% CHE channeled through scheme (2023) |
| **Pooling structure** | National Health Insurance Levy (NHIL; part of VAT)<br>Payroll-based social security contributions<br>Informal sector premiums<br>Fees, investment income, donor, other → **NHIS** All enrolled (formal and informal sectors) | Mandatory contributions → **SHIF** Contributors: specialized/referral services<br>General government transfers → **PHC Fund** Enrollees: PHC services; **ECCIF** Enrollees: emergency services | Household contributions<br>Earmarked levies<br>General government transfers<br>Cross-subsidies from other insurance schemes<br>Other → **CBHI** Mutuelle de Santé: informal, rural & subsidized populations<br>Payroll contributions → **RSSB Medical** Public workers & eligible formal sector |
| **Operations** | **Established:** 2004<br>**Governance:** National Health Insurance Authority (semi-autonomous under MOH) | **Established:** Replaced the National Health Insurance Fund (NHIF) in 2024<br>**Governance:** Social Health Authority (SHA; parastatal under MOH). To access any of the three funds, one must be enrolled through SHA. | **Established:** Mutuelle de Santé (CBHI) in 2007; RSSB Medical Scheme originated as RAMA in 2001. CBHI joined the Medical Scheme under RSSB management in 2015.<br>**Governance:** Rwanda Social Security Board (RSSB; public under MOH) |

*CHE channeled through scheme: Ghana – SHI as % of CHE as reported in National Health Accounts (2023). Kenya – not reported since the 2024 transition to Taifa Care; under NHIF, Kenya last reported 13% (National Health Accounts 2023). Rwanda – SHI + CBHI as a % of CHE in Rwanda Health Resource Tracking Report (2022/23).

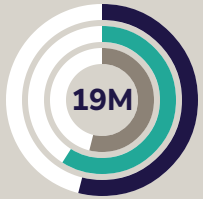
**Population coverage data: Ghana – Social Protection Budget Brief (2025); Kenya – Kenya News (July 2025); Rwanda – Integrated Household Living Conditions Survey Main Indicators Report (2023–2024).

# WHO PAYS, AND HOW MUCH?

| | GHANA<br>National Health Insurance Scheme (NHIS) | KENYA<br>Taifa Care | RWANDA<br>Mutuelle de Santé (CBHI) & RSSB Medical Insurance |
|---|---|---|---|
| **Revenue sources** |  | *Projected split*<br> |  |
| **Key rates** | **2.5%** of taxable goods & services (NHIL), charged alongside VAT<br>**2.5%** of formal-sector basic salary, from the 13.5% SSNIT first-tier contribution (total 18.5%: 13% employer / 5.5% employee)<br>**Flat rate** Informal-sector premium (income-graded by law, flat in practice) | **2.75%** Payroll tax (formal-sector employees)<br>**Means-tested** Informal-sector contributions<br>**27.89 USD** Annual minimum contribution (informal sector) | **15%** RSSB Medical Insurance formal-sector payroll contribution (50/50 employer/employee)<br>**2.05–4.79 USD** CBHI annual flat rate based on Ubudehe category |
| **Subsidies & exemptions** | Children (<18)<br>Pregnant women<br>People with disabilities<br>Elderly (>70)<br>Indigent | Indigent / vulnerable | Ubudehe categories 1 & 2 (poor and vulnerable households) |

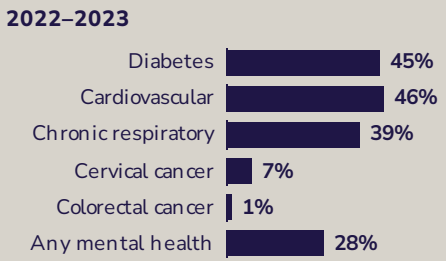
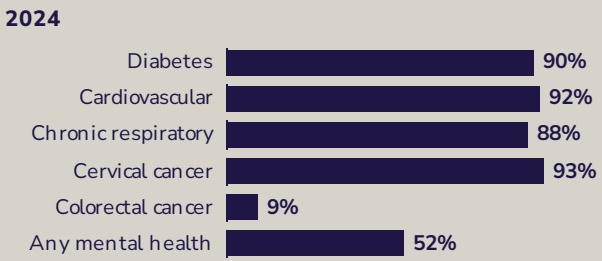
*Ghana revenue breakdown from National Health Insurance Fund Allocation Formula (2023). NHIL/SSNIT split is estimated based on Alliance for Reproductive Health Rights (2025).
**Kenya does not yet have actual revenue reports for Taifa Care. Data shown are projected splits from Budget Summary for the FY2025/26.
***Rwanda revenue: RSSB Financial Statements (2023/24). Currency converted to USD at January 2026 rates.

# WHO IS COVERED – AND WHO ISN'T?

| | GHANA<br>National Health Insurance Scheme (NHIS) | KENYA<br>Taifa Care | RWANDA<br>Mutuelle de Santé (CBHI) & RSSB Medical Insurance |
|---|---|---|---|
| **Coverage** | <br>*Outer to inner ring; each ring = 100% of its group*<br>**54%** of total population<br>**~59%** of SSNIT contributors<br>**54%** of informal sector | <br>*Outer to inner ring; each ring = 100% of its group*<br>**~50%** of total population<br>**~98%** of formal sector<br>**~6%** of informal sector | <br>*Outer to inner ring; each ring = 100% of its group*<br>**85%** of total population<br>**93%** of wealthiest fifth (Q5)<br>**76%** of poorest fifth (Q1) |
| **Informal sector enrollment strategy** | • **Group-based and mobile enrollment** makes enrollment simpler.<br>• **Targeted exemptions / subsidies** reduce financial barriers.<br>• **Income-based premiums** reduce financial barriers.<br>• **Identification of and outreach to the poor** increases awareness and facilitates enrollment. | • **Legal mandate** establishes enrollment as a legal requirement.<br>• **Digital / mobile payment** makes staying enrolled easier.<br>• **Income-based premiums** reduce financial barriers.<br>• **Registration campaigns** make enrollment accessible and simple. | • **Localized enrollment strategies** identify the unenrolled, increase awareness, and facilitate enrollment.<br>• **Quality of care improvements** increase demand for coverage.<br>• **Digital / mobile payment** makes staying enrolled easier.<br>• **Linking enrollment to the household registry (Ubudehe)** identifies vulnerable individuals and reduces financial barriers. |
| **Membership validation** | Biometric registration<br>Link to national ID card | Biometric registration<br>Mandatory digital registration | Link to national ID card |

*Ghana coverage: number of active members from Social Protection Budget Brief (2025). Denominators based on SSNIT Annual Report (2023) (estimate due to age of the data) and Quarterly Labor Statistics (July 2025).
**Kenya: number enrolled from Kenya News (July 2025). Denominators from FSD Kenya and National Bureau of Labor Statistics (Aug 2025).
***Rwanda: number insured and denominators from Integrated Household Living Conditions Survey Main Indicators Report (2023–2024). Rwanda does not report coverage disaggregated by formal/informal sector.

# HOW SERVICES ARE ACCESSED

| | GHANA<br>National Health Insurance Scheme (NHIS) | KENYA<br>Taifa Care | RWANDA<br>Mutuelle de Santé (CBHI) & RSSB Medical Insurance |
|---|---|---|---|
| **Provider network** | Care is provided through NHIS-accredited providers (public, plus private/faith-based where accredited). | Care is provided through SHA-contracted/accredited facilities (40% of all health facilities – public, plus private/faith-based where accredited). PHC is the entry point, with referral pathways. | Care is provided through facilities contracted by RSSB. CBHI covers care across health centers, district/provincial hospitals, and referral hospitals through Rwanda's referral system, while the RSSB Medical Insurance Scheme reimburses care through RSSB-contracted public and private facilities and pharmacies. |
| **Health facility readiness***<br>All facilities – % with services available |  |  | **No data available** |

*Ghana: Harmonized Health Facility Assessment 2022–2023; Kenya: Quality of Care Health Facility Assessment: Service Availability and Readiness Report (2024).

# SERVICES INCLUDED IN THE PUBLIC HEALTH INSURANCE BENEFITS PACKAGE

All listed items are broadly covered | Some items covered or partially covered | No listed items are covered

| Interventions included | GHANA<br>National Health Insurance Scheme (NHIS) | KENYA<br>Taifa Care | RWANDA<br>Mutuelle de Santé (CBHI)<br>*RSSB Medical Scheme: similar/broader benefits; different access rules* |
|---|---|---|---|
| **Primary care diagnosis + basic diagnostics**: Diagnosis at PHC level, basic lab tests, x-rays, basic ultrasounds | Broadly covered | Broadly covered | Broadly covered |
| **Specialized lab tests** | Broadly covered | Broadly covered | Broadly covered |
| **Advanced imaging**: MRIs, CT scans, angiography, fluoroscopy, doppler, echocardiogram, electroencephalograms (EEG) | Partially covered | Partially covered | Broadly covered |
| **Essential medicines**: Medicines included on country's essential medicines list | Broadly covered | Broadly covered | Broadly covered |
| **Primary care management**: Management of acute and chronic conditions at primary care level | Broadly covered | Broadly covered | Broadly covered |
| **Specialist outpatient care**: Outpatient consultation and treatment at specialist level, outpatient surgeries | Broadly covered | Broadly covered | Broadly covered |
| **Inpatient + surgery**: Inpatient services, inpatient surgeries (excluding transplants) | Broadly covered | Broadly covered | Broadly covered |
| **High-cost / transplants**: Organ transplants | Not covered | Broadly covered | Partially covered |
| **Emergency + critical care**: Ambulance, resuscitation, stabilization, critical care admissions, inpatient oxygen support | Partially covered | Broadly covered | Broadly covered |
| **Supportive / rehab / palliative**: Physiotherapy, occupational therapy, therapeutic nutritional support, transfusions, mortuary services, palliative care | Partially covered | Partially covered | Partially covered |

**Scoring:** Items were scored as "0: not specified / included," "1: included with limitations or ambiguity (e.g., partial coverage, eligibility restrictions, unclear scope, or item only covered in some settings)," or "2: included (explicitly as a standard benefit)." When categories were rolled up, the category was scored 0 if all items were 0, 2 if all items were 2, or 1 for mixed scores.
**Kenya note:** An item was scored as covered in Kenya if it was covered under any Taifa pool, as the scheme is designed to refer upwards when a benefit reaches its limit under a lower-level stream. Taifa Care was established in 2024 and is currently scaling.
**Data:** Ghana NHIS Tariffs Operation Manual (Jul 2022), NHIS Medicines List (March 2025); Kenya SHA Benefit Package Summary, Essential Medicines List (2023); Rwanda Ministerial Order N°20/39 (2016), National List of Essential Medicines for Adults (2022).

# CONDITIONS INCLUDED IN THE PUBLIC HEALTH INSURANCE BENEFITS PACKAGE

All listed items are broadly covered | Some items covered or partially covered | No listed items are covered

| Conditions included | GHANA<br>National Health Insurance Scheme (NHIS) | KENYA<br>Taifa Care | RWANDA<br>Mutuelle de Santé (CBHI)<br>*RSSB Medical Scheme: similar/broader benefits; different access rules* |
|---|---|---|---|
| **Cardiovascular disease**: management of hypertension, treatment of stroke, aspirin, hydrochlorothiazide, at least one each of: calcium channel blocker, beta blocker, ACE inhibitor, statin | Broadly covered | Broadly covered | Broadly covered |
| **Cancer – breast, cervical, prostate**: screening, treatment, mammography, LEEP, cryotherapy, thermal ablation | Partially covered | Broadly covered | Broadly covered |
| **Cancer – other / advanced**: screening + treatment for colon / childhood cancers, chemotherapy, radiotherapy, brachytherapy, and oncology medicines | Partially covered | Broadly covered | Broadly covered |
| **Diabetes**: management of diabetes, metformin, at least one each of sulphonylurea, insulin, glucose | Broadly covered | Broadly covered | Broadly covered |
| **Chronic respiratory disease**: ICS inhaler, SABA inhaler, prednisone / prednisolone, hydrocortisone, adrenaline / epinephrine | Broadly covered | Broadly covered | Broadly covered |
| **Neurological disease**: at least one epilepsy medicine | Broadly covered | Broadly covered | Broadly covered |
| **Renal disease**: chronic dialysis, at least one renal medicine, catheters | Partially covered | Partially covered | Partially covered |
| **Mental health + substance use**: outpatient education, screening, management, rehabilitation for substance use disorders, at least one each of: antidepressant, antipsychotic, bipolar medicine | Partially covered | Partially covered | Partially covered |

**Scoring:** Items were scored as "0: not specified / included," "1: included with limitations or ambiguity (e.g., partial coverage, eligibility restrictions, unclear scope, or item only covered in some settings)," or "2: included (explicitly as a standard benefit)." When categories were rolled up, the category was scored 0 if all items were 0, 2 if all items were 2, or 1 for mixed scores.
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# PROVIDER PAYMENT MECHANISMS IN USE

PASSIVE

STRATEGIC

| | GHANA | KENYA | RWANDA |
|---|---|---|---|
| **Line-item budgets:** Fixed budget allocated by inputs | MOH → facility | County → facility | MOH → facility |
| **Block grants:** Fixed budget allocated as lump sum | | MOH → County | |
| **Fee-for-service (FFS):** Retrospective payment per service performed | Private OOP | Outpatient (levels 4–6) | Health services (RSSB Medical Scheme, CBHI) |
| **Per diem:** Payment per hospital day | | Hospital, ICU, palliative | |
| **Case-based:** Fixed payment per diagnosis / episode | Diagnosis-based case rates (G-DRGs) | Defined packages (dialysis, maternity) | |
| **Contracted providers (tariffs):** Lump sum + performance clause | | Ambulance | |
| **Separate drug reimbursement:** Drugs paid separately | Medicines | Pharmacy package (chronic diseases) | |
| **Capitation (basic):** Prospective payment per enrollee | | | Capitation (CBHI in health facilities, piloting) |
| **Fixed global budgets:** Fixed envelope with discretion | | PHC Fund population and case-based allocation via PHC Global Budget | |
| **Blended capitation:** Capitation + FFS + performance payments | | | |
| **Performance-based financing:** Bonus for quality / outputs | | | PHC performance incentives |
| **Bundled / episode-based:** Payment per care episode | | | Bundled tariffs (CBHI in hospitals, piloting) |
| **Value / outcome-based:** Payment tied to outcomes | | | |

Used in national health insurance | Used outside national health insurance | Not used

Mechanisms run from passive (automatic payments without performance incentives) to strategic (deliberately using payment to shape service delivery).

# WHAT'S WORKING WELL AND WHAT ISN'T?

| | GHANA<br>National Health Insurance Scheme (NHIS) | KENYA<br>Taifa Care | RWANDA<br>Mutuelle de Santé (CBHI) & RSSB Medical Insurance |
|---|---|---|---|
| **Operational enablers** | ✓ **NHIL cap removed (Mar 2025):** More NHIL funds flow to NHIS, expanding fiscal space.<br>✓ **Established national platform:** Large pool and well-defined mandates.<br>✓ **Digital foundations expanding:** Biometric/mobile enrollment and verification. | ✓ **Legal mandate and strong political will:** Rapid build-out of a national purchaser.<br>✓ **PHC-focused design with referral pathway:** Structured access to higher-level care.<br>✓ **Digital-by-design systems:** Enrollment/claims infrastructure being established centrally (though platform rollout has had challenges). | ✓ **Strong local implementation:** Local administration and community structures support beneficiary identification, enrollment, renewals, and subsidy targeting.<br>✓ **Ubudehe-linked subsidies:** Mechanism to protect poorer households.<br>✓ **Strategic purchasing reform:** Piloting capitation and bundled tariffs ahead of national scale-up.<br>✓ **PHC and prevention focus:** PHC accounts for ~70% of CHE, while preventive and promotive services account for ~33%, a strong platform for NCD screening, early diagnosis, and continuity of care. |
| **Operational pain points** | ⚠ **Provider payment delays and cost growth pressures:** Delayed NHIS reimbursements lead some facilities to charge separately for covered services or supplies ("unbundling"), while the volume-based case payment system risks raising costs.<br>⚠ **Weak/uneven enrollment of some groups:** Rural, informal-sector, and young adults face lower or lapsed enrollment due to affordability, administrative barriers, and low perceived value, risking adverse selection.<br>⚠ **Data and interoperability constraints:** Fragmented health information systems constrain timely use of data for fraud control and strategic purchasing. | ⚠ **Facility readiness constraints:** Gaps in diagnostics, medicines, and specialized services, especially at PHC level.<br>⚠ **Trust and implementation risks:** Public confusion on contributions; affordability concerns for informal/low-income households; provider concerns on tariffs/reimbursement; some SHI provisions remain suspended pending appellate determination.<br>⚠ **Limited facility accreditation:** With only 40% of health facilities accredited, patients risk incurring out-of-pocket costs. | ⚠ **Financial sustainability:** Following years of deficits, recent reforms have strengthened CBHI's financial position, though sustaining adequate funding remains important as Rwanda expands coverage and benefits.<br>⚠ **Equity/affordability gaps:** Reaching the last 15% of households with insurance coverage is a challenge.<br>⚠ **Service gaps:** Gaps persist in availability of specialized NCD services (e.g., cancer diagnostics and mental health). |

*Ghana: NHIL – ODI Global (Jan 2026); Platform strength – World Bank (2017); Digitization – Akweongo et al. (2022); Sustainability – Joy Online (Apr 2025), Essah (2025); Under-enrollment – Sarkodie (2021), Dixon et al. (2014), Akweongo et al. (2022), Morgan et al. (2024); Data interoperability – MOH (2022–2025), Ghana Health Service (2023–2027).
**Kenya: Mandate – MyGov (Jul 2025), Cabinet Secretary, MOH v Aura et al. (2024); PHC focus – Amboko et al. (2025), Thinkwell (2024), Act No.13 of 2023; Digitization – Business Daily (Oct 2025); Readiness constraints – Thinkwell (2024), NTV (Nov 2024); Trust and implementation – Daily Nation (Jan 2025), Eastleigh Voice (Jun 2025), FSD Kenya (Aug 2025); Facility accreditation – Kenya Health Facility Census Report (2023).
***Rwanda: Local implementation – Nyandekwe & Kakoma (2025); Subsidies – RSSB (2026); Reform – Nyandekwe & Kakoma (2025), New Times (Sep 2025); PHC spending – Rwanda Health Resource Tracking Report (2020/21 – 2022/23); Financial sustainability – Nyandekwe & Kakoma (2025); Equity/affordability – Muremyi et al. (2025).