Understanding multiple trajectories of extending social protection to the poor - An analysis of institutional change in Kenya

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Katja Bender, Barbara Rohregger, Bethuel Kinuthia, Grace Ikua, Esther Schüring, Clement Adamba, Kennedy A. Alatinga**,** Nicky Pouw

Corresponding Author:
Katja Bender
International Centre for Sustainable Development (IZNE)
Bonn-Rhein-Sieg University of Applied Sciences
Grantham-Allee 20
53757 Sankt Augustin
Germany
Tel: +49 2241 865 9660
Email: Katja.Bender@h-brs.de
www.izne.org

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Abstract

Social protection reforms involve comprehensive processes of institutional change. The dynamics differ not only across but also within countries across social protection pillars. In order to develop integrated national social protection systems it is important to move away from an isolated view of single instruments towards a comparative understanding of reform dynamics across different sub-policy areas. The case of Kenya is one example for multiple institutional trajectories within a country: Whereas cash transfer reforms follow a pattern of cumulative incremental change, social health protection reforms reflect patterns of non-cumulative change including blocked reforms and reform reversals.

Being embedded within comparative institutional analysis the paper aims at (1) providing a systematic framework for defining and explaining variations in reform dynamics, and (2) applying this framework to the Kenyan case. The empirical methodology employs a process tracing approach including primary and secondary data.

The analysis suggests that firstly, stronger conflicting interests on social health insurance compared to cash transfers or fee waivers contributed to the observed differences in reform dynamics. Secondly, differences in information structures across domains facilitated the introduction of cash transfers and fee waivers, while providing additional impediments to social health insurance. Thirdly, pre-existing institutions within the domains induced stronger barriers to change for social health protection by shaping conflicting interests. Fourthly, a changing reform context offered focal points facilitating coordination on programs targeted at specific vulnerable groups for defined benefits during early stages of the reform process, but provided focal points supporting systemic approaches during more recent stages.

Content

Abbreviations

CT-OVC	Cash Transfer for Orphaned and Vulnerable Children
DALY	Disability-Adjusted Life Years
DANIDA	Danish International Development Agency
DDF	Direct Facility Funding
DFID	Department for International Development
FW	Fee Waiver
GDP	Gross Domestic Product
GTZ/GIZ	German Technical Cooperation/German International Cooperation
HISP	Health Insurance Subsidy Program
HSNP	Hunger Safety Net Program
HSSF	Health Services Fund
ILO	International Labour Organisation
KSH	Kenyan Shillings
MDG	Millennium Development Goals
MoDP	Ministry of Devolution and Planning
MoF	Ministry of Finance
MoH	Ministry of Health
MoGCSP	Ministry of Gender, Children and Social Protection
MoEACL&SP	Ministry of East African Community, Labour and Social Protection
MoLSSS	Minstry of Labour, Social Security and Services
MoMS	Ministry of Medical Services
MoPHS	Ministry of Public Health and Sanitation
MoNKOAL	Ministry for the Development of Northern *Kenya* and Other Arid Lands
MTP	Medium Term Plans
NHIF	National Hospital Fund
NSHIF	National Social Health Insurance Fund
NSPN	National Safety Net Program
NSSF	National Social Security Fund
OP-CT	Older People Cash Transfer
OVC	Orphans and Vulnerable Children
PWSD-CT	Persons with Severe Disability Cash Transfer
SCT	Social Cash Transfer
SHI	Social Health Insurance
SHP	Social Health Protection
UFSP	Urban Food Subsidy Program
UNICEF	United National Children and Education Fund
WHO	World Health Organization

1. Introduction

Social protection reforms involve comprehensive processes of institutional change. Reform dynamics differ reflecting multiple institutional trajectories and equilibria ranging from 'big bang' approaches over processes of gradual change to situations of blocked reforms or reform reversals. These differences are not only observed across countries, but do also exist within countries across different pillars of social protection. In order to develop integrated national social protection *systems* it is important to move away from an isolated view of single instruments towards a comparative understanding of reform dynamics across different sub-policy areas.

The case of Kenya is an example for multiple institutional trajectories within a country: In Kenya reform initiatives aimed at extending social protection to the poor include cash transfers and social health protection, i.e. facilitating access to health care for the poor by removing financial barriers.

Being embedded within comparative institutional analysis and framing the problem in game-theoretic terms, the paper aims at (1) providing a systematic framework for defining and explaining variations in reform dynamics, and (2) applying this framework to the Kenyan case covering the time period 2001 – 2017 starting with the emergence of social protection on the Kenyan political agenda. In doing so, the paper is mainly concerned with (re-iterated) processes of policy formulation, policy decision-making and institutionalization.

This paper extends existing research in a number of ways. Firstly, the paper contributes to an enhanced conceptual understanding on processes of gradual institutional change and provides an analytical framework to systematically compare differences in change across redistributive (sub-)policy areas. Most studies on social protection in low and middle income countries are empirical studies often with no explicit theoretical background. Exceptions include for example Hickey (2008) and Lavers and Hickey (2016) building on and extending the political settlement approach addressing in particular the role of ideas and non-domestic actors in shaping policy outcomes. Drawing on different strands of literature classifying either policy or institutional change, this paper first suggests a typology to characterize reform dynamics. To explain gradual institutional change the paper then builds on the approach developed by Aoki (Aoki 2001, 2007), who emphasizes the role of bounded reality for explaining institutional stability or change. Next to the preferences of agents involved and the existing institutional framework this paper stresses in particular the role of information structures in influencing processes of change. To address multiple trajectories each social protection pillar is characterized as a specific and unique reform domain.

Secondly, most empirical political economy analyses of social protection reforms in low and middle-income countries do not offer a comparative approach across different pillars of social protection. The seminal contribution by Haggard and Kaufman (2008) provides a comprehensive comparative analysis of social policy reforms in Asia, Latin America and Eastern Europe between 1945 and 2005. Political economic analyses of more recent social protection reforms tend to focus on one instrument only (e.g. Brooks 2015, Fox and Reich 2012, Ichoku, Fonta and Ataguba 2013, Kwon and Kim 2015). In this context, the only study known to the authors explicitly addressing within-country differences in social protection reform dynamics is Wanyama and McCord (2017), who also take Kenya as a case. They examine the interaction between elite factions and non-elites and look at the role of donors in shaping policy processes.

The remainder of the paper is structured as follows: Section 2 will present the theoretical background guiding the empirical analyses. Section 3 describes the empirical methodology. Section 4 provides a classification of reform dynamics in Kenya for the sub-policy areas of social health protection and cash transfers and analyzes divergent reform paths in Kenya. Section 5 concludes.

2. Understanding reform dynamics – A comparative institutional perspective

2.1 Defining and classifying reforms

Various definitions of the terms 'reform', 'policy' or 'institutions' exist. For example, a reform may be defined as "… a policy innovation manifesting in an unusually substantial redirection or reinforcement of previous policy" (Keeler 1993: 434), or"…an episodic change, which reinvents institutional pattern so as to break with prevailing customs and procedures" (Cortell and Peterson 1999: 182). Summarizing the core elements of these definitions, 'reforms' refer to processes of change with the objects of change being either policies or institutions. Here, policies are defined as 'a set of interrelated decisions taken by a political actor or group of actors concerning the selection of goals and the means of achieving them' (Jenkins, 1978). Institutions are understood as "…self-sustaining, salient patterns of social interactions, as represented by meaningful rules that every agent knows and incorporated as agents' shared beliefs about the ways how the game is to be played." (Aoki 2007: 7).[1] Both concepts are interrelated: Whereas the definition of 'policy' focuses on the contents of actor's decision-

[1] This definition of institutions combines the exogenous (institutions as – formal or informal - rules) with the endogenous approach (institutions as equilibrium concept of shared beliefs). The "institutions as rules cum shared beliefs"-perspective is developed in Aoki 2001.

making, institutions regulate decision-making and at the same time, are being endogenously created, changed or sustained through the strategic interaction of players.

To derive at a more nuanced understanding of the types of change considered, a classification system is suggested addressing either dynamic properties or qualitatively relate the outcome of change (new status quo,) to the previous status quo (initial state). It involves three dimensions.

1. Temporal baseline,
2. Mode of change, and
3. Scope of change.

First, explaining reforms presupposes a dynamic perspective with at least two points in time, i.e. a change from an initial state t_0 to a new state t_1. Thus, classifying reform dynamics require defining a *temporal baseline* against which dynamics are evaluated (initial status quo).

Secondly, the *mode of change* reflects the number of steps involved in the overall process as well as the relationship between these stages: Incremental change involves several steps whereas non-incremental change involves one major step only (Howlett and Cashore 2009).[2] Incremental processes may be either cumulative, i.e. subsequent steps build on previous steps (Hinrich and Kangas 2003) or, non-cumulative, i.e. subsequent steps are reversing or diverging from previous ones ('back-and-forth processes').

Thirdly, the magnitude or *scope of change* captures the degree to which the content of reform initiatives deviates from the initial status quo. Based on Peter Hall's (1993) classification, three orders of change will be distinguished: Third-order change refers to a major goal change or a fundamental realignment of major aspects of policy development. It constitutes the most encompassing type of policy change. Second-order change relates to a change in instruments, whereas first-order change constitutes the smallest deviation from existing policies and refers to the calibration of existing instruments. As Hinrichs and Kangas (2003) point out, incremental first and second-order changes may eventually imply a fundamental third-order change without receiving much attention in the political discourse. If

[2] Howlett and Cashore (2009) use the expression 'paradigmatic change' for non-incremental change. Yet, this reference to scope would indicate that paradigmatic changes involve broader scale policy change, whereas incremental change does not. Yet, as will be described below, also incremental change may lead to fundamental system shifts.

an incremental reform process is cumulative, then small changes might eventually lead to third-order changes ('system-shifts').

Streeck and Thelen (2005) provide another approach to capture the qualities of the intended deviation from the status quo from an institutional change perspective: Displacement refers to the removal of existing rules and the introduction of new rules. If new institutions are added on top of or alongside existing institutions, this is defined as layering. Drift indicates a change in the impact of a rule due to changes in external conditions, while the rule itself formally stays the same. Conversion occurs if a rule is interpreted and implemented in new ways but formally stays the same.

2.2 Explaining reform dynamics

The conceptual framework needs to account for processes of *gradual* change and *multiple* trajectories of institutional change. As Mahoney and Thelen (2010) point out, explanations of institutional change tend to either provide explanations as to why institutions are stable over time (inertia) or focus on institutional change prompted by exogenous shocks or environmental shifts (including concepts such as "punctuated equilibrium" or "critical junctures"). These shifts may include for example regular events such as elections or – in particular with respect to social protection – processes of economic development or democratisation (see Bender 2013). Yet, these explanations cannot account for processes of gradual change. Likewise, they cannot explain within-country differences in redistributive reforms as they do not illustrate why the same 'shock' may lead to different responses.

From a game-theoretic perspective a reform equals a shift from an existing equilibrium of repeated plays to a new equilibrium of repeated plays. An institutional innovation, here redistribution to the poor, competes with existing institutional arrangements, for example individualized formal systems building on self-responsibility. The resulting trajectories between different equilibria denote the process of institutional change. Institutional change results from the strategic interactions of actors involved in the reform domain. From this collective action perspective institutional change involves multiple coordination and cooperation processes among agents involved. Processes of policy formulation and decision making may lead to institutional change, i.e. a change in the set of rules and shared beliefs or existing institutions may prove to be stable.

Institutional change involves more than a mere change in rules. The process of institutional change implies a re-assessment and substantial revisions of the game by actors involved. Whereas Mahoney and Thelen (2010) develop an approach that explains gradual institutional change as the result of interaction between the political context, the initial institutional status quo and, different types of change agents, i.e. the rule preserver/non-

preserver and the rule follower/non-follower, Aoki (2001; 2007) stresses the role of bounded rationality, information and subjective beliefs.

Institutional change occurs if "…agents' belief on how the game is played are altered in a critical mass." (Aoki 2011: 231).[3] Common knowledge of these rules and the shared beliefs of actors on action rules being relevant for playing the game are central elements. The framework departs from the complete/incomplete knowledge assumption of formal cooperative game theory. Agents hold subjective beliefs about the objective game structure. ADD def. game structure here? They need not know all details on action sets and payoffs of all agents as long as they share a rough idea, i.e. shared beliefs, about how the game is played. This shared information partition represents the relevant common knowledge (Aoki 2007: 7, 11).

The initial impetus for change may result from a change in environmental conditions leading to changing consequences of action choices or internal shifts in the domain leading to activation of new individual action choices due to for example learning processes or both (Aoki 2001: 242, Aoki 2007: 22-23). This impetus for change may generate internal inconsistencies. Former suboptimal strategies may increase in viability or new strategies might be initiated. Yet, due to the localized nature of information distribution and bounded rationality agents perceive and interpret these changes differently. So different sets of beliefs may emerge and compete with each other. This competition of beliefs characterizes the transitional process. According to Aoki *"The transitional process converges when and only when (i) with the help of a system of predictive and/or normative beliefs that have guided agents' learning, a new pattern of plays of game emerges and became to be collectively recognized as the way how the game is now being played; and (ii) agents' new action choices based on such expectations generate satisfactory pay-offs to them without a big surprise. That part of behavioral expectations common to all the agents then emerge as a new institution."*(Aoki 2007: 24-25). As a result to this transition process a new institution may evolve gradually or spontaneously depending on the specific characteristics of the process of updating and synchronizing subjective beliefs among agents. (Aoki 2001: 242-244).

To capture within-country differences in transition processes the suggested framework distinguishes between reform domains (endogenous conditions) and reform context (exogenous-parametric conditions), to which all domains are exposed alike.

A *reform domain* involves the strategic interaction of agents with identifiable interests in the reform process ('stakeholders'). A reform domain is characterized by

[3] In this line of thought the introduction of a new law does not per se qualify as a new institution, additionally a critically mass of agents must believe it being relevant.

- The institutional equilibrium *ex ante* representing the institutional status quo governing the domain,
- A set of agents and their action choices,
- Preferences of agents ('pay-offs'), and
- Information structures, and

Each social protection pillar is described by a specific domain. Differences in these domains may cause differences in reform trajectories.[4]

The *preferences of actors* indicate actors' attitudes towards the reform in comparison to maintaining the status quo. The more homogeneous preferences are (ceteris paribus), the lower the likelihood for conflicts and cooperation problems to occur and the higher the likelihood for change. The attitudes might reflect 'self-interested behaviour' (e.g. expected changes in level of individual influence or resources), but also reflect prevailing 'mental models' such as values or beliefs held by actors involved (Aoki 2007: 4).[5]

Existing institutions governing the reform domain define the current commonly known rules of the game and set of shared beliefs (initial status quo). These rules may be both formal and informal in nature. They summarize the 'historical legacies' influencing individual pay off structures and define the shared behavioral and decision-making rules assigning authority at the initial status quo.

Information structures specifying the type and degree of information that is available and the distribution of information are key to understanding trajectories of institutional change. As has been pointed out above, the framework departs from the complete information assumption. The behavioural implications of uncertainty are complex. Here, two types of uncertainty will be distinguished: Weak and strong uncertainty. *'Weak uncertainty'* characterizes situations in which information might not be accessible to everyone involved (private information) but still all relevant information exists (Dequech 2011: 624-627). The resulting information problems are those problems considered in standard game theoretic coordination or cooperation games: In the case of incomplete but symmetric information distribution and the absence of conflicting interests actors face a (pure) coordination problem. Whether a reform is enacted

[4] In this regard our approach is similar to the adapted political settlement approach suggested by Lavers and Hickey 2016, which also allows for capturing differences in policy change across different pillars of social protection by characterizing for each policy domain the specific political settlement. Yet the characterization of a political settlement and a reform domain differ.

[5] For example, attitudes towards redistribution are value-based and are influenced by individually held beliefs about the respective roles of individual and social responsibility such as for example the distinction between the 'deserving' vs 'non-deserving' poor.

or obstructed depends on the type of “signal” individuals receive to generate their shared beliefs. A departure from previous means of coordination requires the presence of a ‘focal point’ around which new behavioral traits and beliefs can coordinate (Schelling 1960). If interests between agents differ, asymmetric information provides a strategic advantage to the better informed party to pursue its interests: If the informational advantage is with actors supporting reform, change is more likely; if the informational advantage is with actors not supporting the reform, change is less likely.

Strong uncertainty relates directly to the concept of ‘bounded rationality’ and may either be caused by the absence or paucity of information or by limited mental capacities of players (Dequech 2011: 627-633). Agents cannot unambiguously assign a probability to the different states, or agents have only limited capacities in consistently linking states, actions, consequences and payoffs, thus, uncertainty relates to the functional form of the game. In such situations subjective beliefs may act as substitute for information in decision-making, and the underlying mental models of agents matter for institutional change. Individuals may interpret the same information (or lack thereof) differently (North 2005: 61-62). Although it is not possible to infer ex ante in which direction strong uncertainty impacts on change, it should be noted that differences in strong uncertainty across reform domains may lead to differences in reform paths observed. Situations of strong uncertainty are obviously relevant for policy innovations in general. Yet, in addition, complexity of policies may also impact on prevailing uncertainty. Again, focal points may provide a solution for creating shared beliefs.

Reform domains are embedded in a broader *reform context* which is a broad term including diverse elements such as the broader national or international institutional environment or socio-economic conditions. If reform domains are embedded in the same context (within-country analysis), the reform context indirectly induces differences in reform dynamics with its impact being conditional on characteristics of the specific reform domain. The reform context provides exogenous parametric conditions for social interactions in the reform domains. These parameters may influence the payoff structures of actors involved (alignment or misalignment of interests) or the information structure (providing signals for coordination or influencing the distribution of information).

3. Methodology

The paper presents a case study analysis of two cases comparing the sub-policy areas cash transfers and social health protection within the overall policy area of social protection in Kenya. It covers the time between 2001 (social health protection) respectively 2004 (cash transfers) until the pre-election time July 2017. The paper employs a process tracing

approach. Process tracing aims at explaining policy outcomes by identifying and exploring the mechanisms that generate them and allows for analyzing the role of timing, sequencing and interaction effects between policy stages (Büthe 2002, Kay and Baker 2015). The hermeneutic-interpretative qualitative data-analysis is based on primary and secondary data. Primary data include semi-structured interviews with national-level stakeholders involved in policy design or implementation including members of parliament, ministries, other public authorities, non-governmental organizations and independent observers. Twenty-five interviews have been conducted in between March 2016 – January 2017. Secondary data include legal documents (laws, regulations, decrees, and sessional papers), published policy strategies, reports and evaluations as well as a literature review of published academic literature.

4. Institutional change in Kenya: The cases of social health protection and social cash transfers (2001-2017)

4.1 Current situation – Overview

Kenya is a lower middle-income country with an average per-capita income of 1.595 current USD in 2017. Kenya transitioned to a multi-party system in 1991 and since then, has experienced six democratic elections. Extreme poverty as measured by the international poverty line of 1.90 USD PPP in Kenya has substantially increased since the 1990s, from 31.9 percent in 1997 to 43.7 percent in 2005. Current estimates show a decline to 36.8 percent in 2015.[6]

Despite advances made social health protection remains limited. The share of out-of-pocket payments in total health expenditures has been decreasing from 47 percent in 2000 to 33 percent in 2015, yet still remaining at a high level. The share of external health expenditures has been strongly increasing from 5 percent in 2000 to 18.7 percent in 2015, while the share of government expenditure has been declining from 37 to 33 percent.[7] In 2015-2016 the percentage of Kenyans covered by health issuance was 19 percent (Barasa et al. 2018: 347). The National Hospital Insurance Fund (NHIF) is the major health insurance mechanism in Kenya. Membership is compulsory for formal sector employees and voluntary for informal sector workers. In 2004 the Government of Kenya introduced the 10:20 policy removing user fees at dispensaries and health centres except for a minimum registration fee of 10 KSH and 20 KSH respectively. In 2013, free maternity health care and the complete removal of user

[6] Source: World Bank Development Indicators

[7] Source: World Bank Health Nutrition and Population Statistics

fees at primary health care level followed. Yet, implementation of the fee waivers has been repeatedly reported as being incomplete. Since 2014, the government through the NHIF implements the Health Insurance Subsidy Program (HISP). The program, which receives financial support from the World Bank, aims at increasing access to health care services for the poor and most vulnerable groups in society. The initial beneficiaries of HISP were households being registered under the Orphans and Vulnerable Children Cash Transfer Program (CT-OVC). Since 2015, the HISP has been extended to cover the beneficiaries of the OP-CT and the PWSD-CT as well. In 2016 it was scaled up to include 170.000 households (approximately 600.000 individuals) (Barasa et al. 2018: 350). Non-contributory schemes have been increasing substantially in number including in particular school feeding programs and cash transfer programs.

Since 2013 the National Safety Net Program (NSPN) is the umbrella for four cash transfer programs:

- The Hunger Safety Net Program (HSNP) aiming at reducing extreme hunger and vulnerability among the poorest households in four arid areas in North Kenya (100,000 households)
- The Older People Cash Transfer (OP-CT) targeting poor and vulnerable older persons 65 and above (203,011 households)
- The Persons with Severe Disability Cash Transfer (PWSD-CT) targeting adults and children with severe disabilities (45,505 households)
- The Cash Transfer for Orphaned and Vulnerable Children (CT-OVC) targeting families living with OVCs (ca. 246,000 households).[8]

The OP-CT, PWSD-CT and OVC-CT are collectively known as Inua Jamii (IJP) and are administered by the Ministry of East African Community, Labour and Social Protection (MoEACL&SP).[9] The HSNP is administered by the Ministry of Devolution and Planning (MoDP).[10]

Although government funding has been increasing, the development partners still finance almost 71 percent of the cash transfer programs. Out of the four cash transfer programs, only

[8] Coverage numbers refer to the years 2015/16 and are based on the information presented at the official Kenyan social protection website at https://www.socialprotection.or.ke/.

[9] Formerly Ministry of Labour, Social Security and Services and Ministry of Gender, Children and Social Development

[10] Formerly Ministry for the Development of Northern *Kenya* and Other Arid Lands

the OP-CT is fully financed by the Government of Kenya, whereas the CT-OVC, PWSD-CT and HSNP are mostly-donor financed. ADD SOURCE AND DATA UPDATE

4.2 Classifying reform dynamics

To assess reform dynamics this section applies the three criteria described above - temporal baseline, scope of change, and mode of change - to the Kenyan case (see Annex 1 for a detailed timeline).

4.2.1 Social health protection

Temporal baseline[11]

After the re-introduction of user fees in 1992, the start of the debate on extending social health protection can be traced back at least to late 2001, when the 'First National Congress on Quality Improvement in Health Medical Research and Traditional Medicine' was convened. Back then, President Moi directed ministers to take action on measures to establish a mandatory national social health insurance for all Kenyans and a taskforce was formed holding consultations in 15 districts across Kenya. The final report recommended the establishment of a National Health Insurance Scheme (Abuya, Maina and Chuma 2015).

Mode of change

The reform trajectory of extending social health protection shows a complex pattern (see figure 1). The problem of financial barriers in accessing health care, which are particularly severe for the poor, had been acknowledged very early (see above). Yet, in terms of responding to the problem, two pathways may be distinguished: Pathway A includes attempts to extending social health protection by establishing a social health insurance scheme, whereas pathway B includes initiatives towards extending social health protection through the reduction or removal of user fees.

Pathway A involves three phases. The 1st phase (2001-2006) involved activities aimed at establishing a universal social health insurance. In 2001, an inter-sectoral task force had been established and in January 2002, a resolution on the establishment of a National Social Health Insurance Fund (NSHIF) was announced. In June 2003, the Ministry of Health

[11] As the paper is particularly concerned with the analysis of the political decision-making process, i.e. processes of policy formulation and policy adoption, the temporal baseline is chosen according to the year the policies in questions had been positioned on the political agenda. Since it is often difficult to pinpoint the exact starting point, thus, the analysis identifies events, which signal the presence of the policies under debate on the national political agenda.

approached GTZ and WHO for technical support to set up a social health insurance. As a result, six technical missions were carried out during 2003 and 2004 followed by intensive debates (Abuya et al. 2015). The rejection of the proposed law on the establishment of a National Social Health Insurance Fund (NSHIF) constitutes the end of the first phase. Although the suggested bill was passed by parliament in late 2004, the president did not sign the bill. Instead, he returned it to parliament in 2005 proposing several changes relating among others to financial feasibility, technical design, and a phased implementation (Abuja et al. 2015, Fraker and Hsiao 2007). The unsigned bill lapsed when Parliament adjourned in 2006 (Ly et al. 2013).

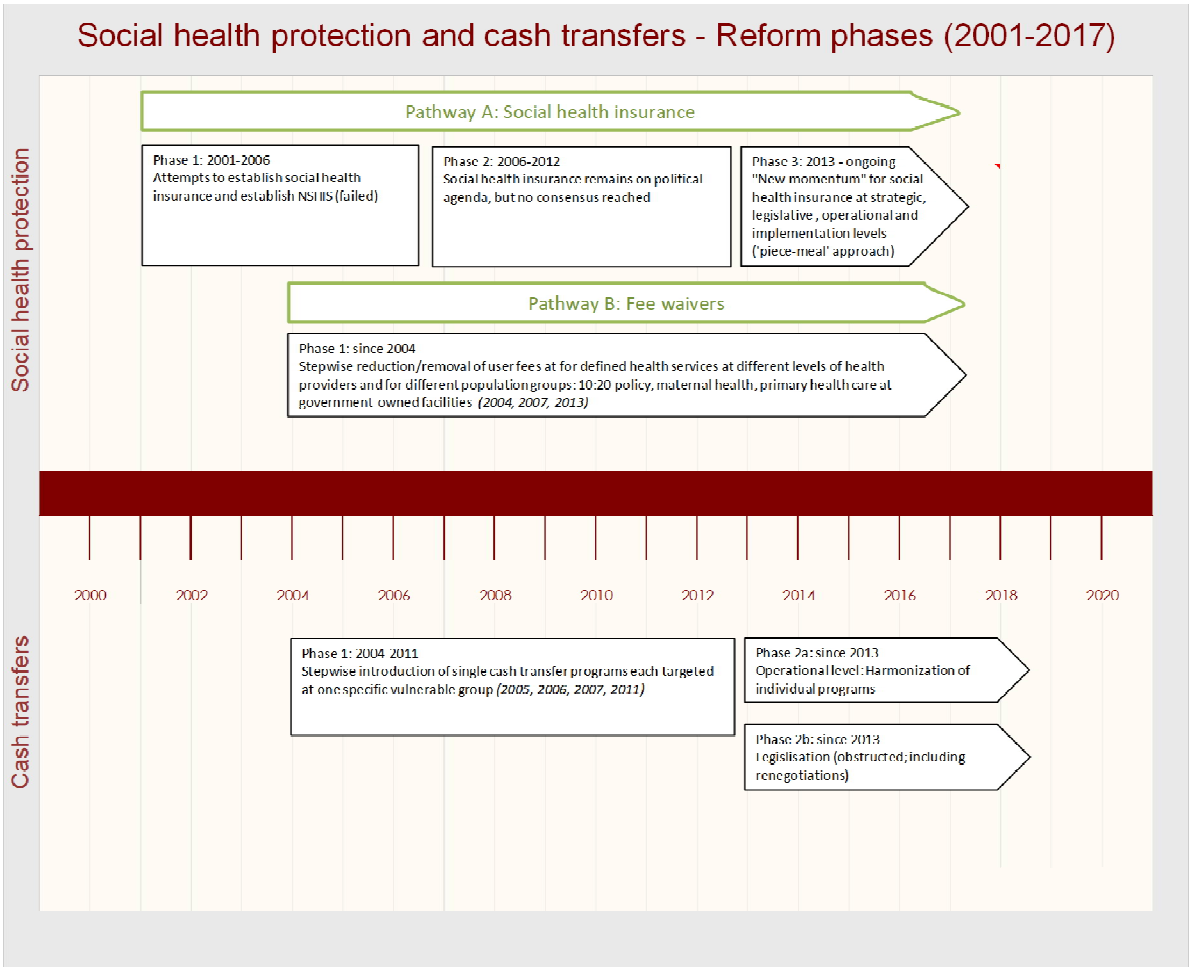

Figure 1: Reform phases
Source: Authors

While remaining on the political agenda, in phase 2 (2006-2012) no political decision could be reached. During 2006 and 2007, a new multi-stakeholder task force was established and a health financing technical working group (re-)installed in 2009. The Ministry of Health presented a draft health financing strategy in 2010, but again, no agreement was reached. In 2012 the Ministry of Health proposed a sessional paper on Universal Health Coverage (Sessional paper No. 7 of 2012), but the paper was not passed by parliament. These 'back

and forth movements' are also reflected in the National Vision 2030 and the first and second 5 years medium term plans (MTP). Whereas in the Vision 2030, which had been prepared in 2006-2007, the creation of a National Health Insurance Scheme was one of the so-called 'flagship programs', the 1st medium term plan 2008-2012 (Government of the Republic of Kenya 2008) defined a broader flagship project including a broad choice of mechanisms to finance health (Ibid: 103). Yet, hidden at the end of the document, the implementation matrices specified for each goal defined in the MTP state that one of the expected outputs in order to implement the defined goal is a "National Social Health Insurance Scheme put in place" (Ibid: 180).

The third phase (2013 – 2017) seems to reflect a renewed momentum for social health insurance including policy decisions on the strategic, legislative, organizational and operational level. Instead of introducing a social health insurance in one paradigmatic step, one can observe several related 'piece-meal activities'.

After the election and change of government in 2013, a presidential mandate on "Health Care: Towards a Healthier Kenya" was announced (Office of the President 2013). Among others, the goals include achieving free primary healthcare for all Kenyans and reforming the NHIF. For the first time, the 2nd Medium Term Plan 2013-2017 (2013) mentions "universal access to health care" as one of the priority areas and defines the Health Care Subsidy program (see below) as a flagship program. While it is less ambitious and less comprehensive than the original flagship program included in the Vision 2030 (2007), it is however, more specific than the review of equitable financing mechanisms included in the 1st MTP (Government of the Republic of Kenya 2008). It aims at extending health insurance coverage to the poor and is implemented by the Ministry of Health with the support of the World Bank. A pilot started in 2014. It is linked to the CT-OVC and since 2015 covers as well the elderly via the OP-CT and persons with severe disability receiving the PWSD-CT. The national-wide scaling up of the HISP has been announced in 2017, but has not been implemented up to date.

Also, in 2014, the new Kenya Health Policy 2014-2030 has been issued and the NHIF Act of 1998 has been revised. Introduced in 2015 and passed by parliament in 2016, the new Health Bill addresses health financing (articles 86 and 87). Without explicitly ruling out options beyond social health insurance, Art 86 (Paragraph 1) formulates the goal of universal health coverage through "(…) developing mechanisms for an integrated national health insurance system including making provisions for social health protection and health technology assessment" (The Health Bill 2016: 272). It further stipulates to develop and formulate policies and strategies within several areas relevant for financing and moving towards universal health coverage.

Pathway B involves one phase (2004-ongoing) subsequently introducing a set of political measures, which are not directly aimed at reducing out-of-pocket payments by establishing social health insurance but at removing user fees (fee waivers) for defined health services at different levels of health providers or for different population groups. Starting point is the introduction of the 10/20 policy in 2004, followed by the announcement of the health minister at that time to remove user fees for deliveries in 2007. Yet, this announcement had never been translated into a policy until June 2013 when all user fees for maternal health care and children under five as well as for all services at primary care level were abolished. Although not explicitly focusing on the poor, the fee waiver/reduction policies do have an implicit focus on low-income groups as they utilize public health facilities at lower level more frequently. Yet, the implementation of these measures remains incomplete showing strong regional variations (see Chuma et al. 2009, Maina and Ongut 2014).

Scope of change

Attempts to extend social health protection in Kenya clearly involve a third-order change: Facilitating access to health services by moving from user fees to increased pre-payment, redistribution and mutual risk pooling involves a change from efficiency-oriented goals to equity-oriented goals or at least a strong shift in the relative balance of both goals.

Applying the classification proposed by Streeck and Thelen (2005) on modes of institutional change to the Kenyan context, attempts to introduce a social health insurance can be characterized as processes of displacement, i.e. the removal of existing and introduction of new rules.

4.2.2 Social cash transfers

Temporal baseline

The CT-OVC program is the oldest among the cash transfer programs in Kenya. Discussions started in early 2004 as a response to the rising number of orphaned children due to HIV/AIDS. The first cash transfers pilot started in December 2004 after the former Vice-President Wood Awori had approached UNICEF for jointly identifying policy solutions.

Mode of change

The reform process related to cash transfers may be subdivided in (at least) two phases (see figure 1). A 1st phase (2005-2011) involves the stepwise introduction of single cash transfer programs each targeted at a specific vulnerable group (orphans, elderly, poor households affected by hunger and persons with disabilities). The second phase (2012 – ongoing)

comprises of organizational and operational changes and is concerned with the harmonization (phase 2a) and obstructed processes of formalization/legislation (phase 2b). In 2013, the National Social protection program was initiated. The MOEACL&SP consolidated the Inua Jamii programs under the newly founded Social Assistance Unit. In 2016 a single registry has been introduced. Also in 2013, the Social Assistance Act was passed by parliament, but soon after repealed and is being renegotiated since 2014/2015. A new draft bill has been finalized in 2016, but is still under debate at the time of writing.

Scope of change

Assessing the mode of change when looking at the introduction and proliferation of cash transfers is ambiguous and allows for different interpretations: The change may be interpreted as adding a new instrument (cash transfer) to existing instruments (in-kind transfers) targeted at vulnerable groups. The introduction of cash transfers would then fall into the category of second-order change. Yet, considering the entire process the induced changes seem to be a typical example for cumulative change, starting from isolated and small-scale measures targeted at selected vulnerable group and leading to the institutionalization of an increasingly integrated social assistance system. Thus, the change rather represents a system shift and corresponds to a third-order change as well.

Social assistance has been a new policy area and monetary transfers have not been in place before. Thus, from an institutional perspective the introduction of cash transfers programs represents processes of layering, i.e. new institutions are added on top of or alongside existing institutions.

4.2.3 Comparison of reform dynamics

Reform processes in both policy areas are characterized by processes of gradual and incremental institutional change and involve fundamental third-order changes. However, reform dynamics differ in terms of the relationship between individual steps and the intended deviation from the institutional status quo (see Table 1).

	Social health protection	**Cash transfers**
Temporal baseline	2001	2004
Scope of change Content Institutions	 3rd order change Displacement	 3rd order change Layering
Mode of change	Incremental: discontinuity/non-cumulative	Incremental: continuity/cumulative

	fragmented (two non-related pathways)	

Table 2: Characteristics of reform dynamics
Source: Authors

Whereas the extension of cash transfers follows a pattern of slow-moving yet cumulative changes, the extension of social health protection to the poor reflects pattern of non-cumulative change including stages of blocked reforms or even reform reversals. In particular, efforts to extend social health insurance have been obstructed, whereas political decision-making on fee waivers has been less difficult.[12]

4.3 Explaining within-country variations in reform dynamics

4.3.1 Initial impetus for change

The initial impetus for change in both domains has been quite similar combining environmental and internal impetus for change: Influential national-level stakeholders (president respectively vice-president) reacted to perceived situations of socio-economic crisis (low attainments of health system, HIV-AIDS epidemic), i.e. environmental impetus for change. Internal sources of change comprise of processes of learning about new action choices .instigated by donors introducing policy innovations.

4.3.2 Differences in reform domains: Preferences, information structures and institutional status quo

4.3.2.1 Preferences

Considering the role of preferences a higher degree of conflicting interests in social health insurance (SHI) compared to social cash transfers (SCT) and fee waiver policies (FW) contributed to the observed differences in reform dynamics.

Stakeholders involved during the first stage of introducing and extending SCTs programs initially included the former vice-president at that time, the respective ministries involved in administering the programs, the Ministry of Finance (MoF) and donors providing support. For OVC-CT, donors included UNICEF, joined later by DFID and World Bank. Conflicting interests mainly evolved around debates about the effectiveness of the instrument displaying differences in mental models of stakeholders. It was questioned whether SCTs are an

[12] Yet, it needs to be stressed that the implementation of fee waivers is severely constrained.

effective instrument for poverty reduction or rather contributing to dependency thereby reinforcing existing poverty:

> *"...of course there was a lot of caution even within government, is it affordable, is it politically correct, is it not creating dependencies. All those debates happened."*[13]

> *"The problem initially was, the way some actors think: If you are just giving people money, they'll be lazy. They never saw economic value in it."*[14]

> *"It was thought that cash transfers would make the recipient lazy, just waiting to receive and to be seen to be poor and therefore they would not make any efforts to move out of the poverty cycle. Many people, including myself, were a bit in that school."*[15]

During interviews the Ministry of Finance was frequently referred to as one important actor not being convinced about the benefits of cash transfers, but also at lower tiers of government objections were raised

> *"Finance obviously was not so much for it. Even the local administration (…)when you went there you heard their sentiments that this thing is going to create dependency -You know people are not used to so much cash - and all that."*[16]

Yet, the observed degree of conflicting interests in ideologies did not provide a prohibitive barrier to change. In addition, conflicts concerning the distribution of reform gains and losses among the stakeholders seem to be of lesser or no importance at all. The reasons for this seem to be twofold: The program was largely donor-financed and a reallocation of financial resources was not necessary. This reduced the potential for conflicts. In addition, social assistance was a new policy area with limited institutional legacies (see below 'Institutional status quo').

[13] National level interview No. 13, Planner, Kenya
[14] National level interview No. 1, Implementer, Kenya
[15] National level interview No. 5, Independent Observer, Kenya
[16] National level interview No. 13, Planner, Kenya

Likewise, only very few stakeholders – mainly the president, Ministry of Health, Ministry of Finance and donors - were involved in the policy formulation process of the *fee waiver* programs strongly reducing the possibility of conflicting interests (see below'Iinformation structures'). Health facilities or medical associations were not involved initially. In addition and contrary to SCTs, with fee waivers either being universal programs or targeted at the broad categorical group of mothers and children cutting across the entire population, acceptance for the fee waiver programs has been easier. In terms of financing, a Direct Facility Funding (DFF) by DANIDA was set up in 2005 to support the 10/20 policy. Yet, although changes at the policy formulation and policy adoption level were quickly brought about, implementation remains a challenge, mainly due to inadequate financing and governance problems.

The situation within the reform domain of *social health insurance* was very different: Right from the start, a larger number of stakeholders had been involved. In contrast to social cash transfers, stakeholders are more diverse and the number and degree of resulting conflicts is higher. Main stakeholders included the president, vice president, parliament, different ministries (in particular the MoH, the MoEACL&SP former MoGCSP/MoLSSS, and the MoF), the National Hospital Insurance Fund, the private insurance sector, medical associations, trade unions representing formal sector employees, employer associations and multiple bilateral or international donors.

Contrary to SCTs, multiple sources of conflicts were prevalent already in early stages. First, technical complexities of social health insurance are higher when compared to SCT and many debates were about technical conflicts including design choices such as single pool versus multiple pools or single versus multiple purchasers. Second, major debates centered on the financial feasibility of SHI. Estimating costs for SHI is also more complex than estimating cost for SCTs. In addition, with GTZ and WHO mainly providing 'only' technical support, no donor was available to provide financial support. Different cost estimates were suggested and the reform proposal was strongly opposed by the Ministry of Finance. Third, a major conflict arose over the suggested transition of the NHIF into the NSHI as the reputation of the NHIF was low and mistrust in its capacity and compliance high. Fourth, conflicts were driven by underlying sources of conflicts over the distribution of reform gains and losses for individual stakeholders. As Abuja et al. (2015) illustrates, the Ministry of Health that was driving the reform proposal was confronted with strong opposition from various groups: The private sector insurances objected the proposal as they expected a negative impact by the transition towards universal social health insurance on their business. Trade unions and workers associations were against the proposed bill, as they feared that formal sector employees would have to bear the major burden of financing the scheme. Major concerns related to the fact that a high number of poor people would never be able to contribute to the

fund. In addition, it was not clear how informal sector workers were supposed to contribute to financing the scheme. As one interviewee summarized:

"I think the Social Health Insurance that was being pushed by Ngilu is one of the best options in terms of being able to cover the entire population. (…) But to some extent, there was no good actor assessment and actor management and the private insurance companies did not know how they were going to benefit from the whole thing."[17]

During interviews, it also has been suggested that public attitudes reflect a low acceptance of redistribution, for example:

> *"What is important is that the political stalemate is one based on equity/financing issues: Universal health coverage in Kenya would mean that the rich and the middle-class would also need to contribute to finance such a scheme; and this still needs a wider discussion for acceptance."*[18]

Looking at the group of donors, one can observe another striking difference such as compared to cash transfers. First, the number of donors involved in the health sector was considerably higher including about six bilateral donors, various international organizations such as World Bank, WHO, different UN-agencies, and the European Union, as well as international initiatives as the Global Fund. Second, whereas donors supported (and financed) cash transfers unambiguously, policy preferences with regards to SHI within the group of donors differed. GTZ (now GIZ) and WHO were actively involved developing the proposed bill on social health insurance. Other donors (for example World Bank, USAID or Global Fund) were focusing on improving health service delivery, in particular by supporting vertical, non-systemic approaches that focused on combating specific diseases (e.g. HIV-AIDS) and/or strengthening a decentralized provision of (selected) health services.[19] Against the background of inefficient health systems and the MDGS (see below 'Reform context'), these approaches represented the 'spirit of the time'. The establishment of a social health insurance included several features - system approach, comprehensive benefit package and a strong role for the central level - which ran contrary to the pursued vertical approaches

[17] National level interview No. 22, NGO representative, Kenya
[18] National level interview No. 15, Policy Planner, Kenya
[19] For example, during 2000 – 2007, the World Bank financed the 'Decentralized Reproductive Health and HIV/AIDS – DARE' Program.

Abuya et al. (2015) report that donors opposing social health insurance formed coalitions with the private insurance sector to campaign against SHP.

Although the early process contributed to an increasing polarization of stakeholders, the topic was not off the political agenda and processes of policy formulation continued. In 2007 stakeholders in support of social health insurance successfully used the process related to the development of the national strategy 'Vision 2030' as a vehicle for keeping the topic on the political agenda and continuing the debate (Abuja et al 2015).

Yet, only after a change in strategy, which is reflected by phase 3 and involves switching from a 'big-bang' approach to the current 'piece-meal' approach, progress with respect to decision-making could be achieved. The piece-meal approach seems to help disentangle the complex net of conflicting interests by separating issues. In addition, with World Bank having changed their approach and now being supportive of social health insurance supporting reforms of the NHIF and financing the HISP program, the degree of conflict has been decreased (see below 'reform context').

4.3.2.2 Information structures

For cash transfer and fee waiver policies the group of stakeholders initially involved was substantially smaller compared to social health insurance. Due to the limited involvement of stakeholders, strong information asymmetries prevailed facilitating policy change with respect to cash transfers and fee waivers: The piloting of the CT-OVC program and its first scaling up were mainly discussed among the leading ministry, the MoGCSP, donors and the MoF, the latter being less concerned given that donors provided the funding. For example, as one interviewee, pointed out:

> *"It was very silent, because they didn't want to raise expectation, so they were trying to hold it small."*[20]

Likewise, the introduction of fee waivers in 2013 was directly announced by the newly elected President Kibaki after winning the elections. Even the Ministry of Health had not been involved or consulted, but – as indicated during the interviews – had been "warned" shortly before that "something was coming". Non-governmental stakeholders were completely left out.

[20] National level interview No. 4, Implementer, Kenya

"Were there stakeholders involved in this fee waiver policy? Nobody. That thing was a political thing and as I was saying it was being costed while being implemented. (…) This is an ad hoc kind of policy to achieve a political objective."[21]

For social health insurance, the situation was different. The development of the proposed bill was preceded by a report of the inter-sectoral task force report and six subsequent technical missions during 2003 and 2004 conducted by GTZ and WHO including interviews with and presentations to stakeholders (Abuya et al. 2015). The broader technical discussions helped to raise awareness among stakeholders on potentially upcoming changes reducing information asymmetries. Thus, whereas due to the non-availability of information the opportunities for expressing opposition were lower with respect to cash transfers and fee waivers, more widespread information on the social health insurance reform proposal, enabled the formulation of alternative views.

Apart from weak uncertainty, strong uncertainty influenced trajectories. Many definitions and different interpretations of "social protection" exist. During interviews it has been suggested repeatedly, that the level of awareness on social protection in general is low and is combined with a narrow understanding of social protection equalizing social protection with cash transfers only:

"However, one major issue is that there is little awareness on part of the politicians but also among the public on what social protection is. They equalize it in terms of cash transfers and some may see it as a political vehicle to gain votes or increase their political base. In general there is little debate on the topic in public or the newspapers except mainly during functions specifically for cash transfers. There are debates on cash transfers in terms of the need to extend them and the need to increase them." [22]

"One big issue is the narrow view of social protection that especially some politicians and some relevant stakeholders have; they view social protection mainly as cash transfers, because it gains them political mileage. There is low awareness on the complexity and magnitude of the issue."[23]

[21] National level interview No. 24, Independent Observer, Kenya
[22] National level interview No. 15, Policy Planner, Kenya
[23] National level interview No. 15, Policy Planner, Kenya

Against this framing of social protection as cash transfer social health protection takes a back seat within the discourse on social protection bringing about a larger impetus for change with respect to cash transfers.

In addition, the concept of social insurance is highly abstract and seems to be not well understood by the general population adding another barrier for pushing social health insurance:

> *"And then getting the Kenyans to understand what it [social insurance] means. You cannot accept when you don't know what it entails, and that has been a big problem. Most people don't understand what NHIF is all about."*[24]

> *"They [Kenyans] do not believe in paying for something they are not seeing. (…) The opportunity cost are considered as too high because they can use that money for something else now. They do not look at the uncertainty, because they look at their current consumption."*[25]

Thus, interpretations of the concept of social protection in combination with' insurance' being a complex construct seem to facilitate processes related to cash transfers whereas providing impediments to SHI reforms.

4.3.2.3 Institutional status quo

Existing institutional arrangements induced stronger barriers to change for extending social health protection than for extending cash transfers by aggravating conflicting interests and shaping mutual expectations on what to expect from key stakeholders.

At the time the reform processes started, social assistance understood as providing monetary or in-kind transfers targeted at the poor or vulnerable households was almost non-existing. Operating programs dealt in particular with food security or child development (e.g. school feeding programs). Cash transfers represented a new instrument within the context of an almost non-existing social assistance system with no specific legal provisions for social assistance being in place. In addition, cash transfers rather complemented existing initiatives without overlapping with any of them. Existing cash transfer programs were also linked to

[24] National level interview No. 17, Donor, Kenya
[25] National level interview No. 24, Independent Observer, Kenya

different public authorities (two different departments within the former MoGCD and one department within the MoNKAL). This fragmentation facilitated the proliferation as none of the stakeholders lost influence due to the introduction of additional programs.

Yet, with respect to social health protection, the health sector already was a highly organized sector and well organized interests groups:

> *"The health sector is a very well organised sector with an already existing legal framework and a well-defined division of labour as opposed to social assistance. These actors, such as NHIF, the trade unions, medical associations (amongst others) are partly very strong and represent their interests well; this is why it is a little challenging to work with them and get some reforms through"*[26]

The attempted reforms to introduce a social health insurance aimed at changing these established structures by re-defining responsibilities and structures for financing as well as delivering health services: This clearly put into discussion established stakeholder constellations and spheres of influence: Stakeholders involved in the debate on introducing social health insurance already held well defined positions based on which conflicting interests with regard to expectations on 'reform winners' and 'reform losers' in terms of changes in influence or resources could emerge. In addition, these historical legacies defined prevailing expectations on what to expect from other stakeholders (e.g. low reputation of and mistrust in the NHIF). Contrary, none of these barriers were present within the reform domain of cash transfers. On the contrary, for most stakeholders the cash transfer reform represented an opportunity to win and increase influence. Thus, conflicts mainly related to the perceived adequacy of the policy, whereas in social health protection conflicts on adequacy and design of the policy came on top of fundamental distributional conflicts.

Yet, during the second phase involving the harmonization and legalization of the program more conflicting interests seem to emerge inhibiting the adoption of reform proposals. Contrary to phase 1, ongoing reform processes involve processes of displacement: The enactment of the Social Safety Net program in 2013 led to the creation of a new stakeholder, the Social Protection Secretariat in the Ministry of Labor and Social Protection, responsible for overseeing and harmonizing the individual programs. Coordinating and harmonizing programs involve redefining and restructuring responsibilities, thus introducing conflicts on who gains and who loses influence. In addition, conflicts relating to the financing of the

[26] National level interview No. 15, Policy Planner, Kenya

programs become more prevalent. Whereas the older person cash transfer program is the only program completely financed by the Government of Kenya, the remaining programs still rely to a substantial degree on donor funding. Interestingly, Art. 35 of the Social Protection Act of 2013 lists under 'Sources of Funding" bilateral and multilateral donors first and avoids any direct reference to tax-based funding. [Quotes]

4.3.3 The reform context: Influencing preferences and shaping information structures

ADD?: Incentive structures/prefernces: Decentralization (pushing cash transfers)/elections (initially no electoral topic; later pushing SCT=clientelistic policy making) /economic growth (no discernible impact) [but: overall length of paper….]

The reform context provided signals serving as focal points facilitating coordination on programs targeted at specific vulnerable groups during early stages of the reform process, whereas during recent reform stages the reform context provides signals supporting systemic approaches.

Kenya had been severely affected by the HIV/AIDS crisis, which left many children orphaned.[27] In 1999, President Moi declared HIV a national disaster. In addition, Kenya was performing poorly with respect to child and maternal health. In 2015 Kenya barely reached MDG 4 on reducing child mortality. With respect to maternal mortality Kenya did not succeed to reach the respective MDG 5.[28] During interviews it was repeatedly mentioned that this background – the perceived HIV/AIDS crisis, serious problems with respect to child and maternal health and the high likelihood of not meeting the MDGs - served as an instigator for the introduction of the CT-OVC program and the introduction of free maternal health:

> *"The government was concerned about the growing number of orphans from HIV/AIDs and the other causes of death of parents and for many of them there*

[27] The HIV-AIDS prevalence rate reached its peak at 11.1% of the total population between 15-49 in 1997, slowly decreasing to 7.4% in 2005 and remaining at a comparatively high level of 5.6% in 2015. The cumulative number of children orphaned by HIV-AIDS increased to 1.5 million in 2005 and 2006. Data: Health Nutrition and Population Statistics, World Bank: Data Bank, http://databank.worldbank.org/data/reports.aspx?source=health-nutrition-and-population-statistics# [last accessed at 2018/02/23]

[28] Under-5-mortality rose from 98.1% in 1990 to 100.8% in 2000 decreasing to 50.1% in 2015. Maternal mortality numbers increased from 687 in 1990 to 768 in 200 and remaining at a high level of 510 in 2015. Data: Health Nutrition and Population Statistics, World Bank: Data Bank, http://databank.worldbank.org/data/reports.aspx?source=health-nutrition-and-population-statistics# [last accessed at 2018/02/23]

was no support structure. (…). There has been a lot of pressure, for example from NGOs, which felt that this needed to be handled."[29]

"(…)But other than the initiatives by the African Union and the governments of Africa, HIV/AIDS and its impact in terms of orphans, played a major role in pushing government to do something about it. There were several campaigns, especially organizations that were working with older persons and organizations that were working with children. (…) But also there has been a momentum moving across Africa. If you look at what is happening in the southern Africa region which has been leading in most of the social protection work, they were declaring HIV/AIDS a national disaster. So it has been a movement cutting across Africa and I think that's how Kenya also got into the bandwagon to do something in that regard."[30]

"They were also informed by reports by countries that were doing well. Although we had done well in terms of education, and indicators on child mortality had also come down, MDG 5 was doing badly. This probably informed the political class."[31]

"And again, the other motivation was the issue of MDGs and all that, and especially related to maternal mortalities, we realized we cannot achieve that unless we address the financial barriers, and that was one of the interventions that was put in place ensuring that all maternal related services are free, starting with the ANC (Ante Natal Clinics)."[32]

Yet, while the MDGs were facilitating targeted and vertical interventions for maternal and child health, they at the same time provided counter-incentives for systemic approaches such as social health insurance, which require longer-term institution building.[33]

[29] National level interview No. 5, Independent observer, Kenya
[30] National level interview No. 2, NGO representative, Kenya
[31] National level interview No. 22, NGO representative, Kenya
[32] National level interview No. 25, Independent Observer, Kenya
[33] Interestingly, the perception of MDGs seems to be selective. In none of the interviews reference was made to MDG 1 (reducing absolute poverty by 50%), although Kenya performs poorly in this respect (see section 4.1).

Thus, the initial reform context provided focal points for coordinating actions and fostered a shared understanding of underlying problems within the reform domain of cash transfers and fee waivers, but had the opposite effect on social health insurance reforms.

Yet, over time, the reform context changed. Throughout the last decade, policy goals such as 'Universal health coverage' or 'Extending social protection' have been firmly embedded on the international policy agenda and systemic approaches have been increasingly emphasized (Bender 2013). These changes are also reflected by the policy discourse in Kenya:

> *"But again, that is where the world is headed, health coverage. Looking at Kenya's situation, the need is big. There are a lot of people suffering out there without access to essential services in health."*[34]

> *"Globally if you look at the SDG now, social protection is featuring in so many of those goals, so there's been a lot of progress nationally, and also globally on issues of social protection,"*[35]

It remains to be seen how these changes at the international level - the new 'spirit of the time' - will eventually impact upon social protection reforms in Kenya, However, it already did allow for a 'new momentum' for social health protection reforms: The World Bank – initially not favouring social health insurance– is now supporting the reform of the NHIF and the extension of social health insurance to the poor via the non-contributors "Health Insurance Subsidy Program" covering health care costs for beneficiaries of cash transfer programs.

5. Conclusions [draft]

The paper aimed at understanding why social protection reform dynamics differ within a country across different pillars of social protection. Stronger conflicting interests within the area of social health insurance in combination with stronger historical institutional legacies and less information asymmetries contributed to the observed differences in reform dynamics. Notions of how to interpret the concept of social protection in combination with' insurance' being a complex construct seem to facilitate processes related to cash transfers whereas providing impediments to SHI reforms. In addition, the international reform context (discourse on MDGs) in interaction with the socio-economic context (HIV/AIDS crisis)

[34] National level interview No. 18, Donor, Kenya
[35] National level interview No. 2, NGO representative, Kenya

provided a stronger impetus for change with respect to the extension of cash transfers compared to social health insurance during early reform stages.

Yet, whereas these initial settings pushed institutional trajectories into certain directions, it is interesting to note that the observed reform dynamics are not time-invariant: Whereas recent efforts to create an integrated and formally institutionalized cash transfer system may potentially reduce reform dynamics, the change to a more “piece-meal-approach” with respect to social health protection may potentially reflect a new momentum for change. Reasons for these (possible) changes in reform dynamics include the development of defined interests and stakes in the reform of cash transfers over time or a changing reform context (international discourse on universal health coverage) with respect to social health protection.

Linking the formerly separate policy areas of cash transfers and social health insurance, is also a step towards a more integrated social assistance system. In terms of anchoring the reform initiatives at legislative level both areas still lack an elaborated legal framework: The Social Assistance Act of 2013 is being renegotiated whereas the new Health Bill formally mandates a social health insurance, but makes no detailed provisions.

The paper raises a number of questions for further research. The framework presented in this paper aims at providing a rather broad approach how to explain variations in reform dynamics. In order to move to a more defined theoretical treatment it is necessary to zoom in on specific aspects. Whereas conflicting interests as barriers to reforms are a well-researched area, it seems promising to look in more depth into the complex role of information structures and their impact on change. Also, the analysis of the Kenyan case has shown that paths may change, and reform dynamics may accelerate or decelerate over time. Addressing the time-variant structure of reform processes seems to be another interesting area for further research. As has been discussed, changes in the reform context may change conditions within the reform domain. In addition, the reform domain itself might provide a source of time variant processes For example strong uncertainty may imply learning processes, leading to changes in the information structure within a reform domain over time. Addressing those endogenous sources of changes seems another novel area for research.

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Annex 1: Social protection Kenya - Timeline

Year	Cash transfers	Social health protection
before 2001	*Before 2004: limited number of in-kind transfers to the poor* *2003: reintroduction of the universal free primary education program*	1989 Introduction user Fees 1991 Suspension user fees 1992 reintroduction user fees
2001		1st National congress on quality improvement in health, medical research and traditional medicine Establishment Inter-sectoral Taskforce on Extending Social Health Insurance
2002		Resolution Establishment NSHIF (January)
2003		Economic Recovery Strategy (ERS) for Wealth and Employment Creation (2003-2007) aimed at transforming the existing NHIF into a NSHIF MoH approached GTZ/WHO for technical support to set up national health insurances;
2004	Idea CT for OVC emerging/being discussed: former VP Wood Awori approached UNICEF for support	Proposed law on NSHI (rejected) Introduction 10/20 program
2005	Pilot OVC-CT started	Direct Facility Funding (DFF) (late 2005, to support 10/20)
2006	National Social Protection Committee installed (direct commitment from Livingstone, i.e. to do something on SP) OP-CT started	Parliament adjourned without an amended NSHI bill being presented
2007	HSNP-CT (funded by DFID)	Abolishment of user fees for deliveries at public health facilities (July): Announcement by former MoH Ngilu; but not backed by a written policy
2008		
2009	WB and DFID started supporting the OVC-CT program	

2010		National Health Financing Strategy (Draft)
2011	GoK – National Social Protection Strategy 2011 National Social safety Net program and National Social Protection Secretariat founded PWSD-CT started	
2012	Urban food cash transfer program (Mombasa/Nairobi)	Sessional paper No. 7 on Universal Health Coverage (failed to pass through parliament)
2013	Social Assistance Act 2013 New Ministry of EAC, Labour and Social Protection National Safety Net Program (NSNP); attempt to harmonize existing programs (co-funded by WB 2013-2018)	Presidential mandate on "healthcare: towards a healthier Kenya" announced; goals include: Achieve free primary healthcare for all Kenyans; Reform of NHIF *(Social Assistance Act 2013)* Removal of user fees at lower health care level and free maternal health care
2014	Renegotiation Social Assistance Act 2013 Sessional paper 2014/2 on the National Social Protection Policy Draft National Social Protection Council Bill,2014 Health Insurance Subsidy Programme for the Poor (pilot) -> linking OVC and SHP	Sessional paper 2014/2 on the National Social Protection Policy Draft National Social Protection Council Bill,2014 Kenya Health Policy 2014-2030 Revision of NHIF Act of 1998 Health Insurance Subsidy Programme for the Poor (pilot)
2015	1st National Social protection Conference (27-30 January 2015) Renegotiation Social Assistance Act 2013 Urban food cash transfer program abolished	1st National Social Protection Conference (27-30 January 2015) Health Insurance Program for the elderly and people with severe disabilities
2016	Zero Draft National Social Protection Bill Single Registry Changing structure of the SP secretariat	Zero Draft National Social Protection Strategy Health Bill 2016 (passed by National Assembly 30 March 2016; published in National Gazette in 2015)

2017	Linking CT-SHP via HISP	Roll out HISP Linking CT-SHP via HISP Free maternity health care administered by NHIF