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

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Abstract

Political economic analyses of recent social protection reforms in Asian, African or Latin American countries have increased throughout the last few years. Yet, most contributions focus on one social protection mechanism only and do not provide a comparative approach across policy areas. In addition, most studies are empirical studies, with no or very limited theoretical linkages. The paper aims to explain multiple trajectories of social protection reform processes looking at cash transfers and social health protection policies in Kenya. It develops a taxonomy and suggest a conceptual framework to assess and explain reform dynamics across different social protection pillars. In order to allow for a more differentiated typology and enable us to understand different reform dynamics, the article uses the approach on gradual institutional change. While existing approaches to institutional change mostly focus on institutional change prompted by exogenous shocks or environmental shifts, this approach takes account of both, exogenous and endogenous sources of change.

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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
MoF	Ministry of Finance
MoH	Ministry of Health
MoGCSP	Ministry of Gender, Children 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 may differ reflecting multiple institutional trajectories and equilibria ranging from 'big bang' approaches to processes of gradual change. These differences are not only observed across countries, but do also exist within countries across different pillars of social protection.

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 providing cash transfers and extending social health protection, i.e. facilitating access to health care for the poor by removing financial barriers. As will be shown, both sub-policy areas are characterized by processes of gradual institutional change. However, whereas the extension of cash transfers follows a pattern of slow-moving yet cumulative incremental change, the extension of social health protection to the poor is reflecting a non-cumulative pattern including stages of blocked reforms or even reform reversals.

Being embedded within comparative institutional analysis and framing the problem in game-theoretic terms, the paper aims at analyzing variations in reform dynamics from an institutional change perspective by assessing the factors impacting on the political feasibility of social protection reforms in each sub-policy area. Furthermore, the analysis aims at identifying those factors to which differences in reform dynamics across the two sub-policy areas can be attributed. In doing so, the paper is mainly concerned with (re-iterated) processes of policy formulation, policy decision-making and institutionalization.[1]

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. As Mahoney and Thelen (2010) point out, available explanations of institutional change either provide explanations why institutions are stable over time (*inertia*) or focus on institutional change prompted by exogenous shocks or environmental shifts (*parametric changes*, *punctuated equilibrium*, *critical junctures*). Yet, these approaches cannot account for

[1] Policy stages are heuristically captured by policy cycle models. Different policy cycle models exist with varying numbers of stages defined. For example, the policy cycle suggested by Howlett et al. (2009) defines five stages (agenda-setting, policy-formulation, decision-making, implementation, evaluation), whereas the policy cycle of Grindle and Thomas (1991) is defined by three stages (agenda-setting, decision-making, implementation). As both reform areas under consideration are firmly embedded within national policy agendas, yet showing differences in the processes related to policy formulation and decision-making, the focus here is on the latter two stages. The implementation stage is addressed in Rohregger et al. 2017.

processes of gradual, respectively incremental institutional change. In order to understand gradual institutional change it is necessary to complement existing approaches with an endogenous approach to institutional change and take into account both, exogenous and endogenous sources of change (Mahoney and Thelen 2010). Mahoney and Thelen (2010) develop an approach that explains gradual institutional change as the result of interaction between political context, the mode of institutional change with respect to existing institutional status quo and different types of change agents, i.e. the rule preserver/non-preserver and the rule follower/non-follower. Processes of gradual institutional change are explained by disaggregating the reform process in stages, which are understood as interlinked games, with the results of previous stages influencing subsequent stages (*sequencing*). In addition, by considering institutional change as an outcome of collective action and distinguishing between the reform context (*exogenous conditions*) and the reform domain (*endogenous conditions*), it is possible to address the interplay between external and endogenous factors. The interaction between a changing reform context and changes in the reform domain provide the impetus for gradual change. By addressing differences in reform domains and taking time (*timing*) into consideration, it is also possible to explain multiple institutional equilibria across different social protection.

Secondly, with respect to social protection a vast literature is devoted to the political economy of the development and reform of welfare states in high-income (mostly European) countries. Political economy analyses of social protection reforms in low and middle-income countries are more recent. A relatively well-researched area relates to pension reforms in Latin America during the 1980s and 1990s (e.g. Brooks 2009; Mesa-Lago 1994, 2002, Mesa-Lago and Müller 2002). The seminal contribution by Haggard and Kaufman (2008) provides a comprehensive historical and quantitative analysis of social policy reforms in Asia, Latin America and Eastern Europe between 1945 and 2005. The number of political economic analyses of more recent reforms in Asian, African or Latin American countries is still limited, but has increased throughout the last few years (e.g. Ayede et al. 2015, Bender and Rompel 2010, Brooks 2015, Duman 2013, Grebe 2014, Grebe and Mubiru 2014, Fox and Reich 2012, Ichoku, Fonta and Ataguba 2013, Schuering and Gassmann 2013, Kwon and Kim 2015). Yet, most contributions focus on one social protection pillar only and do not provide a comparative approach across policy areas. In addition, most studies are empirical studies, with no or very limited theoretical linkages. Noteworthy exceptions include for example Hickey (2008) and Lavers and Hickey (2016) building on and extending the political settlement approach.

Thirdly, academic contributions addressing social protection reforms in Kenya are scarce. Wanyama and Mc Cord (2017) address the extension of social protection across different pillars of social protection, but use a different approach. Abuya et al. (2015) focusses on the early stages of social health protection reforms in Kenya addressing the interaction of stakeholders, conflicting interests and technical impediments. Künzler (2016) illustrates the limitations of standard theoretical explanations in providing a full account of "failed reforms".

The remainder of the paper is structured as follows: Section 2 will present the conceptual framework guiding the empirical analyses: First, a classification system to assess the dependent variable 'reform dynamics' will be presented. Then, the analytical framework for analyzing reform dynamic will be introduced. 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. Section 5 puts forward propositions why reform dynamics between both policy areas differ and provides a comparative analysis of factors impacting on the observed dynamics. Section 6 concludes.

2. Understanding reform dynamics – Conceptual framework

2.1 Defining and classifying reforms

Contributions dealing with reforms rarely define the term at all. Even if the term is defined, the concept remains rather vague. Yet, in order to explain variations in reform dynamics, it is necessary to provide a clear conceptualization of the term first. A reform may be defined as "… a policy innovation manifesting in an unusually substantial redirection or reinforcement of previous policy" (Keeler 1993: 434), "… an intended fundamental change of the policy and/or administration of a policy sector" (Resodihardjo 2009: 29) or, "…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 (i) processes of change (dynamic perspective) with (ii) the subjects of change being either policies or institutions. In addition, (iii) the definitions indicate that not every change qualifies as a reform: As indicated by terms such as 'unusually substantial' or 'fundamental' the scope of change seems to matter, but terms such as 'unusually substantial' or 'fundamental' are rather fuzzy concepts and do not allow to decide on clear thresholds separating 'fundamental' reform from 'non-fundamental' policy change.

Based on Bender (2013) and drawing on different strands of literature on classifying either policy or institutional change, the following section suggests a classification system based on four dimensions:

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

First, classifying reform dynamics requires defining a *temporal baseline* against which dynamics are evaluated (status quo). As the paper is particularly concerned with the analysis of the political decision-making process (processes of policy formulation and policy adoption) and not with processes of agenda setting, the temporal baseline is chosen according to the year the policies in questions had been positioned on the political agenda, i.e. after having successfully passed the policy stage of agenda setting. Of course, it is often difficult to pinpoint the exact timing, thus, the analysis identifies events, which signal the presence of the policies under debate on the national political agenda.

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 previous ones ('back-and-forth processes') or reform processes are obstructed.

Thirdly, the magnitude or *scope of change* captures the degree to which the content of reform initiatives deviates from the 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

[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.

to the calibration of existing instruments.[3] 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 an incremental reform process is cumulative, then small changes might eventually lead to third-order changes ('system-shifts'). If not, then small changes remain first- or second-order changes.

Fourth, with respect to *tempo of change* reform dynamics may vary between slow moving and fast moving processes (Howlett and Cashore 2009).

2.2 Explaining reform dynamics

Starting point for institutional analysis is the interdependence of individual actions or mutual dependencies. Interdependence implies that the outcome of an action depends not only on one's own action, but also on the action of at least one other actor (e.g. Voigt 2002, Sandler 2002). From this perspective, extending social protection involves multiple coordination and cooperation processes whose specific outcome depends on how prevailing coordination and cooperation problems are dealt with.[4]

Different meanings have been attached to the term 'institutions'. The concept of institutions applied here is based on the 'institutions-as-equilibrium-of-the-game'-approach, which regards institutions as the outcome of social interactions and enables an endogenous analysis of institutional change resulting from the strategic interaction of players involved. 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).[5] According to this definition,

[3] Referring to the definitions above and interpreting the term "reform" in a narrow sense then first order change would not qualify as reform as the definitions include reference to the magnitude of change as defining characteristics of a reform.

[4] (Pure) coordination problems involve information problems, but do not involve any conflicts of interest. Problems arise due to a lack of information or a lack of communication between actors. Cooperation problems refer to situations where conflicting interest inhibit the realization of cooperation gains. Information problems such as asymmetric information or the possibility to manipulate information may exacerbate the problem.

[5] It is possible distinguish further between formal and informal rules (i.e. codified or non-codified rules) or between external and internal rules (external rules are enforced by public authorities; internal rules are enforced by societal actors or by the individual herself via internalization). The first classification (e.g. North 1990) emphasizes the rule component – also to a certain extent mixing up both perspectives with formal institutions euqalling public institutions. The latter classification addresses the enforcement component (e.g. Voigt 2002). Combining both classifications provides a more nuanced understanding of institutions: External institutions of type 5 (constitutions, laws, regulations) are formal institutions, whereas internal institutions of type 1 (conventions), type 2 (internalised rules) and type 3 (social norms) are informal institutions, Internal institutions of type 4 (formal private rules) are also formal institutions, but are not enforced by the state. It goes without saying that institutional arrangements may comprise of a mixture of different types of institutions.

institutions regulate behavior and at the same time, are being endogenously created, changed or sustained through the strategic interaction of players. In addition, common knowledge of these rules and the shared subjective beliefs of actors on action rules being relevant for the play of the game are necessary elements as well. Institutional change equals a shift from an existing equilibrium to a new equilibrium (Aoki 2007). The resulting trajectories between different equilibria denote the process of institutionalization.

A reform domain relates to a specific policy area and involves the strategic interaction of individuals/organizations with identifiable interests in the reform process (see Figure 1). Institutional changes are a result of the strategic interaction of stakeholders in the reform domain. In case of incremental change, the outcomes of one reform stage provide the status quo for the next reform stage (interlinked games). Differences in reform domains induce differences in reform dynamics and outcomes due to differences in prevailing cooperation and coordination problems in each domain.

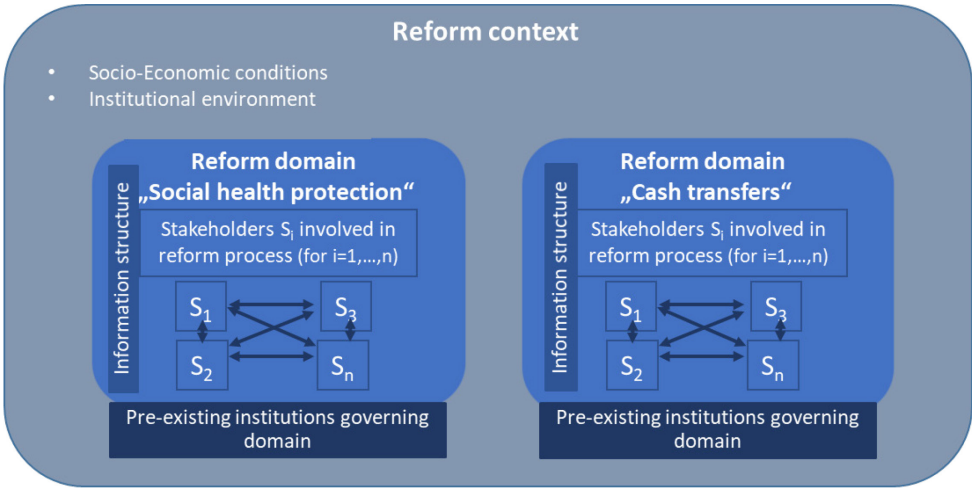
Reform domains are characterized by

- Preferences of stakeholders involved,
- Prevailing information structures,
- Pre-existing institutions governing the domains,
- Characteristics of the specific policy in question.

The preferences of stakeholders indicate actors' attitudes towards the reform in comparison to maintaining the status quo. The attitudes might reflect 'self-interested behaviour' (e.g. expected changes in level of influence or resources), but also reflect prevailing 'mental models' such as values or beliefs held by actors involved.[6]

[6] 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.

Figure 1: Reform domain and reform context



Source: Own compilation

The more heterogeneous preferences are (ceteris paribus), the higher the likelihood for conflicts (cooperation problems). The information structure specifies the type and degree of information that is available, the distribution of information (symmetric or asymmetric) and the complexity or ambiguity with respect to interpreting information. Strategic uncertainty arises where there is incomplete or non-reliable information on how other actors behave (coordination problem). If interests between agents differ, individuals may also have an incentive to pursue their own self-interest in a way that runs counter to co-operation (cooperation problem).

Both, pre-existing institutions and policy characteristics impact upon coordination and cooperation requirements. Pre-existing institutions governing the reform domain define the current rules of the game (status quo) and thus, summarize the 'historical legacies' influencing current social interactions. Policy characteristics influence the required future rules of the game. With respect to social health protection and cash transfers these characteristics relate to the type of transfer (monetary or in-kind), instrument choice and design options (social health protection involving a higher number of possible design choices than cash transfers), and complexity (complexity being higher for social health protection). In addition, social health protection is an inter-sectoral policy-issue (health and social protection), which is not *per se* the case for cash transfers.

Streeck and Thelen (2005) provide an approach to assess the mode of institutional change by relating existing institutional status quo to the intended change: 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. This approach helps to specifiy the characteristics of historical legacies with respect to institutional change.

Reform domains are embedded in a broader reform context including the broader institutional environment, socio-economic conditions or international influences. The reform context provides parametric conditions for social interactions in the reform domains (exogenous). These parameters may influence the incentive structures of actors involved (alignment or misalignment of interests) or the information structure (providing signals for coordination or influencing the distribution of information). As in our country case both reform domains are embedded in the same context (within-country analysis), the reform context can only indirectly induce differences in reform dynamics, as its impact is conditional on specific characteristics of the reform domain.

3. Methodology

The paper presents a case study analysis of two cases comparing two sub-policy areas within the overall policy area of social protection (cash transfers and social health protection). 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, Hall 2003, 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 including members of parliament, ministries, other public authorities, non-governmental organization and independent observers. Twenty-five interviews have been conducted. 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. Case study Kenya

4.1 Country background[7]

Kenya is a lower middle-income country with an average per-capita income of 1380 USD in 2016. After 22 years of one-party-rule, Kenya transitioned to a multi-party system in 1991 and since then, has experienced five democratic elections. In 2010, the country adopted a new constitution, which introduced checks- and balances between executive and legislative, with the aim to reduce the substantial rights and powers that the presidency has accumulated over the years (Hassan 2015). More importantly, the constitution also foresaw the long awaited decentralization, which in comparison to many other African countries is very extensive.

While observers suggest that the new constitution provides an important opportunity towards enabling substantial reforms within the political system, they also argue that it did not succeed to alter the basic political feature of Kenyan politics. While leaders have changed and the political system has undergone substantial transitions, the basic features of authoritarianism and patronage continue to dominate Kenyan politics to date (Branch and Cheeseman 2010).

Kenya's economy has experienced a revival since 2000, but growth remains volatile due to internal and external shocks. While growth has reached an all-time high at 8.4 percent in 2010, growth rates over the last six years have oscillated between 5 percent and 6 percent.

Poverty in Kenya has substantially increased since the 1990s, from 21.5 percent in 1997 to 47 percent in 2005. Current estimates assume a decline to 42 percent in 2012.[8] Major reasons for overall increase in poverty are uneven and poor agricultural development paired with rising food and fuel prizes since 2009. Poverty in Kenya is markedly higher in rural (50 percent) than urban areas (34 percent). 90 percent of Kenyans in the bottom 40 percent of the income distribution live in rural areas. Poverty also shows high variations across regions from a high of 74 percent in the North Eastern province to a low of 22 percent in Nairobi.

Pro-poor public policies have been put in place in order to reduce poverty rates. Development spending, including social protection policies (2.28 percent of GDP in 2010[9]) and education (6 percent of the GDP) have increased substantially, while public health spending remains low at an average of below 2 percent of the GDP over the last decade (Government of Kenya

[7] If not mentioned otherwise all data: World Bank Development Indicators database.
[8] Poverty in Kenya was last measured in 2005.
[9] The percentage rate covers expenditure on civil service pensions (1 percent), contributory programs (0.48 percent) and social cash transfer programs (0.8 percent).

2012). This also explains the high rates of out-of-pocket expenditure as a share of private expenditure on health that amounted to 67.4 percent in 2014. Out-of-pocket expenditure as a share of total expenditure on health amounted to only 26.1 percent in the same year, indicating a generally low user rate of health services in Kenya. Overall life expectancy has increased from 50.7 years in 2000 to 62 years in 2015 while Under-five mortality went down from 107.9 percent in 2000 to just below 50 percent in 2015 enabling Kenya to reach a Millennium Development Goal (MDG) goal. However, at the same time, maternal mortality is one of the highest in Africa with 488 deaths per 100,000 live births.

Gross-enrolment rate increased substantially from 95.6 percent in 2000 to 108.9 percent in 2015 enabling Kenya to achieve the MDG goal on education. While Kenya spends a lot on education as compared to other countries, efficiency of the sector is however, a major problem. The high degree of absenteeism of teachers during school hours is a major challenge with regard to the quality of education.

4.2 Social protection in Kenya – Overview

Social protection in Kenya comprises of contributory and non-contributory mechanisms. Contributory schemes include the National Social Security Fund (NSSF) and the National Hospital Fund (NHIF). The fund is open to all employees and self-employed persons and provides benefits for themselves and their dependents. Benefits include retirement pension, invalidity pension, survivors benefit, funeral grant and emigration benefit. Only 15 percent of the population is covered by retirement benefits of which more than two thirds are under the NSSF, 22 percent under the Civil Service Pension Scheme and another 11 percent under Occupational private schemes (Hakijami 2014). The National Hospital Insurance Fund (NHIF) is the major health insurance mechanism in Kenya. From the population covered by health insurance 85 percent are under the NHIF. The fund is compulsory for salaried employees (64 percent of insured). In an attempt to extend coverage to the informal sector, membership has been opened up to the sector on a voluntary basis. Informal sector workers make up 34 percent of the total number of insured while 1.2 percent are indigent or poor (state-sponsored programs). Currently it covers 19 percent of the population (Sigey 2016). The benefit package includes amongst others a comprehensive in-patient cover for the contributor and his/her family, as well as comprehensive maternity coverage in all public and a few private and mission hospitals across the country.

Non-contributory schemes have increased substantially over the last decade in Kenya. There are more than 19 non-contributory programs across the country. A range of school feeding programs is in place, in particular in areas prone to food shortage and poor areas with the aim to keep children in school. These include the Most Vulnerable Children program targeting more than 1,700 0000 pupils in poor areas, the regular school meals program targeting primary school children (803,669 pupils), the expanded school meals program (346, 000 pupils) and the home-grown school meals program (540, 000 pupils) (Government of Kenya 2011). The National Safety Net Program (NSPN) is the umbrella for four cash transfer programs, which cover a total of 830,000 households.[10]

- 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 (353,000 households in 2016).[11]

The OP-CT cash transfer program has recently been revised. The 2017/18 budget foresees a universal cover for persons 70 and above, who are not covered by any other pension schemes (Capital News 2017).

The HSNP is being implemented by the Ministry of Devolution and Planning, whereas the Ministry of Labour, East African Affairs and Social Protection implements the OPCT, PWSD-CT and the CT-OVC.

The CT-OVC program is the biggest and oldest among the cash transfer programs in Kenya having started in 2004 as response to the rising number of orphans and vulnerable children due to HIV/AIDS. Through regular cash transfers, it seeks to provide support to families living with OVCs in order to encourage fostering and retention of such children within their families

[10] A fifth cash transfer program targeting the urban poor has been being piloted since 2012. The Urban Food Subsidy Program (UFSP) covered around 102,000 households in Nairobi and Mombasa, but has been suspended in 2016.

[11] According to estimates, Kenya has 2,400 000 orphans and vulnerable children. (Gender and Equality Commission 2014)

and communities and to promote their human capital development. More specifically, the program aims at increasing enrolment and retention rates of OVCs, improve their health status through immunization, growth monitoring and vitamin supplements, increase civil registration of children as well as their caregivers and finally, support households through training measures to better take care of their health and nutrition as well as to manage HIV/AIDS.[12] Beneficiaries receive KES 2,000 per household per month paid on a bi-monthly through the Kenya Commercial Bank and Equity Bank.

With regard to health, the Government of Kenya introduced the 10:20 policy in 2004 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 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 will be households 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. Since 2017, the program is being rolled out at national scale.

In Kenya, government is the largest source of financing to social protection (55 percent), followed by the development partners (22 percent) and members of the contributory schemes (22 percent). Government funding goes mainly into contributory schemes, in particular civil service pensions (88 percent in 2012) while external funds are spent almost entirely on cash transfer programs. As a result, 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 the OP-CT is fully financed by the Government of Kenya, whereas the CT-OVC, PWSD-CT and HSNP are mostly-donor financed yet with an increasing share financed by the Government of Kenya. Formal social protection schemes (both contributory and non-contributory) cover around 13 percent of the Kenyan population.

[12] Homepage Social Protection Secretariat, Available at: http://www.socialprotection.or.ke/national-In safety-net-program/cash-transfer-for-orphans-and-vulnerable-children-ct-ovc, [31.05.2017]

4.3 Classification of social protection reform dynamics in Kenya: The cases of cash transfers and social health protection

To assess reform dynamics within the reform domains of social health protection and cash transfers this section applies the four criteria described in section 2.1 - temporal baseline, scope of change, mode of change, and tempo of change - to the Kenyan case (see Annex 1 for a detailed timeline):

Temporal baseline

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 whose report recommended the establishment of a National Health Insurance Scheme (Abuya, Maina and Chuma 2015).

With respect to cash transfers, discussions started a few years later in 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, upon which UNICEF suggested the introduction of a cash transfer program.

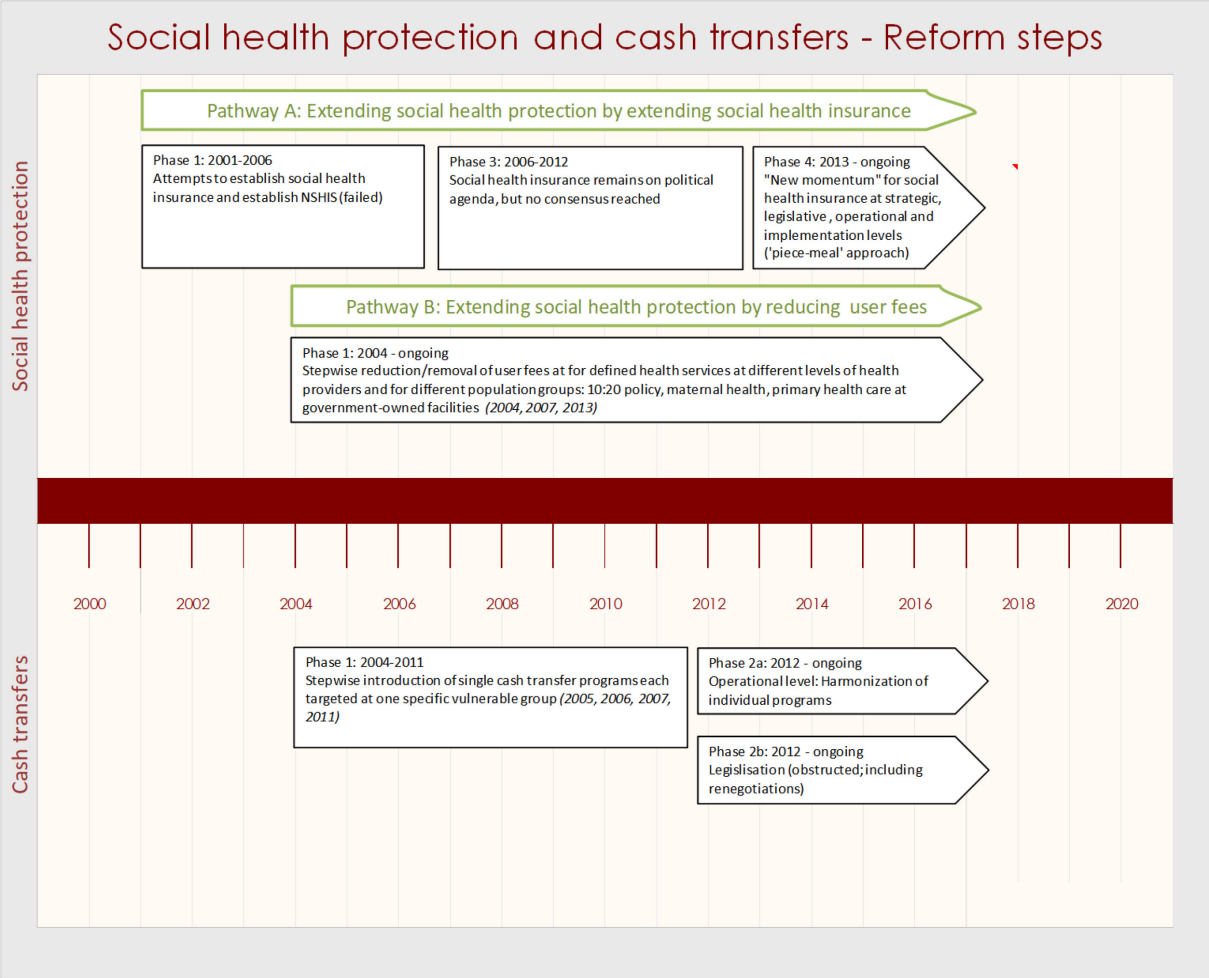
Scope of change

With respect to the Kenyan case, both sub-policy areas (social health protection and cash transfers) reform processes involve several steps and are incremental in nature. However, both sub-policy areas differ in the relationship between individual steps (see Table 1).

The reform trajectory with respect to policy initiatives aimed at extending social health protection shows a complex pattern. The problem of financial barriers in accessing health care, which are particular 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 extending social health protection by 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 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 first phase ended when the proposed law on the establishment of a National Social Health Insurance Fund (NSHIF) was rejected. Although the suggested bill was passed by parliament in late 2004, the president did not sign the bill. Instead, he returned it back 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 2: Reform phases



Source: Own compilation

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 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 also this paper was not passed by parliament. These 'ups-and-downs' 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 instruments to extend social health protection:

> "An equitable financing mechanism will be developed through the introduction of a system to channel funds directly to health care facilities to ensure that funds allocated are utilised for their intended purpose. The following initiatives will be reviewed: Implement the National Health Insurance Scheme as a means of financing curative and rehabilitative services thus leaving the government health system to concentrate on prevention, research, and policy; Channel health funds direct to Health facilities in line with the HSSF gazette notice; Increase resources to underserved or disadvantaged areas; Scale up the Output Based Approach System for other health services; Review the Public Health Act to allow disbursement of funds as grants directly to health facilities; Empower health facility boards to manage and supervise resources generated locally and those allocated from the Central Government." (Ibid: 103)

Yet, interestingly, 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). Thus, the First MTP indicates the presence of different positions being at play with respect to social health insurance.

The current and fourth phase (2013 – ongoing) 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 . Thus, 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). Starting in 2014, the Ministry of Health supported by the World Bank is implementing a pilot on extending health insurance coverage to the poor (Health Insurance Subsidy Program for the Poor – HISP). The pilot 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. By linking the formerly separate policy areas of cash transfers and social health insurance, it is also a step towards a more integrated social assistance system. The national-wide scaling up of the HISP has been announced in 201and is being implemented at the time of writing. 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 including an explicit focus on the poor, the fee waiver/reduction policies do have an implicit focus on low-income groups as public health facilities at lower level are utilized more frequently by low-income groups. Yet, the implementation of these measures remains incomplete showing strong regional variations (see Rohregger et al. 2017, Chuma et al. 2009, Maina and Ongut 2014).

The reform process related to cash transfers may be subdivided in (at least) two phases. 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 legislative, organizational and operational changes and is concerned with the harmonization (phase 2a) and obstructed processes of formalization/legislation (phase 2b). 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.

Mode 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.

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.

Tempo of change

Looking at the entire time span both reform processes seem to be rather slow moving. Yet, comparing the reform dynamics in both sub-policy areas, cash transfer reforms progress faster with respect to implementation, but the development of a legal framework is a slow moving process in both sub-policy areas: Contrary to cash transfers, reform processes related to the extension of free health services to the poor entered the implementation stage only recently in 2013. Yet, 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 provision.

Table 2 summarizes the key characteristics of reform dynamics with respect to cash transfer reforms and social health protection reforms in Kenya.

Figure 3: Characteristics of reform dynamics

Reform Characteristics	Social health protection	Cash transfers
Temporal baseline	2001	2004
Scope of change	3rd order change	3rd order change
Mode of change	Incremental: discontinuity/back-and-forth; non-cumulative; fragmentation (two non-related pathways)	Incremental: continuity/cumulative; convergence from fragmentation to harmonization
Tempo of change	Slow moving	Slow moving

Source: Own compilation

To conclude the social protection reform dynamics in Kenya differ in particular with respect to the mode of change: Both sub-policy areas (SHP and social cash transfers) are characterized by processes of gradual institutional change bringing about fundamental third-order change. However, whereas the extension of cash transfers follows a pattern of slow-moving yet incremental 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.

4.4 Explaining variations in reform dynamics

The analysis above has shown that mode of change differ between sub-pillars of social protection. The following section puts forward propositions why reform processes aiming at the extension of social health protection have been more obstructed than those dealing with the extension and proliferation of social cash transfers.

Proposition 1: 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. (Preferences)

Stakeholders involved during the first stage of introducing and extending SCTs programs mainly included the former vice-president at that time, Wood Awori, the respective ministries involved (MoGCSP/MoLSSS/MoLEAASP for CT-OVC, OP-CT, PWSD-CT, MoNKOAL for the HNSP and the Ministry of Finance) and donors providing support. For OVC-CT, donors included UNICEF, joined later by DFID and World Bank. At the end of the first stage and the

start of the second, members of parliament also entered the reform domain. 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.

During the first stage, 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 effective instrument for poverty reduction or rather contributing to dependency thereby reinforcing existing poverty. Yet, the observed degree of conflicting interests was not strong and interests were mostly homogeneous centered on SCT as a political lever and a new form of clientelistic policy making. Initially, the program was largely donor-financed and a reallocation of financial resources was not necessary. This also reduced the potential for conflicts. In general, conflicts concerning the distribution of reform gains and losses among the stakeholders seem to be of lesser or no importance at all (see also proposition 3 below).

Yet, during the ongoing second phase involving the harmonization and legalization of the program more conflicting interests seem to emerge inhibiting the adoption of reform proposals (see proposition 3). In addition, conflicts relating to the financing of the 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.

Likewise, only 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 (see also proposition 2). Health facilities or medical associations were not involved initially. In addition, 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) funded 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 (e.g. Rohregger et al. 2017).

With respect to social health insurance, the situation is different: From the very beginning, a larger number of stakeholders has 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 Ministry of Health - former MoMS/MoPHS, the Ministry of East African Community, Labour and Social Protection – former MoGCSP/MoLSSS, and the Ministry of Finance), 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 existed 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. However, it is not clear whether these concerns also reflect a generally negative attitude towards a stronger redistribution of public resources towards the poor. Contrary to the current financing model of cash transfers, the rich and middle class have to contribute directly to finance SHI, rendering redistribution more visible. During interviews, it has been suggested that public attitudes reflect a low acceptance of redistribution, but this general statement warrants further

investigation. Also, many stakeholders outside government felt left out which induced further opposition (Carrin et al. 2007)

Looking at the group of donors, one can observe another striking difference as compared to cash transfers. First, the number of donors involved in the health sector was considerably higher including about 6 bilateral donors, various international organizations such as World Bank, WHO, different UN-agencies, or the European Union and international initiatives as the Global Fund. Second, whereas donors supported (and financed) cash transfers unambiguously, policy preferences towards 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.[13] Against the background of inefficient health systems and the MDGS (see proposition 4), these approaches represented the 'spirit of the time'. Thus, establishing a social health insurance included several features, which ran contrary to the pursued vertical approaches (system approach, comprehensive benefit package and a strong role for the central level). Abuja et al. (2015) report that donors colluded with private sector to campaign against SHP.

Although the early process induced path dependencies by increasing the polarization of stakeholders, the topic was not off the political agenda and processes of policy formulation continued. A new inter-sectoral committee established in 2007 successfully decided to use the process related to the development of the national strategy 'Vision 2030' as a vehicle for further continuing the health financing agenda (Abuja et al 2015). By strategically linking the reform process to the reform context, it was possible to keep the topic on the political agenda and continue the debate.

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 helps to 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 by supporting reforms of the

[13] During 2000 – 2007, the World Bank financed the 'Decentralized Reproductive Health and HIV/AIDS – DARE' Program.

NHIF and financing the HISP program the degree of conflict has been decreased (also see proposition 4).

Proposition 2: Differences in information asymmetries across domains provided stronger impediments to SHI reforms compared to SCT and fee waivers. (Information structures)

None of the reform areas involved a broad and inclusive stakeholder dialogue, but for cash transfers and for the fee waiver policies the group of stakeholders initially involved was smaller compared to social health insurance. The piloting of the CT-OVC program and the first scaling up was mainly discussed among the leading ministry, the MoGCSP, donors and the MoF, the latter being less concerned given that donors provided the funding. The introduction of fee waivers in 2013 was 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. Thus, strong information asymmetries prevailed facilitating policy change.

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 thus reducing somewhat 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.

Proposition 3: Pre-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. (Historical legacies)

At the time when 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). Yet, with respect to social health protection, the health sector was already a highly - organized sector with an existing legal framework, a defined division of labour and well organized interests groups. 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. Conversely, 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 different public authorities (two different department within the Ministry of Gender, Children and Development and one department within the Ministry of Northern Kenya and Arid Lands). This fragmentation facilitated the proliferation as none of the stakeholders lost influence due to the introduction of additional programs.

When 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. The introduction of cash transfers programs in contrast, represents processes of layering, i.e. new institutions are added on top of or alongside existing institutions.

These constellations present in each of the reform domains provided different incentive structures for stakeholders involved. 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 loosers' in terms of changes in influence or resources could emerge. In addition, these historical legacies also 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. 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.

Considering the ongoing reform phases, proposition 1 already mentioned that during the ongoing second phase involving the harmonization and legalization of cash transfer programs conflicting interests are becoming stronger. Contrary to phase 1, ongoing reform processes

involve processes of displacement: Coordinating and harmonization programs involve redefining and restructuring responsibilities, thus introducing conflicts on who gains and who loses influence.

Proposition 4: The international institutional environment (Millennium Development Goals) and domestic socio-economic conditions provided a constellation more conducive to the introduction of programs targeted at specific vulnerable groups than it was for the introduction of systemic approaches. (Reform context)

Kenya's health indicators show a mixed trend with only marginal improvements in recent years after strong worsening during the early 2000s. The achieved results do not meet the specific targets for the MDGs except for under-five mortality, which went down from 107.9 percent in 2000 to just below 50 percent in 2015 barely enabling Kenya to reach this MDG-goal. However, at the same time, maternal mortality is one of the highest in Africa with 488 deaths per 100,000 live births. In addition, the HIV/AIDS crisis left many children orphaned. Still today, HIV/AIDS accounts for the majority of disease or injury related deaths and for the highest percentage of Disability-Adjusted Life Years (DALY).

During interviews it has been 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. 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 SHI, which required longer-term institution building.[14]

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 with respect to fee waivers, but had the opposite effect on social health insurance reforms.

Yet, over time, the reform context changed. Throughout the last decade, social protection has been continuously emerging on the international policy agenda and systemic approaches have been increasingly emphasized (Bender 2016, Bender et al. 2014). This is reflected for example by the ILO „Recommendations concerning National Floors of Social Protection"

[14] 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 very badly in this respect (see section 4.1).

(2012) or the fact that social protection is anchored in 5 out of the 17 Sustainable Development Goals. In 2012, the World Bank formulated its new Social Protection Strategy 2012-2022. It remains to be seen how these changes in the international context - the new 'spirit of the time' - will eventually impact upon social protection reforms in Kenya. However, it already did support the 'new momentum' for social health protection reforms: The World Bank – initially opposing social health insurance reforms – is now supporting the reform of the NHIF and the extension of social health insurance to the poor.

5. Conclusions

The paper aimed at understanding why social protection reform dynamics differ across different pillars of social protection with a particular focus on the extensions of social health protection and cash transfers in Kenya. The paper suggested an approach how to classify the dependent variable 'reform dynamics' according to the dimensions of temporal baseline, mode of change, scope of change and tempo of change. It then presented an analytical framework for explaining differences in reform dynamics and understanding processes of incremental institutional change by distinguishing between reform domain and reform context.

Social protection reforms in Kenya are characterized by processes of slow moving and gradual institutional change. However, whereas the extension of cash transfers follows a pattern of slow-moving yet cumulative incremental change, the extension of social health protection to the poor is reflecting a non-cumulative pattern including stages of blocked reforms or even reform reversals. Stronger conflicting interests within the area of social health insurance in combination with stronger historical legacies and less information asymmetries contributed to the observed differences in reform dynamic. In addition, the international reform context in interaction with the socio-economic context provided a stronger impetus for change with respect to the extension of cash transfers compared to social health insurance.

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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