

LONDON  
SCHOOL of  
HYGIENE  
& TROPICAL  
MEDICINE



LSHTM Research Online

Koon, AD; (2017) Framing Universal Health Coverage in Kenya: An Interpretive Analysis of Health Financing Politics. PhD thesis, London School of Hygiene & Tropical Medicine. DOI: <https://doi.org/10.17037/PUBS.04398421>

Downloaded from: <https://researchonline.lshtm.ac.uk/id/eprint/4398421/>

DOI: <https://doi.org/10.17037/PUBS.04398421>

**Usage Guidelines:**

Please refer to usage guidelines at <https://researchonline.lshtm.ac.uk/policies.html> or alternatively contact [researchonline@lshtm.ac.uk](mailto:researchonline@lshtm.ac.uk).

Available under license. To note, 3rd party material is not necessarily covered under this license: <http://creativecommons.org/licenses/by-nc-nd/3.0/>

<https://researchonline.lshtm.ac.uk>

LONDON  
SCHOOL *of*  
HYGIENE  
& TROPICAL  
MEDICINE



**Framing Universal Health Coverage in Kenya: An Interpretive  
Analysis of Health Financing Politics**

Adam Dale Koon

Thesis submitted in accordance with the requirements for the degree of  
**Doctor of Philosophy** of the  
**University of London**

2017

Department of Global Health and Development

Faculty of Public Health and Policy

London School of Hygiene & Tropical Medicine

Funded by: No funding received for studies, research funding provided by LSHTM  
Research Degree Travelling Scholarship

Research group affiliation: Anthropology, Politics and Policy

# Declaration

---

I, Adam Koon, confirm that the work presented in this thesis is my own. Where information has been derived from other sources, I confirm that this has been indicated in the thesis.

Signed:  .....

Date: 24 April 2017

# Abstract

---

Universal Health Coverage (UHC), comprehensive access to affordable and quality health services, is a key component of the newly adopted 2015 Sustainable Development Goals (SDGs). Prior to formally adopting the goals at the United Nations in September 2015, several countries began incorporating elements of UHC into the domestic policy arena. Little research has been conducted on the process through which UHC financing policies have been contested in the political realm. In 2013, President Uhuru Kenyatta of Kenya announced initiatives aimed at moving the country towards UHC, which have proven controversial. This study drew on recent theoretical innovations in the field of critical policy studies to examine the ways in which actors understood and engaged with three highly contested health financing policies introduced as part of the movement towards UHC in Kenya: user fee removal, raising contributions to the mandatory health insurer, and the failed 2004 Bill on Social Health Insurance. In addition to document review, this study involved interpretive analysis of transcripts from 50 semi-structured interviews with leading actors involved in the health financing policy process in Kenya. The frame-critical analysis focused on *how* actors 1) make sense of the policy environment and create meaning through circulating finance ideas; 2) name various elements of the policy design through a process of selecting and categorizing; 3) tell stories and create narratives in ways that illustrate salient features of the process and generate shared understandings. Furthermore, this analysis also focused on *what* is subject to framing in this dynamic process, including 1) the substantive issues of the policies in question; 2) actor identities and relationships; and 3) the policy process itself. This study found that user fee removal was framed by finance experts as an achievable short-term target for the Jubilee Coalition's party manifesto. The rate increase for the mandatory insurer, the National Hospital Insurance Fund (NHIF), was consistently obscured by framing the debate around the shortcomings of NHIF and its damaged legacy. Lastly, the failed 2004 Bill on National Social Health Insurance has since fragmented into several incremental policy proposals that remain the subject of divisive framing contests. This study provides timely insight into the political dynamics surrounding the UHC movement, the policy process for health financing in Kenya, as well as theoretical and methodological considerations for frame-critical policy analysis and the field of critical policy studies more widely.

# Acknowledgements

---

This research argues against the cynical view that politics is intractable and driven primarily by self-interested actors. The optimistic and philosophical tone of critical policy studies was inspirational and continued to carry me throughout what, at times, can feel like a self-indulgent enterprise. Similarly, I gravitated toward this research because of its focus on people and the difficult task they have in making sense of a complex world. Though I have learned much about health policy in Kenya, I continue to be perplexed by the energy and deep support by many of the selfless individuals involved with this research project.

First, I would like to thank the Anthropology, Politics and Policy Group (APP) at LSHTM for providing me with a home, particularly during my first year in London. The caliber of academic discourse and the enthusiasm of my colleagues helped me navigate what would otherwise have been a minefield of dead ends. Also, writing this after a prolonged period of writing in solitude, I realize just how much I missed the office banter and fun outings with Fiona, Natasha, Sudeepa, Jo, and Ben when I left for the field. I would also like to give thanks to Dr. Justin Parkhurst who freely lent his critical eye both during the upgrading and subsequent drafts to ensure that this project was up to APP's standards. Thanks also to the Department of Global Health and Development for providing me with a Traveling Research Grant that enabled me to conduct my field research. I will always be proud of being attached to such a meaningful institution.

Second, I would like to thank Dr. Jane Chuma and the Health Economics Unit at KEMRI-Wellcome Trust. Despite all of Jane's commitments, and giving birth to baby Joy right in the middle of data collection, she was able to help steer me in the right direction and trusted me with her, at times, skeptical professional acquaintances. Not a mere landing spot when I arrived in Nairobi, I was caught off guard by how easily the health economics unit allowed me to slip into the fold, joining their daily lunch outings and intellectually challenging me throughout my time in Kenya. Ken, Peter, Doris, Steve, Martin, Eric, Metrine, and Edwine, I hope that this work is up to the standards of the unit and I sincerely hope that we can continue to find ways to collaborate in the future.

Third, I would like to thank my supervisors, Dr. Susie Mayhew and Dr. Ben Hawkins. From the time I met Susie, I knew that I would make it through this process and would be in good hands. Her careful attention to detail for all of the nuances and idiosyncrasies of both the school and the PhD process were immeasurable. Thank you for allowing me to contribute to the climate governance project which enabled me to afford my first year (and a new baby) in London. Despite her escalating number of commitments, she always had time for me and made sure that I was in a personal and intellectual position to keep meeting my deadlines.

Then there's Ben. I don't know of a single person who doesn't smile when they think of Ben. His warm, candid advice as well as his practical outlook on the research process helped get me through stubborn obstacles along the way. I was absolutely elated when he agreed to take on a more prominent role in this work as I don't think I would have known how to design a comparable project (or at least one that I cared about) without him. Through his deep knowledge of subject matter that lies outside of LSHTM's traditional expertise, as well as his own life experiences, I've learned far more than I anticipated when I applying to LSHTM.

Fourth, I would like to thank my family. My parents Cathy and Ron have built careers out of working to better people's lives and they programmed their children with a deep commitment to social justice. While it may not be altogether obvious, there are shades of both of my parents' work present here and something I reflected on throughout the research process. There's something about judgement that necessitates an evaluation of intellectual stimuli in the context of deeply felt emotion that leads to the frustration (and fun!) of politics. I love you and look forward to checking in about things other than progress toward my PhD soon.

Finally, I would like to thank my wife, Emily. Congratulations on completing your second PhD! I always knew you had the stomach for this and at times I felt like I didn't. In those times, you convinced me otherwise. In the midst of establishing your own (undoubtedly more illustrious) career and sacrificing your body for two pregnancies/births, you also carved out space to allow this to happen. Whether reviewing...editing (let's be honest)...drafts, or bundling up the kids and dashing off to buy me some more time, this couldn't have happened without your blind and unrelenting support. Thank you for putting up with all the late nights and for pushing me every step of the way. I would likely still be drafting the first chapter now if it weren't for you! Fiona and Zoë, I love you and hope that someday the work contained in these pages makes some sort of sense to you.

# Table of Contents

---

<b>Declaration</b> .....	<b>2</b>
<b>Abstract</b> .....	<b>3</b>
<b>Acknowledgements</b> .....	<b>4</b>
<b>Table of Contents</b> .....	<b>6</b>
<b>List of Acronyms</b> .....	<b>8</b>
<b>Chapter 1: Introduction</b> .....	<b>10</b>
<b>1.1. The Politics of Universal Health Coverage</b> .....	<b>12</b>
<b>1.2. Health Financing</b> .....	<b>16</b>
Health Financing Politics in Kenya .....	20
<b>1.3. Study Design</b> .....	<b>22</b>
1.3.1 Purpose of the Research .....	22
1.3.2. Thesis structure.....	22
<b>Chapter 2: Theory and Methods</b> .....	<b>25</b>
<b>2.1 Interpretive Approaches to Policy Analysis</b> .....	<b>25</b>
<b>2.2 Ideas and the policy process</b> .....	<b>27</b>
<b>2.3 Frames and framing</b> .....	<b>30</b>
2.3.1 The “How” of framing.....	33
2.3.2 The “What” of Framing.....	35
<b>2.4 Interpretive Research Methods</b> .....	<b>36</b>
2.4.1 Research Design .....	39
2.4.2 Data Collection .....	41
2.4.3 Data Analysis.....	44
<b>Chapter 3: Scoping Review</b> .....	<b>46</b>
<b>3.1. Introduction</b> .....	<b>46</b>
<b>3.2. Methods</b> .....	<b>47</b>
<b>3.3. Results</b> .....	<b>51</b>
<b>3.4. Discussion</b> .....	<b>54</b>
<b>3.5. Limitations</b> .....	<b>60</b>
<b>3.6. Conclusions</b> .....	<b>61</b>
<b>Chapter 4: Framing User fee removal</b> .....	<b>62</b>
<b>4.1 Introduction</b> .....	<b>62</b>
<b>4.2. Making sense of user fees in Kenya</b> .....	<b>64</b>
4.2.1. Development Partners.....	64
4.2.2 Professional and Disciplinary Training.....	71
4.2.3 Values and Policy Design .....	72
<b>4.3 The Language of User Fees</b> .....	<b>74</b>
4.3.1 Features of User Fee Removal .....	74
4.3.2 Metaphors: Low-Hanging Fruit, Quick Win, and Political Gimmick .....	76
4.3.3 Counter Portrayals: Slush Fund and Rushed .....	78
4.3.4. Categorizing User Fees as Incremental Policy Measures .....	81
<b>4.4. Stories that Frame User Fee Removal</b> .....	<b>82</b>
4.4.1. Origin of the User Fee Removal – Domestic .....	83
4.4.2. Origins of the User Fee Removal – International.....	85
4.4.3. Establishing User Fees as part of the Jubilee Manifesto .....	87
<b>4.4. Conclusions</b> .....	<b>93</b>

<b>Chapter 5: Framing the NHIF Rate Increase .....</b>	<b>97</b>
<b>Introduction.....</b>	<b>97</b>
<b>5.1. Making Sense of Kenya’s National Health Insurance Fund.....</b>	<b>99</b>
5.1.1 NHIF’s Governance Structure .....	101
5.1.2. NHIF Administration.....	105
5.1.3. NHIF Mandates .....	107
<b>5.2. The Language of corruption and NHIF.....</b>	<b>110</b>
5.2.1 Naming salient features of NHIF and the rate increase.....	110
5.2.2 Corruption Metaphors: The Cash Cow, Monster, and Black Box.....	113
5.2.3 Exclusivity Metaphors: Members Club and Bed-and-Breakfast.....	114
5.2.4 Categorizing NHIF Negatively .....	116
<b>5.3. Contested Stories of the NHIF Rate Increase .....</b>	<b>118</b>
5.3.1. Prelude to a Scandal, 2010-2012 .....	118
5.3.2 Civil Servants Scandal - “Ghost Clinics” vs. “Business Wars” .....	122
5.3.3. Corruption is Pervasive and Personal .....	126
5.3.4. Path-dependency and the NHIF Act of 1992.....	130
<b>5.4. Conclusions .....</b>	<b>133</b>
<b>Chapter 6: Framing The Ngilu Bill .....</b>	<b>137</b>
<b>Introduction.....</b>	<b>137</b>
<b>6.1. Making Sense of the Ngilu Bill .....</b>	<b>139</b>
6.1.1. The Design of the Ngilu Bill .....	140
6.1.2 The Political Economy of the Ngilu Bill .....	143
<b>6.2 Language of the Ngilu Bill .....</b>	<b>154</b>
6.2.1 Selecting Charity Ngilu .....	154
6.2.2 Framing the Ngilu Bill as ‘Unaffordable’ .....	155
6.2.3 Framing the Ngilu Bill as ‘Unsustainable’ .....	157
6.2.4 Framing NHIF within the Ngilu Bill as a ‘Monopoly’ .....	158
6.2.5 Framing the Ngilu Bill as providing ‘free health care’ .....	159
<b>6.3 Stories of Battle, Stories of Defeat.....</b>	<b>160</b>
6.3.1. Private Sector Stories of Battle .....	160
6.3.2. Stories of Defeat .....	165
<b>6.4. Conclusions .....</b>	<b>169</b>
<b>Chapter 7: Discussion.....</b>	<b>173</b>
<b>Introduction.....</b>	<b>173</b>
<b>7.1 Comparing framing processes across policies.....</b>	<b>173</b>
<b>7.2 Comparing the objects of framing across policies.....</b>	<b>178</b>
<b>7.3 Significance for UHC in Kenya .....</b>	<b>182</b>
<b>7.4 Significance for framing research .....</b>	<b>188</b>
<b>Conclusion.....</b>	<b>193</b>
<b>References .....</b>	<b>196</b>
<b>Appendix A: Ethical Approval.....</b>	<b>214</b>
<b>A.1. Local Institutional Review Board.....</b>	<b>214</b>
<b>A.2. LSHTM Institutional Review Board .....</b>	<b>215</b>
<b>Appendix B: Consent Form .....</b>	<b>216</b>
<b>Appendix C: Interview Guide .....</b>	<b>221</b>
<b>Appendix D: Kenyan Health Systems Data .....</b>	<b>224</b>
<b>Appendix E: Scoping Review Sources .....</b>	<b>228</b>

# List of Acronyms

---

AKI - Association of Kenyan Insurers  
AMREF - African Medical and Research Foundation  
ANC - Antenatal Care  
ARVs - Antiretroviral drugs  
CBHI - Community-based Health Insurance  
CEO - Chief Executive Officer  
CHAK - Christian Health Association of Kenya  
COTU - Central Organization of Trade Unions  
CS - Cabinet Secretary  
DFID - Department for International Development (UK)  
EAHF - East African Healthcare Federation  
FKE - Federation of Kenyan Employers  
GIZ - German Corporation for International Cooperation  
HPSR – Health policy and systems research  
IMF - International Monetary Fund  
IRB - Institutional Review Board  
KEMRI - Kenyan Medical Research Institute  
KEPSA - Kenyan Private Sector Alliance  
KHF - Kenyan Healthcare Federation  
KMA - Kenyan Medical Association  
KNFN - Kenya National Farmers Union  
KNUT - Kenyan National Union of Teachers  
KRA - Kenyan Revenue Authority  
KSH - Kenyan Shillings  
LICs – Low-income countries  
LMICs- Low- and middle-income countries  
MDGs - Millennium Development Goals  
MOH - Ministry of Health  
MP - Member of Parliament  
NCDs - Non-communicable Diseases  
NGO – Non-governmental organizations

NHIF – National Hospital Insurance Fund  
NSHIF – National Social Health Insurance Fund  
NSSF - National Social Security Fund  
OBA - Output-based Aid  
OOPs - Out-of-pocket (payments)  
PMTCT - Prevention of Mother-to-Child Transmission of HIV  
PS - Permanent Secretary  
SARS - Severe Acute Respiratory Syndrome  
THE - Total Health Expenditure  
UHC – Universal Health Coverage  
UN - United Nations  
UNAIDS - Joint United Nations Program on HIV and AIDS  
UNICEF – United Nations Children’s Fund  
USAID - United States Agency for International Development  
VAT - Value-added Tax  
WB - World Bank  
WHO – World Health Organization

# Chapter 1: Introduction

---

With growing support from the international community, the World Health Organization (WHO) is leading a campaign to promote Universal Health Coverage (UHC), or complete access to quality, affordable health care (WHO 2013a). In 2012, several high-level events reinforced the growing movement for UHC as evidenced by the Bangkok Statement, the Kigali Ministerial Statement, the Mexico City Political Declaration, and the Tunis Declaration (WHO 2013c). This support led to the inclusion of UHC into the post-2015 development agenda where it features prominently in the UN's Sustainable Development Goals (UN 2015a; UN 2015b). According to WHO Director General, Margaret Chan, UHC "is the single most powerful concept that public health has to offer" (Chan 2012).

Moving towards UHC is difficult and requires sustained political commitment from national leaders (Nicholson et al. 2015). Retrospective analyses of successful UHC reforms frequently identify "political will" as a key ingredient for success (Brearley et al. 2013). Only recently have global health researchers begun to examine the concept of political will more closely and to theorize its potential influence on the UHC movement (Yamey & Evans 2015). Efforts to understand the political dynamics of health policy and the policy process are not new (see for example Eckstein 1960). However, few existing studies link scholarship from disciplines that engage the analytical complexities of social phenomena with current efforts to understand global health movements such as UHC (for exceptions see Hafner & Shiffman 2013; Fox & Reich 2015; Shiffman 2016). The research presented here addresses this gap by using framing theory, derived from the field of critical policy studies, to understand UHC-oriented health financing policies in Kenya, a country that has indicated high-level support for the movement. The purpose of this research is to gain additional insights into the health financing policy process in Kenya through an analysis of the ways in which three distinct health financing policies have been framed.

The concept of a "frame" comes from ideas-based policy research, and is related to the ways in which issues are rendered meaningful. Frames constitute either a package of ideas (Gitlin 1980) or a central organizing idea (Gamson & Modigliani 1987). Framing research gained currency through the early work of anthropologist Gregory Bateson and sociologist Erving Goffman in the 1950s and 1970s (Bateson 1972; Goffman 1974). In his

seminal work “Frame Analysis”, Goffman defined the interpretive frame as a principle of organization “which governs the subjective meaning we assign to social events” (Goffman 1974: 10-11). The concept of framing has been used in a wide variety of settings and disciplines, from its psychological origins in the idea of ‘schemata’ (Bartlett 1932) to linguistics (Tannen 1993; Lakoff 2004; G Lakoff 2006), social movements research (Gitlin 1980; Snow et al. 1986; Snow & Benford 1988), communication and media studies (Tuchman 1978; Iyengar 1991; Gamson 1992; Entman 1993), political psychology (Chong & Druckman 2007b), the study of social problems (Gusfield 1981), health communication (Rothman & Salovey 1997), behavioral economics (Tversky & Kahneman 1981; Kahneman & Tversky 1984), and policy studies (Schön & Rein 1994; Van Hulst & Yanow 2014). Common to most of these interpretations is the premise that issues in society can be viewed and interpreted in multiple ways that emphasize different values and considerations (Berger & Luckmann 1967). As such, framing is a dynamic process through which those who produce and receive frames make sense of ideas by interpreting them through the available social, psychological, and cultural concepts, axioms, and principles (Fischer 2003). Thus, frames provide, “meaning to an unfolding strip of events” (Gamson & Modigliani 1987).

This research will demonstrate how interactions amongst an array of stakeholders generate meaning and provide a basis for political behavior in the health sector. This is consistent with a conception of politics as the struggle over ideas about what is fair (Stone 2012). Through a process of sense-making, naming, and storytelling, actors create a social understanding of UHC policies including their technical issues, the identities and relationships of participants, and the process by which some ideas gain primacy (Van Hulst & Yanow 2014). In this way, the research presented in this thesis introduces a nuanced understanding of politics relevant to contemporary debates surrounding the UHC movement, as well as the practical considerations of Kenyan policymakers through the use of these frames, or ideas. It employs a version of framing theory situated within the larger intellectual lineage of critical policy studies (Schön & Rein 1994; Van Hulst & Yanow 2014; Braun 2016), to investigate how actors frame certain aspects of the policy process, while obscuring others in order to define problems, diagnose causes, make moral judgments, and suggest remedies (Entman 1993). This is important in the policy world because frames determine what the actors in the policy community consider the ‘facts’ of the matter to be and the ways in which competing problem definitions lead to normative prescriptions for action (Rein & Schön 1977; Rochefort & Cobb 1994). Framing precludes certain policy responses,

identifying legitimate participants in policy debates, and galvanizing coalitions of interest (Schattschneider 1960). Moreover, when comparing multiple perspectives on a policy issue, the definition of a problem itself may change through framing (Fischer 2003). Actors may act strategically to change the problem by reframing a policy dilemma to incorporate a broader array of ideas and potentially free the decision-making process from the gridlock of conflicting frames (Schön & Rein 1994). Applying this scholarship to understand *how* actors within the health sector frame health financing policies provides an interdisciplinary lens for critical analysis of how health policies come to be and are negotiated through political action.

In the following section, I introduce the politics of health financing in global health and in Kenya. I first describe the growing movement in support of UHC as a means to improve access to health care through financial protection. Second, I describe the fundamental role of health financing in UHC and explain why certain types of revenue collection policies are favored. Third, I introduce health financing in Kenya, with a focus on the three policy domains of interest: the politics of user fees; the National Hospital Insurance Fund (NHIF); and the 2004 Bill on National Social Health Insurance. I analyze these three policy domains in depth in this thesis – each occupying their own chapter – to demonstrate *how* actors use sense-making, naming, and storytelling to frame various dimensions of the Kenyan health policy process. In addition to this, I include a discussion in the final chapter of *what* is framed in this process including substantive policy issues, actor identities and relationships, and the policy process itself. In doing so, I demonstrate how critical policy studies can further our understanding of the politics of global public health within low-income countries like Kenya where ideas around UHC are contested and negotiated among multiple actors.

### **1.1. The Politics of Universal Health Coverage**

The concept of UHC is the subject of much debate. According to the WHO, UHC is the ability to ensure that everyone within a country can access health services (including prevention, promotion, treatment, and rehabilitation), which are of sufficient quality to be effective, and to provide all people with financial protection from the costs of using them (WHO 2010). Although this definition and its relevance in certain contexts has been contested (Evans & Etienne 2010; O’Connell et al. 2013; Victora et al. 2013), it is widely

agreed by international stakeholders that the values espoused by UHC extend back to the Alma-Ata Declaration and “Health for All” movement more than 30 years ago (Bump 2010). Similarly, UHC is best conceptualized as an aspiration to be achieved through careful progress in health systems strengthening (Kutzin & Sparkes 2016). These ideas are increasingly associated with the broader development agenda that aims to elevate the health and well-being of vulnerable populations (WHO 2013b; UN 2015a; UN 2015b).

As a mobilizing concept, UHC is underpinned by strong social values espoused by the global health community. In this way, global health advocates frequently align UHC with notions of “progressive universalism” whereby the poor benefit as least as much as the wealthy at every step of the process (Gwatkin & Ergo 2011). This is further illustrated by WHO’s 2013 World Health report, which states:

To support the goal of universal health coverage is also to express concern for equity and for honoring everyone’s right to health. These are personal and moral choices regarding the kind of society that people wish to live in, taking universal coverage beyond the technicalities of health financing, public health, and clinical care (WHO 2013b).

This statement also suggests that policymaking around UHC requires sound judgment and flexible deliberation as much as technical expertise. Thus, ideas about social equity or “progressive universalism,” are hotly contested in the public and political domain. To move towards UHC, countries must make a variety of choices about what is fair in the context of specific historical, political, and economic circumstance (Svedoff et al. 2012). Hence, what UHC looks like and how it develops in one context – such as Kenya – may differ from other places with diverse historical and political meta-narratives.

The UHC movement has been supported by numerous projects and research describing these pathways from health policy and systems research (HPSR). This includes:

- WHO’s World Health Reports in 2010 (*Health Systems Financing, the path to universal coverage*) and 2013 (*Research for universal coverage*) (WHO 2010; WHO 2013b);
- International conferences (the *First Global Symposium on Health Systems Research: Science to accelerate universal coverage* and the *Second Global Symposium on*

*Health Systems Research: Inclusion and innovation towards universal health coverage*);

- Journal supplements on UHC in *The Lancet* led by the firm Results for Development (Lancet 2012); a series of country case studies published in *Health Research Policy and Systems* by WHO's Alliance for Health Policy and Systems Research (Di McIntyre et al. 2013); a multi-country research project called Social Health Insurance for Equity in Less Developed countries (SHIELD) published in *Health Policy and Planning* (McIntyre & Mills 2012); *The Lancet* Commission on Investing in Health (Jamison et al. 2013);
- A large follow-up research study and book on successful health finance initiatives entitled, "Good Health at Low Cost – 25 years on: What makes a successful health system" (Balabanova et al. 2013);
- A systematic review and report on UHC published jointly by the Rockefeller Foundation, Save the Children, UNICEF, and WHO (Brearley et al. 2013);
- The World Bank's series of 25 country case studies on the "nuts and bolts" of UHC (WB 2013) and its review of the existing evidence (Giedion et al. 2013);
- Websites to document and track country progress towards UHC (Anon 2013a; Anon 2013b);
- Policy briefs describing country "success stories" for policymakers and health officials engaged in UHC deliberations (Anon 2013c).

This literature underscores the fact that, while research exists on the pathways towards UHC in middle-income countries, there is relatively little evidence of effective approaches to move towards UHC from low-income countries, particularly in sub-Saharan Africa. Furthermore, little is known about the process of policy formulation and their progressive intentions (Koon & Mayhew 2013). Stories of success tend to emerge from upper middle-income countries such as Mexico and Thailand, where UHC was pursued over a long period of time and benefitted significantly from high economic growth during reform (Brearley et al. 2013; Di McIntyre et al. 2013). While progress has been documented in Ghana and Rwanda, it is unclear how lessons learned from these countries can be applied to other low-income African countries (Appiah 2012). For example, Ghana is actually a lower *middle*-income country with an increasingly progressive system of health financing, but continues to face challenges covering the informal sector despite having coverage estimates higher than most other sub-

Saharan African countries (Akazili et al. 2012). Rwanda, on the other hand, has achieved rapid success, but primarily through external donor financing, while serving a relatively small and accessible population (Appiah 2012). Important work has emerged from other countries, such as Tanzania, but research suggests that, despite political commitment, they remain far from achieving UHC (Borghi et al. 2013). Policymakers in other low-income countries have few successful examples for guidance on developing a path towards UHC and face considerable capacity and financial constraints (Lagomarsino et al. 2012). Kenya exemplifies one of these low-income countries where political commitment to UHC is growing but country-specific research is lacking.

In the above research, “political will” or “political commitment” has been identified as a key ingredient for successful UHC reforms, but has not been studied. Previous financing reforms also have proven that political contestation can determine the very changes to finance policy advocated for under UHC (Gilson et al. 2003; Agyepong & Adjei 2008). Yet, this has not been explicitly studied in the literature above. For this reason, some researchers have challenged the evidence base for UHC, while calling for more research into the political nature of the process (Bennett et al. 2010). These calls have been echoed by those trying to build the field of Health Policy and Systems Research (HPSR), who claim that “disciplinary capture,” or the strong legacy of biomedicine in public health, might help explain HPSR’s overwhelming bias towards evaluating impacts and outcomes as opposed to analyzing processes (Sheikh et al. 2011). In doing so, these scholars call for more qualitative, interpretive studies of the health policy process in order to understand the clash of values that determines the mix of policy considerations and collectively contributes towards the achievement of UHC (Gilson et al. 2011; Sheikh et al. 2014).

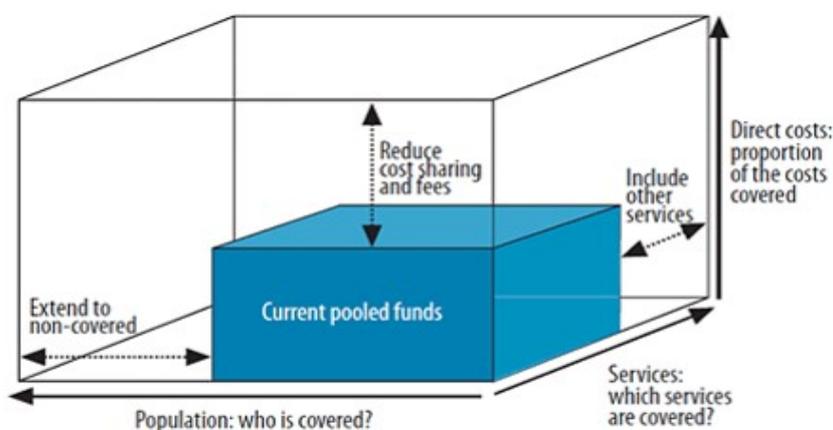
This thesis speaks directly to these calls for more interpretive studies of the policy process that analyze qualitative research with multiple actors involved in the policy process. Leaders in the HPSR literature have argued that gaps in the UHC literature (as well as the broader HPSR literature) are significant because they leave us with a weak understanding of the policy process (Gilson & Raphaely 2008; de Leeuw et al. 2014; Ghaffar et al. 2016). This thesis adds to the current literature on UHC and HPSR by engaging with theories and methods commonly used in policy studies. The qualitative interpretive approach presented here examines how policies around UHC are understood and acted upon. This stands in marked contrast to the quantitative approach employed by many of the above studies, which

do little to explain complex social phenomena such as problem definition, contestation, and conflict resolution. Interpretive approaches demonstrate how actors interact in the policy process, generating situated meaning and informing subsequent political behavior (Yanow & Schwartz-Shea 2006). Consideration is given to the way in which power, perceived interests, and institutions affect policy, but their interaction with underlying values and cognitions serves to clarify the otherwise opaque political arena. Thus, this research addresses these shortcomings in the UHC and HPSR literatures and contributes to a more nuanced understanding of the health policy process in Kenya.

## 1.2. Health Financing

Improvements in health financing are at the heart of the UHC movement. According to WHO, “The goal of universal coverage is for everyone to obtain the services they need at a cost that is affordable to themselves and to the nation as a whole” (WHO 2013b). As depicted in Figure 1.1 (WHO 2010), This requires policy actors in countries that decide to pursue UHC to attend to three key areas: 1) What services will be provided?; 2) Who should be covered by them?; and 3) Who should pay for them? These three questions tap core values about the nature of society, which are inherently contested in resource-constrained environments, and naturally cultivate divergent views on what UHC means within and across contexts.

**Figure 1.1. WHO’s Dimensions of Universal Health Coverage**



Three dimensions to consider when moving towards universal coverage

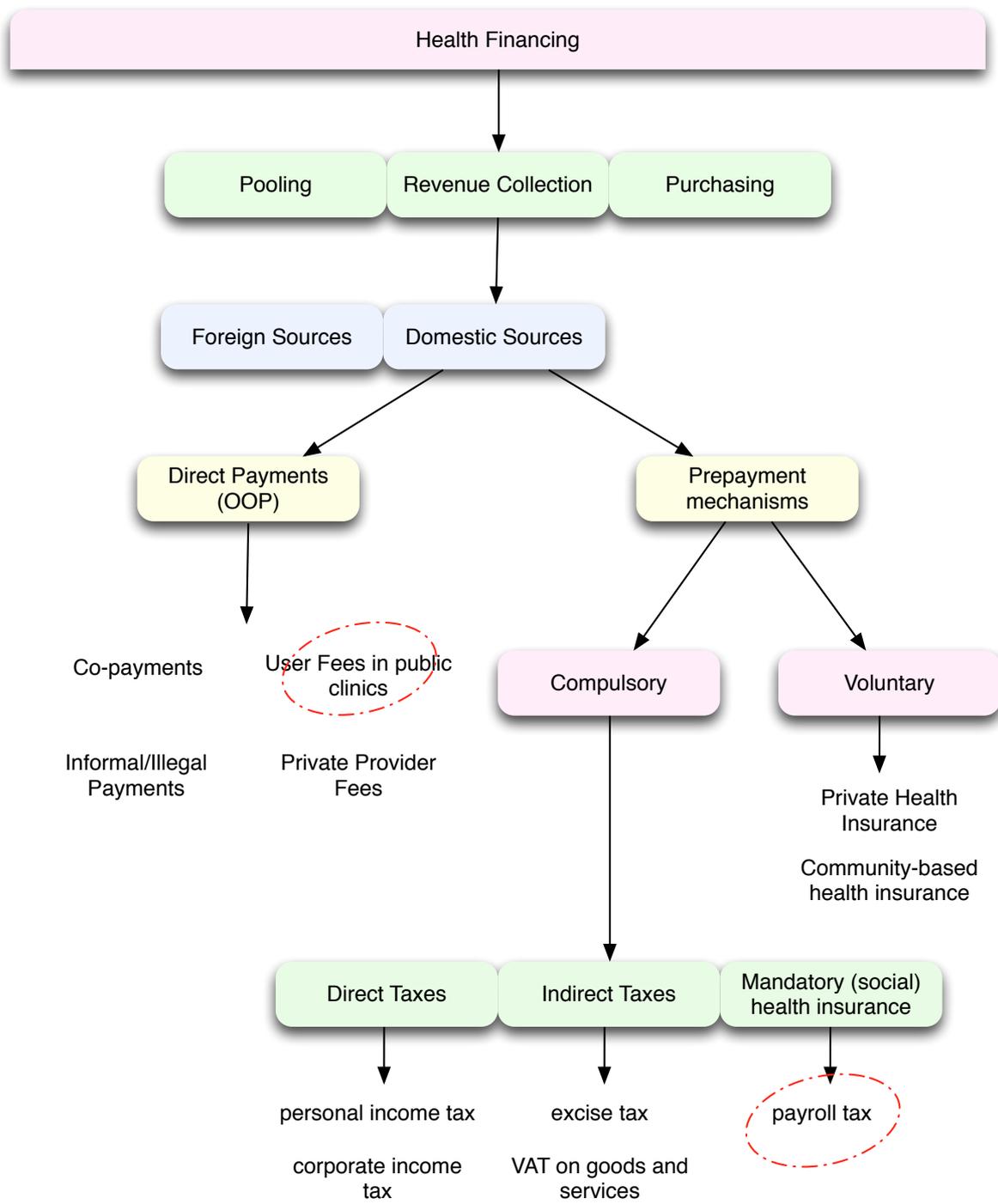
UHC, therefore, is an exemplar study of health policy where the interplay of ideas and competing interpretations are essential (Walt 1994; Gilson & Raphaely 2008). Ideas that resonate with a broad spectrum of policy participants are embedded into each of the three functions of health financing: revenue collection, pooling, and purchasing (Kutzin 2001). *Revenue collection* addresses questions about who contributes to health care funding, how these contributions are structured, and the agencies responsible for collecting funds; *pooling* refers to the accumulation and management of prepaid health care revenues to spread risk across a segment of the population; and *purchasing* describes the process of transferring pooled funds to service providers (McIntyre & Kutzin 2012). Although these are often seen as somewhat static concepts, researchers note that financial arrangements cannot be dissociated from interconnected historical, economic, ideological, and international forces that shape how policy actors interpret and enact these strategies (Green 2007).

This study focuses on revenue collection because low-income countries (LICs) inherently have difficulties funding their health systems, which poses one of the biggest barriers to UHC (Gottret & Schieber 2006). In order to adequately move towards UHC, LICs must find ways to leverage additional revenue at some point early in the process. This means that revenue must be re-allocated from other sectors (such as agriculture or education), transferred from high-income countries (through aid or lending institutions), collected from new sources (various taxes and tariffs), or collections need to increase from existing sources (such as through tax raises) (Ensor 2008; Kutzin 2001). Conflicting understandings surface in debates over each of these strategies for collecting revenue in the health sector.

Revenue originates from both foreign and domestic sources. Figure 1.2 presents a number of revenue streams that contribute to health financing. Foreign sources of revenue are common in LIC health systems, where donors finance certain aspects of health care through grants or loans (Ensor 2008). This accounts for 31% of total health expenditure (THE) in Kenya (Government of Kenya 2009). However, because foreign sources of revenue are tied to political processes in the donor country (Vassall & Martinez-Alvarez 2012), it is beyond the scope of this research to investigate. Instead, this project focuses on domestic sources of revenue from households or firms that are collected through direct payments or prepayment mechanisms (McIntyre & Kutzin 2012).

The global UHC movement is characterized by a bold policy shift away from direct payments in favor of more equitable and efficient prepayment mechanisms (Kutzin 2012). Direct payments, or out-of-pocket payments (OOP), include user fees in public facilities, informal or illegal payments to health workers, or fees paid to a private provider (McIntyre & Kutzin 2012). Co-payments, where a smaller portion of the cost is covered by the patient, are also considered direct OOP payments (WHO 2010). In Kenya, direct OOP payments account for 35.6% THE (Government of Kenya 2009). In contrast, prepayment mechanisms can be divided into compulsory and voluntary schemes. Compulsory prepayment mechanisms collect revenues from direct taxes (income tax) and indirect taxes (excise taxes, value-added taxes (VATs) , etc.) as well as contributions to mandatory (social) health insurance programs (typically payroll taxes) (McIntyre & Kutzin 2012). In Kenya, compulsory prepayments to the country's largest insurer, the National Hospital Insurance Fund (NHIF), account for 29.3% THE (Government of Kenya 2009). Voluntary prepayment mechanisms include private and community based health insurance schemes (McIntyre & Kutzin 2012) and account for a miniscule portion of THE in Kenya. Like many countries, Kenya finances health care through a range of sources based up upon an interpretation of societal values and political considerations (Svedoff 2008).

**Figure 1.2. Breaking down revenue collection** (focus for this research circled).



Revenue collection in LICs is complicated by a number of factors. Many countries rely on OOP payments as a significant source of funding (Ensor 2008). These payments, such as user fees, are highly regressive (inequitable), which is why UHC strongly encourages health systems to move away from them (WHO 2010). However, abruptly removing regressive user fees can exacerbate inequalities by leaving health facilities underfunded and incapable of coping with increased demand (Gilson & McIntyre 2005). Contributions to mandatory (social) health insurance programs are typically collected through payroll taxes, but the small size of the formal sector in many LICs limits coverage of mandatory (social) insurance as well as the size of the tax base (Ensor 2008). As a result, LICs tend to rely on voluntary community based health insurance schemes (CBHIs) to cover the informal sector (Chuma et al. 2013). This is problematic because enrollment in CBHIs is challenging, funds are administratively expensive to operate (Borghi et al. 2013), risk pooling is fragmented, and there is limited capacity to generate revenue (McIntyre & Kutzin 2012). Like many LMICs, Kenya is confronted by each of these revenue collection challenges (Chuma & Okungu 2011). This study will examine how actors attempt to understand these issues by analyzing interpretations of three finance policies associated with revenue collection, including the removal user fees, increased contributions to the mandatory health insurance program, and a failed attempt to install national social health insurance.

### *Health Financing Politics in Kenya*

Kenya is a compelling country to study health finance reform. A low-income East African nation with a population of 38 million people, Kenya ranks 145<sup>th</sup> (low) on the United Nation's Human Development Index (UNDP 2015) and despite its hopes of becoming a middle-income country by 2030, maintains health indicators of a low-income country (Kenya 2008). The health system in Kenya faces numerous challenges, which are reflected in its low life expectancy (62 years), high maternal mortality (400 deaths/100,000 live births), high child (under five) mortality (71/1000 live births), and stubborn HIV prevalence (6%) (UNDP 2015). Health financing is regressive (Munge & Briggs 2013) and just 10% of the population is covered by health insurance (MMS/MPH 2009). Still, Kenya is one of the few low-income sub-Saharan African countries with a long history of mandatory health insurance (Chuma et al. 2013; Abuya et al. 2015). In 2008, Kenya put forth a new health sector strategy outlining a path to UHC (Kenya 2008) that was further refined in 2012 (MMS/MPH 2012) and reformulated into a sector wide strategic policy plan in 2014 (MoH 2014). For more

information on the Kenyan health system as well as health financing in Kenya, please refer to Annex D.

These efforts reflect a growing consensus that health financing reforms require high-level political support in order to re-align the health system with the principles of UHC. These issues featured in the most recent presidential election (HPP/Kenya 2013), and initially occupied the attention of the new administration (Coalition 2013), embedding UHC into the public discourse around health care (Mwangi 2013). Nevertheless, the Kenyan health sector is characterized by a plurality of stakeholders, often with divergent preferences and entrenched policy positions (Chuma & Okungu 2011; Abuya et al. 2015). The values and understandings of UHC-related policy measures are understood in different ways, which surface in political rhetoric and symbolic action. For example, when threatening a nationwide strike over the proposal to introduce higher contribution rates for the employer-based insurance program, the head of the largest labor union waved a copy of the constitution and stated:

Nowhere does it say that workers should bear the responsibility of treating the poor...If any employers deduct the money [during the open court challenge], they'll face the wrath of the workers...we will go on strike and still be paid. We are street fighters. We'll strike and they'll be calling us at midnight to talk. We are not worried about our ability to sustain a strike. It is the rich, the government, and the employers who are worried (Munguti 2010).

Thus, policy contestation is frequently aired through public channels and often relies on symbolic language. Despite this, an academic knowledge gap remains in the politics of health financing and the policy process more generally in Kenya. The ways in which actors frame health finance policies, understand issues, construct identities and relationships, and make sense of the process itself are poorly understood. Furthermore, how these interpretations shape agenda-setting phenomena such as problem definition, coalition formation, and institutional design is unknown. Perhaps more importantly, these gaps in understanding the dynamics of policy contestation are increasingly seen as significant barriers to the design of effective health policy in Kenya (HSPH 2013; P4H 2012). This is particularly true in recent health financing reforms, which have focused on reducing direct OOP payments, adjusting contributions to NHIF, and generating political support for social health insurance (Carrin et al. 2007; Fraker et al. 2007; Anangwe 2008; Chuma et al. 2009;

Abuya et al. 2015). For this reason, these three financing policies are introduced and subject to analysis in Chapters four, five, and six.

### **1.3. Study Design**

#### *1.3.1 Purpose of the Research*

This study investigates the political nature of UHC health finance reforms in Kenya through the application of framing theory. The opaque nature of the policy process in the Kenyan health sector creates the potential for confusing interpretations of structure and agency, in which health financing debates are nebulous and political action is puzzling. By identifying the specific framing of policy issues, policy debates are rendered comprehensible and a deeper understanding can be achieved of the process through which policies emerge (Hawkins & Holden 2013). Hence, framing of health financing strategies represent contested ideas and conflicting values within the political arena. This approach draws on a well-developed literature on the power of ideas, in concert with perceived interests, in understanding the structure of policy debates, the exercise of power in the political process, and policy dynamics (Béland & Cox 2011). The study will gain critical insight into the complicated ways in which a technical domain, health financing, serves as a venue for value-based policy deliberation.

To gain a better understanding of how policy actors co-construct meaning for health finance reforms, this thesis focuses on the interactional dimensions of framing. The research utilizes interpretative methods from the field of critical policy studies to answer three related questions:

- 1) How do policy-relevant actors frame health financing policy in Kenya?
- 2) What features of health finance and the policy community are framed in this process?
- 3) How does framing help us understand the health policy process in Kenya?

#### *1.3.2. Thesis structure*

The structure of the thesis is designed to clarify the intricacies of framing in the Kenyan health sector. Given the amount of deliberation around UHC and its financial undertones, financing was selected as the domain for policy analysis. This served two purposes: 1) it

sought to explore whether health financing was the subject of rational policy formation based on technical expertise, or rather subject to value-based considerations and contestation; 2) it allowed for potentially discreet policy comparison, with some policies being legislated (user fee removal) and others being rejected (the NHIF rate increase). Furthermore, while two of the health financing policies were premeditated, a third emerged (2004 Bill on National Social Health Insurance) as a necessary feature of the meta-narrative and was pursued. The decision to focus on health financing as a central component of UHC became less obvious over the course of data collection and as the global UHC discourse continued to evolve (Kutzin & Sparkes 2016). Nevertheless, actors themselves naturally gravitated toward financial explanations of UHC at the outset of the interview process. Finally, the thrust of the thesis is to explore how framing interacts with and advances our understanding of the policy process in the Kenyan health sector. The structure of the thesis thus reflects these considerations and is described sequentially.

Chapter two presents the theoretical orientation and methodology of the research project. This is a vital but overlooked aspect of HPSR, and in providing a rich theoretical basis for analytical interpretations of social phenomena, this thesis will contribute to filling this knowledge gap. Chapter two introduces interpretive approaches to policy analysis as well as the role of ideas in the policy process. This section further expands on framing theory and is informed heavily by the re-theorized account of frame-critical policy analysis (Van Hulst & Yanow 2014). In addition to this, issues related to interpretive research design and methodology, such as data collection, analysis, and ethics, are introduced.

Chapter three presents a scoping review of the health policy literature on framing (published in different form as Koon et al. 2016). Prior to undertaking the research, the literature on framing, including its use and influence on the health policy process, was systematically reviewed. This effort revealed that a moderate amount of framing research has been conducted on just a few health domains. Similarly, the majority of the research was conducted in high-income countries. The scoping review identified a knowledge gap for framing research in health financing and low- and middle-income countries (LMICs), such as Kenya, and presented important considerations for conducting framing research that informed the study design and guided the analysis.

Chapters four, five, and six, present the framing analysis of three distinct financing

policies. In each chapter, the process through which policy debates are framed is analyzed in terms of sense-making, naming (including selecting and categorizing), and storytelling. This is pursued for each policy, beginning with the policy to remove user fees (Chapter four), the policy to increase rates for NHIF (Chapter five), and the 2004 Bill on Social Health Insurance, also known as the ‘Ngilu Bill’ (Chapter six). It is important to note that, though they are presented as discreet policies for analytical purposes, in actuality there is a significant degree of overlap in the framing process and its objects amongst the three policies. This is particularly true for the sense-making process, which is best conceptualized as differing in emphasis related primarily to the issues and role of actors associated with a given policy. Through the attendant use of co-produced knowledge, primarily through interview transcripts, these sections provide an account for framing that portrays health finance policy as the subject of a highly charged political struggle over competing ideas about what is fair for Kenyan society at a given moment in time. The results for each of these chapters will be summarized with reference to the framing process, while discussion of the objects of framing will be discussed in chapter seven.

In Chapter seven, the analytical chapters are compared and their implications discussed. Comparisons of both “how” and “what” considerations are made across each policy. This includes the ways in which sense-making, naming (including selecting and categorizing), and storytelling work to frame issues, identities and relationships, and the policy process itself. Next, the similarities and differences across framing processes will be examined. Note, these framing concepts will be discussed in the following chapter. Chapter seven also uses these analytical insights to understand how framing theory helps to clarify the complicated health financing policy process in Kenya. These observations are situated within UHC and policy studies literatures to demonstrate their contributions. Finally, this chapter discusses intermediate policy options as well as broader suggestions about the conduct and import of frame-critical policy analysis for understanding social phenomena.

The final chapter is the conclusion, where the findings of this study and its contribution to knowledge will be summarized.

# Chapter 2: Theory and Methods

---

This chapter introduces the theoretical foundation of the research project and the interpretive process of conducting frame-critical policy analysis. First, I present the ontological and epistemological foundations of the constructivist/interpretivist approach employed in this thesis. This integrated form of policy analysis drove the formation of research questions as well as the research design, including both data collection and analysis. This research strategy is distinct from most instrumental health policy and systems research (HPSR) that seeks to provide evidence to influence decision-making (Koon et al. 2013). Instead of research designed to explicitly influence policy, this study is defined by its theoretical and methodological approach (Schwartz-Shea & Yanow 2012). The theoretical foundation presented in this chapter, therefore, provides an intellectual framework for the interpretivist methods employed in this study and locates frame theory and frame-critical policy analysis within the domain of critical policy studies more broadly. In doing so, I achieve two goals: 1) to situate framing theory within the broader research agenda of critical policy analysis, and 2) to explain the interpretive methods employed in this thesis and their utility for HPSR.

## 2.1 Interpretive Approaches to Policy Analysis

Interpretative modes of policy analysis, reject the narrow, rationalist assumptions of “mainstream” political science, which takes its epistemological and methodological lead from the natural sciences (Fischer & Forester 1993; Fischer & Gottweis 2012; Flyvbjerg 2001). Against this, interpretivists argue that there are fundamental differences between the social and the physical realm (Rabinow & Sullivan 1987), which necessitate different methods by the researcher (Yanow & Schwartz-Shea 2006). The difference between the social and physical worlds relates principally to the focus of the social sciences on reflexive human agents (Rabinow & Sullivan 1987; Flyvbjerg 2001). Humans, unlike physical objects, are involved in a constant process of interpreting and assigning meaning to the events, processes, objects, and actions they experience; meanings which morph and change through social interactions with other agents (Schutz 1962). Thus, humans are engaged and embedded in the social construction of multiple, but equally legitimate, interpretations of social reality, which are open to change and reinterpretation (Berger & Luckmann 1967). Thus, recognizing the fluidity of human interaction and understanding is an important part of interpretive scholarship and allows for a nuanced study of individuals participating in the

policy process.

This thesis draws heavily on the work of Dvora Yanow in her assessment of the interplay of ideas represented in phenomenological and hermeneutical literatures, and across the humanities (Yanow 1996; Yanow 1999; Yanow 2007; Yanow & Schwartz-Shea 2006). Interpretive methods that incorporate a focus on the process of perception (phenomenology) and the principles of interpretation (hermeneutics) generate contextualized understandings of the social world. This includes the role of human attempts to “make, communicate, interpret, share, and contest meaning” (Yanow & Schwartz-Shea 2006; 9). In this way, human activity is seen through the prism of intentions, interactions, and structured sense-making processes that affect change within institutions, policies, and rituals. For this reason, interpretivists argue that social science focuses on meanings that are important in embedded social situations (Yanow & Schwartz-Shea 2006).

Both phenomenology and hermeneutics share the interpretivist premise that human actors should be studied through Wilhelm Dilthey and Max Weber’s concept of *verstehen*, or ‘understanding’ (Yanow & Schwartz-Shea 2006). The researcher, as a socially embedded agent, plays a fundamental role in perceiving and shaping knowledge. While perception is in fact subject to the interpretation of stimuli from the senses, the process of sense-making is historically, culturally, and socially contextualized and situated. For this reason, understanding is not possible from an objective position outside of the agent under analysis, but rather is seen through the prism of *a priori* knowledge (Yanow & Schwartz-Shea 2006).

A key assumption of interpretivism is that social reality is construed differently by different actors (Husserl 1931; Schutz 1962; Schutz 1967). An important feature of phenomenological research is that, in the study of social situations, the individual self can be understood in the context of the social self. Moreover, the social self is enmeshed in rules that transform individual identity into a collective phenomenon. This manifests in shared cognition, acts, and language among the collective (including both the researcher and the researched) based on tacit understandings of norms. Thus, it is only through interactions between and among multiple individuals (intersubjective interactions), that the social world is constructed (Husserl 1931; Berger & Luckmann 1967). For hermeneutic scholars, human meaning is expressed in indirect ways through embedded projections in the material world. Social inquiry in this tradition assumes the form of a hermeneutic circle whereby a process of

reasoning and interpreting is pursued in an iterative and reflexive manner (Dilthey et al. 1989). In this way, “further layers of understanding are added as each new insight revises prior interpretations in an ever-circular process of making meaning.” (Yanow & Schwartz-Shea 2006; 16).

Despite subtle differences in emphasis, aspects of phenomenology and hermeneutics can be combined to provide a powerful theorization of the role of interpretation in the social world (Yanow & Schwartz-Shea 2006). While phenomenology emphasizes the role of prior *experience* in shaping understanding, hermeneutics conceives of the role of prior *reading* in shaping knowledge. Taken together, the hermeneutic circle describes the process of sense making. Through language-mediated interactions, both the researcher and researched gradually develop understandings of one another. In fact, the entire research process can be depicted as a sequence of events that leads to situated interpretations of social phenomena in ways that should be clarified by reflexivity on behalf of the researcher as well as the researched (Schwartz-Shea & Yanow 2012).

Recognizing how the interpretivist view differs from traditional positivist approaches in public health is important when defining both theoretical and methodological approaches for this thesis. This is important for scholarship of the policy process because it allows for a more critical evaluation of the myriad actors and ideas that shape policies. From this position, social phenomena such as the interplay of structure/agency, or the environment/individual are the focus of inquiry. Thus, as social constructs, policies follow social and political processes that are not rational like those of the natural world, but rather are perceived and interpreted through the interaction of actors situated within a particular socio-political context (Flyvbjerg 2001). In this thesis, then, I argue that the exchange of ideas among myriad actors plays a more fundamental role in the success or failure of health financing policies than institutional priorities or rational ends.

## **2.2 Ideas and the policy process**

Policy scholars study the policy process through a combination of interests, institutions, and ideas (Hall 1997; Lieberman 2002; Campbell 2002; Béland 2009). Initial political research focused on the behavior of individual actors in furthering their interests in the policy process

(Dahl 1961; Mills 1956). This line of inquiry was extended to public choice theory which sought to explain the problems of collective action in politics (Olson 1965). By exploring similar group dynamics, the field of institutional economics gradually emerged as a vehicle for understanding political action (Ostrom 1990; North 1990). New institutionalism emerged as an alternative means of analyzing how actors enshrine their interests in formal and informal institutions or “rules of the game” (March & Olsen 1984). More recently, researchers have focused on the interplay of contested ideas and values and how this process shapes policy (Béland & Cox 2011). Policy scholars who focus on ideas have been heavily influenced by theoretical and methodological movements in the humanities, such as the linguistic turn (Rorty 1992), the interpretive turn (Rabinow & Sullivan 1987), and the argumentative turn (Fischer & Forester 1993; Fischer & Gottweis 2012). Finally, models of the policy process that combine interests, institutions, and ideas continue to be refined and tested (Kingdon 1984; Sabatier & Jenkins-Smith 1993; Baumgartner & Jones 1993). Others have argued that disagreement among these traditions are emblematic of deeper divisions and that a fuller analysis of policy can be achieved only by moving ‘beyond paradigms’, through a more eclectic approach to policy analysis (Sil & Katzenstein 2010). The focus of this research is on the third tradition or, the ideas-based approach to policy analysis for a number of important reasons described below.

Weber’s metaphor that, “‘ideas’ have, like switchmen, determined the tracks along which action has been pushed by the dynamic of interest,” vividly illustrates the strong influence ideas have on political action (Weber 1946). Many have come to the conclusion that the question is not simply whether ideas are important but when and how these ideas influence public policy (J.A. Hall 1993). As causal beliefs, ideas shape our understanding of policy problems, anchor our preferences, express our goals, and inject a sense of purpose to political debate (Béland & Cox 2011). The interplay of ideas connects individuals and institutions through value-based policy discourse (Smith 2013a). They establish relationships, in formal and informal ways, between events, individuals and other ideas (Béland & Cox 2011). Thus meaning in the world of ideas is relational, associative and is a derivative of contrasting linguistic terms (Saussure 1959).

The reasons for focusing on ideas-based research in health policy are multiple and bring together scholars working across the policy domain. First, as leading scholars have noted, there is little research on the role of ideas in the health policy process (Shiffman 2009;

Béland 2010; Smith 2013b) despite its well-established presence in political economy research (Bevir & Rhodes 2003; Blyth 2002; Campbell 2004; Cox 2001; J. A. Hall 1993; Peters et al. 2005; Schmidt 2002), research into transnational policy diffusion, policy transfer, policy borrowing and lesson drawing (Bennett 1991; Dolowitz & Marsh 2000; Orenstein 2008; Stone 2008; Weyland 2005), and a growing brand of international relations scholarship (Bull 1977; Checkel 1993; Epstein 2008; Haas 1990; Katzenstein 1996; McNamara 1998; Parsons 2003). Second, ideas are an important avenue through which issues such as power and domination can be viewed (Fraser 1989; Jenson 1989; Lieberman 2002). Third, ideas provide important linkages to institutions and political processes (Schmidt 2011). In this way, policy analysts increasingly account for the ways in which ideas hang together as ordering sets, aligning beliefs, desires, and goals to facilitate political action (Blyth 2002).

Perhaps the strongest consideration for focusing on ideas has to do with ontological concerns over the conception of interests in traditional forms of policy analysis. In some ideational political economic research, interests are treated lightly or brushed aside, whereas in others they receive harsher treatment. For example, in work on international monetary policy, McNamara (1998) attempts to show how interests and ideas are interconnected, instead of disentangling them as competing explanatory variables. Hay (2011) questions, however, the rational and material basis of interests, and concludes that, consistent with a constructivist epistemology, it is counter-productive to consider interests as discreet knowable entities. He argues that interests are non-foundational and cannot be reduced to specific, objectively-given material conditions. Instead, they are constructed through intersubjective discourse. This is an important philosophical point of departure and one that is endorsed by this thesis. It is not enough to consider that ideas are simply better than interests at explaining change in social systems. Rather, ideas are the basis for how people see themselves and the world around them, and how they interact with it. Scholarship from a variety of disciplines has demonstrated that human beings behave in ways that are not altogether rational (i.e. Kahneman & Tversky 1984). Furthermore, the concept of objectively-given, material self-interest in political decision-making is severely problematic. Humans operate on the basis of assumptions that are often incomplete, faulty, fluid, and context-dependent. As normative, intersubjective constructions, interests are better conceived as cognitive filters through which agents orient themselves toward their environments (Hay 2011). For these reasons, this thesis allows little room for the consideration of material interests and instead focuses on ideas as orienting sets of (shared)

preferences and beliefs.

As Smith (2014) notes, there are distinct levels at which ideas are typically located in accounts of the policy process. In the first, ideas are commonly depicted as ideologies and broad organizing frameworks (Béland 2005). This work brings to the fore the role of values and as such is connected to the concepts of policy paradigms (P. A. Hall 1993) and ‘the *référential*’ (Jobert & Muller 1987). The second interpretation of ideas is found in the literature on agenda-setting (Schattschneider 1960; Cobb et al. 1976; Edelman 1988), where ideas frequently appear at an intermediate level in the form of ‘policy frames’ (Smith 2014). In this scholarship, ideas have been characterized as ‘weapons of advocacy’ (Weiss 1989; 117) to be wielded for purposes of strategic gain or as competing definitions of policy problems and parties privy to the controversy (Rochefort & Cobb 1994). The third level at which ideas often operate in policy studies is in the form of simple policy proposals (Béland 2005; Kingdon 1984). Though providing a multi-level heuristic for different types of ideas might seem useful, as Béland points out (2005; p.2), ideas can simultaneously assume various forms and co-exist at multiple levels in policy research (Béland 2005). Similarly, other scholars have cautioned against using vague ‘catch-all concepts’ of ideas, thus extending their influence to too many types of social phenomena to be theoretically useful (Blyth 1997). While this research largely defines ideas consistent with the agenda-setting literature as ‘policy frames,’ it also shifts the focus to ideational processes. As I will demonstrate below, through focusing on ideational processes, namely the dynamics of interactional framing, this analysis will illustrate how policy actors co-create interpretations of ideas in ways that influence policy.

### **2.3 Frames and framing**

In policy analysis, framing analyses use interpretive and critical approaches to analyze policymaking as a contested meaning-making enterprise (Fischer 2003). These concepts underscore the importance of language and symbolic representation in the policy process (Edelman 1985; Edelman 1977; Edelman 1988; Elder & Cobb 1983; Gamson 1992). Following this approach, critical or interpretive policy analysts attempt to “...understand how, under what conditions, and through which processes specific frames emerge and are maintained” (Hawkins & Holden 2013; p.55). In this way, the analyst favors knowledge claims of subjective understanding over objective truths, to the extent that interpretation

provides a reasonable explanation of human behavior, including evidence use, argumentation, and persuasion in the policy process (Majone 1989).

In the disciplines of political psychology and communication, the concept of framing is deployed to analyze public preference formation. Within this literature, framing draws heavily on the field of behavioral economics (Kahneman & Tversky 1979; Tversky & Kahneman 1981) to look at the cognitive basis for decision-making (Druckman 2004). Frames, in this context, are heuristic devices which shape our understanding and evaluation of the world around us based upon the extent to which they are cognitively available, accessible, and applicable (Druckman 2011). Emphasis (or issue) frames represent cognitively coherent dimensions of an issue that are assigned weights in preference formation (Scheufele & Iyengar 2012; Druckman 2011). In contrast, “equivalency” or “valence” frames represent value-based evaluations within a single set of dimensions, causing a frame to be portrayed either negatively or positively (Levin et al. 1998). This literature distinguishes these cognitive frames from their communicative forms, by drawing on research from the field of political communication (Scheufele & Iyengar 2012). When communicative frames affect individual cognitive frames a “framing effect” has occurred, which allows the researcher to analyze the rhetorical basis for public attitudes (Druckman 2011) and the effectiveness of rhetorical strategy (Jerit 2009; Jerit 2008). In media studies, framing effects are carefully distinguished from the related processes of agenda-setting and priming (Scheufele & Tewksbury 2007). A frame’s “strength”, akin to the concept of “frame resonance” from social movements research (Snow & Benford 1988), seems to play a more crucial role in determining the size of the effect in competitive environments than a frame’s repeated usage (Chong & Druckman 2007a; Druckman 2010). In this way, the literature on framing from political psychology and political communication has become influential in exploring social and political phenomena such as voter behavior and public opinion formation (Druckman et al. 2009).

The concept of framing is used in related, yet distinct, ways in other academic disciplines. In Goffman’s conception, frames balance structure and agency because our world is framed by events and experiences and yet we actively frame events and experiences (Gamson et al. 1992). Because frames serve multiple purposes, scholars from a variety of disciplines have attempted to classify them at various “levels of abstraction” (Gamson et al. 1992). As mentioned previously, frames can be classified based on whether they define,

diagnose, judge, or prescribe (Entman 1993). Similarly, other scholars suggest that diagnostic, prognostic, and motivational collective action frames are requisite for the emergence and mobilization of social movements (Snow & Benford 1988). As highlighted above, some researchers differentiate between communicative frames and cognitive frames, which can be classified into emphasis and equivalency frames (Druckman 2011). Equivalency frames can be further ordered into risky choice, attribute, and goal frames (Levin et al. 1998). Others draw distinctions between rhetorical and policy action frames, which can be further subdivided into metacultural, institutional, and policy frames (Schön & Rein 1994). This is analogous to linguist classification according to a frame's depth such as values frames (deep), broad issue domain frames (intermediate), and detailed descriptive issue frames (shallow) (Lakoff 2006; Lakoff personal communication as cited in Dorfman 2005 ). Other linguists classify the components of frames into four structural dimensions of a greater news discourse, including their syntactical, script, thematic, and rhetorical structures (Pan & Kosicki 1993). Similarly, a brand of media content analysis identifies the linguistic artifacts of a given frame, and allows the analyst to organize them into a "signature matrix" (Gamson & Lasch 1983). Together, this array of frames, framing processes, and approaches to frame analysis provide a fertile body of knowledge to cultivate insights into previously unexplored policy domains.

Recently, a great deal of attention has been paid to framing research in an attempt to bring further conceptual clarity to the research paradigm. These endeavors have emerged from the fields of political communication (Entman 1993; Scheufele 1999; Scheufele & Iyengar 2012; Pan & Kosicki 1993; Cacciatore et al. 2016), political psychology (Druckman 2011), and policy studies (Dewulf et al. 2009; Van Hulst & Yanow 2014). The political communication and psychology literatures advocate for a conception of framing research that is focused largely on the narrow psychological interpretation of frames as cognitive constructs as opposed to a decidedly more sociological interpretation of frames as organized elements of discursive communication, which cognitive researchers see as problematic (Cacciatore et al. 2016). Interpretivist researchers from the field of critical policy studies argue along somewhat different lines, with an important distinction being the explicit linkages to paradigmatic social theory (Laws & Rein 2003; Hawkesworth 2012; Van Hulst & Yanow 2014).

While interpretivists recognize that one domain of framing research is largely identified

with a cognitive paradigm in which frames are knowledge structures, another brand of scholarship operates from an interactional paradigm in which parties negotiate meaning through a process of framing that generates interactional co-constructions. As Dewulf et al. (2009) explain, cognitive frames are best understood as meaning located “between the ears” of each individual whereas interactional framing situates meaning “between the noses” of individuals (Dewulf et al. 2009). From this perspective, it has been argued that the cognitive frame paradigm portrays participants as lay scientists or information processors who use frames as heuristics to understand the world around them (Nisbett & Ross 1980). On the other hand, the interactional framing paradigm depicts participants as lay rhetoricians or conversationalists who rely on a constellation of social interactions to co-construct the world around them (Billig 2001; Edwards 1997). In summary, framing research has operated along distinct research paradigms tied to ontological and epistemological positions in the philosophy of science (Dewulf et al. 2009).

This thesis is an interpretive study of interactional framing in Kenyan health financing. As discussed in the introduction to this chapter, this study operates from a constructivist epistemology underpinned by phenomenological and hermeneutical presuppositions. The reasons for approaching framing in this way are 1) the approach is consistent with the researcher’s worldview, 2) its flexibility is well-suited to analyze the varied landscape of actors and entrenched values in the Kenya health sector, and 3) it remains unexplored in both health policy research and research in low-income countries. Furthermore, social scientists argue that useful research accounts for values and power to understand the centrality of context and judgement in human behavior (Flyvbjerg 2001). By focusing on a dynamic conception of framing, including the framing process and the entities framed, this research will critically reflect on the forces that shape human behavior and potentially generate insight to inform subsequent political action.

### *2.3.1 The “How” of framing*

This section sets out theoretical and methodological advancements in the field of policy studies to analyze the framing of three distinct health financing policies. This draws on the pioneering work of Martin Rein and Donald Schön (1994) on frame-critical policy analysis, which has been revisited by policy scholars in recent years (Van Hulst & Yanow 2014). In the original conception of frame-critical policy analysis, the primacy of frames in problem

definition or “problem setting” (Rein & Schön 1977) was seen as involving a process of “naming and framing” (Rein & Schön 1996). In this conception, the policy analyst is tasked with interpreting the complex process of naming, selecting, and telling stories related to the frame. While this has generated a body of insightful research, the discursive nature of framing and its salience in the fields of political communication, psychology, public administration, and media studies has led to a number of additional insights into the process by which this occurs. Recently van Hulst and Yanow (2014) have attempted to incorporate these advancements into a more nuanced conception of frame-critical policy analysis. They propose a brand of analysis that re-organizes Rein and Schön’s framing process of naming, selecting, and storytelling, while supplementing it with the two related concepts of sense-making and categorizing. For van Hulst and Yanow, the act of framing involves sense-making, naming (which includes selecting and categorizing), and storytelling. In so doing, the authors provide an account of frame analysis that focuses less on the frames and more on the dynamic process of *framing* (Van Hulst & Yanow 2014). I use the framing of three policies in a comparative way to provide a more process-oriented and politically nuanced way of illustrating the role actors play in shaping and being shaped by policy.

### *Sense-making*

The first component of the framing process is making sense of a problematic situation by constructing meaning of the issues, actors involved, and their roles in the policy process. Oftentimes, the work that is done to understand a problematic situation is done quite passively or without the actor actually being aware that they are gaining an understanding of the situation (Yanow 1996). This gets at the tacit nature of knowledge and actors’ abilities to operate based on existing cognitive frames acquired by experience. Accordingly, to understand how actors make sense of a situation, one must account for the ways in which the situation itself often “intermingles persons, acts, events, language, and/or objects,” in an “interactive and iterative” manner (Van Hulst & Yanow 2014; p.7).

### *Naming*

Through the process of selecting, naming and categorizing, policy actors use framing devices to “highlight some aspects of a policy discourse while occluding and even silencing others” (Van Hulst & Yanow 2014; p.9). *Selecting* features of a problematic policy situation precludes a set of considerations that concern a cohort of actors defined in part by the act of

selecting. This “contingent and political” act is a practical necessity for policymaking as it focuses the range of stimuli into a comprehensible set of proposals that can be acted upon (Van Hulst & Yanow 2014). *Naming* refers to the features of this selection that must be communicated, often through clever rhetorical and symbolic devices. By borrowing meaning from a decontextualized situation, actors wield ideas in an attempt to clarify an existing problematic scenario through the process of naming (Van Hulst & Yanow 2014).

*Categorizing*, a form of naming, helps to further define the situational elements of a policy discourse. Through the act of categorization, objects, events, acts, and actors are given meaning often through their association with other, often inexplicit, items (Van Hulst & Yanow 2014). In this way, the following section will show how the “world-making” devices of selecting, naming, and categorizing worked together to frame three health financing policies in Kenya.

### *Storytelling*

Storytelling is an important part of the framing process that allows actors to situate various components of a problematic situation into a broader narrative, helping to explain how they perceive an outcome to have been achieved. Storytelling allows participants to weave actors, including their identities, relationships, and actions, into a coherent pattern of interaction that provides a discursive basis for persuasion (Van Hulst & Yanow 2014). By “emplotting” various elements of a complicated process into a particular context with narrative arch (Mattingly 1998), storytelling relies on the persuasive power of logic, motivation, and causation to orient the listener in such a way as to absorb implicit features of a policy situation while grasping their significance from the perspective of the storyteller (Van Hulst & Yanow 2014). In this way, storytelling does ‘a certain kind of work’ by moving beyond mere problem definition (Rein & Schön 1977).

### *2.3.2 The “What” of Framing*

In addition to the “how” of framing, van Hulst and Yanow (2014) draw from Dewulf’s work on conflict negotiation to elucidate the “what” of framing. This includes three entities that are subject to framing, namely, the substantive content of the issues, actor identities and relationships, and the policy process itself (what Dewulf calls the interactional process) (Dewulf et al. 2009). This focus on three entities moves beyond political analysis of issues as a static concept, including related concepts of problem definition (Rochefort & Cobb 1994),

issue ownership (Petrocik 1980), issue development (Putnam & Holmer 1992), issue portrayal (Shiffman 2009), and issue categories (Rasmussen 2011). In Schön's work on reflective practice (1971) as well as work from conflict research (Dewulf et al. 2009) practitioners and disputants frame the identities and relationships of themselves and others engaged in deliberation. The introduction of process stems from a reconceptualization of Tannen and Wallat's observation (1987) that in addition to knowledge schemas (issues) the interaction process is subject to framing (Dewulf et al. 2009). In this way, ideational features of framing take on a less static, more dynamic, and politically interactive means of negotiating meaning (Van Hulst & Yanow 2014).

This study used the van Hulst and Yanow (2014) theorization of framing to understand the various ways in which ideas around Universal Health Coverage and health financing are co-constructed through contestation in the Kenyan health sector. This involved analysis of sense-making, naming (including selecting and categorizing), and storytelling. Co-generated data from multiple sources, including interview transcripts with relevant actors, were analyzed based on the researcher's interpretation of their understanding of the salient features of the debate. Furthermore, as a secondary aim in the discussion, these were assessed in the context of framing objects including portrayals of the issues, actors' relationships and identities, as well as their interpretations of the policy process itself. In this way, three distinct financing policies were subject to analysis including the user fee removal, the NHIF rate increase, and the 2004 Ngilu Bill. The analysis of each policy is assessed discretely by features of the framing process, as chapters five, six, and seven. The final chapter reflects on the substance of the framing process as well as comparisons across the financing policies. In this way, the researcher will generate a dynamic interpretation of the forces that converge to co-construct a view of the Kenyan health financing domain that is interactional and based on a plurality of interpretations.

## **2.4 Interpretive Research Methods**

Approaches to policy analysis that draw on a constructivist epistemology often employ interpretive methods to accommodate the tacit role that values, beliefs, and feelings play on our ability to impart meaning to social action (Yanow 1996) and negotiate interpretations about what is right and wrong (Stone 2012). Interpretive research is subject to a different set of knowledge claims and therefore trustworthiness is assessed differently from research in the

natural sciences. In this way, the standard notions of validity, reliability, and replicability that are used to determine the trustworthiness of scientific research are not appropriate for interpretive research (Schwartz-Shea & Yanow 2012). Because the researcher is seen as a distant and neutral observer in scientific inquiry, the related concepts of bias, contamination, and objectivity are frequently used to assess the truth of a given research output. Some argue that this is fundamentally problematic for research in the social sciences (Flyvbjerg 2001).

Interpretivist research, rooted in phenomenological and hermeneutic philosophy as described in the beginning of this chapter, seeks to provide an interpretation of the ways in which problematic situations can more easily be understood and clarified. For this reason, interpretivist methodologists emphasize different considerations in designing research that involves co-generation between the researcher and the researched (Yanow & Schwartz-Shea 2006). Furthermore, interpretive ideational approaches, such as framing, are complicated by and must account for the “double hermeneutic,” which posits that not only are policy actors engaged in a process of sense-making, but researchers studying these processes are too (Giddens 1993). Research designed in this way provides opportunities for a type of scientific rigor that is unlike scholarship in the natural sciences. Moreover, the rigorous pursuit of contextualized meaning remains unattached to the related notions of ‘predictability’ and ‘generalizability’, or even patterned social behavior (Rabinow & Sullivan 1987; Flyvbjerg 2001). Instead, rigor is found in interpretive research by “following its own canons of practice” (Yanow & Schwartz-Shea 2006; p.6) discussed below.

As a contextualized approach to analyzing situated, interactional meaning-making, interpretive research can best be designed and executed based on the following premises. First the research is flexible and generated from the bottom-up, or stems from *in situ* processes of concept development. Second, understandings of causality are considered constitutive. Third, the researcher is reflexive about their identity, and its relevance in accessing and interpreting information. Fourth, the research demonstrates a transparent process of accounting for research modifications and improvisation. Fifth, interpretations are understood as co-constructed data that reflect the nature of relationships between the research and the subject matter. In this way, interpretations of the sense-making process involve a significant degree of reflection on behalf of the researcher, throughout data generation and analysis. This can be enhanced through a process of “member-checking” in which the research outputs are seen as formative and revisited by actors or material engaged in the

process of interpretive meaning-making. In explaining how the researcher has arrived at a situated understanding, he/she should be able to demonstrate consistency of evidence across sources, explain conflicting interpretations, and clearly articulate the logic behind interpretive arguments (Schwartz-Shea & Yanow 2012). Interpretivist methodologists argue that researchers make a variety of decisions in designing their research projects that reflect the norms and standards of their epistemic communities (Yanow & Schwartz-Shea 2006).

The scope of research for the present study was determined based on the researcher's existing knowledge of health finance policy in Kenya and the perceived role of a variety of stakeholders in the policy process. The research questions evolved throughout the life of the study and the author's own understanding of the research, consistent with interpretivist methodology (Schwartz-Shea & Yanow 2012). For example, the project initially set out to explain policy change and stasis using the concept of 'political priority', as described elsewhere (Shiffman 2007). Similarly, two relatively recent policies were selected to compare why some policies receive support and others are contested. At the onset, interview participants were recruited from the health professions with nursing, doctor, and auxiliary health worker union and association representatives. Finally, in the preliminary study design a pre-defined societal value, that of equity, was conceived to be the subject of deductive investigation to determine whether or not it plays a role in the Kenyan health financing discourse.

As the researcher's understanding of the research, its intentions and its theoretical basis evolved, several aspects changed in the following ways. The concept of political priority was seen to be too static and tied to the issue of public finance. Instead, processes of framing were the substance of inquiry. Moreover, despite approximately ten years since the failure of a comprehensive effort to overhaul health financing in the country (the "Ngilu Bill"), actors insisted on talking about it. In this way, it became clear that an analysis of health financing policy success or failure would be incomplete without understanding this critical juncture in Kenyan health policy. While health care providers were active and engaged stakeholders, they were increasingly seen by the researcher as simply being amongst a number of influential actors in the arena. Similarly, because health policy often involves legislation, is an electoral issue, and features with relative frequency in the mass media, the remit of the interview process was expanded to include the input from politicians and journalists outside of the health sector. Finally, consistent with the epistemological

orientation of the research and inductive inquiry, explicit mentions of values were reserved for the end of the interview process. Only occasionally did actors explicitly identify equity as an underlying value in the Kenyan health system, though nearly all did when prompted at the end. This also suggests much about the complexity of the interview process and the importance of efforts to reduce priming or keying.

#### *2.4.1 Research Design*

This study adopts a dynamic and reflexive conception of the research process consistent with an interpretivist epistemology. In much public health research, the process of generating evidence for analysis is called “data collection”. Interpretivists argue, however, that given ontological differences on the material representation of data, the process can best be described as “data generation”. This is premised on an understanding that data are not simply lying around to be located and collected by the researcher, but rather are created and constructed through the interaction between the researcher and his/her interpretation of the world around them. In this sense, evidence and data for analysis is best understood by interpretivists as co-generated. By framing a research question or even the entire research endeavor in a particular way, the researcher generates an understanding of social phenomena that is always partial, perceptual, and selective (Schwartz-Shea & Yanow 2012).

This study relied on four distinct materials for data co-generation. The first was subject material specific to the health sector, policy studies, and Kenya published in the academic literature. The second form of data was published reports, position papers, and government documents identified throughout the research process. This often occurred in conjunction with the third form of data - co-generation through semi-structured in-depth key informant interviews. An important note is that this material was not simply seen as a one-sided source of information, but rather the interview, its location, tone, the nature of the dialogue, characteristics of the interviewer, and reflections on physical space were all seen as important features of the data (Yanow 2007). This was captured through field notes that accompanied each interview. Since the field notes were not systematically coded in the same way as the text of the interview transcript, these served as reference points throughout the course of analysis and interpretations of findings, but were not directly cited.

The method of using in-depth key informant interviews to understand interactional

framing requires further discussion. As Dewulf et al. note (2009), interview data is useful for exploring cognitive dimensions of framing whereas other forms of data co-generation are typically employed in interactional framing research. While I argue that all forms of interaction, even between researcher and the researched, are important forms of framing, it is important to consider how other forms of data such as transcripts of meetings, participant observation, or media transcripts, would have influenced the research. While these would have provided nuanced interpretations of framing as they occur *in situ*, I question the authenticity of those interactions given the identity of the researcher as an external actor operating under a number of logistical constraints (i.e. time and financial).

Furthermore, I adopt the position that interactional framing is not isolated to specific interactions, but rather is evolutionary in nature. Through the act of compiling detailed fieldnotes and the constant process of revisiting interview transcripts, I was able to consistently read across the data and explore emerging framings as the study matured. Moreover, the understandings of interview participants were clearly articulated in candid and unguarded ways that would be difficult to assess from the review of scripted media statements. However, one could argue that a significant degree of strategic framing takes place in the public realm which allows actors to project their understanding in a particular way. While conversational analysis would reveal much about the interactional dimensions of framing as they occur in professional settings, these remain largely performative and the interview format grants the researcher space for a deeper engagement with the values and understandings that underpin those performances. Interview participants themselves alluded to, and at times explicitly reflected upon, a particular kind of framing that they frequently employ in policy discussions.

Throughout the course of the research, there was no evidence that the rhetorical strategies and symbolic devices actors used in public differed from those that were revealed in private. The primary difference was the analytical depth granted by the interview process. Thus, while more data, particularly from prolonged participant observation and perhaps conversation analysis would have supplemented the existing work, I argue that their exclusion here is not detrimental to the situated interpretations I present. In addition to this, the added cost and time required to generate interactional data *in situ* amongst participants would have yielded a considerably lower return on investment, so to speak. Finally, the use of interviews in framing research is not without precedent as it has been employed to look at the alcohol

(Hawkins & Holden 2013) and natural gas (Metze 2014; Lis & Stankiewicz 2016) industries, for example.

#### *2.4.2 Data Collection*

As the interview process was so critical to analysis and interpretation, reflection on its methods are pertinent. Interviews (n=50) took place over the course of a four-month stay (May – August 2014) in Nairobi, Kenya which was hosted by KEMRI-Wellcome Trust, an international research collaborative based in Nairobi, Kenya. The Institutional Review Boards of AMREF in Kenya and LSHTM in England approved this study (See Appendix A). Interview participation was developed through an iterative snowball method (Bernard 2011) of identifying principal actors based on relevant documents and knowledge of their involvement by a Kenyan member of the research team. This individual, a health economist with KEMRI-Wellcome Trust, has many professional relationships with actors involved in health financing and was gracious enough to provide their contact information and allow the researcher to identify their relationship in recruitment. Emails and phone calls were sent to potential interview participants (or their personal assistants) that briefly informed them about the study topic and their rights as a participant. The consent form used for this study was required by the local IRB, AMREF, and is attached in Appendix B. A delicate balance was pursued in which actors were given just enough information about the study to warrant interest and participation, but not enough to overtly prime, key, or influence the interview itself. Nevertheless, through affiliation with the research advisor, actors were likely to perceive this interview to be emanating from a particular set of considerations.

Interview participants were either leaders, high rankings members, or financing experts within their respective organizations. This included public sector employees (n=12, including n=6 MOH, n=3 NHIF), international stakeholders (n=11), professional association and union representatives (n=9), private sector representatives (n=8), politicians (n=5, n=2 Senators, n=3 Members of Parliament), academics (n=3), and journalists/editors (2). The interview process did not seek to reach theoretical saturation, though this was somewhat achieved. Also, there were few individuals, other than a former Minister of Health (Charity Ngilu) and former President Mwai Kibaki, who were noticeably absent from this cohort.

The setting of the interviews somewhat varied. All interviews occurred at a place of the

participant's choosing, usually an office or side room attached to their place of work. Occasionally, however, participants sought to have the interview take place in a public location, stating logistical concerns. All interview subjects gave written consent that they agreed to participate and be recorded. Many gave verbal consent that they could be publicly quoted and identified, but given the sensitive nature of the subject material and their position as elite stakeholders, the researcher waived this and treated all information as confidential, as stipulated by both IRBs.

A number of strategies were employed to manage confidential data. First, each interview received a coded number that was only linked to a locked document on the researcher's personal computer, which was stored in a secure location at all times. Second, efforts were made to not disclose the position of previous interview participants in conversations with subsequent participants. Third, a Kenyan transcriber signed a confidentiality agreement and was not privy to the identity of the interview participants throughout the transcription process. Fourth, data were coded and analyzed using a highly secure social science software package called *Dedoose*. Fifth, throughout the analysis and in writing this thesis, the researcher has gone to great lengths to mask the identity of key interview participants, often at the expense of legitimacy. The majority of interview participants, for example, were not simply members of their respective organization or office, but rather were high-ranking officials or the heads themselves. In these ways, the researcher respected the rights of interview participants and ensured that their participation presented minimal risks to themselves or others.

Consistent with interpretive methods, the recruitment and structure of the interview itself evolved throughout the course of the study (Yanow 2007). As noted, a number of health professionals and finance experts were initially recruited. All interview participants were asked for, and often provided the contact information of, other actors who might be willing to participate in an interview. As the process of co-generating data matured, the researcher gained access to, and in some instances reserved a place for, higher-profile participants. This strategy was effective in generating increasingly relevant data from actors that were more familiar to the situation or the particular framing dynamics at play. In this way, former Ministers of Health/Cabinet Secretaries, Members of Parliament, trade union heads, and principal actors identified through earlier interviews were reserved for the end of the field data generation process.

The researcher was consistently involved in refining the form of the interview and it became less structured throughout the course of the process (see Appendix C for interview guide). This was a function of availability and time-constraints of the higher-level participants who often required that the researcher be direct and demonstrate that the basic contours of the debate were understood. Elite interviews are common in interpretive research (Yanow 2007), but they present a number of challenges (see for example Rivera et al. 2002; Lilleker 2003; Harvey 2010; Gains 2011; Goldman & Swayze 2012), which were subject to routine reflection on the part of the researcher. Following each interview, the researcher spent approximately one to two hours writing detailed field notes about the interview itself and pertinent observations or ideas that surfaced from the interaction. By reviewing the field notes and consistently returning to the aims of the research project, the researcher sought to pursue some lines of thinking, issues, and dynamics that provided a more nuanced interpretation and understanding of politics in-action (Schwartz-Shea & Yanow 2012). Similarly, the research advisors served as an additional check by maintaining consistent contact with the researcher and ensuring that the data reflected a larger and more coherent narrative.

All interviews were conducted in English, which is one of two official languages in Kenya. Initially, the researcher was concerned that a working knowledge of Swahili would be a limitation of this study, but for three primary reasons, it was not. First, virtually all of the interviews were conducted with elites, who have sophisticated academic training and established professional competencies. Not only is English the language of government and business in Kenya, but elites are skillful at expressing themselves in ways that lend easily to framing analysis. Second, with the exception of an occasional aside to personal assistants, Swahili was simply not spoken in the interviews. No interview participant appeared uncomfortable with their ability to communicate in the English language and all were able to elaborate on abstract concepts. Third, though some media outlets do report in Swahili, a formal media analysis was not pursued for this study. For these reasons, interviewing in English did not appear to be a limitation of this study.

Perhaps of greater consequence was the researcher's position as an international external agent without a shared cultural heritage. Though the researcher had spent a significant amount of time in Kenya prior to this research (approximately 6 months

collectively), it is possible that a native Kenyan researcher would have interpreted some findings differently. Nevertheless, following the epistemology of interpretivism, it is likely that another researcher, native or otherwise, could have come to equally legitimate, yet slightly different, interpretations of the same data. This was similar for the interview process. While, on the one hand, it is important to consider the researcher's positionality and whether or not English language metaphors would translate linguistic nuance cross-culturally. On the other hand, some respondents themselves reflected on the fact that as a foreign white male, the researcher was seen as an outsider and as such was granted access to elites that would have otherwise been difficult for native Kenyans to obtain. Thus, what was lost by the researcher's lack of cultural positioning, was likely gained by the candor and openness of interview participants who did not perceive the researcher to be an immediate threat. This is largely consistent with the data presented in this thesis.

#### 2.4.3 Data Analysis

Prior to coding, all interview transcripts were reviewed by the researcher and brief notes were taken to identify global themes. The data were then analyzed using *Dedoose*; a qualitative social science software package. A thematic coding framework was initially used based on the interview guide and study questions (Green & Thorogood 2009). Similarly, a pilot run of the coding schema was used by the researcher and reviewed by the research advisors to ensure that it reflected the overall aims of the research project. These codes were largely based on the researcher's interpretation of the issues of interest and themes that emerged throughout the coding process. More generally, codes were linked to various features of three finance policy domains, actor identities, and features of the policy process. Word frequency, text, and coding queries were run within the software package to identify emergent themes (Ryan & Bernard 2003). The results of these queries were then exported as separate Microsoft Word and Excel documents. Next, data were grouped by salient theme and an outline compiled using illustrative quotes in Word. Finally, this was analyzed using the aforementioned reconceptualization of the framing process, namely sense-making, naming (including selecting and categorizing), and storytelling (Van Hulst & Yanow 2014).

Member-checking was used at various stages of the research project. Throughout the process, the researcher consulted different kinds of data as well as three different research advisors. Similarly, in the interview interaction, the researcher frequently used previously

voiced opinions (anonymous) to assess their resonance with interview subjects. In this way, counter-arguments were sensitively used to generate a fuller understanding of the ways in which actors frame different aspects of the debate. Another form of member-checking was a preliminary data dissemination workshop in which the researcher's interpretations were presented to a small set of actors, all of whom were previously interview participants. For logistical and financial purposes, this workshop, while open to all, was attended predominately by a small group of finance experts working in the public and international sectors. Their observations were recorded and documented extensively in field notes. Similarly, preliminary interpretations of this study were presented to the community of HPSR scholars and practitioners in two separate panels at the Third Global Symposium for Health Systems Research in Cape Town, South Africa (October, 2014) and the Fourth Global Symposium for Health Systems Research in Vancouver, Canada (November 2016). Finally, contingent upon funding, the researcher plans on presenting an overview of this thesis and soliciting feedback on its interpretations in a wider forum in Nairobi, Kenya, to which all interview participants and relevant stakeholders will be invited. In this way, the material presented in this thesis is always open and subject to reinterpretation, debate, and refinement, consistent with interpretive research design (Schwartz-Shea & Yanow 2012).

# Chapter 3: Scoping Review

---

## 3.1. Introduction<sup>1</sup>

*“Tanks and divisions, and dollars and cents, you know all those things obviously make a difference, but ideas are the most powerful thing on Earth.”* – President Barack Obama, *CBS 60 minutes (TV)*, March 28, 2014

The health policy arena is characterized by a number of ideological positions over a vast array of issues. In the field of public health, concepts such as “universal health coverage” or “health workforce strengthening” evoke particular value systems, courting public debate (Koon & Mayhew 2013). Similarly, technological innovation in biomedicine, the complexity of public and private financing arrangements, and the elaborately varied workforce, help to create a highly contested policy domain in which policy change is often incremental and slow (Béland 2010). New fields such as Health Policy and Systems Research (HPSR) have arisen to meet the growing demands of policymakers, researchers, and practitioners for research that helps solve the problems of health systems in low- and middle-income countries (LMICs) (de Savigny & Adam 2009). Understanding the policy process is a central concern in this context because actors are often unsure what causes the rise and fall of certain ideas (Shiffman 2009). Furthermore, to understand how to respond effectively to policy challenges, actors need to know the nature of problematic situations and how specific actions generate particular policy responses (Fischer 2003). In this way, policy analysis can potentially help resolve protracted policy controversies (Schön & Rein 1994) and further the collective goal of sustainable health systems strengthening.

As a coherent body of scholarship materializes, HPSR researchers have increasingly pointed to conceptual and analytical shortcomings within the existing body of LMIC policy research (Walt et al. 2008; Walt & Gilson 2014). This includes research with little reference to methodological design, scarce use of established policy analysis theory, a lack of

---

<sup>1</sup> This chapter has been previously published, see: Koon, A.D., Hawkins, B. & Mayhew, S.H., 2016. Framing and the health policy process: a scoping review. *Health Policy and Planning*, 31(6), pp.801-816.

explanatory focus, and a paucity of studies that “apply forms of analysis (such as discourse analysis) that consider the role of language, rhetorical argument and stories in framing policy debate,” (Gilson & Raphaely 2008). These shortcomings leave us with a fragile understanding of the policy process and the political forces that create policy change (de Leeuw et al. 2014). Moreover, the HPSR literature often fails to provide insight into how and why proposed policies are supported, dismissed, or overlooked (Berlan et al. 2014; Gilson & Raphaely 2008; Shiffman 2009). For this reason, HPSR scholars have called for more research on the health policy process in order to understand the clash of values that determines the mix of policy considerations and collectively contributes towards the achievement of shared health objectives (Sheikh et al. 2011; Bennett et al. 2011). In order to answer these calls, HPSR scholars are looking to other disciplines for methodological inspiration (Gilson et al. 2011).

This chapter assesses the scope of the current body of framing scholarship on the health policy process. This review represents an initial attempt to harness a body of work on interpretive policy analysis, specifically framing research, to understand more about the ways in which ideas influence the policy process. In so doing, I hope to bridge the health policy and broader policy studies literatures. This review aims to demonstrate the potential value of constructivist and interpretative approaches to policy analysis for health policy and practice. It highlights the ways in which researchers outside of the health domain use theory to gain a better understanding of contestation and change in the policy process, using a well-established framework (Arksey & O’Malley 2005). This literature is then critically appraised, highlighting the insight gained through framing analyses and the relative merits/shortcomings of such an approach. Potential lines of enquiry are suggested to help position HPSR as an important vehicle for furthering our understanding of the policy process in the health sector.

### **3.2. Methods**

This chapter used scoping review methods developed by Arksey and O’Malley (2005) to characterize, the full range of framing research in health policy, its content, and any potential gaps that require further exploration. Scoping review methodology has been discussed in key methodological texts (Grant & Booth 2009; Rumrill et al. 2010; Petticrew & Roberts 2006; Aveyard 2014) and is increasingly used in HPSR (Ridde & Morestin 2011; Brien et al. 2010;

Mitton et al. 2009). This approach was selected because of its emphasis on flexibility, relying on an abductive logic of enquiry, and its bias towards narrative driven summation (See Table 1). Like all research, and particularly qualitative research, this approach is interpretive in nature. The Arksey and O’Malley framework is presented as an iterative, qualitative review with five distinct stages, each of which is described in greater detail below: 1) Identifying the research question 2) Identifying relevant studies 3) Study Selection 4) Charting the data 5) Collating, summarizing, and reporting the results.

**Table 3.1.** Comparison of Scoping vs. Systematic Reviews.

Systematic Review	Scoping Review
<ul style="list-style-type: none"> <li>• Narrow research question &amp; parameters</li> <li>• Pre-defined Inclusion/exclusion</li> <li>• Quality filters often included</li> <li>• Data extraction highly detailed</li> <li>• Quantitative synthesis typically</li> <li>• Structured assessment, with quality appraisal, to answer focused research question</li> </ul>	<ul style="list-style-type: none"> <li>• Research question usually broad</li> <li>• <i>Post hoc</i> Inclusion/exclusion possible</li> <li>• Quality not an initial concern</li> <li>• Data extraction not required</li> <li>• Qualitative synthesis typically</li> <li>• Identification of key issues and knowledge gaps in a body of literature</li> </ul>

Adapted from: (Brien et al. 2010)

The research question emerged gradually through the review process. This became the following: “*What is known from the existing literature about the influence of frames on the health policy process?*” This question drew important distinctions that precluded the exclusion of salient framing research from other sectors and framing research that does not illustrate the effects of frames on the policy process itself. This is important because framing is commonly used to describe a variety of research endeavors that explore the effects on individual actors and behaviors, but doesn’t always show how their contested interpretations shape policy design, especially in the health sector. Therefore, the initial decision was to include only articles that explicitly state a frame, its construction, its articulator, and the ways in which it influenced the policy process in the health sector.

A review of the peer-reviewed literature was conducted for original research articles that used some form of frame analysis within the broad domain of health. Nine different social science and health databases were searched in June 2014 with search criteria that incorporated the term “fram\*” combined with the term “health policy”, excluding the term

“framework”. This search strategy proved impractical as it yielded too many studies that referred to lay conceptions of “framing” while not representing a coherent body of framing research. To produce a more representative body of work, the search was repeated using the search term “framing” combined with “health policy”, both of which had to be present in at least the abstract of an article. No time or language restrictions were placed on any of the databases. See Table 3.2 for a list of databases with their corresponding search terms and number of hits. In addition to the database search, I used Google and Google Scholar search engines to identify sources not included in electronic databases. Finally, I conducted a hand-search of four health policy journals that publish framing research on occasion, including: *Health Policy and Planning*, *Social Science and Medicine*, *Health Policy*, and *Journal of Health Politics, Policy and Law*.

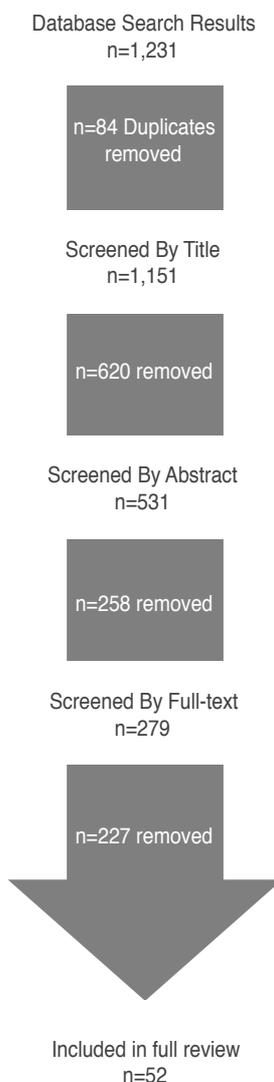
**Table 3.2.** Search Terms

<b>Database</b>	<b>Search Term</b>	<b>Hits</b>	<b>w/o duplicates</b>
<b>ProQuest</b>	“Health Policy” AND framing	315	-
<b>PsychInfo</b>	exp (gov. policymaking / or exp (health care policy) or exp (policy making) or exp (health policy) AND exp (framing effects / framing mp.	419	356
<b>Pubmed (Med-line)</b>	“policy “[MeSH Major Topic] AND framing	140	67
<b>EMBASE</b>	“health policy” AND “framing”	317	150
<b>EBSCO Academic Search Premiere</b>	Health Policy AND framing	259	142
<b>Web of Science</b>	“health policy” AND framing	204	131
<b>EBSCO SSFT</b>	Health Policy AND framing	58	19
<b>CINAHL</b>	txt(Health Policy) AN ab(framing)	62	11
<b>JSTOR</b>	“health policy” AND ab(framing)	61	40
<b>TOTAL</b>			1231

Articles that alluded to framing, language, metaphor, discourse and its effects on health policy issues were included in the title review. During abstract review, an article was required to have the word “frame” or “framing” present in the abstract as well as a vague health policy issue to be included. Finally, in the full-text review, all articles were reviewed to assess the extent to which frames, a frame articulator, and a contested policy process was explicitly represented. Because our conception of the policy process was oriented around established notions of contestation and deliberation, reference to a lineage of framing theory

served as additional inclusion/exclusion criteria. In this way, the review attempted to draw from the wider pool of non-health policy issues, to assess the various ways in which frame conflict and change shapes the policy process. See Figure 1.

**Figure 3.1.** Scoping Review Flow Diagram



Akin to data extraction, a process of data “charting” was initiated by ADK, consistent with the Arksey and O’Malley framework. The charting fields were developed in consultation with co-authors BH and SHM. A master table was created that included article details, corresponding research traditions, epistemology, theory employed, methodological approach, data sources, health and policy themes, frames, frame articulator, and the extent to which contestation had an effect on the policy process. Though this was systematic, the process of charting involved some degree of interpretation on the part of the investigators to classify various themes such as research traditions and the epistemology represented in each article. The investigators made no claims of objectivity in judging whether or not an article presented contestation or adequately showed an effect on the policy process. This reflects a growing distinction between systematic and scoping reviews and was in fact one of the motivations for relying on the Arksey and O’Malley framework.

The final stage of the scoping review process involved collating, summarizing, and reporting the findings, as described in greater detail below. A descriptive analysis of collated articles by field was reported and general trends were identified. The findings were summarized with an emphasis on the scope of existing knowledge and an eye to what remains unclear from the body of research. Further suggestions about the conduct and import of framing research in the health sector are discussed and limitations of such an approach are considered, below.

Author reflexivity is important because interpretation and narrative summation are central to the Arksey and O'Malley scoping review framework. All three authors are social scientists with experience conducting qualitative research. The authors' disciplinary training and in-depth knowledge of interpretive policy analysis, particularly frame-critical approaches, have shaped their understanding of the health policy process and the role of framing more generally. Though I make no claims to objectivity, I have attempted to provide a fair and balanced account of the various strands of framing research and their representation in the health policy literature.

### **3.3. Results**

A large number of framing studies were conducted on health policy issues, predominately from the social sciences. A total of 1,231 articles were returned from the initial search. From these, a title review, supplemented with cursory abstract review, further narrowed the number of articles to 279. The exclusion/inclusion criteria were applied in the next round of reviewing to all abstracts and when necessary, a cursory full-text review. Finally, 52 articles were determined to represent framing research in which the following was explicitly stated: theory and methods used, data source, at least one frame, frame sponsor, and some evidence of a given frame's effect on the health policy process (see Appendix E for full sources).

The number of relevant research articles is increasing in volume and geographic coverage. Articles ranged from 1996 to 2014. The number of relevant research articles is increasing rapidly (1990s, n=3, 2000s, n=17; 2010s, n=32). Studies were reported from several countries (n=12), with the United States representing the highest number of articles (n=15). There were a handful (n=4) of cross-country comparative studies and 12 studies focused on global framing of health policy issues. While the majority were research articles from peer-reviewed journals, several doctoral theses/dissertations were included (n=5). A large framing research project with a summary paper (McInnes et al. 2012) and individual papers (n=6) packaged as a journal supplement were included and counted individually. Two articles summarize obesity framing research (Kwan 2009; Saguy & Riley 2005) from larger bodies of work represented in separate books (Kwan & Graves 2013; Saguy 2013). The books themselves were not included as the peer-reviewed articles were considered sufficient. Conversely, a book on children's health insurance (Sardell 2014) was included in the review

because framing research within the book was not found in the peer-reviewed journal literature.

Framing research varied across social science disciplines, epistemology, and drew from multiple framing theories. Of the 52 articles included in this review, 25% (n=13) were classified as health policy research endeavors. The majority of framing research on health has been conducted in the following research traditions: policy studies (n=14), political science (n=4), sociology (n=9), international relations (n=8), psychology (n=2), and media studies (n=2). The majority of articles were classified as operating from a constructivist epistemology (n=42). The remaining articles used positivism (n=2), realism (n=1), or used epistemologies that were difficult to identify (n=4). To be included, an article had to draw on established framing theory (as described earlier). Many articles drew from theoretical advances in the Interpretive/Critical Policy Analysis tradition (n=13). Nearly all articles signaled Goffman (1974) as the theoretical origin, though Entman (1993), Gamson (1992), and Benford and Snow (2000) were frequently cited as well.

Framing research relied on multiple data sources and covered a range of health topics. Nearly all articles made reference to some degree of document review. The majority used published texts (n=34), such as newspapers or government reports, often analyzed by a variant of content analysis. Research also relied on in-depth interviews with key informants (n=22). Several health issues were covered by the scope of research, including infectious disease (n=10), substance misuse (n=9), non-communicable disease (NCDs) (n=6), reproductive and sexual health (n=5), access to medicines (n=4), environmental health (n=3), and others. Of the infectious disease studies, 60% (n=6) were studies that focused on HIV/AIDS, 30% (n=3) focused on various aspects of influenza, and 10% (n=1) concerned SARS. Of the studies categorized as substance misuse, 55.6% (n=5) were tobacco studies, 33.3% (n=3) were alcohol studies, and 11.1% (n=1) concerned injection drug use. The NCDs studies were split between cancer (n=3) and obesity (n=3). In sum, a wide range of data sources and health topics were covered with some issues (i.e. HIV/AIDS and tobacco control) better represented than others.

Numerous frames were presented with variable interpretations of the concept. The number of frames represented in a single research project ranged from 44 (Andress 2007) to one (Abraham 2011; Kamradt-Scott & McInnes 2012). The term “frame” was used in

different ways. Some articles referred to frames when describing packages of ideas that align with a particular value base (Esmail & Kohler 2012; Parkhurst 2012; Oronje 2013). Other articles used the idea of framing to refer to the construction of social problems (Kolker 2004; Studlar 2008; Blackman et al. 2012). This included contestation over diverging interpretations or portrayals of both the causes and solutions to specific policy dilemmas (Daw et al. 2014; Driedger & Eyles 2003; Garvin & Eyles 2001). Other articles focused on the linguistic construction of frames, akin to Lakoff's work on metaphor (Dodge 2008; Ibrahim 2007). Finally, articles used the term "frame" synonymous to "argument", where policy dilemmas are structured by competing claims about what is fair and what is right (Moret-Hartman et al. 2006).

Similar to the multiple uses of the term frame, authors located frames at varying degrees of abstraction ranging from broad values (Rasmussen 2011; Reubi 2012; Esmail & Kohler 2012; Johnson 2010) to specific policy positions (Redington 2009; Parkhurst & Vulimiri 2013; Paterson & Marshall 2011; Fogarty & Chapman 2011; Fogarty & Chapman 2012). This corresponds to various strands of framing research including Schön and Rein's (1994) ladder of policy action frames (Iannantuono & Eyles 2000; Firbank 2011), Snow and Benford's (2000) classification of collective action frames (Frickel 2004; Noy 2009), and Gamson and Lasch's (1983) signature matrix (Jenkin et al. 2011; Kwan 2009; Tynkkynen et al. 2012). This was sometimes difficult to identify, as many articles failed to specify the theoretical basis for their specific interpretation of frames. Few articles distinguished between different types of frames or the ability of various ideas to overlap and correspond to multiple legitimate frames constructed at various levels of abstraction.

Diverse policy stakeholders were identified as frame sponsors, responsible for creating, supporting, or opposing contested policy frames. Though most articles presented at least one group of frame articulators from the public sector, frame articulators lacked many unifying characteristics and were often specific to the issue or focus of the research project. Most articles provided a strong account of policy contestation (n=40) while others provided some evidence of conflict (n=8), and a few provided very little (n=3). Contestation was context specific, but frequently represented deeper conflicts over the size of government and its mandates. Similarly, the way in which a frame affected the policy process was context specific, but research showed framing influences in variation from great detail (n=33), to some detail (n=15), to little or no detail (n=3).

A number of respectable framing articles from political psychology and communication were excluded from this review of the health literature for two reasons. First, this body of work was focused on identifying the ways in which the media frames health issues, such as obesity (Barry et al. 2011; Gollust et al. 2013; Niederdeppe et al. 2014). Many of these articles did not assess how specific health policies, programs, or legislation was framed, but rather how disease or problems are socially constructed by the media. Second, these articles frequently focused on how framing affects public opinion. The authors often mentioned that public opinion affects policy, but this was not the explicit focus of these studies. Content analysis, a method of analyzing media discourse, was well-represented in 52 selected articles, but only because these showed how media constructions affected the health policy process. To suggest that the media shapes public opinion, which in turn affects policy, was considered insufficient to address our main research question and be included in the final review.

### **3.4. Discussion**

Descriptively, the results of this scoping review suggest that the research on framing in health is somewhat limited. First, compared to the large number of articles that mentioned framing, there are relatively few studies that focus specifically on the ways in which ideas and policies are framed. Second, this lack of framing research is accentuated when looking geographically and thematically. The bulk of framing research has historically been conducted in North America and Europe on a small set of health issues such as infectious disease control and the regulation of harmful substances. Third, most framing research has been conducted by social scientists, with considerably less situated within health policy departments or published by health policy journals. This skew, in geographic, thematic, and disciplinary focus, is possibly explained by rationalist hegemony in industrialized countries as much as by simple disciplinary capture.

In addition to a descriptive overview of the scope of framing research, this review generated many analytical insights. The central goal of this review was to determine what is known from the existing literature about the influence of frames and framing on the policy process. The short answer is that quite a lot is known about a few issues in a few contexts. A more nuanced interpretation of the findings, however, points to several areas that require in-

depth explanation to identify strengths and shortcomings of the existing research. This involves an appraisal by the review's authors of what constitutes insightful framing research and what constitutes somewhat underdeveloped framing research.

First, it is important to revisit the underlying purpose of framing research. Much framing research operates from a constructivist epistemology that contests the view that knowledge is an objective, knowable, and measurable entity which exists independently of the researcher and the research process. The theoretical basis of a discursive mode of policy analysis associated with framing research is derived in from Critical Theory and Post-modernism. Following Habermas's theory of communicative rationality, reason is located in the structures of interpersonal communication rather than the natural world (Habermas 1985). Similarly, Foucault emphasized that power cannot be possessed but is exercised through knowledge and discourse, which serve as a form of social control (Foucault 1980). While Habermas and Foucault differed significantly in their understandings of the social world, their work provides the intellectual foundation of interpretive policy analysis (Fischer 2003). As such, interpretive research on framing looks at how actors create meaning in the policy process and how they package these meanings for instrumental and expressive purposes. In this way, a frame emerges, interacts with others and helps shape the terrain of the debate. Framing research does not predict change or advocate for a particular way of seeing the world. Instead, it seeks to provide an explanation for human behavior in the policy process and how this collectively structures subsequent interactions. To use Goffman's original conception (1974), framing is useful for understanding, "What is going on here?" It enables actors (and policy analysts) to make sense of daily experience, understand a problematic situation, organize experience, and act in particular way (Goffman 1974).

The scoping review was partially successful in answering the original question of what is known about the way frames and framing influences the policy process in the health sector. On the one hand, a great deal is known about highly contextualized debates over a narrow set of health issues. On the other hand, the body of scholarship on framing research offered relatively little internal coherence. This suggests that the interdisciplinary nature of framing research presents a challenge for both the reviewer and a review methodology native to biomedicine. Nevertheless, a few strong themes emerge and are reflected in Table 3, which surveys the 52 included articles.

First, some issues, such as environmental management, may not appear to be “health” issues, but through policy deliberation, are framed as such (Iannantuono & Eyles 2000). This raises questions about the exclusivity of the health policy process. Many articles illustrate that policymaking is an expansive process that transcends issue domains and involves deliberation from multiple segments of society. In this way, social problems such as homelessness (Noy 2009), injection drug use (Berger 2013), violence (Dodge 2008), environmental hazards (Frickel 2004), and assisted reproductive technologies (L’Espérance 2013) can gain political support by being reframed as “health” issues.

Second, a variety of theories and methods can be used to interpret the influence of frames on health policy. Though theory tends to reflect framing research’s multiple disciplinary lineages, common to most studies was a strong constructivist epistemology. Whilst a variety of methods were employed for analysis, most articles relied on a similar set of data sources, including some combination of interview transcripts, media transcripts, and an array of different documents from legislative briefs to organizational position papers. To adequately describe the effects of frames on the policy process, most articles were qualitative, though many of the media analyses involved quantitative analysis of a frame’s usage over time.

Third, articles that presented multiple frames provided a more convincing assessment of its influence on policy than articles that described the evolution of a single frame over time. The reviewers, who were uninformed about the substantive issues in the identified articles prior to conducting the review, found it much easier to identify the interplay of ideas in the policy process, when there was a moderate amount of organized frames. But, in framing (as in life) more is simply not better. More important than the quantity of frames, was the way in which the authors organized them either hierarchically or based on established theory. In this way, careful analysis of the evolution of a single mental health collective action frame in Scotland proved insightful (Sturdy et al. 2012). In another example, it was relatively easy to follow research into the framing of contraceptive decisions because the authors showed how two “inclusive” frames interacted with three “exclusionary” frames (Rasmussen 2011). Even when a larger number of frames were represented, as in Roth et al’s work on tobacco (Roth et al. 2003), the interaction among them was easy to follow because the authors organized frames into master (n=1), diagnostic (n=1), prognostic (n=3), and counter (n=5) frames, based on Benford and Snow’s typology of collective action frames (Benford & Snow 2000).

On the other hand, work on the social determinants of health that identified 44 different frames, proved cumbersome and raised as many questions as it answered (Andress 2007). This finding, that organization is possibly more insightful than revealing minute distinctions, underscores the significance of incorporating theory into framing research.

Fourth, research that embedded and internalized a range of framing research proved more insightful than research that gave little attention to theory. This finding was somewhat surprising given that the presence of framing theory served as an inclusion/exclusion criterion. In research on infectious disease (Doan & Kirkpatrick 2013) and health inequalities (Adams et al. 2010), the absence of framing theory is evident in the limited extent to which framing demonstrates conflict and change in the policy process. Similarly, a neo-institutionalist article (Inoue & Drori 2006) provided a sound theoretical basis for a sociological study, but an unconvincing analysis of how frames influenced the policy process. On the other hand, work on reproductive health (L'Espérance 2013), health financing (Tynkkynen et al. 2012), tobacco (K. E. Smith 2013), and alcohol (Hawkins & Holden 2013) illustrate how a strong theoretical foundation on framing and the interplay of contested ideas guides the analysis. Furthermore, these studies illustrate the value of abductive reasoning, to move iteratively between empirical findings and framing theory.

Fifth, research that presented multiple actors, contested policy arenas, and highly charged ideas proved to be useful in furthering our understanding of framing in health. This finding may be attributable to the fact that some disciplines, such as policy studies and political sociology, are inherently better positioned to capture the contested field than others, such as linguistics or cognitive psychology. Studies that looked at a narrow range of stakeholders, in a single domain, and fewer frames provided little account of contestation and therefore underdeveloped linkages with the policy process (Abraham 2011; Moret-Hartman et al. 2006; Iannantuono & Eyles 1997). Many of the articles that provided a nuanced account of contestation and change in the policy process were in longer dissertation/thesis/book formats (L'Espérance 2013; Redington 2009; Ofori-Birikorang 2010; Oronje 2013; Andress 2007; Berger 2013; Sardell 2014). This suggests that the highly contextual nature of framing research, combined with a qualitative analysis of the often-opaque forces that shape policy, is difficult to present within the confines of the journal format. This might provide a partial explanation as to why concise, coherent, and

comprehensive framing research appears to be in short supply in the health policy literature (given the restrictive word counts of journal articles in the field).

Based on the insights of this review, I propose a list of considerations for framing research on the policy process (see Table 4). While this list is by no means exhaustive, nor does it favor a disciplinary approach to framing research, it should serve as an adequate launch point for discursive investigations into the role that ideas play in health policy. Furthermore, because this list has been developed based upon the evidence presented in this review, the strength or weaknesses of proposed research can be assessed based on the extent to which the endeavor aligns with these broad considerations.

**Table 3.3.** Considerations for conducting framing research

<b>Consideration</b>
<ul style="list-style-type: none"><li>• Is the research informed by framing theory?</li><li>• Is there a clear statement of epistemology?</li><li>• Are a variety of actors identified?</li><li>• Are multiple frames presented/interpreted?</li><li>• Are frames organized based on established theory?</li><li>• Are multiple levels of frame abstraction clearly distinguished?</li><li>• Is a frame sponsor identified as a participant in the process?</li><li>• Does the research demonstrate how frames evolve and conflict?</li><li>• Is there a portrayal of policy contestation as a struggle over ideas?</li><li>• Does the research explain why some frames prevail and others fail?</li><li>• Is there a clear influence of framing on the policy process?</li></ul>

There are several important findings from this review that further our understanding of frames and point to directions for strengthening their analysis across disciplines. First, there was a lack of clarity between framing analysis as theory and method in the health literature. In fact, frame or framing analysis seems to mean different things to different researchers, depending largely on their disciplinary focus. Many articles drew on the concept of framing as the basis for an empirical research project in which various themes were identified, labeled as frames, and contradictions between frames were described. Other articles, used a range of analytical techniques, identified as frame analysis, to systematically work through the discursive elements of a given text or speech act. This methodologically-oriented frame research included a popular form of content analysis based on Entman's four framing functions as well as a method for identifying the linguistic artifacts of frames using

Gamson's signature matrix. Though the indiscriminate use of framing as both theory and method might seem problematic for defining the boundaries of a research paradigm, it also represents a potential strength of framing research. Creed et al (2002), further elaborate, "Because of its underlying attention to context, standing, and power, frame analysis provides us with a linked theory and methodology that gets us farther in our projects than other methodologies" (Creed et al. 2002). To be fair, many articles did make mention of some type of framing theory and implied that the methods were a form of frame analysis, but the most insightful studies were those that used abductive reasoning to move iteratively between empirical findings and framing theory.

Second, despite attempts to develop frame analysis as a research paradigm, the health policy literature suggests a lack of consensus exists across disciplines. Efforts to bring conceptual clarity to framing research have come from the fields of political communication (Entman 1993; Scheufele 1999; Scheufele & Iyengar 2012; Pan & Kosicki 1993), political psychology (Druckman 2011), and policy studies (Van Hulst & Yanow 2014). This review suggests that these endeavors have yet to produce a coherent and unified corpus of framing research in the health policy literature. Nevertheless, the review illustrates that framing research is an important form of policy analysis and that it is distinct from "simple researcher-designated labels" (Kosicki 1993). I contend that researchers interpret and deploy the concept of frames (and the process of framing) in particular ways. Yet, this contention is in keeping with a constructivist epistemology.

One goal of this review was to use framing research as a vehicle to marry the health policy literature with the wider policy studies scholarship. The rationale for using frames, as an ideational approach, is that by nature framing is interdisciplinary and its use as both theory and method is gaining credence. This review suggests the same is true both quantitatively and qualitatively in the health policy literature. For example, the "evidence-based" literature is increasingly looking to ideational approaches to analyzing complexity in decision-making (K. Smith 2013). Another example, a widely cited framework for assessing the generation of political priority in health, makes use of "internal" and "external" frames (Shiffman and Smith 2007). This is analogous to "coordinative" and "communicative" discourse, as advocated by a new brand of discursive institutionalist scholarship in political economics (Schmidt 2008). This indicates that some ideas are beginning to enter mainstream modes of policy analysis in the health sector, but it also points to some differences. While the two

forms of discourse in institutionalist scholarship are integrated into a highly contextualized way of looking at the discursive interplay of policy ideas, in the health policy framework, they are positioned as two variables amongst twelve that must be considered in explaining why something happens (Shiffman & Smith 2007). The argument by ideational scholars is not that ideas or frames are an ingredient in bringing about change, rather they represent the causal beliefs that bring change about (Béland & Cox 2011). The policy studies literature on framing emphasizes the primacy of ideas and an adequate analysis of them would take into account other salient aspects included in the Shiffman framework (2007) such as actor power, political context, and issue characteristics. This shift in emphasis is manifest in the applications of the health policy framework, which is biased in favor of a deductive mode of proving or testing theories about why some things happen (Walt & Gilson 2014). A mode of analysis that focuses to such a limited degree on frames often raises more questions, particularly with respect to the irrational nature of decision-making, than it actually answers. By looking at the way in which the articles included in this review are structured, the intentions of the researchers writing them, and what they are trying to achieve, I shift the nature of the discussion around policy analysis in health. Similarly, by looking at the scope of framing research in one issue domain, such as health, insights may be generated to further broader policy studies scholarship on framing.

### **3.5. Limitations**

The limitations of this review are multiple. The body of evidence proved difficult to corral given the abstract nature of the subject material and the systematic nature of the scoping review framework. This ranged from the relatively simple tasks of defining categories for strains of disciplinary background, theory, and methods to distinguishing amongst more abstract characteristics of the articles such as epistemology, evidence of contestation, and demonstrated effect on the policy process. Similarly, the inclusion/exclusion criteria were such that it resulted in cursory abstract review of a large number of articles, which may have led to some articles being unfairly excluded. Further, by including articles with a strong theoretical basis, I excluded various strands of relevant framing research, including experimental findings germane to behavioral economics and media analyses from political psychology, discourse studies, and communications research. These articles were largely excluded because they showed little or no direct bearing on the policy process. Still, they remain important and under-represented dimensions of framing research.

### **3.6. Conclusions**

This scoping review demonstrates the potential of framing research as a means of understanding the influence of ideas and human behavior in the policy process. Despite, a relative paucity of data for many health issues, demonstrable policy struggles occur in a variety of contexts for a few health issues such as tobacco control and pandemic influenza preparedness. By framing ideas in a particular way, actors evoke deeply held values that shift the terrain of the debate, transforming social phenomena into problems, implying a set of solutions, forming coalitions of interest, and mobilizing specific policy responses. More research should be conducted, particularly in low- and middle-income countries, to gain a better understanding of the complex policy terrain in the health sector.

The scoping review was a useful approach for harnessing the diverse pool of evidence located on the periphery of traditional health policy research. As a relatively new methodology and perhaps an unfamiliar body of theory, framing research has yet to receive adequate attention in the health literature. The analytical insight generated by the 52 articles included in this review was quite variable with framing approaches reflecting distinct research traditions. This review contributes to the wider (non-health) policy literature on framing by identifying several features of insightful framing research that were then employed in this study. In this way, I hope to strengthen the health sector's contribution to the policy studies literature while positioning framing research as an important vehicle for understanding human behavior in the health policy process and ultimately leading to a deliberative mode of policy analysis that contributes to the shared goal of health systems strengthening.

# Chapter 4: Framing User fee removal

---

## 4.1 Introduction

This chapter addresses the framing of the recent policy to remove user fees from primary health care facilities and dispensaries in Kenya. I focus on the policy to remove user fees for the following reasons. First, it initially appeared on the agenda as a fully formed policy, designed and enacted within the first 100 days of the current Jubilee coalition's term in office. This period marked a peaceful and hopeful transition of political power following free and fair elections. Given the political opportunity, many spectators and even political actors in Kenya were initially surprised that the new coalition government selected user fee removal amongst a range of policies to enact. Moreover, the President announced this policy by decree as part of Madraka (Independence) Day celebrations, effective immediately. Given the scale, pace, and in light of the platform upon which it was announced, it presented an interesting opportunity to explore just what exactly "is going on here" (Goffman, 1974).

Second, this chapter examines the user fee removal because it was linked to a wider universal health coverage (UHC) agenda that was reaching its peak within the global health and development communities. This movement towards UHC resonated with many in the international community as well as the domestic policy arena in Kenya. I wondered whether or not this movement and its emphasis on health financing had an influence on the decision to adopt this policy so early in the incoming administration's term in office.

Third, the rise of the frame of "user fee removal" itself is quite contested and marks the demise of the previous frame of "cost sharing" that had dominated international health financing circles. The conflict between "cost sharing" and "user fee removal" is one of broader global political debates and beyond the scope of this study to adequately investigate. Yet, this very tension has shaped Kenya's complicated history with health financing and its historical pendulum swings in domestic policy. By looking at how the user fee removal policy was framed, I hoped to gain insight into the ways in which the transnational flow of ideas may have influenced the domestic health financing space.

In the course of conducting interviews and reviewing other data, including media reporting, it became clear that user fee removal policy was difficult to uncouple from a related, and arguably more visible, policy announced simultaneously: that of free maternal health care. When the President issued his Madraka Day decree that user fees would cease to be collected, he also announced that all maternity care, including deliveries would also henceforth be free of charge (Leftie 2013). Initially, this seemed to be a distinct and loosely related policy, but during the course of the research, I found that actors frequently referred to the two policies as a pair. This varied significantly based on actors' levels of involvement in financing and their understanding of what these policies meant in practice. Thus, while there is sufficient data to distinguish the two in analysis, the framing of "user fee removal" must at the very least consider the synergistic and complicated relationship with its highly publicized partner "free maternal health care". For this reason, I will occasionally refer to free maternal health care and its relationship to the removal of user fees. This chapter will look at each dimension of the framing process in turn, including the collective ability of actors to make sense of user fees, the language they use, and the stories that frame user fee removal.

Data communicated in the form of quotes in this and subsequent chapters will be cited using the source transcript code (i.e. A\_01). The first field of this code follows the general form: A=Union or professional association representative; B=Government employee; C=International development partner; D=Private for-profit (business) representative; E=Journalist or media representative; F=Academic; G=Politician (MP or Senator). The second field of the code is the sequential number of the interview in each category. Affiliation was determined based on the current (salaried) position of the interview participant. It is important to note that this is just for tracking purposes as many interview respondents drew from overlapping identities. Either their professional experience has been acquired in multiple domains (i.e. previously MOH employee and currently international development partner), or they currently operate simultaneously with multiple affiliations (i.e. NHIF board member, KMA member, and MOH employee). Nevertheless, the attribution of quotes is important to determine the frequency and salience of a particular worldview as communicated through the presented data.

## 4.2. Making sense of user fees in Kenya

Like many countries, Kenya has a long and complicated history with a particular form of direct out-of-pocket (OOP) payment, called user fees (see Figure 4.1). In the late 1980's, The World Bank and others advocated for patients in developing countries to pay a small fee, framed as “cost-sharing,” as a way to recover costs and prevent over-utilization of precious resources at the facility level (Akin et al. 1987). This endorsement by the World Bank was reflected globally to uphold their neoliberal reorientation of development (Armada et al. 2001; Mooney 2012). In Kenya as in other countries, this was often tied to the larger structural adjustment programs imposed by large multi- and bilateral organizations (Dahlgren 1994; Anangwe 2008). From the outset, health policy academics were skeptical of the degree to which the poor could realistically be expected to pay without exacerbating existing inequalities (Gilson 1988; Gilson et al. 1995; Gilson 1997). Though unclear from the literature, it is possible that the concept of “user fees” emerged as a counter-framing to the neoliberal concept of “cost sharing.” Nevertheless, over two decades since their introduction, research from Kenya has shown that user fees, and the difficulty in implementing waivers and exceptions, has hurt demand for health care, impoverished households, widened inequality, and actually generated little revenue (Mwabu 1986; Moses et al. 1992; Huber 1993; Mbugua et al. 1995; Mwabu et al. 1995; Gilson et al. 2001; Anangwe 2008; Chuma et al. 2009). This has led to much speculation of whether or not user fees should be removed (James et al. 2006) and the importance of carefully considering the potential negative consequences of abrupt user fee removal (Gilson & McIntyre 2005). Descriptive policy research from multiple African countries has shown that indeed the way in which user fees have been removed matters (Meessen et al. 2011). More recently, evidence is emerging to suggest that if user fees are abruptly removed without increased public finance to account for the lost revenue and increased demand, user fee removal can hurt health systems (Ridde & Morestin 2011; Ridde et al. 2012). Nevertheless, the tide seems to have turned on the “cost sharing” frame and the international community has increasingly advocated for pre-payment schemes and risk-pooling in favor of regressive user fees (WHO 2010; Chan 2012; WHO 2013b).

### 4.2.1. Development Partners

Like many LMICs, the health policy arena in Kenya is directly shaped by the priorities of the international community or “development partners.” Thus, the rise and fall of the “cost

sharing” and “user fees” frame in Kenya closely mirrors the trajectories of each in the international community (Dahlgren 1994; Anangwe 2008). This has played a role historically in Kenya’s complicated and volatile relationship with user fees as outlined in Table 4.1. In many cases, multilateral finance institutions such as the World Bank, have helped to design, pilot, monitor, and evaluate, and even financially backed some of these schemes to introduce, reduce, and now remove user fees (Dahlgren 1994). Research from development studies has documented the problematic way in which international actors play an outsized role in domestic policy decisions while being largely unaccountable to the populations these programs serve (Leys 1996). Moreover, the staff composition, changing policy landscape, and the competing priorities of various development partners leads to high degree of fragmentation in the health arena, which creates a confusing landscape for health policy actors (Travis et al. 2004; Mills 2014). While it is beyond the scope of this research to address in its entirety, the interview data suggest that these are some of the considerations in how actors understand issues such as user fee removal in Kenya. I will discuss these key factors in turn.

**Table 4.1: Historical Review of User Fees in Kenya**

Year	Event
<b>Colonial Period</b>	User Fees in all public facilities
<b>1965</b>	User fees removed at all public facilities. Health services provided for free and funded predominately through tax revenue
<b>1989</b>	User fees introduced in all levels of care
<b>1990</b>	User fees suspended in all public health facilities. Waivers and exemption put in place to protect the poor and vulnerable. Failure linked to poor policy design and implementation
<b>1991-2003</b>	User fees were re-introduced in 1991, through a phased implementation approach starting from hospital level. Children under five, special conditions/services like immunization and tuberculosis were exempted from payment. User fees continued to exist in Kenya at all level of care.
<b>2004</b>	User fees abolished at dispensaries and health centers (but remain at higher levels of care) and instead registration fees of Kenyan shillings 10 (.11 USD) and 20 (.23 USD) respectively was introduced. Children under five, the poor, special conditions/services like malaria and tuberculosis were exempted from payment
<b>2007</b>	All fees for deliveries at public health facilities were abolished
<b>2010</b>	A health sector services fund (HSSF) that compensates facilities for lost revenue associated with user fee removal introduced. Dispensaries and health center receive funds directly into their bank accounts from the Treasury.
<b>2013</b>	All user fees, including registration fees removed from public health centers and dispensaries. Fees for maternal health (including deliveries) waived at all levels.

First, the structure of the health workforce is balanced in favor of a highly skilled and technically proficient international community. While increasingly Kenyans staff the offices of development partners, foreign nationals continue to occupy the vast majority of the leadership positions. One expatriate bilateral representative (C\_11) attempted to downplay this situation, “*I normally say we work on high level [...] not hierarchical down looking at a partner but you are considering the partner the same level as you.*” These foreign nationals often are equipped with academic training from elite institutions abroad and have developed a highly sophisticated set of skills. This is pronounced in interactions with their counterparts in leadership roles of domestic public sector organizations, who are often political appointees or have worked their way up the bureaucratic ladder. For example, the current CEO of the National Hospital Insurance Fund (NHIF) spent most of his career in motor vehicle registration. Multiple stakeholders suggested he consequently has a limited understanding of the technical nature of health insurance, instead having been placed in one of most

controversial positions in the health sector because, “*The minister appointed him [...] because he has the power and the law to appoint him,*” as one former NHIF employee (B\_03) flatly reported. This divide between evidence-informed technical experts in the development community and politically-informed bureaucrats in the public sector demonstrates the subtle role that sense-making plays in framing health financing policy.

Another complication of the leadership of development partners is that they often rotate and are hired on a contract basis, often serving one to four years in a specific country. Thus, institutional memory of these organizations can be strikingly limited. This surfaced in a variety of ways in interviews and even when reaching out to potential interview respondents. Email addresses are discontinued, colleagues report that an individual is now working in X country, and interview participants have a very specific time frame in which they can recall the finer details of previous work executed by their organization. In addition to this, the technical and programmatic staff of the development partners who are domestic employees represent a relatively privileged class in Kenyan society. Kenyans working for development partners often have degrees from abroad or private schools in Kenya, receive advanced career development training through their jobs, and engage in a variety of other professional commitments including consulting services and private sector work. Their status confers privilege in ways that are not readily apparent, as one Kenyan staff member of a development partner explained:

I mean probably [policymakers] are your friends, so after work you probably live in the same neighborhood, or meet somewhere that’s... so, basically there are many ways of reaching to the government officials because you, there are many things that tie you together, probably in the same school and things like that, so that’s why it’s easier for me when am working in my country because you know the people beyond what they do [...] If the Minister [of Health] is in town and I absolutely need to see him today, and it’s urgent, I can squeeze in and see him if it’s really urgent because you probably know him from some other...you know each other at a personal level (C\_03).

Nevertheless, health initiatives from development partners are often designed to serve impoverished communities. The fact that that development partners are often led by expatriates and staffed by the Kenyan elite, could potentially lead to disconnected health programming, as another expatriate development worker (C\_01) commented, “[...] *it’s surprising how much people in Nairobi are disconnected [...] even ‘up-country’ means*

*different things to different people.*” In this way, some characterize health programs as experimental endeavors, implemented according to the latest development fads and subject to loose scrutiny. Furthermore, development partners pursuing their own agendas often struggle to understand the broader strategic significance of the development agenda and how their programs fit into the mix. At a minimum, the status of development partner employees and their position in Kenyan society contextualizes the sense-making process and collective framing of health financing policies.

Second, the rapid pace of policy development creates a situation in which all actors struggle to make sense of policy decisions, especially development partners who often have narrowly defined scopes of work. Information is often out-of-date, delayed, or missed altogether given the fragmented nature of the health arena. For example, when asking participants about the removal of user fees, a few actors, including a senior academic (F\_02), were unaware about the proclamation, *“That is not what he said [...] He said that maternal care will be available free of charge in all public hospitals [...] he did not remove user fees.”* This was a relatively common misperception, where many others understood the proclamation to refer exclusively to free maternal health care. On the other hand, as will be revisited later in this chapter, much policy and decision-making around user fee removal occurred in the upper strata of health organizations, often leaving the technical actors to muddle through the details and struggle to keep up with the latest policy developments.

Third, the role of development partners in designing and implementing programs according to their priorities complicates the job of organizations such as the Ministry of Health (MOH) and leads to fragmentation. As one development partner commented about colleagues who actually have a physical office in the Ministry of Health building:

It’s very difficult, also you may have to draw the line, [...] it’s very difficult to see where the line is but you have to stay behind. I’m not allowed to write the documents for them...it’s their job. I can give my non-objection to the document, I can’t write the document for them (C\_11).

This level of restraint and moderation was not shared by all development partners. For example, a representative of one multinational proudly described their involvement and influence in decision-making processes:

**Respondent:** We draft policies, we help the government to draft policies if needed [...] we do seminar, lots and lots of publications on behalf of the government. We write, we help them write laws, we help them write regulations, we are supporting the regulators here to develop [XXXXXXXXXXXXXXXXXX].

**Interviewer:** Wow it looks like you are an extension I mean of the government...

**Respondent:** Yeah, we do, we are deep in there [...] remove the laws that are not working introduce laws that are missing and make compliance easier, improve [XXXXXXXX] so that it's no longer a rent seeking but a quality improvement approach (C\_03).

The fragmentation resulting from competing demands is particularly true in health finance, where development partners have tried to remove financial barriers to health through various channels. Some of these include rolling out voucher programs, designing conditional cash transfers, developing a basket fund to finance facilities, piloting health management committees, advocating for reforms of the largest insurer, and supporting the private sector's growth agenda. As one representative from a multinational pointed out:

[...] most of the things are outside the government control, for example even in financing, a large amount of resources is outside the country, the support that is coming from [development] partners which is contributing, which actually, in a way, is kind of crowding the government contribution, the partner support has doubled in the last four five years and close to 90% of that is off budget [meaning not part of public finance] (C\_07).

Given the poor flow of health information across systems and administrative limitations at the point of service delivery, interview participants reported that this leads to significant replication, inefficiency, and in some cases, leakage of the intervention. Furthermore, all development partners are supposed to be coordinated by the national government through the MOH, but as one development partner (C\_01) conceded, this can be problematic, “[...] *within the ministry you can find a champion [...] but the greater challenge for the ministry is now to [act] with eyes wide open but according to what each stakeholder brings [...]*”. This creates a headache for individuals who are oftentimes put in the role of mediator between competing development partners who seek to pursue divergent health initiatives. According to another multinational (C\_07), “*Yeah, the problem is [donor] interest get represented with individuals not with institutions, that is the challenge.*” The tension this creates is one

possible source of the low morale among public sector employees and has been cited by study participants as a persistent impediment to national strategic policy development.

Given the milieu of stakeholder participation from the development partners who are attached to large sums of money, the interviews I collected suggest that domestic policy actors, such as government employees, react in three fundamental ways, which shape sense-making. Some become frustrated at the lack of autonomy and look with skepticism upon any proposal that emanates from the development partners, as one former NHIF employee explained:

[...] interests drive policy decisions. In the sense that, sometimes it's the international community. I mean right now there's post MDG 2015[...] One of the things that is at the top of their agenda is universal health care, so next year, it will be universal health care. And everybody who will be talking, will be talking universal health care, the funding will be universal healthcare, if that becomes their agenda, which most likely it's going to go that way. [...] So it's either being driven by the international community or business interests. And rarely is there analysis of exactly what we want as a country (B\_03).

Others choose simply to leave the public sector in favor of jobs in the private sector and often limit their interactions with the development partners. Many, however, choose the opposite approach. They undertake a series of consultancies of varying length within development partner organizations, often working simultaneously for multiple organizations. For example, as one consultant (C\_02) explained, “[...] *you know the draft [financing] strategy was developed with GIZ support and when people say that, it basically means some consultant hired by GIZ wrote that document.*” Regardless of how domestic policy actors react to evidence, argument, or influence from the development partners, my interlocutors intimated that their ability to make sense of any financial proposal, especially one as loaded as user fee removal, is viewed through their experience with development partners over the span of their careers in the sector. According to one Kenyan health economist (C\_04), “*there is so much conflict of interest wherever you go [...] the donor community plays a huge role, the World Bank, the WHO, the USAID, the DFID, and each one of them has got their own interest.*” Moreover, the ability of actors to learn from previous experiences with user fees in Kenya is somewhat limited by the shallow institutional memory in the public and international health sectors. These features combine to suggest that local actors lack autonomy and are manipulated by development partners to further their goals, as captured by one consultant:

[...] different [donor] agencies are able to push and pull the debate in, sort of, the direction that they want, and even, especially, with health care financing [...] often its these donors who have different views on what strategies Kenya should be using and then they are having their arguments through the ministry of finance, sorry, through the ministry of health (C\_02).

For these reasons, the legacy of user fees in Kenya is also tied to the sense-making process for health financing actors.

#### 4.2.2 Professional and Disciplinary Training

Similar to interactions within the international sector, the actors in this study often allied policy considerations with their professional or disciplinary training. Sense-making in this instance was tied to framing actors' identities and relationships to one another. For example, an actuary claimed:

The problem is that [...] the health economists believe they know it all, then you give a numbers man like me, whose work is trained to look at the numbers and then step aside and say, 'does it make sense?' (D\_05)

A private sector representative (D\_07) likewise complained, "*So you know, the actuaries are also tricky in terms of how they measure and what they measure.*" Finally, a hospital executive admitted:

Yeah, there are no secrets, especially within the profession and for many doctors, they see their professional affiliation to be stronger than their link with the [MoH] [...] they also see the people now who came from other disciplines as busy bodies (D\_06).

The way in which actors understand themselves and others involved in policy debates around health financing is a key feature of the sense-making process in framing.

Academic and professional training also revealed much about how actors described and interpreted a problematic situation; this was differentiated by the axioms and idioms diverse actors employed throughout. When looking to address a problematic situation in the health sector, actors often drew upon their own experiences within the health sector to frame what they understood to be the most urgent of priorities. In interviews, health care providers,

for example, tended to emphasize the challenges of service delivery, while health economists spoke about efficiency. This was exemplified by the following statement from a health financing expert:

My gut feeling is that there's enough money for health expenditure. The question is how do we utilize it...gut feeling. I mean the national health accounts are there also, the next three months and my gut feeling is it will be over 60 dollars...and that's enough. That's enough to enforce some decent levels. If there's inefficiencies in the system, there's no point in putting more things. Inefficiency always tends to bring more inefficiency. [...] I give you classical example of inefficiency is Kenyatta [National Hospital [...]] we're spending, I don't know, about 14% of our budget on Kenyatta hospital [...]. Yeah, that's a lot of budget on one hospital and nobody's ever even measured the efficiency (B\_12).

By nature, a profession structures worldly interaction in a certain way and exposes actors to a multiplicity of responses within that structuration (Freidson 1970). Because the health sector draws on a variety of experts from diverse backgrounds, policymaking is bound to be highly contested and often divisive (Béland 2010). At the very least, profession and discipline affects the flow of ideas in Kenyan health financing and contributes to the sense-making process in framing policies such as the user fee removal.

#### *4.2.3 Values and Policy Design*

The concept of user fees has historically been a divisive issue in Kenya (Chuma et al. 2009) and farther abroad (Gilson et al. 1995; Gilson 1997; James et al. 2006). It resonates with the notion that everybody should pay his or her fair share (Akin et al. 1987). On egalitarian principles, however, the poor cannot be realistically expected to pay and society's duty is to protect them (James et al. 2006). For this reason, the general view in favor or against user fees tends to be underpinned by deep-seated value-based judgments about what is fair and can be expected from society. Nevertheless, in the course of these interviews, many people expressed a degree of sympathy for the plight of the poorest and the regressive nature of these fees. The divisive issue was not necessarily represented by the concept of user fees, but how exactly to go about addressing them.

Multiple respondents commented that in Kenya the issue is not “policy design”, but rather “policy implementation.” Some actors even argued that the knowledge base is sufficient for policy design, as this government official explained:

It's not that the study has not been done. There are enough studies. The last thing anybody needs is another study and it's just making sure that somebody picks it out of the shelf and reads it. There have been enough studies in Kenya funded by USAID. It's not a question of doing more studies, it's a question of implementing their recommendations (B\_12).

This seems to be true with respect to user fees and the ability of actors to make sense of what they perceive to be problematic. For example, fees had already been reduced to a one-time registration fee of 10 or 20 Kenyan shillings, which is very cheap and is even exempted for children and expecting mothers. Yet, research suggests that these exemptions are rarely followed and that illicit user fees are often collected at facility level (Chuma et al. 2009). This led some people to understand that the real problem lies not with legislation or the modification of existing policies, but rather, enforcing policies that already exist. Some argued that whether or not people are paying at the point of care, somebody has to pay for those services and how this is structured (i.e. through taxes, NHIF, or other means) is what concerns them. In fact, many study participants suggested that ‘free is not actually free’. As one private sector representative (D\_07) quipped, *“Nothing is free. [...] if you think health care is expensive wait ‘til it becomes free because it will be actually more expensive.”* Finally, as we will see with the ways in which this policy has been discursively framed through a process of naming in the next section, many actors were concerned that the fees composed a sort of “slush fund” for the facilities that in theory was imperfect, but in practice was vital to the functioning of the facility. Without an increase in contribution from government, complicated by the newly devolved administrative structures in the health sector, these facilities and the patients they serve would be negatively affected.

As I have shown, a variety of circumstances shape the way in which actors make sense of a problematic situation in the Kenyan health sector. These include global political economic forces, the experiences of policy actors themselves, and Kenya’s unique history with user fee removal. While sense-making provides insight into how actors understand the world around them and their role in it, we need to look closer at how the user fee policy was constructed through naming in order to understand its framing.

### 4.3 The Language of User Fees

The rhetorical basis for the ways in which user fees and their removal have been framed is partially represented by naming processes. Naming, through a process of selecting and categorizing, is a means of framing user fees in ways that inform subsequent policy positions in support or opposition to user fee removal. By selecting some features of a problematic situation, the policy itself is framed in important ways that influence the tone of the debate and signal intentions of actors in the process. In this section, key metaphors are identified that helped to bring ideas together in ways that color perceptions of the user fee removal.

#### 4.3.1 Features of User Fee Removal

In the policy discourse around the removal of user fees, several key concepts have been selected through naming processes, which indicate that the policy should be interpreted in a particular way. This includes intention to remove financial barriers to care at the lowest entry points in the health system, at primary care facilities and public health dispensaries, both of which are run by the Government of Kenya. This narrow and carefully crafted policy selects for a number of important features.

An important caveat that is frequently mentioned in official government positions on the policy and in the proclamation itself is that user fees have been removed from *government* facilities. The selection of public sector as the venue for this policy served multiple purposes. First, the Jubilee Coalition was careful to highlight their economic growth strategy (Coalition 2013) and likely did not want to be seen as encroaching on their private sector base. Private provision of care is robust and growing in Kenya and increasingly there is a move to separate financing from the provision of care (Deloitte 2011; P4H 2012). Government facilities, however, cater to the poorest and most vulnerable segment of the population, serving as a key component of the country's social safety net (Chuma & Okungu 2011). By stipulating that fees would be removed from government facilities, I argue below that policymakers subtly promoted the paternal role of government, but that by removing a relatively small amount of funds at the low end of the health market, the policy was unlikely to arouse private sector fears of a wider government incursion into health.

The selection of primary health care facilities and dispensaries served a similar purpose and suggested that the government was committed to its stated principles of equity.

According to one economist (C\_08), “*before the policy, there was a jubilee manifesto, [...] it’s very clear on the direction and linking that manifesto to vision 2030, [...] towards ensuring that we target the vulnerable, the poor and vulnerable [...]*” The costly (and more lucrative) services provided by secondary and tertiary care facilities would remain unaffected by the user fee removal. Instead, by selecting the level of primary care, the government was able to focus on the preventive and promotive aspects of the health system that are the most cost-effective, yielding population wide health outcomes, and would therefore have the strongest impact on national health indicators (as explained in more detail in the storytelling section of this chapter, below). Additionally, the users of the primary care system are often the poorest members of society and improving their health status can help to equitably rebalance the health system. In this way, the selection of primary care achieved many of the government’s stated goals while avoiding many of the pitfalls of past policies affecting the more lucrative segments of the market (see Chapter five and six).

Finally, the policy to remove user fees selected for a particular health financing domain and theoretically simplified financial flows. By shifting the divisive policy discourse away from risk pooling (see Chapter five) and focusing on revenue collection, the government assumed a marginally larger role in financing. Instead of focusing on purchasing or risk pooling, policies aimed at revenue collection remain surprisingly tractable in Kenya. As multiple interlocutors suggested, there is still “scope” for raising additional revenues through various tax-funded mechanisms. While it was still unclear where the additional revenue to compensate the facilities for removal of user fees would come from within the budget, the government indicated that it would increase expenditures at facility level. Similarly, this was intended to simplify administrative procedure by more efficiently aligning financial flows. In any health system, there is a payer (often a third party insurer), a patient, and provider. When user fees were in place the payer/patient supplemented the payer/provider function of the state with a marginal fee. Without these fees, the state assumed the entire cost of primary care in addition to its responsibilities as provider of that care. As a result, the patient was now responsible for just being a patient. This was important for two reasons. First, it is more efficient, with less administrative and transaction costs, to have a joint provider/payer (Gottret et al. 2008; Savedoff & Gottret 2008; WHO 2010). Second, even when user fees were reduced or exempt on paper, research showed that they were rarely so in practice (Chuma et al. 2009). In theory, by removing the paying function from the patient, however marginal, providers would have a harder time demanding

illicit payments and patients could more easily realize their entitlement to primary care. In this way, the selection of a particular health financing domain and the rebalancing of financial flows allowed for a marginal policy to potentially strengthen the health system while remaining free from the gridlock of previous policy disputes.

#### *4.3.2 Metaphors: Low-Hanging Fruit, Quick Win, and Political Gimmick*

Of the metaphors used to name the user fee removal, one of the most frequently employed by interview participants was “low-hanging fruit.” In this portrayal, the policy measure of user fee removal was one of the simplest, easiest, and least contentious. A finance expert (D\_05) commented that during the election campaign, “[...] *I suspect somebody told them, this is a low hanging fruit [...]*” Another MoH employee (B\_01) likewise commented, “*you know politician they are this sort [that target] low lying fruits, so that people can see, but the fundamentals are not seen, the impact maybe would be felt after five, ten years.*” This was an apt metaphor as a number of policy proposals surfaced throughout the political discourse in much the same way that fruit populates a tree. Yet, most actors were sure that the decision to remove user fees was motivated by the fact that it was the easiest to pluck and put into action. The manner in which facilities would be compensated would make use of established administrative channels instead of introducing new financial arrangements. Also, the user fees were perceived to be quite minimal and poorly understood to begin with. Another reason for its perceived simplicity was that this was by and large a familiar concept and no real learning needed to take place amongst the relevant actors. Similarly, the fees were widely acknowledged to be inhibiting access to care, something which many policy actors were keen on rectifying. Because the government had a rich history of tinkering with these fees, this policy was readily available, easy to understand, and administratively simple to enact.

The related frame of “quick win” was frequently used to further name and characterize the strategic nature of the user fee removal policy. As a former leader of MoH explained:

It’s easy to do. Yeah, Adam, it’s easy. You know working with NHIF, you are trying to organize a restructure, it takes a long time, right? This is a quick win, abolish user fees and reimburse the facilities. That was easier to do [pause] much faster (B\_12).

On account of the Jubilee Coalition being under intense pressure to fulfill campaign pledges, several individuals, including those who advised the party directly (see below section on storytelling) reported that there was a strong desire within the party to support a proposal which could be designed, costed, and enacted within the first 100 days in office. As one finance expert (D\_05) commented, *“First of all it’s a good policy. It’s one of the things that they actually said they will do.”* The simplicity of executing the financial disbursements to facilities and the method of enacting the policy by popular decree, created the favorable impression that the newly elected government was working towards its health commitments.

Interestingly, this “quick win” was viewed both positively and negatively, a fact which was largely relayed by intonation and supporting argumentation during the course of interviews. For some, a “quick win” was precisely what was needed by the incoming party to generate political momentum for health and to signal its commitment to strengthening the social safety net for poorest members of society. For others, a “quick win” represented a shallow, shortsighted policy aimed at achieving the goal of promoting the party leaders above all else. This feature of the “quick win” naming of the user fee removal policy hints at the ambiguous and interpretive nature of policy framing. While relatively benign in this instance, pervasive policy frames often can mean different things to different people at different times, despite sharing a common language for communicating these ideas.

Related to the “quick win” and “low-hanging fruit” frames was another that assumed a much more cynical view of the motivations behind the user fee removal, that of the “political gimmick.” A few actors thought that the purview of politicians responsible for promoting the user fee removal was to win the votes of the target audience. As one public sector employee (B\_01) exclaimed, *“But my brother these are just political decisions which as we say you know they override any economic rational.”* In this frame, politicians exchanged government handouts for political support (D\_07), *“[...] they are vote-hungry and they run with these populist ideas.”* Because Kenya is a low-income county, many of the voters actually rely quite heavily on the public health system. These are the same individuals, according to some actors, who stood to benefit from the removal of fees in primary care facilities and consequently would have been motivated to vote for any such proposal, which allowed the government to use its coffers to pay for their care. A health care provider explained why this is problematic:

So it is a problem, its un acceptable problem so one of the ways in which you can get votes, is to use that to tell them am going to improve services in health care. And a very political way of telling them that now I want you to get more services is to tell them now it's free, you see. So some of these decisions are not well thought out, proper consultation does not go into them and at the end of the day, you find that when they have taken it like now the removal of fees, the end product does not really end up helping the patient themselves or the health workers, it ends up being something that has just benefitted the politicians (A\_02).

Like the “low hanging fruit” and “quick win” metaphors, the “political gimmick” frame was shaped by the underlying values of the frame sponsors, their ability to understand the environment around them, and the frame’s perceived use for expressive and instrumental purposes.

#### *4.3.3 Counter Portrayals: Slush Fund and Rushed*

In contrast to the naming of the successful policy to remove user fees, two consistent counter-frames were used to voice concerns about the policy’s unintended consequences. First, many actors pointed out that although these fees were small, they were not insignificant, but rather provided a flexible funding mechanism, what I call the “slush fund”, that was essential for the functioning of the health facility. Second, many actors were concerned that the policy was enacted virtually overnight and the “rushed” nature of its implementation would lead to interruptions in service delivery. Both of these concerns, while legitimate were largely overshadowed by concerns about devolution and the serious consequences this new form of governance entails for the functioning of health faculties.

Several actors, particularly health care providers, interpreted “user fees” in a way that can best be characterized as the “essential slush fund” counter frame. As one economist explained:

[...] the reason why we started user fees is to be able to generate additional funding for the health sector, and we allow facilities to spend that source so that money was at the disposal, so if they missed something they can/ they have a kit to dip in buy ok, and that in a way was able to ensure that facilities have got cash to meet any shortfall in case there is any delay of funding from the Treasury. So that additional funding...and that funding in most facilities, accounted for a very big chunk of the operational and maintenance budget (C\_08).

For these individuals, user fees provided the informal means for managers to discriminate and prioritize a range of non-health services and commodities that ensured the smooth operation of facilities. This included pay for security, cleaning, and cooking staff or commodities such as cleaning products, personal hygiene, and even non-essential medicines. By invoking the metaphor of “slush fund” actors implicitly suggested that the new compensation by the government would come with new restrictions on how to use the funds. Some (i.e B\_06) remained skeptical that the kinds of things the user fees paid for were things that managers could adequately foresee and budget accordingly, “*the money they were collecting were ploughed back to run the institution, [...] from water, security, gloves those petty things.*” In this counter-framing, government allocation in lieu of user fees necessarily would entail a small degree of regulation, which would limit the flexibility of facility managers.

An additional counter frame that emerged from study participants characterized the user fee removal as “rushed.” This often worked in tandem with the “essential slush fund” counter-frame. A representative of the nursing profession described these frustrations:

Then now we don't have money to pay our casual laborers, because you see it was also employing casual laborers at the facility level, those who are going to clean, those who are going to [...] security they were employed by that user fee. Now we cannot employ them so what happens? There is no security, there is no cleanliness, who is going to do the cleaning? Essentially the small things that we used to buy, the BP machines, the drugs we don't have money to buy that, so we wait for the government to come and give [them to] us (A\_04).

Given that these fees are not small financial barriers to care, but rather help facilities to logistically ensure that essential services provided, their removal, virtually overnight, was seen as a serious threat to continuous facility operation. Instead, many actors voiced concerns that a trial period was not initiated in a select number of clinics, or that the implementation was not phased in over a period of time. One MOH actor described this as a supply and demand problem:

[...] but I think we also need to look at the supply side [...] you know the removal [...] it's just you are solving one problem by removing the financial burden, but from the supply side, [...] are the services there? And that is one of the challenge is that the services may not be adequate to cater for the needs of the different constituents of the Kenyan population. So it's a good thing but on the other hand, from the supply side, the government

has really [...] to make sure that the staff are there, the equipment are there, the drugs are there and everything is there [...] the evidence is quite scanty but from my gut feeling I think that the supply side we have not really worked on [...] (B\_01).

Academically minded actors would have preferred to see more research before embarking down the path towards complete removal of user fees, to assess the true equity benefits and the ability of facilities to respond to swelling demand, for example. For proponents of the “rushed” counter-frame, simply removing user fees and compensating facilities without increasing human resources, expanding facilities, or increasing the purchase of essential commodities, would likely result in service delays and sporadic periods of interruption.

While both the “essential slush fund” and “rushed” frames may seem to pose damaging opposition to the policy to remove user fees, they were ultimately overshadowed by other changes in the health system. These changes are somewhat beyond the scope of this study to address, but are nonetheless important to note. Though primary care staff in government facilities were worried about their ability to maintain a smoothly operating program of care, they were likely more concerned about broader governance changes in the health sector that were occurring simultaneously under devolution. Within a short period of time, all government health care providers became county employees as opposed to national government employees. The newly devolved system of governance marked a shift from a national system of wages provided by the MOH to a system whereby health professionals would be paid by the county health executive. Participants complained that this change has been associated with a raft of administrative problems leading to strikes in the health sector and tense relations between multiple tiers of government and the health professions. Similarly, purchasing of commodities and services is now to be executed through the county office with little input from the central government, which early evidence suggests has been challenging at best (Nykuri et al. 2015; Tsofa et al. 2015). Still another reason that the counter-frames have yet to gain traction is that many health care providers and policy actors in fact see the benefit. Policy actors who stand to be negatively affected by the policy displayed a surprising amount of humility by oftentimes agreeing that the equity benefits to the poor and vulnerable outweigh any negative consequences incurred by the facilities themselves. For these reasons, despite contestation, competing frames have yet to pose any significant threat to the user fee removal policy and it is currently in operation nationwide.

#### *4.3.4. Categorizing User Fees as Incremental Policy Measures*

The term “user fee” situates the policy proposal in relation to both the world of health financing and as a policy that is incremental in nature. While it is impossible to know for sure exactly why the domain of health financing was selected as opposed to other salient aspects of the health system such as service delivery, human resources, and information systems, the data suggests a variety of interpretations. The incremental nature, on the other hand, was clearly seen as an attractive feature of the policy as it did little to alarm or inspire stakeholders.

The possible explanations for the heavy financial bent of the policy are multiple. First, through the legacy of the failed attempt to roll out social health insurance in 2004/5 (see Chapter six), a sweeping financial overhaul of the health system has captured the imagination of policy makers and bureaucrats alike (Fraker et al. 2007; Carrin et al. 2007; Mathauer et al. 2008). Second, reform of NHIF and the toxic nature of associated scandals have made it a particularly unattractive vehicle for reducing financial barriers to care (see Chapter five). By focusing on user fees, actors sidestepped a fundamental frame conflict over risk pooling (see Chapter seven) and instead called attention to the tractable problem of incremental changes to revenue collection imbalances. Third, evidence suggests that the Kenyan health system is wildly inefficient with both horizontal and vertical inequities that result in a high level of out-of-pocket payments and catastrophic health expenditures (Munge and Briggs, 2013). Fourth, the global discourse around UHC was generated in large part by a number of health financing actors and is largely associated with an unfinished finance agenda in LMICs (Bump 2010; WHO 2010). Fifth, winning the financial argument has been perceived as a way to influence the most powerful member of the President’s executive team, the Treasury Secretary (see Chapters five and six). Finally, the presence of uniquely qualified and persuasive health economists, working through the political party structure, helped to ensure that health finance reform was represented in the party manifesto (see section below on storytelling).

Frequently, participants categorized the policy to remove user fees as an incremental measure. Instead of focusing on a financial overhaul of the health system, the relatively small adjustment to the way in which revenue was collected in public facilities left many policymakers ambivalent about its consequences. While providers, such as nurses, who have

been directly affected, described the policy as “catastrophic”, most actors seemed to think that these fees were insignificant. By categorizing the policy as incremental, actors were often inclined to see the policy as either a positive step in the right direction or a harmless adjustment by the government. Similarly, for actors who were negatively affected by the abrupt increase in utilization or interruption of established administrative procedure, the incremental nature of the policy suggested that it would serve as an inconvenience in the near future, but prove to be beneficial in the long run as systems are developed to more adequately handle the transition. Many perceived that nothing significant was gained nor lost, supporting the theory that incremental measures make for tractable policy proposals (Mahoney & Thelen 2010; Beland 2007).

#### **4.4. Stories that Frame User Fee Removal**

Storytelling was used to a limited extent in explanations of the decision to remove user fees. This may reflect the authoritative way in which the removal of user fees was rapidly enacted with little stakeholder engagement. Rather, it may also be indicative of the fact that this particular policy concerned few of the interview participants directly, which perhaps provides insight into why this policy was selected in the first place. Another possible explanation for why so few interview participants provided stories to account for the removal was that this policy was something that seemed relatively clear and in fact required very little explanation. This is supported by the interview data, in which many people suggested that the reasons for removal of user fees were obvious and politically motivated. As we have seen, this resulted in the deployment of various metaphors such as “low-hanging fruit” and “quick-win” in framing the policy itself. Nevertheless, some actors did tell stories about user fee removal, which are useful to my understanding of how this policy came to be selected.

The origin of the idea of removing user fees from primary care facilities and dispensaries was initially quite clear. Most actors suggested that it was in the Jubilee Coalition’s manifesto, on which they were determined to deliver within their first 100 days in office. When pushed a little further, however, many participants were unsure how the idea came to be incorporated into the manifesto. Several participants suggested that it came from a close group of advisors. This was not seen as unique to the health sector, with one employee from ministry of health (B\_05) claiming, “*You know in politics when it comes to political parties, political parties always hire their experts on agriculture, experts on health*”

*but most probably it was somebody who had worked in health sector.*” This statement also alludes to the technical nature of user fee removal. Several participants suggested that given the fact that the user fee removal was a relatively niche health financing policy, actors whom were consulted by the Jubilee Coalition during the campaign period must have had some sort of technical knowledge unique to the health sector. Interviews and the stories told in subsequent interviews by several of these actors indeed confirmed these suspicions.

In the course of interviewing study participants, a handful of stories related to the rise of user fee removal, both during the campaign period and in the first 100 days following election, stood out above the rest. These stories come from actors in both the private (for-profit) and public sectors, and vary in length and detail. Common to all stories are a strong familiarity with the policy process, the actors involved, and their role as participants during this time period.

Storytelling is useful insofar as it helps to explain the complex ways in which the user fee removal policy was framed. In this way, I highlight stories that help understand two related questions 1) What was the origin of the user fee removal concept in Kenya, and 2) how did the user fee removal policy become incorporated into the Jubilee manifesto. In this way, I show how actors use stories to illustrate their interpretation of how user fees came to be removed.

#### *4.4.1. Origin of the User Fee Removal – Domestic*

For a politician who previously worked in a leadership capacity in the ministry of health, the decision to remove user fees was a natural extension of previous efforts initiated at least a decade earlier. This individual suggested that the policies (user fee removal and free maternal health care) were “good policies” that started within the ministry. They started with international support in the form of the OBA (Output-Based Aid), where according to him (G\_01), “*women were paying a little money and they would get a big cover.*” This program was perceived to be successful by the leadership in the ministry and they started to explore ways to expand the program. One approach they struck upon was to incrementally introduce free services and the primary target was the 10/20 user fees policy in primary care facilities. He continues:

And then we realized that there were people who couldn't afford. There was some small money that was being paid. One day we went with Ngilu somewhere and we saw a number of kids who couldn't be treated, very sick. For 20 shillings, people couldn't get access, so we abolished the 20 shillings in health center, people still call it 20/10, because I think it's for 10 shillings, we said this is abolished (G\_01).

This policy was linked to free maternal health care because at that time they noticed that despite other gains in the health sector, maternal mortality was still “unacceptably high.” He reflected that this was “a sore thumb” and that they realized that the only way to get maternal mortality to drop was to get women delivering in facilities. He (G\_01) went on further, “*Good thing, but you need structures, [...] and maternal mortality does not respond to health care only. Maternal mortality includes other things in the environment like even roads that take people to the hospital.*” He further suggested that the ability to address acute surgical needs is an additional strain and challenge to be accounted for. Though he promotes maternal mortality as a “systems issue,” he claims that the current policy is a good start and that’s why it has won his support.

When pushed further about how these issues made it into the Jubilee Coalition’s Manifesto, he replied with the candor of a seasoned bureaucrat and politician:

But the manifesto is meant to get votes and people know what will get votes. People know what is good for the people; I mean leaders know what is good for the people. And they say that they’ll get elected. Implementing them is a different matter (G\_01).

He then further suggested that he (G\_01) knows the story well, “*a lot of things are put in bins, and then when politics come, you pick them up and it’s very nice... (laughter).*” For him, politics is about recycling good ideas when the political climate turns favorable. As a natural segue he then closed his story by stating that after they abolished user fees, it became clear that what was truly needed was social health insurance, an issue to which I will return in Chapter six.

A number of features of this short narrative are noteworthy. First, though the record suggests otherwise, he claimed that at this time the 10/20 registration fees were removed. Quite possibly this was during a period of time where the ministry issued exemptions from the 10/20 fees and he interprets this as complete abolishment. Second, he stated that the

former minister of health and current cabinet secretary of Lands, Charity Ngilu, was instrumental in the decision to abolish and/or provide exemptions for the 10/20 user fees. This message was repeated by another study participant from the public sector (B\_11) who reported that health was, “*anchored in [the Jubilee Coalition’s] manifesto, something that they can pursue, and [...] Charity Ngilu, was part of Jubilee, was minister for health, and she is a strong advocate for health, so she must have influenced that.*” Third, the politician’s narrative suggests that the desire to remove user fees was motivated by a connection with the disenfranchised at the point of service delivery. In his description of the very sick children that precipitated the move to remove fees as well as his description of the high maternal mortality, he draws on emotion with a strong undercurrent of morality to justify his position and explain his rationale. Whereas many individuals see the user fee removal as a technical issue, this individual could connect the policy to what he perceived to be a problematic and urgent issue on the ground, in primary health facilities. In this way, “ideas” foreshadow institutional priorities or technicalities.

#### *4.4.2. Origins of the User Fee Removal – International*

It seems clear that at least part of the explanation for user fee removal comes from the international realm. As noted in the introduction to this chapter, evidence has been mounting that user fees are regressive (James et al. 2006; WHO 2010; Gilson 1997) and several countries, including some of Kenya’s neighbors, have experimented with their removal (Meessen et al. 2011). As a young politician understood the sequence of events:

We had this when I was a child in Kenya. This was introduced by the World Bank and IMF in the late 80s and early 90s [...] we went to structural adjustment program, that cost sharing, that’s how the fees came in for the first time (G\_04).

Another development partner pointed out, the decision to remove user fees whether in Uganda or Kenya, is largely a political one since technical experts have trouble reaching consensus about how to do it. At least one actor actually worked as a doctor in another country where user fees had been removed and his views of the policy in Kenya were colored by his experiences there:

I worked for a year in Uganda, where health care and public hospitals is absolutely free and in my own view, it is free because it has nothing to offer. Yes, there is absolutely nothing that it is offering. Patients admit

and discharge themselves from hospitals. Hospitals are just like lodgings where you can get a bed. The only thing that hits is when someone walks on their bed side to find out how they were and if they complain of something, there is no medicines in the hospital pharmacy, they have to go outside in the private chemists to buy them. So, you see, it is on paper, you might think that it is something really classy that Uganda has free medical access but if you walk in and see what this free entails, negative things. So, it is the kind of thing that we want to be careful as a country not to get into. We don't want to say that we are offering free health care yet, the quality of it. We want to make sure it's handled in all aspects, it is free, accessible, quality, you know, that kind of thing (A\_01).

This brief account of the negative effects of user fee removal in Uganda shows how discursive subtleties allow the narrative to anchor to its intended target. For example, he uses the simile of "hospitals are just like lodgings," to illustrate that patients receive no attention and are entitled to little more than a place to lay their heads (as discussed further in Chapter five). The central point is that user fees are an empty promise and that this idea has failed in Uganda and shouldn't be pursued in Kenya.

A representative of a private sector organization described the strong legacy of user fees domestically as well as its attendant obligations for government:

I mean it has been like that before 1988 where we introduced user fee, user fee is not old in this country, it came back, it was there actually at independence, during the colonial time it was five shillings. Now it came back in the 80s as user fee in public institution and then removing it is ok for people if you are focusing your resources as a government to promotive, preventive services public health initiatives, primary health care. That is where government is supposed to put its resources (D\_02).

Regardless of where the idea came from, the data suggest that the concept of user fee removal had been in circulation for quite some time in Kenya. Moreover, most of the actors were familiar with the concept and to a lesser extent the pendulum swings it has been subjected to domestically. It is safe to say that the global discourse on user fees and cost sharing shaped the policy landscape in Kenya, but that Kenya's unique and complicated history with the policy played at least as important of a role in shaping actors' views of it. How it ascended to the 2012 general election and the Jubilee Coalition's victorious campaign is another issue that I explore in greater detail below.

#### 4.4.3. *Establishing User Fees as part of the Jubilee Manifesto*

Many respondents seemed satisfied with tracing the origin of this policy back to the Jubilee Manifesto, but few were interested in how it was inserted into the manifesto in the first place. During the course of interviewing, I found that when I pursued my interlocutors, many became visibly uninterested and gave short clipped responses when pressing them on this issue. This perhaps betrays an ignorance about politics that made many of the participants uncomfortable. In order to get participants to think more creatively about this issue, I frequently resorted to asking whether or not President Uhuru Kenyatta woke up one day on the campaign trail and decided these charges in clinics should be removed. The view of one union representative (A\_04) was typical, *“I think their own campaign managers or their own political analysts told them that for you to really score high politically...”* When asked who these advisors were, most were ambivalent and many were reluctant to answer. On a few occasions, however, I detected they were holding back important information and asked the participants directly if they were consulted. A few respondents replied that they did not want to get involved, but that they were aware that some of their colleagues actively advised the campaign. More importantly, on three such occasions when asked directly, respondents replied that they were either consultants or advisors to the campaign. Their responses, embedded in stories from this period, are revealing and described in greater detail below.

In Kenya, there are very few health economists and the economics profession in general is held in high esteem. In the health financing discourse there seemed to be those who had a solid understanding of the technical issues, often health economists, and those who were uncomfortable with their fragile understanding. Moreover, the economists, as technical experts, were often seen as engaging in an enterprise that is extremely complex, enshrouded in language that often mystifies, and largely impartial. For these reasons, they are highly sought-after and many hold multiple overlapping jobs. Yet, an important finding of this study is that the most influential of the health economists use the political party as a vehicle to influence policy design.

An influential Kenyan economist was an early supporter of the Jubilee campaign. It was very clear from his initial, nuanced response to the vague question of how he views user fee removal, that he had a more intimate relationship with the concept than many. He began with a lengthy, balanced explanation of the pros and cons of user fee removal, demonstrating that he has a solid grasp of the administrative side of budgeting and accounting at the facility

and county levels. He was the only person who was able to clearly articulate how the user fee removal will fit into the newly devolved system of governance and how, on the balance, this will largely benefit the health system. Also, he was the only study participant to clearly link the policy to the Public Financial Management Act, which, according to him, forms the legislative framework for the policy. On the value basis for the decision-making, he stated that the expressed purpose of the Jubilee Manifesto and Vision 2030 was to reduce inequality by targeting the poor and vulnerable. The government then requested organizations to “crunch the numbers” to find out if this policy will work and how much facilities will need to be compensated. It is only after I pursued him on this account that he began creating narratives around the key events, which is particularly revealing:

**Respondent:** No jubilee is, who is jubilee?... when you talk about a party, you know the party consults technicians, so they must have consulted people you know...

**Interviewer:** Were you consulted? Are you one of those people?

**Respondent:** Yes, I was.

**Interviewer:** So and what was it like [...] was it seen as an opportunity by the administration or by these consultants?

**Respondent:** I think, remember since although user fees were introduced, there are some of us who felt that in terms of impact, user fees actually were negative, ok? In terms of impact because we have done household surveys, you know three household surveys, and what we are showing is that poor people are staying away. When they stay away, let's say for example you are charging 100 shillings, and a kid is anemic or has malaria, let's say malaria, which you can fix maybe with about 100 shillings, the mother doesn't have 100 shillings, so what happens is that they will delay for a day or two looking for 100 shillings, so by the time the kid gets to the hospital, that kid is sicker and requires expensive treatment, and if you add all those things, the people we are seeing who are sicker because we delayed treatment, because they couldn't raise the 100 shillings initially, the cost to the health sector actually was more than what you are getting ok? Everybody accepted that. You talk to DFID, you talk to the World Bank, people appreciated that we need to do something but then we need to have someone with a muscle to say so, so we got someone who was willing to buy an idea that already was cooking, you know which has been cooking for many, many months and then we said 'this is it'. Just abolish whatever they are collecting. Whatever they are collecting is actually less than what the health sector is spending on those people who are deferring the seeking of care. We have seen utilization going up which is good, because when utilization goes up that means we are able to catch children for immunization, we are able to catch those mothers for ANC, we are able to

provide PMTCT. You know those things are actually, they may look small but cumulatively, they add a lot to the health care impact (C\_08).

There are several things worth noting in the passage above. First, according to this respondent, the decision to remove user fees was initially based on Kenya's experience with them and three rounds of household surveys, which illustrated their regressive nature. He also mentioned that key international actors accepted these findings, suggesting that consensus amongst the development partners was at least one consideration.

Second, he introduced a new idea by way of describing what would happen to a sick child with an illness requiring urgent medical attention. This represents a form of synecdoche or, using a part to represent a whole (Stone 2012). This is interesting because many people have described that the user fees are a barrier to seeking health care, but this is the only instance where a participant mentioned that when people do seek care, it is often too late, due to the transaction cost of raising the sum from friends and neighbors. In essence, by stating that these individuals are actually costlier to the system in the long run, he is introducing a macroeconomic argument based on efficiency and cost-effectiveness. By using a small child with a blameless and prevalent condition, he is anchoring this economic frame to one of human rights and protection for the vulnerable. As a counterexample, one would have a hard time imagining that his argument would be as effective if he were to substitute the child for a 25-year-old injection drug user seeking anti-retrovirals for HIV. This potentially illustrates the subtle role emotions play in framing and the political process more generally (Gould 2009).

Third, in describing the increase in utilization as a result of removing user fees, he focuses on its benefits for a wide range of conditions. This is interesting for two reasons. First, it illustrates that his primary purpose of the policy is, in his mind, to promote the health of quintile one and two, the poorest in Kenya. Second, most of these conditions fall squarely in the domain of preventive and promotive health as opposed to curative services. This is a subtle shift in that he indicates a range of conditions that is cost-effectively addressed through prevention amongst the poorest, thus achieving the stated policy outcome of reducing inequality.

Fourth, he clearly articulates the primacy of ideas in the policy process, an issue we will return to in greater detail in the discussion section. According to this individual, policy change happens when somebody with a will to act (“muscle”) buys an “idea which has been cooking.” This is an astute metaphor insofar as he makes the convincing case that the work of technical people is to develop the idea (“to cook it”) and then find somebody willing to put it into action. In the case of user fee removal, it is very clear that he sees himself as one of the individuals doing the cooking and the leadership of the Jubilee Coalition as providing the muscle. It may be interesting to note here that the former minister of health (Charity Ngilu) is a close acquaintance of this influential economist, having worked together previously in the ministry, and she also holds a leadership position within the Jubilee Coalition. While the above provides insight into why this idea, user fee removal, was perceived to be legitimate and worthy of attention, I pursued further to explore how this came to be the top-ranking priority. The interview thus continues:

**Interviewer:** In the list of all the things you can do, why did you see that [user fee removal] was, you know, something that the government could do immediately when they came into office?

**Respondent:** Because it was the easiest, you know abolishing user fees is the easiest, and there is evidence to show that it is having a negative impact on utilization, especially for quintile one and two, and that’s your focus as a government, so that’s the easiest thing to sell.

**Interviewer:** So you say this is like an evidence-based policy then? Backed by rich...I mean, you and the ministry probably had a headache with these user fees over the years?

**Respondent:** This year we were part of the 10/20, we abolished the 10/20, we didn’t use, it was the same thing, we couldn’t abolish [them] at that time because Finance couldn’t give us the money to actually compensate [facilities]. That’s why we just reduce but at that time I think it was abolished (C\_08).

At this point in the interview, I ran the story by him to make sure that I had grasped the sequence of events properly. He and a small group of finance experts have struggled for several decades over how best to collect revenue at the point of care. The ascendancy of the Jubilee Coalition, for ideological reasons, presented him with an appropriate opportunity to scrap these fees once and for all. He actively promoted this policy in consultations with leadership, framing it, as we have established in the previous section, as something that can be easily executed within a short amount of time. The party ran with this as an item in the

health provisions of the campaign manifesto. Once the party was elected, he and a few other individuals from the public sector, were contracted by the government within the first 100 days to crunch the numbers and determine the appropriate level of compensation for facilities, and the administrative channels this would have to flow through given the newly devolved sector. Once the analysis was completed, the technical group was reconvened and presented its findings to the newly elected administration. He confirmed that this is the sequence of events. He added that this was related to the UHC agenda in that there are several ways to get to UHC, as this is an incremental policy, which is a step in the right direction.

Two other interviews support various elements and give us a fuller picture of the story these actors tell to explain their role in planting the policy on the party manifesto. The first is a former leader from the MoH who commented on the origin of these ideas. He stated that the Jubilee team had its own set of advisors, then:

But I distinctly remember that we were asked to do a paper, which we did and submitted to Treasury and Treasury assured us of funding and the funding came, right? And I was there when he [President Kenyatta] put that small paragraph into his speech. [interviewer asks for clarification] Yeah, we were in his office in state house [...] he was quite excited about it and the Minister of Finance was there. And from the ministry's point of view, the money was there, it was easy to release the money immediately (B\_12).

When I asked him whether or not he directly advised the government, he clarified, “*No, what they asked us for is, ‘is it feasible?’*” This shows that while the concept may have entered the manifesto through a champion of the particular idea via the party platform, when the newly elected government sought to put it into action, they consulted widely to ensure that it was feasible. Also, it is notable that Treasury played an important role in validating the enterprise; the participant mentioned that the minister of finance was even on-hand to draft the speech in which the decree was issued.

Another economist reported getting involved with the Jubilee Coalition in the early stages of the campaign. This individual was reluctant to mention their involvement, suggesting that the policies were shaped by the context of the policy landscape. Later in the interview, they mentioned the Deputy President for the second time, which was a little unusual in the context of the wider set of interviews. I told them as much and asked if they knew the Deputy President. The individual became visibly uncomfortable, but said, “yes I

do.” They were initially quick to downplay the significance of their interaction, but through the exchange they opened up and the exchange was not unlike the other, more senior economist. When asked how they came to know members of the Jubilee campaign, the person replied:

I probably knew a few of them and particularly the member of parliament where I come from, I knew the person and so of course, through him I mentioned the fact that I am back in the country and I wouldn't mind being part of, contributing in whatever way, offering my free services more or less, and the whole idea is that having spent the [XX] year out, I thought what I have learnt really could contribute a little bit towards moving Kenya to a middle-income country...more or less to achieving, well moving towards, universal health coverage. So, yes, and the starting point was that I need to share the lessons that I have learnt from [Xcountry], from [Xcountry], and of course from other health care systems that are doing very well with the decision-makers in the country and I thought also that would be a good opportunity because during the campaign period politicians are desperate to utilize whatever information they can find to support their argument, so that's how I got invited to some of the meetings (C\_04).

When asked whether they were surprised that the user fees had been abolished after all, the economist replied (with embarrassed laughter, having contradicted their earlier statement), “*I wasn't totally surprised, yeah [...] although I didn't expect it to happen so fast, and I also didn't expect for it to happen without supporting evidence.*” The respondent was however surprised at the process:

I was surprised how easy it was, yeah because when you read from [...] its almost like [...] meeting a politician is like rocket science, almost asking for a ticket to go to the moon, but yeah it was quite surprising but also the fact, also there is a culture that they embrace. They are educated, they think that you have more information, [...] you have got something to offer (C\_04).

From this story of how an economist was made available and was surprised to see their opinions taken so seriously during the campaign period, we can see how the interlocutor is reluctant to commit to their positions in the same way as the previous senior economist. At the end of the interview, they (C\_04) made clear, “*I didn't push my opinions and recommendations,*” and “*its good sometimes to just be independent.*” Throughout, the person used the technical language of financing, spoke at length about evidence, and made every effort to distance themselves from politics. And yet, the individual was given room during a

formative time for the campaign to help shape the policy agenda. It is of little surprise, therefore, that they had such a favorable view of the decision to remove user fees calling it, “*the best policy that they have really ever introduced.*”

There are a number of similarities between the multiple economic consultants that were involved with establishing this policy on the party manifesto. First, each was very reluctant to admit involvement in politics and only did so after significant prodding. Second, they relied on their technical knowledge and could draw from international experience in order to justify their positions. Third, each spoke at-length about the deliberative nature of policymaking and the primacy of ideas in the policy process. Fourth, these three economists all made frequent reference to the poor and vulnerable throughout their interviews and appeared to be motivated by egalitarian principles. Similarly, it is clear that this was widely perceived to have aligned with the party platform and perhaps drew these actors into the political domain. Finally, the removal of user fees was seen by all three as an incremental step on the path towards universal health coverage. While each acknowledged shortcomings and difficulties in implementing the policy, they mostly agree that the simplicity and progressivity of this policy made it a viable step in the right direction.

#### **4.4. Conclusions**

##### Sense-making

The sense-making process for this bill was anchored by actors’ understandings of the political economy of health financing, previous experience of the actors themselves, and Kenya’s complicated history with implementing user fees. Though many actors understood there to be deeper issues related to fairness of financial contribution and self-responsibility at play in understanding the decision to remove user fees, most actors interpreted the user fee removal policy through technical understandings of revenue collection. These understandings were nested in actors’ impressions of the health financing landscape including the outsized role played by international development partners and the relative paucity of financial expertise within the MOH. Similarly, actors’ understandings of user fee removal appeared to be largely shaped by profession or disciplinary training. For finance experts and health economists, the decision to remove user fees was seen as relatively inconsequential, as they represented a marginal improvement over the current practice of issuing a one-time registration fee. For non-technical actors, the user fee removal was often coupled with the

policy aimed at free maternal health care announced during the same presidential address. Similarly, these actors, healthcare providers and practitioners in particular, understood user fees in the context of service delivery with implications for revenue collection and resource allocation at facility-level. Finally, the legacy of user fees, as marked by successive changes in policy implementation was strongly tied to actors' understandings of its technical merits and political relevance.

### Naming

The naming process for user fee removal frames the decision in ways that select for a variety of intended outcomes and categorizes the policy as a technical consideration. In selecting a policy established in the international discourse, actors indirectly selected an issue to be tied to a seasoned discourse more familiar to international development partners than domestic health actors. This and the fact that the policy issue is supported and widely discussed in the academic literature, serves to legitimize the user fee naming. Selecting also works as a means of indirectly identifying intended beneficiaries, the venue for receiving services, a variety of implementation considerations, and its political salience. In addition to this, the naming process relies on a categorization of user fees as one of health financing and incremental in nature. Actors consistently used metaphors mostly in an attempt to describe what they often perceived to be a populist decision based on an easily-enacted measure aimed at fulfilling a campaign pledge and satisfying the social desires of a broad and politically active segment of the citizenry.

### Storytelling

The process of storytelling for the user fee removal policy was utilized to some degree by joining together multiple themes, including domestic sources of politically nuanced policy design, previously circulating ideas from the international sector (particularly WB/IMF), and personal accounts of technical advice given to political parties during and shortly after the 2012 campaign. In this way, storytelling served to position the idea of user fee removal as an old problem whose solution had finally become both politically palatable and expedient. The role of health economists in the co-production of policy problematization was likewise articulated and the initial reluctance of actors to reveal their participation suggests much about the emotional nature of storytelling. In addition to this, reluctant first-hand accounts

could also be interpreted to reveal a professional stigma associated with technical experts engaging directly with political parties. Finally, through a process of storytelling, a sequence of events, beginning with earlier policy struggles over user fee removal within MOH, an intermediate stage of consultation with a new political party, and culminating with the Presidential decree within the first 100 days in office, was convincingly articulated.

### Framing Similarities

Analysis of the distinct stages of the framing process for the policy to remove user fees produces a number of important similarities across stages. Actors understand the policy terrain through the lens of their disciplinary training or epistemic community, which corresponds to a particular naming that emphasizes the technical and incremental nature of user fee removal. Furthermore, by understanding that the issue belongs to that of a greater global discourse, with academic gravitas, detractors are likely to find it difficult to attack the policy on the basis of legitimacy. Furthermore, sense-making in the context of 50 years spent tinkering with user fees lent the frame a powerful air of familiarity and actors told stories that suggested their rich personal experience was a reassuring feature of the technical advice used to inform the Jubilee Manifesto. Another common theme across the three framing processes was the intersection of technical considerations with political calculations. In this way, it became relatively clear that the framing of the decision to remove user fees was not an isolated decision generated through elite discourse or autocratic decree, but rather occurred through a process of prolonged internal deliberation, careful planning and consensus-building. In these ways, shared ideas and common themes are present across the dimensions of the framing process.

### Framing Differences

Important differences were also found across stages of the framing process for user fee removal. These differences were present to a mild degree in substance and to a greater degree in emphasis. For example, the sense-making enterprise was shaped to a large extent by actors' disciplinary and professional worldviews. This essentially limited the extent to which a large and vocal segment of the workforce was involved in deliberative discourse that served to name the user fee removal policy. This is perhaps one explanation for why so many actors coupled the user fee removal policy to the free maternal health care announced in tandem. Practitioners were knowledgeable about the substance of free maternal health care

and its implications were perceived to be more acutely felt at the level of service delivery. Similarly, by categorizing the policy as one of health finance and even selecting for a minor revenue collection issue within the financing domain, the naming of the removal served to distance the issue from divisive debates about social justice, which conversely surfaced in the sense-making enterprise. The incremental nature of the policy, as featured prominently in the naming process, served to downplay its intended effect, a point that appeared in slightly altered interpretations in stories of the historical legacy of user fees in Kenya. This was a particular strength of storytelling in that, by situating a narrative in a broader social interaction and sequencing statements accordingly, it was able to portray the user fee removal in a more subversive fashion, a fact the naming process sought to avoid. Though it should be noted that the emotions attached to the stories by technical experts were more reflective of their views on participating in politics or revealing political party affiliation than the concept of user fee removal. Nevertheless, important differences existed and were emphasized for different segments of the interconnected framing process.

# Chapter 5: Framing the NHIF Rate Increase

---

## Introduction

This chapter addresses the framing of the recent policy to increase contributions to the largest health insurer, the National Hospital Insurance Fund (NHIF). NHIF is an insurance fund that is required by all employees working in the formal economy to cover inpatient medical care. This chapter focuses on the policy to increase NHIF rates for several reasons. First, recent estimates suggest that contributions to NHIF account for approximately 30% of Total Health Expenditure in Kenya; however, this sizable revenue stream is considered inadequate to finance comprehensive services for a significant segment of the population (Chuma & Okungu 2011). Moreover, despite the rising cost of medical care and increased wages, mandatory contributions to NHIF have not been revisited since 1989 (Abuya et al. 2015; Chuma & Okungu 2011). Second, this issue has been subject to a great deal of media speculation (Juma 2011; Otieno 2012), the basis for nation-wide strike threats (Munguti 2010), and repeated judicial challenges (Jilo 2010). Third, given the attention that NHIF has received from a variety of stakeholders in the health sector, it is unclear how governance of NHIF is affecting the resolution of other protracted financing controversies in the health arena (Lakin & Magero 2012). Fourth, because this institution represents one of the oldest forms of mandatory health insurance on the continent, it is curious as to why so little change has historically happened in terms of revenue collection (see Table 5.1 for historical overview). Furthermore, a sizable degree of contestation has been taking place in the health sector in Kenya over the last 10 years and an analysis of policy stasis (the inability to raise the level of contributions) could possibly illuminate the role of NHIF at the center of the debate. Whereas the previous chapter provided an account of policy change, this chapter describes an example of policy stasis.

**Table 5.1: Historical Overview of the NHIF in Kenya**

<b>Year</b>	<b>Event</b>
<b>1966</b>	NHIF created through act of parliament to serve as a department within the Ministry of Health
<b>1972</b>	Act amended to allow voluntary contributions to NHIF
<b>1990</b>	Act repealed to allow contributions to NHIF on a progressive basis (instead of flat rate)
<b>1998</b>	NHIF Removed from MOH and transformed into a state corporation
<b>2004</b>	Proposal to transform NHIF into a national social health insurance scheme passed through parliament, but rejected by President
<b>2005</b>	NHIF begins to allow voluntary contributions (from the 1972 amendment)
<b>2010</b>	NHIF expands benefits package to include outpatient care for teachers and the military
<b>2010</b>	Attempts to revise the NHIF contribution rate opposed by union litigation and strike threats
<b>2012</b>	NHIF expands to include outpatient cover for civil servants
<b>2012</b>	Scandal and corruption leads to highly publicized dispute involving the dismissal of NHIF board of directors and trial of some
<b>2013</b>	Court rules in favor of the increase to the NHIF contribution rates, but rates do not increase due to union strike threats

In the course of data collection, two notable difficulties arose when discussing the rate increase. With the exception of a few financing experts and health economists, most research participants (and wider public) refer to the contributions as a “rate.” This is misleading as rates include a measure of time and often are designed to adjust according to a variety of economic indicators. Instead, the NHIF relies on the 1989 tiered contribution structure, which does not account for macroeconomic or medical inflation (Deloitte 2011). This is an important caveat that should be considered when reading quotes from study participants and is a feature of the debate to which I will return later in this chapter’s section on “naming.” Nevertheless, I will use the term “rate” to describe the increase in contributions because that is the language that interview participants, the media, and documents use. One could argue that the alternatives, “contributions” or “premiums” are also particular names, which reflect a framing of revenue collection for NHIF that has yet to be adopted in Kenya.

Another difficulty that arose is that early on in the process of data collection, it became clear that the vast majority of interview participants could not dissociate the policy to

increase NHIF rates from the NHIF itself. It is easily the most controversial and contested entity in the Kenyan health sector and one that elicits impassioned responses. For this reason, many study participants were quite dismissive of the rate increase policy and instead focused on the perceived shortcomings of NHIF and their historical basis. One outcome of this was that a significant degree of consensus was expressed for why policy stasis has traditionally occurred around this issue. Another feature of this development emphasized the strength of a flexible and interpretive research design. Namely, the original scope of this research objective broadened significantly and I was able to collect data on a number of sub-themes related to NHIF governance that provide insight into policy dynamics and contestation in the health sector. While this expanded dataset proved cumbersome to analyze, the following sections in this chapter will show how governance of NHIF is intricately tied to the broader financing and policy domain in the Kenyan health sector. This will be accomplished by analyzing each dimension of the framing process, including the collective ability of actors to make sense of NHIF, the language they use to characterize the organization, and the contested stories they use to frame the rate increase.

### **5.1. Making Sense of Kenya's National Health Insurance Fund**

The National Health Insurance Fund has evolved since its inception in 1966 (see Table 5.1). Originally legislated as a department within the Ministry of Health, it shifted to a state corporation, also known as a “parastatal,” in 1998. The concept of the parastatal in Kenya pre-dates independence, when the agriculture and manufacturing sectors of the East African colony established market boards with regulatory functions (Tangri 1999). In the 1990s, it was actively promoted by the international sector as a way to bolster the private sector and stimulate domestic production (Aseto & Okelo 1997). The number of parastatals operating across all sectors in Kenya was recently reduced from 262 to 187 (Omondi 2013). The structure of these and their relationship to the government varies slightly across organizations. Generally, however, parastatals are private for-profit corporations with mandates executed by a government-appointed Board of Directors (Kenya 1986). They are governed by the State Corporations Act of 1986. As a private hospital executive explained:

But a parastatal to me basically is a semi-autonomous government company. I think semi-autonomous in the sense that they have a structure of management [...] but they're still answerable to government in the long run (D\_01).

Recently, President Uhuru Kenyatta appointed a task force to revisit the 1986 Act with the intention of implementing substantive reforms (Omondi 2013). Some see this as a way to strengthen underperforming entities while others have argued that this amounts to further privatization of state-owned enterprise (Ndii 2015).

Multiple respondents understood that the perceived shortcomings of NHIF are actually symptomatic of governance structures associated with parastatals. According to one former NHIF employee (B\_03), the parastatal actually amounts to government bureaucracy, *“It’s a very weird set up, because it’s just a government animal that has the skin of a private sector, but everything inside is government.”* The problem with parastatals is much the same as the historical problems with inefficiency and corruption in Kenyan government; a number of participants suggested that incompetence and political patronage are rampant in parastatals. As a representative for a professional association (A\_07) stated, *“NHIF is a parastatal [...] where I have got my position because I know somebody and I know as long as I report on duty I really don’t have to work and I get my salary at the end of the month.”* A private entrepreneur (D\_06) understood it slightly differently, *“people know you can sit there and do nothing, as long as the person you report to is happy. You only have to keep one person happy, you don’t have to keep the rest of Kenya happy.”* Thus, many perceived that the bureaucratic nature of a government institution creates an environment where political considerations oftentimes trump performance evaluations. As one former MoH official stated:

A politician will always extend his powers to the institutions, parastatals, that are under him or her. Meaning that whatever decisions are made in those institutions, are favorable to that politician and in a bigger scale, the party (C\_05).

While the very concept of the parastatal shapes actors’ understanding of the NHIF and its failure to increase rates, nearly all interview respondents readily identified shortcomings specific to NHIF.

A number of structural features of NHIF, including the composition of its Managing Board of Directors, its administrative capabilities, and its core mandates, shape how actors make sense of policies to strengthen its performance. Interview participants frequently cited an external evaluation of NHIF, conducted by Deloitte in 2012, that revealed the extent of

dysfunction within NHIF and offered recommendations for reforms (which will be discussed in greater detail below). Among other things, the report recommended that the CEO should be competitively selected as opposed to politically appointed, that the board should be composed of persons cognizant of health financing and risk pooling, and that the high cost of administration should be reduced (up to 45% of total expenditures were spent on administration). This report was frequently cited as a reference point for multiple interview participants. The estimates cited from the report, however, were occasionally exaggerated by interview participants, but as a whole, they mostly agreed with its broader conclusions.

### 5.1.1 NHIF's Governance Structure

Consensus exists across virtually all interview participants, including NHIF employees, that the governance structure within NHIF is deeply flawed. The NHIF Board of Directors is called the NHIF Management Board, who are responsible for overseeing a small group of civil servants within NHIF, known as Management Directors, as well as the Chief Executive Officer (CEO) of NHIF. The Chair of the Management Board is appointed by the President of Kenya and the CEO of NHIF is appointed by the Cabinet Secretary for Health. Several interview participants who were either active or former NHIF employees, Management Board members, and stakeholders noted that the problems run through the spine of the organization. As one NHIF Management Board member (D\_08) stated, *“It sounds radical, but it needs a whole clean-up, from top to bottom to middle management.”*

Insiders spoke in detail of the problems with Management at NHIF. The four managing directors who report to the CEO are recruited from within the ranks of civil service and are not required to have a background in health insurance. As one former NHIF Management Director (B\_03) explained, *“if you know the culture of Kenyan civil servants, it's that many times the people at the top are not always the most qualified people.”* For example, a physician who was Director of Quality Assurance within NHIF was reportedly shown the door for political reasons and replaced with a non-medical civil servant. The same former NHIF employee (B\_03) grew animated in describing this development: *“I mean; this is quality assurance. He's dealing with providers. He's doing accreditation. He's doing quality assessments of providers, but he has never been trained in medicine even one day.”* This situation is not restricted to middle-management and several interview respondents voiced concerns over the current CEO who has little background in health, having previously

been the Registrar of the department responsible for motor vehicles licensing and registering. Some speculated, for example, that this individual perhaps was appointed because of ethnic ties to high-ranking government officials. Others argue that the current CEO represents the shortcomings of a civil servant management structure that rewards “survival” as opposed to competency. As a former Director within MoH (B\_12) noted, however, NHIF leadership is oftentimes appointed by government officials who are also poorly equipped to handle the complexities of the health arena: *“The Permanent Secretary (PS) [of Medical Services] is a veterinary surgeon right, so he probably has no idea about health or health systems. The CS is a banker so he probably has no idea where to invest money in health.”* Regardless, whether at the top or in middle management, actors understand that NHIF oftentimes seems to resist change from within. A current NHIF Management Board Member (D\_08) further stated their frustration with this arrangement, *“it's the old guys who've been sitting in there and we're trying to clean up the place. You get what I mean? [...] the board is totally detached from management. We don't get involved in operational activities.”*

In addition to the management challenges within NHIF, actors interpret that much of the blame for institutional inertia resides with the structure of the Board of Management. Currently, there are 14 seats on the Managing Board, including the Chairman. While the Chairman is appointed by the President, the other positions are legislated under the NHIF act of 1998 to represent a diverse array of stakeholders within the health sector. The following non-governmental organizations have a seat on the board: Kenya Medical Association (KMA), Central Organization of Trade Unions (COTU), Christian Health Association of Kenya (CHAK), Kenya National Union of Teachers (KNUT), National Council of NGOs, Kenya National Farmers union (KNFN), Federation of Kenya Employers (FKE), and the Association of Kenya Insurers (AKI). In addition to these, there are permanent seats from government officials representing the office of the Director of Medical Services (MOH), PS from Ministry of Devolution and Planning, PS from MOH, National Treasury representative, and the Inspector General of Corporations. This is widely seen as problematic for a decision-making body for, as a high-ranking health official noted:

The interests are too many [...] you want to have a lean board according to Corporate Governance Principles [...] Safaricom has five million subscribers (I think now there are more subscribers) and there are five board members (B\_07).

On the other hand, a current NHIF employee (B\_08) argued, *“Leave alone even the number of, for me as an economist I would look at it as, I mean if you are adding value, even if you are 100, that’s ok.”*

Despite the number of actors represented on the Management Board, the composition of this board is widely understood to be inefficient due to the incompetency of Board officials, overlapping conflicts of interest, and the superficial nature of discussions that take place within Board meetings. When asked how this situation came about, a journalist (E\_01) explained that when legislating the NHIF Act, *“We discovered as a country so-called stake holder boards [...] I don’t know whether it came from the world bank, but it became a very sexy idea, that instead of having a politician appoint his relative, lets tie our hands.”*

Unfortunately, according to many active or former Board members, this leads to a situation where interest groups who have a large collective voice (i.e. teachers and farmers unions) are responsible for making broad strategic decisions about health insurance, a domain that is largely unfamiliar to them. This is where some have speculated that blatant corruption takes place. A former employee even suggested in an interview that the easiest way to understand why an organization on the board would completely flip to the opposite side of an entrenched policy position would be to not look at rhetoric and the influence of public opinion, but to look at the leader’s personal bank account. Indeed, there is some evidence to support this claim in the form of a leaked recording of a phone conversation between a private sector representative and the NHIF Chairman in which the former implies that they have “funded” the key dissenting voice (COTU) within the Managing Board (see later section of this chapter on Storytelling). Regardless, the lack of expertise in financing or even health care by several of the board members creates a vacuum in which bribery, not persuasion, is perceived (rightly or wrongly) to be the *modus operandi*.

Actors involved in policymaking in the health sector largely understand that the composition of the Managing Board is programmed for stalemate. On the one side, there are five seats occupied by public officials responsible for governing and ensuring that NHIF is an effective steward of the country’s resources. On the other side, there are representatives of key constituents that stand to overtly and covertly gain from a dysfunctional NHIF. This is true for the Federation of Kenyan Employers (FKE), who is suspicious that eventually employers, and not just their employees, will be forced to contribute to NHIF. Hence, they frequently insist that government must contribute something, which could be interpreted as

obscuring their role as a contributor. Similarly, some linked this notion to industrial productivity, as one private sector representative stated:

So if it's too expensive to do business in Kenya or if it's too expensive to employ my staff, then I'll make everybody a casual. If you introduce a new payroll tax of 4% employer and employee and all this funny acrobatic things that they're planning to do [...I'll] practice my business elsewhere (D\_07).

There are at least two other Board seats that actors understand to be problematic: Association of Kenyan Insurers (AKI), the body representing the private insurance industry, and Kenyan National Union of Teachers (KNUT). This was even acknowledged by the representative of the private sector in health (D\_07), “*And how do you have AKI sitting on the board of NHIF. It's like saying we have Barclays sitting on the board of Stanchart. So there's some non-congruent representation.*” On the other hand, as multiple Board members stated, the sad reality is that the AKI representative is one of the only individuals who actually adds value to the board because he is well-acquainted with the mechanics of health insurance. Only the representatives of the development partners seemed to understand that there is a significant conflict of interest when the Board member equipped with the most technical knowledge about health insurance happens to represent the entity that stands to be the most negatively affected by a larger, more efficient NHIF. In the case of KNUT, many seemed to accept that because teachers are the largest segment of the formal economy, they deserve a seat on the Managing Board. One of the few actors who found this problematic was the private sector executive, who stated:

[...] so you have a group a people that are stakeholders because they are generally a large customer. So I wonder if you were the largest customer of Safaricom and you are company X with so many subscribers, would you have to have a seat on the board? (D\_07)

Actors seem to understand that the composition of the board and its political nature translates to relatively poor productivity. NHIF employees who attend meetings and current Board Members admit that the substance of the meetings are quite limited because most Board Members are not equipped with the proper training to understand risk pooling. A former Board Member (B\_03) claimed, “*It is actually - it is a sad state. For instance, and this is something that I used to question even the CEO about.*” A current Board Member further

elaborated on the challenges faced at Board meetings. After listing off the various committees formed by the board, he stated:

Now the problem with these committees is that the way NHIF is now, we rely so much on the management to process information and bring it to us and then we are supposed to interrogate, and a lot of times we end up agreeing with it, without quite getting into the details (A\_07).

A different board member (D\_08) commented on the “yes” culture of board meetings in which dissent is not traditionally aired because the technical information they receive from managing directors is unintelligible. Instead, controversies are aired in public, once the implications of a position are fully understood outside of the confines of the boardroom.

There are at least three things to note from this unusual array of stakeholders in a decision-making capacity as members of the Managing Board of NHIF. First, there is strong union representation, which reflects a dynamic labor market in which industrial action frequently occupies national headlines. COTU, FKE, and KNUT have the capacity to virtually shut down the country overnight, a power they proudly wield. Second, the principles of corporate governance, as alluded to by a public official, don’t seem to apply to the parastatal governance structure, something that the government appears to be aware of in its efforts to enact sweeping legislative reforms aimed at state-owned enterprise (Omondi 2013; Ndi 2015). Third, most actors understand that the board is too politicized and that one of the key stumbling blocks to effective governance within NHIF rests with restructuring the board to ensure that competency and not representation is the criteria by which board members are selected. Towards the end of data collection, in fact, a Miscellaneous Bill was gazetted that removed the mandated representation under the NHIF Act from all but the most powerful board members (COTU and FKE). This reflects the level of activity and the powerful role of the legislative branch in working to reform NHIF under the auspices of the Parliamentary Committee on Health.

### *5.1.2. NHIF Administration*

In addition to the challenges with the governance structure of NHIF, several actors understand that its performance is often tied to a number of administrative limitations. Some of these limitations are features of the health workforce, which is compounded by perceived shortcomings of the public sector. Other limitations stem from misguided strategic

investment, which has allowed non-health expenditures to escalate. Still other challenges are perceived to exist as to the mandates of the NHIF and its fundamental role in risk pooling. Much like the perceived shortcomings with the decision-making apparatus, these understandings are frequently wielded in ways to discredit and limit the size of the NHIF on grounds of efficiency.

Some actors understand that the administration of NHIF is limited by its workforce.

According to one Board member:

Traditionally NHIF has been like a dumping ground, that's where the problem comes because it's been that [a] lot of people who are employed there are employed because of who they know, and where they come from, not necessarily because of the kind of qualification...and so promotions have also been flowed on that basis, so until, and unless, we change that perspective, so that we are now recruiting people on a competitive basis, based on merit and set target for them to achieve [...] NHIF is actually a business, consider that we are talking of billions of shillings, you collect from the populous every month, so these billions of shillings have to be managed to achieve the objective and you require the right staff to do this (A\_07).

Other actors understand that while NHIF may have certain limitations, there are a few positive attributes of the staff. These optimistic impressions came from the development partners that work closely with NHIF. According to one (C\_09), *“people are sure one thing about NHIF is that the workers are very loyal, I have never heard a staff of NHIF talk negatively about NHIF so that tells you something.”* Also, multiple actors suggested that the providers actually like using NHIF in large part because they reimburse claims quicker than private insurers. Similarly, from an administrative standpoint, NHIF is well-positioned to function within a devolved governance structure, with branches in all 47 counties. While questions were raised about the motivation and the technical expertise of the staff, some actors understood that given its size and history, NHIF has a fairly routinized administrative apparatus.

Actors frequently alluded to misguided investments at NHIF in their understanding of the organization's efficiency. This includes the controversial construction of a new NHIF building, which reportedly cost 1.8 billion KSH (17.3 million USD). This facility includes retail space, as a revenue-generating scheme on the first several levels, resembling a shopping

mall. More frequently actors mentioned the widely publicized parking garage attached to this facility that reportedly cost 4 billion KSH (38.4 million USD). This expenditure represented an increase of 337% over what many saw to be an already inflated original cost estimate (Anon 2014). Finally, there was a push to build a state of the art health care facility using NHIF funds in Karen, an affluent suburb of Nairobi. Widely publicized purchasing arrangements have since halted the push for this “Center of Excellence.” While NHIF officials have argued that these real estate and infrastructure investments generate revenue for its members, many are skeptical about the financial viability of these investments and the intentions behind them.

### 5.1.3. NHIF Mandates

With a few notable exceptions, actors largely understand that NHIF is overextended and engaged in activities that limit its stewardship ability. In health financing, experts frequently distinguish between the purchaser and the provider of health services. Multiple actors stated that the goal of NHIF should be to become a lean purchaser of health services. Currently it is not. Because NHIF is involved in accreditation, revenue collection, and reimbursement, it has created a complicated administrative structure, with endemic inefficiencies and the potential for exploitation. In order to run such a complicated system, several actors suggested that an organization would need strong leadership from the top down to middle management. The prevailing opinion is that this does not exist at NHIF and so the problem is compounded. In this way, actors frequently suggested that to raise the rates NHIF would need to re-focus on its fundamentals, by removing the revenue collection and accreditation functions and focus instead on purchasing.

Understandings of the benefits of removing the revenue collection function from NHIF are divided. Nearly all actors understood that the Kenya Revenue Authority (KRA) was the primary alternative for revenue collection. Those in favor of this arrangement were largely technical experts from within the MOH or international organizations. As one former MOH official and now international actor (C\_05) commented, “*That is what some of us believe in because it’s even efficient, you heard with our pension scheme, when we brought in KRA to do that, actually the monthly contribution went up.*” A former MOH Director (B\_12) similarly stated, “*so it removes this burden [...] KRA will do it much cheaper. Right?*” A representative of the one of the development partners (C\_11) further elaborated, “[...]it could

*be quite efficient if KRA would do the contribution collection and I have talked to one lady of KRA and [...] technical experts have proposed this even a few years ago, [but] there is strong hesitation from NHIF to give that away...*” The implication behind this push to remove revenue collection is frequently that the availability of a large pool of resources creates the opportunity for some of it to leak away through murky financial dealings within NHIF.

But other actors are quick to point out misperceptions about removing revenue collection from NHIF. As one current NHIF Management Director (B\_04) pointed out, *“We don’t collect revenue, revenue goes to the bank, but yeah people pay to the bank.”* Another NHIF employee went a step further by explaining that KRA previously collected revenue for NHIF and commentators frequently forget this fact in discussions:

we were in a meeting the other day with the Treasury where they want the KRA to collect the revenues but [...] in the past [...] KRA used to collect revenue [...] and NHIF could not even get 40% of that revenue [...] it would somehow disappear [...] you see it all boils down to accountability (B\_08).

The one actor interviewed for this study that has worked extensively with KRA further cautioned against this proposed arrangement:

No, no, no, never, never give it to KRA, once it gets to KRA, it gets into black hole in Treasury and KRA, by law must take all the money to Treasury before it disburses it. So, once it goes into Treasury, how are you going to remove NHIF money out? Treasury guy will not bother with that, the first thing they will do...the contribution for NHIF will increase tremendously, [...] that money will go into black hole in the consolidated fund, which needs different laws to remove them...if the minister says [...] he has got a problem with building a road, he will build the road [using those funds] (D\_05).

Unlike revenue collection, there is consensus that NHIF should not accredit health care providers. As a former MOH director (B\_12) stated, *“accreditation, it is a conflict of interest, right? They don’t have the capacity to accredit.”* As one current Board Member (D\_08) stated, *“I think there should be a separation. I personally think so. Because as long as these facilities can influence the managers to accredit them and issue some ridiculous claims and get them accepted then this whole cycle will never end.”* This Board Member further stated that providers are *“part of the corruption.”* They explained, *“some of those claims when you*

*look at them, they do not...they look so unrealistic, you wonder how possibly, such a small hospital can be seeing all those thousands of people.”* Furthermore, an individual who frequently provides external consultations for NHIF (D\_05) claimed, *“I fundamentally believe, they disagree with me, but I actually believe that there are service providers who influence what goes on in the NHIF.”* A representative of the medical profession (A\_02) put it more bluntly, *“there were reports of bribery so that if you come and you are an owner of a hospital, first of all to be included into the list of providers, you must bribe or you should be known your tribalism and nepotism.”* Even NHIF employees conceded that accreditation within the organization is sub-optimal, as one (B\_08) reported *“So far [what] NHIF has been doing in fact is not accreditation, is just empaneling because I can’t do the so called accreditation of a facility that has not been accredited by the government.”* According to this individual the fault lies with a regulatory gap in government: *“there has not been a single body that does that, so who will take responsibilities for the risk?”* International actors who work with NHIF are sympathetic to this understanding. According to one (C\_11), *“NHIF [...] are saying they don’t even want to do this, but they have started out of a need that there was nobody else [...] they are still continuing to do it because there is still nobody else to do it.”* One actor suggested that the Kenyan Medical Research Institute (KEMRI) would be a viable candidate, but when asked, the Director of KEMRI stressed that he runs a research organization and would be reluctant to work too far outside of its legislated remit. Multiple international actors further suggested that a government body called the Kenyan National Accreditation Services, which currently accredits lab facilities, could be contracted to provide this service to NHIF. In fact, as one highly influential actor (C\_08) put it, focusing on small regulatory changes like transferring accreditation from NHIF to a new entity, *“without touching the premiums,”* would signal to the health financing community that *“you are serious.”* *“But,”* as he explained, *“If you start with the premiums, as Nyong’o (former CS) was doing, you will lose.”*

As this section has shown, the policy to increase rates for NHIF is embedded in a larger narrative of disorganization and dysfunction within NHIF. Understandings about structural and governance limitations, including faulty strategic direction and representation on the Management Board, NHIF’s complicated and inefficient administration, as well as its inability to fulfill its core mandates, serve to obscure policy directives aimed at reform. As we shall see in the coming sections, these understandings reveal deeply entrenched values

that underpin attitudes about contentious features of Kenyan society. This includes the role of private enterprise, the relationship between the government and its citizens, and the skeptical attitudes Kenyans share about public sector stewardship. In this way, actors make sense of policy proposals aimed at strengthening NHIF through the lens of past experience, which is largely negative. By keeping the negative traits of NHIF in the foreground, actors frequently reinforce many of these understandings in ways that produce policy stasis.

## **5.2. The Language of corruption and NHIF**

Consensus exists that the NHIF should not be expanded or rates should not increase until it demonstrates that it is a responsible steward of the country's resources. Naming, selecting, and to a lesser extent, categorizing, are all important tactics used to generate this consensus. This typically plays out in important ways. First, salient features of NHIF and the rate increase are cast in a certain light. Second, NHIF is characterized as a corrupt enterprise through the use of symbolic and negative portrayals of the organization. Third, the institution is frequently discredited by references to public scandals, regardless of their veracity.

### *5.2.1 Naming salient features of NHIF and the rate increase*

As a form of naming, all actors selected the NHIF as the platform for discussions about increasing member contributions, or "rates". What is notable about this feature of the debate is the fact that NHIF is actually not the entity directly responsible for increasing their rates as this requires an act of Parliament with approval of the President. Furthermore, in the health sector, many actors reported that the executive branch uses MOH to carry out its policy priorities. Participants acquainted with the policy process suggested that the pace and timing of policy directives are determined at the Cabinet level. By virtue of the Board Chairman being appointed by the President and the CEO of NHIF reporting to the health Cabinet Secretary (CS), there are direct ties between the executive and NHIF itself. From 2008-2013, Anyang' Nyong'o, the former CS of Health, invested a great deal of attention and political capital into the NHIF rate increase. As will be discussed below, this generated significant opposition, with actors aligning at one point to call for his resignation. Perhaps for this reason, some interview participants observed that the current CS of health and high-ranking officials are keeping an arm's length relationship from the NHIF and are hesitant to be associated with its legacy. As one international actor quipped, NHIF is a "hot potato." For

this reason, perhaps, the recent focus of the discussion has been not that the President or CS is increasing the rates, but rather that NHIF is increasing the rates. This is ideal for those who oppose the new rates because NHIF is an easy target; however, the reality is that the policy decision does not rest with NHIF. To the contrary, NHIF has complained, even to the media, for decades about the inadequate premium structure, yet every time MOH or the executive branch tries to do something about it, they encounter significant opposition from powerful stakeholders. Oftentimes, this opposition is conveniently accompanied by a scandal involving NHIF.

Given the complicated nature of risk pooling, a significant amount of vague or inaccurate information can be potentially wielded by those engaged in policy struggles. This is because NHIF has a bad reputation, is perceived not to be transparent, and staffed by few people equipped with the technical knowledge to identify faulty claims. One such example was from an interview participant representing the private sector who claimed that, based on what they have been able to “extract” from NHIF, 80% of user contributions are directed towards administrative overhead. This is nearly double the figure that the widely cited Deloitte report found using a standardized methodology. Because the forum is risk pooling and the organization is NHIF, false statements such as these are often perpetuated.

The debate over the rate increase is interesting in the language actors use to characterize the policy proposal. As mentioned previously, I refer to this policy as the NHIF rate increase simply because that is what it is called in Kenya. The alternative choices of “contributions” or “premiums” are rarely framed as such by the actors involved. Instead most people refer to the policy as the NHIF “rate increase,” and some even call it “fee increase.” As with user fees (previous chapter four), the use of this “fee” carries with it a negative connotation that is largely associated with consumer finance. Similarly, the use of the word “rate” is misleading because, at least in my interpretation, this allows actors to express that a self-correcting figure is being revised to exert a toll on the consumer. There is no rate; there is just a tiered level of static monthly contributions based on income. Perhaps, the fact that the term “rate” is used instead of “contribution” or “premium” contributes to detractors’ framing of the policy as an unnecessary burden on the average consumer.

On a conceptual level, the debate around the policy to increase contributions to NHIF is noteworthy because it selects for a revenue collection issue. This is important since any

effort to bring more resources into NHIF essentially increases the size (a potential threat to private insurers) of the organization. The rationale behind the increase in contributions is that NHIF will be better positioned to offer an expanded benefits package to its clients. It has not said exactly what those benefits are; however, most speculate that it will be largely outpatient coverage. Instead of focusing on increasing the size of the risk pool, strengthening regulatory oversight, or streamlining its purchasing arrangements, the NHIF will simply collect more money. Some actors admit that this is a curious arrangement since the organization could so greatly benefit from a regulatory overhaul, for example. The threat of private insurers, competition for the informal sector, and the complications of cross-subsidies to cover the indigent have probably forced this debate out of the domain of risk pooling. Still, many wonder, ‘why the urgency to focus on revenue collection?’ given NHIF’s perceived accountability problems in the past. For example, a private sector Board Member (D\_08) showed just how easily it was to dismiss this policy based on the particular health financing domain it selects for: *“30 years is a long time not to increase the rates. If we really want proper health care in this country...those rates have to go up. [But,] we don't want to increase rates to just line people's pockets.”*

Finally, the name of the organization itself is telling and frequently forgotten in the wake of its infamous acronym: The National *Hospital* Insurance Fund. The fund was largely established to provide health insurance coverage for inpatient hospital care. As it increasingly branches into outpatient care for different segments of the population, it is actually growing beyond the selected name. This is very rarely pointed out by NHIF’s opponents perhaps because it has assumed an entirely different identity. Still, in voicing support for reform efforts, multiple actors speculated that the whole name, management structure, and branding of the organization would have to change if it was going to be perceived to be a legitimate steward of the country’s resources. Others argue that these features of NHIF, particularly the name, would require a legislative change to the NHIF Act, which is often dismissed as insurmountable, an issue explored in greater detail in the storytelling section (5.3.4) later in this chapter.

Much like the user fee removal policy, the policy to increase rates is framed in a particular way by policy actors. This largely entails the use of metaphor and symbolic depictions of NHIF as a means of discrediting and delegitimizing the organization. This is not a characterization of the contribution increase, as most actors dismissed this policy

largely by focusing attention on the perceived shortcomings of NHIF. For this reason, I analyze below the names actors attribute to the NHIF and the ways in which this helps to contest the policy to increase its revenue stream.

### *5.2.2 Corruption Metaphors: The Cash Cow, Monster, and Black Box*

Of the names used to characterize NHIF, the most frequently used was “cash cow.” In this portrayal NHIF was characterized as a lucrative means of extracting resources for personal gain. By dissecting this metaphor in greater detail, one can see the subtle assumptions through which it operates and metaphor’s ability to bridge multiple domains in the creation of meaning. This metaphor, one in which a prized domestic animal, a cow, provides nourishment in the form of currency, illustrates the manner in which actors perceive NHIF historically to function. Because of the volume of funds it collects (from roughly 10 million customers), actors characterize NHIF as a swollen government institution perhaps in much the same way that a productive cow is swollen with milk. For those who are privy to its resources, the animal yields a consistent product with regularity. I would argue that this is an important feature of the depiction of NHIF as “cash cow.” There is a subtle suggestion that this extractive process is a routine occurrence and by extension that the practice persists. In tandem with this is the passive nature by which the extraction might take place. As with milking a cow, the organization remains idle, with coffers swollen, and available for indiscriminant extraction. While this is a common form of speech that cuts across cultures, it shows how the subtleties of the depiction influence attitudes about the object of its metaphor.

Like the previous name, some actors characterized NHIF as a source of campaign money. This was difficult to follow and may have some historical basis that did not surface in interview or document data collection. Whether founded on evidence or not, by naming the NHIF as a source of campaign funding, actors explicitly politicize the enterprise. This implicates high-ranking government officials in what is perceived to be nefarious activity, a recurrent theme in Kenya politics. When pressed to give an example of this, no actor could explain why NHIF has been characterized as a source of campaign funds. Instead actors simply resorted to the popular framing, as one Board Member further explained:

The colossal amounts that you talk about in billions will never be recovered and that's been the cycle since the last 20 years. Every time there's elections, the government of the day comes up with an innovative idea to generate income and take money from NHIF. Because they need campaign

money. That's what happens every five years [...] it's a well-known secret (D\_08).

Other metaphors were also used in an effort to select perceived salient features of NHIF bureaucracy, such as the name, “monster.” Some actors framed the NHIF as a monster that you feed and it grows and will eventually devour everything. This portrayal serves at least three purposes. First, it casts the organization in an unfavorable and threatening light. Monsters are rarely seen as happy and good. Second, it suggests that the organization is beyond the control of those inside and outside of government. The relative autonomy many actors assign to the operation of NHIF is also a recurrent theme in how the organization is framed. Third, a monster is typically wild and uncivilized, engaging in unacceptable behavior. One can infer aspects of this portrayal in the following statement about NHIF from a private sector representative discussing the rate increase:

So already health has its records of unutilized funds, inefficiency, like in any government and NHIF was already tainted. So how do you take a small monster to make it a larger monster? Should you not change the monster first, before you're destroyed? (D\_07)

Another metaphor used to characterize NHIF as an opaque government institution was the use of the phrase, “black box” to characterize its operation. Multiple actors referred to the fact that audits have historically not been widely released and are not common knowledge for NHIF. Pricing, scheduling, accreditation, and a variety of functions are not well understood by many participants. In this way, the black box metaphor, whereby a device is understood by its inputs and outputs, but not its internal workings, serves to highlight the perceived insular and opaque nature of dealings that occur within the confines of NHIF. Oftentimes this type of characterization is used as a platform to call for greater transparency in NHIF governance.

### *5.2.3 Exclusivity Metaphors: Members Club and Bed-and-Breakfast*

Several actors, mostly from the private sector, framed the NHIF with respect to the package of health services it offers its consumers. This took the form of related names that were used in interviews to characterize the inadequacy of NHIF and to down-play its role in purchasing, and by extension, risk pooling. Actors referred to NHIF as a “members club,” that covered what they called “lodging fees,” or more colorfully, “bed and breakfast expenses.” The latter

is, of course, an exaggeration, as multiple schemes for different segments of the workforce offer expanded packages that even cover outpatient services. Still, in much the same way as negative portrayals of NHIF governance, by underscoring the meager benefits package offered by NHIF, those opposed to expanding its mandate seek to diminish NHIF's legitimacy and credibility.

Explanations for names given to NHIF and its services select for a feature that is closely associated with multiple shortcomings with the design of a federally-mandated risk pool. As one actor explained:

NHIF is a club, [...] NHIF cannot give you universal health care in my judgment, it can't, it's a club, it's for me and you who contribute so it can't [...] and government must put something [...] to give people, the whole population, basically to get something (D\_05).

This statement casts the shortcomings of NHIF as a risk pool as inadequate to achieve UHC because it exclusively includes the formal and not the informal sector or indigent segments of the population that cannot afford to pay. This individual suggests that for NHIF to extend its benefits to the wider populace there needs to be a contribution on behalf of government (presumably to cover the poorest). By linking NHIF membership to that of a club, the name uses a symbolic device to imply the negative attribute of exclusivity. In this way, NHIF is called something that is very much the opposite of UHC.

The deployment of the terms "lodging fees" and "bed and breakfast expenses" serves to underscore what the actors perceive to be the trivial nature of the NHIF's benefits package. Lodging fees are typically a cost incurred through the solicitation of temporary housing. This is important because lodging typically takes place away from, rather than in addition to, a home. As an additional housing cost, it serves to create the impression that it is not an essential arrangement. Also, this portrayal introduces a subtle cue of temporality. Lodging, away from a permanent residence, is a temporary arrangement. I would argue that the name might gently suggest that the NHIF benefits package, largely inpatient care, covers a short length of stay. These aspects of the names actors use to characterize NHIF coverage are even more acute when using the metaphor of "bed and breakfast." This is associated even more directly with, not only a temporary housing arrangement, but also a comfortable retreat from daily life. Despite the fact that coverage is determined by hospital classification and inpatient

coverage is comprehensive at many government hospitals, one actor elaborated on the “bed and breakfast” framing:

Because NHIF, the way it was structured [...] if you wanted this hospital [...] these room will cost you 4000 shillings per day, NHIF reimbursed 200 shillings per day, and that was it right, that's all. So it didn't cover outpatient, no outpatient expense waived where else the hospital didn't cover for any drugs, any consultation that you have received in there, if you went to theatre that was not covered it was just a reimbursement of your bed and I would say whatever breakfast, that's why I call it bed and breakfast (D\_04).

Thus, actors use names to select for certain features of NHIF, including its lack of transparency, inefficiencies, poor governance, and limited benefits package. This selects for features which have been widely scrutinized in the past and which actors perceive to persist in NHIF's current form. It often matters very little whether the information is correct, up-to-date, or relevant to the concept being communicated. Actors had little difficulty in selecting a negative array of names to characterize NHIF in an effort to dismiss it as a significant source of financial protection for the general population.

#### *5.2.4 Categorizing NHIF Negatively*

There are three ways in which this process of naming and defining NHIF through its negative attributes categorizes the efforts to expand its mandate through increased rates. First, augmenting NHIF is relegated to the sidelines in debates about how to strengthen the health sector on the basis of priority. Given the availability of myriad shortcomings, actors portray the rate increase as categorically misguided. The “real issue” is fixing NHIF. When describing efforts to increase contributions, most actors suggest that this approach is disconnected from more pressing policy considerations. In fact, several actors believe increasing revenue for NHIF conveniently obscures many of the underlying problems with the organization. While most acknowledge that the rates should increase, there is consensus that NHIF needs to demonstrate that it is an effective and reliable steward of taxpayer resources first.

The second way in which the rate increase is categorized through negative portrayals of NHIF is to trivialize its value. The logic is frequently described as pouring more resources into a broken system. The assumption is that by paying more, the average consumer is not

going to get more, because NHIF currently does not even have the ability to deliver on its marginal commitments. This leads many actors to question the value of increasing the contributions and to dismiss its potential to increase the return on their larger investment.

The final way in which the rate increase is categorized through metaphors and names that perpetuate negative stereotypes about NHIF is to associate the policy with nefarious activity. Actors frequently voiced concerns about investing more resources in what they perceived to be a corrupt enterprise. They argue that this exacerbates the problem because it reinforces the notion that NHIF is a “cash cow,” and thus attracts opportunists looking to line their own pockets. Furthermore, if directives to increase contributions are forced through without drastic governance reforms, many question the motives behind those directives. As one frustrated Board member explained:

When these rates were gazetted, it was all from the highest office. You know, saying, you have to gazette these rates [...] Tomorrow. Tomorrow, I want to see it in the gazette and that's what happened [...] it makes us uncomfortable. Because we wonder what the urgency is [...] we don't understand what the mad rush is all about when things haven't even been put in place (D\_08).

In addition to the active categorization of the rate increase through a process of assigning names to NHIF, there is a passive categorization of the rate increase by what is often not portrayed. In highlighting this policy proposal, most actors failed to mention the recent efforts to reform the institution and the expanded benefits packages that are already in place for certain segments of the population (civil servants, teachers, military, etc.). Similarly, there was little mention of the inadequacy of contributions that are the equivalent to the cost of a loaf of bread annually and do not adjust with economic inflation or the rising cost of medical care. Furthermore, actors obscure the stated motives behind the rate increase, which is to expand the existing benefits package for the average consumer to include costlier outpatient care. Similarly, the long-term objective of collecting enough revenue to cover the poor and vulnerable is rarely mentioned and is often relegated to the purview of a pilot program run by the World Bank. In this way, the rate increase is categorized both actively and passively by a process of naming that emphasizes the perceived weaknesses of the existing organization.

### **5.3. Contested Stories of the NHIF Rate Increase**

Storytelling was used to a moderate extent in arguments against the proposed increase in contributions to NHIF. This reflects the technical complexity of NHIF, its perceived shortcomings, and its damaged legacy. It may also be indicative of the fact that many actors understood this policy to be misguided and in fact required very little explanation. Though many people suggested that the reasons for the failure to increase contributions were obvious and easy to comprehend, some actors “emplot” (Mattingly 1998) rich detail in narrative form to encapsulate the problem with NHIF and the barriers to effective governance. In this way, storytelling is an important correlate to sense-making. An adequate understanding of how actors perceive the governance of NHIF to impede its expansion is best situated in narratives that illustrate a number of salient contextual factors related to NHIF. This includes stories about 1) the scandalized roll out of the civil servant outpatient scheme, 2) pervasive corruption in the health sector, and 3) path dependency and the difficulties of legislative reform. In this way, I will show how storytelling is used to contest the proposed rate increase.

#### *5.3.1. Prelude to a Scandal, 2010-2012*

Perhaps one of the most widely cited, controversial, and convoluted stories used to discredit the NHIF, is the scandalized roll out of the civil servant scheme in 2012. In this story, key themes such as the structural challenges associated with NHIF, its management, and cumbersome mandates combine with the symbolic devices used to select and categorize. There are wildly different accounts of what happened. These often elicit impassioned positions from interview participants, in part, because so much of the controversy was aired publicly. In fact, a cross-section of newspaper headlines over the last five years (see Table 5.2) provides an overview of controversy surrounding NHIF and how this is tied to the policy to increase the rates. Below, I will attempt to link contestation over the rate increase to the “scandal” over the civil servants scheme. The easiest way to do this is to provide a brief interpretation of the sequence of events followed by a more in-depth analysis of the civil servants scandal. I will rely on actors’ accounts to provide conflicting stories of the scandal.

**Figure 2. Selected Newspaper Headlines for NHIF 2010-2015.**

Headline	Source	Date
NHIF to Cover Outpatients in Two Months	Nation	6/28/10
Workers Union Opposes Health Tax	Nation	7/21/10
Minister Defends Increased Hospital Fund Rates	Nation	8/25/10
Court Suspends New Medical Cover	Nation	8/30/10
COTU in Strike Threat Over New NHIF Rates	Nation	9/8/10
Court Allows NHIF to Implement New Rates	Nation	9/27/10
Trade Union Demands Ministers Sacking Over Hospital Insurance Rates	Nation	10/1/10
Kibaki Steers Clear of New NHIF Rates Debate	Nation	10/7/10
Trade Unions Want MPs to Block New Health Insurance Rates	Nation	10/18/10
Teachers Vow to Reject Revised Medical Scheme	Nation	3/20/11
New Changes Set NHIF up for War with Employers	Business Daily	10/20/11
New Health Scheme Offers More Cover for Public Servants	Nation	1/5/12
New NHIF Reforms May Slow Private Insurers' Growth	Business Daily	2/7/12
NHIF Monthly Contributions Go Up from April	Business Daily	1/17/12
COTU Issues Strike Notice on New NHIF Rates	The Star	5/12
Chaos at NHIF Over Suspensions	The Star	5/12
Nyong'o Reinstates NHIF Board	The Star	5/12
New NHIF Rates Put on Hold for Three Months	The Star	5/12
COTU, FKE Oppose New NHIF Rates	The Star	9/29/12
Court Allows New NHIF Rates	The Star	1/25/13
FKE Wants New Rates Put on Hold	The Star	2/8/13
KMA Calls for Restructuring of NHIF	The Star	3/24/13
Ruto Proposes to Have NHIF, NSSF Contributions Increased	The Star	7/12/13
NHIF Boss Arrested Over KSH116 Million Fraud	The Star	10/2/13
Civil Servants Protest NHIF Cover	Sunday Nation	1/26/14
Employers Warn of Job Losses Over New Rates	Daily Nation	9/26/14
Civil Servants Say No to New NHIF Rates	Daily Nation	10/23/14
COTU Withdraws Lawsuit Against New NHIF Rates	Business Daily	1/14/15
Talks with Unions Delay New NHIF Rates	Sunday Nation	1/18/15
Higher NHIF Fee Deductions Finally Get Employers Nod	The Star	1/30/15
KNUT Petitions Government Over NHIF Rates	The Star	5/9/15
New NHIF Rates are a Robbery, says FKE	Sunday Nation	5/10/15
New NHIF Rates Good, says COTU	The Star	5/16/15
High Court Suspends NHIF Premiums	The Star	5/20/15
Workers to Strike Over NHIF Rates	Daily Nation	6/18/15
Teachers to Walk Out Over Raised NHIF Rates	The Star	6/27/15

\*NHIF=National Hospital Insurance Fund; COTU=Central Organization of Trade Unions; FKE=Federation of Kenyan Employers; KNUT=Kenyan National Union of Teachers; KMA=Kenya Medical Association; NSSF=National Social Security Fund; Kibaki=Mwai Kibaki, 3<sup>rd</sup> President of Kenya (2002-2013); Atwoli=Frances Atwoli, Chairman of COTU; Nyong'o=Peter Anyan Nyon'o, Former Minister of (Health) Medical Services, Current Senator; Soisson=Walter Soisson, Chairman of KNUT; Thakker=Amit Thakker, CEO Avenue Health care, Chairman of Kenyan Health care Federation; Raila=Raila Odinga, Former Prime Minister of Kenya (2008-2013); Ruto=William Ruto, Deputy President of Kenya (2013- )

In 2010, NHIF resumed a protracted struggle to increase contributions from levels legislated in the NHIF Act of 1998. As with previous attempts, this was contested largely by the private sector, which is apprehensive of any potential government encroachment in the health sector. While private insurance accounts for only 3% of the health insurance market, many of the firms have strong alliances within the sector and private industry more widely. NHIF as a mandatory insurer maintains a competitive advantage over the private sector in providing inpatient coverage. While the private insurers are not happy about this arrangement, they accept that it won't change and have invested their attention elsewhere, namely in boosting enrollment from the informal sector as well as providing a comprehensive package to wealthier clients looking to top-up their NHIF package. Table 5.2 clearly illustrates that whenever NHIF announces that they are planning to move into outpatient care (by raising rates), the private sector contests them on multiple fronts.

The period of time before NHIF began rolling out the comprehensive civil servants scheme is important for understanding actor identities and how stories of scandal situate competing frames. As Figure 2 suggests, the rate increase was proposed to take place at the end of August 2010. The unions, particularly COTU, vigorously opposed the rate increase for a couple of reasons. As one representative explained to me:

We said, currently NHIF has three billion Kenya shillings, which they don't spend because of lack of capacity to handle the same, so we advised them that if you want more money first of all utilize this three billion that is unused annually (A\_09).

Second, COTU (whose Chairman is also an NHIF Board Member), described that they were concerned that NHIF was using the funds to reimburse private facilities and they understood that NHIF should focus its attention instead on “*revamp[ing] and refurbish[ing] district hospitals.*” In their understanding, NHIF could create a separate wing and section of health facilities devoted to members.

COTU's description of why they opposed the rate increase is revealing in that it relies on a particular understanding of how NHIF works. For example, most health insurers of NHIF's scale in LMICs frequently run large surpluses simply because doctors either fail to issue claims or the collection and processing structures are underdeveloped. Second, their

understanding of NHIF's purchasing arrangements, to strengthen infrastructure, for example, is not entirely accurate. On the one hand, this illustrates the problems with having an active stakeholder who also occupies a seat on the NHIF Managing Board, without a solid technical understanding of how risk pooling and insurance works. On the other hand, as multiple actors pointed out, this also serves to rationalize a position that is tenuous at best. According to several parties privy to the controversy, this hides nefarious activity on the Board and the corrupt practices that organizations use to fight wars by proxy. According to some, the Chairman of COTU is the largest gun for hire, so to speak.

Regardless, COTU was a strong opponent of the early attempts to increase the rates and used multiple tactics to counteract the move. As Table 5.2 shows, press coverage increased as the rate increase grew nearer. This is in part because actors suggested that COTU is easily the most effective at using the media to voice its opinions, as it counts journalists and editors amongst its members. With the debate firmly established in the public domain, COTU then established a legitimate basis for shifting the forum to the judicial branch. The rate increase was then tried in an industrial court and ultimately a higher court. The rate increase was suspended during the hearings. In the meantime, COTU and others sought to build an alliance with other Board Members such as KNUT and FKE to further oppose a rate increase should the court approve. When the court finally ruled the rate increase to be constitutional, COTU issued a strike notice.

At the same time that the proposed rate increase was being contested, NHIF embarked on an ambitious strategy to break up the formal workforce into segments. The idea was that if rates cannot be raised more broadly, the benefits package could be strengthened for a key constituent so that the organization can demonstrate the value of providing both inpatient and outpatient cover. As with previous attempts, the private sector grew nervous and actively opposed attempts to provide outpatient cover, on grounds that NHIF did not have the capacity to manage such a complex arrangement. An enhanced or stronger NHIF would harm the ability of the private sector, both provider groups as well as private insurers who have a significant advantage in current fee-for-service outpatient delivery systems. In this way, contestation intensified in the lead up to the civil servants scheme.

With the strong support of the private sector, multiple unions again issued strike notices and vowed to do everything in their powers to block the pending rate increase and by extension, the civil servants comprehensive package. Some argued (i.e. D\_07) that the rushed nature of the civil servants roll-out, the superficial accreditation process, and misunderstandings about the new capitation model of reimbursement set in motion a “*circus at NHIF that created a comedy of errors.*” In this way, I will show below how a scandal was then either manufactured or revealed, that deeply undermined both the proposed rate increase as well as NHIF’s move to expand the benefits package for key segments of the workforce. In the end, the CEO of NHIF as well as several important Directors were sacked, tried for corruption, and the organization was placed under a temporary caretaker Managing Board. It is important to note, however, that to-date no individual has been found guilty of wrongdoing, nor does conclusive evidence exist that funds were lost. There are several versions of what took place, which I will highlight below. Regardless, the end result was that it would be several years before NHIF regained its momentum with the rate increase finally being enacted (long after data collection for this thesis ended) in April 2015.

### *5.3.2 Civil Servants Scandal - “Ghost Clinics” vs. “Business Wars”*

In the course of interviewing, actors frequently used stories of scandal, and the botched roll out of the civil servants scheme, to discredit NHIF and proposals to move towards UHC. In conversation, this took the form of easily identifiable symbolic devices such as the parking lot, administrative overhead, or “ghost clinics.” While the excessive expenditures of NHIF and the misguided real estate investments were often mentioned in passing, actors expanded upon the civil servants scandal, which has come to be known as the “ghost clinics” scandal.

In many accounts of what went wrong with the roll out of the civil servants scheme, actors placed the blame with NHIF. When the scheme was devised, it was “rushed” through to implementation in a way that made several people uncomfortable. As one MOH finance expert explained:

I think the process in terms of registering the facilities and all that because you know there was no time, I think some agreement was reached by a few people in sometime in December then I was on leave over the Christmas holiday so I read on the papers, the government is going to provide/ NHIF is going to provide a comprehensive medical cover for civil servants, these are the ranges, then from where date effective January first, yes then I

asked the CEO eeh! How come? That's fast, yes is it going to work? He told me yes, it is going to work (B\_10).

The period of time in which they recruited providers to bid for accreditation under an outpatient civil servants scheme proved crucial and short-sighted to many. In the end, the facilities of two private for-profit providers, Clinix and Meridian, were disproportionately approved to provide outpatient services financed through NHIF's new civil servants scheme. This raised some eyebrows amongst the health care providers. The medical union, which has 'a small fund for research', went out to the approved facilities, according to one representative (A\_02), *"to have a look at these hospitals and to see if actually the same number of patients who have been paid for, is what they see...anyway just on average or maybe over a certain period of days."* The medical union representative continued:

**Respondent:** We were surprised to find that even some of these hospitals are not there?! They are nonexistence, a very good number of them and yet the money has already been paid. So you see now what this tells you is that the whole scheme, the whole things was just a fraud you know to get money, tell people now when you tell me pay 3000 shillings and you are going to pay it to a non-existent facility that is wrong? The idea was good, but it is criminal [...] We came out and lobbied / rallied even the central organization of trade unions (COTU)

**Interviewer:** So you went immediately to COTU or you went to the media, you went to the ministry?

**Respondent:** Media, we talked about it and it raised a lot of temperatures we talked to COTU, it raised it as well and actually the scheme was stopped because it was discovered that there were a lot of bad things that were happening and even the top bosses some of them were fired. They were fired so it is something that we brought out and we had a lot of information about...although we know that at the end of the day, there was an attempt to try and again bring back the same culprits you know and that's just how we do our things here, you keep on fighting so that when things cool down a bit again you come back and you want to commit the same crime (A\_02).

This version of events was also supported by members of KMA as well as COTU, who have strong relationships with the medical union. These clinics quickly became known as "ghost clinics" with multiple actors speculating that COTU was responsible for labeling them so vividly. COTU leadership explained the intensity of the scandal as follows,

It's me who fought that war almost costing my life, but I stood firm and eventually the president supported me, today those people who are in charge of those ghost clinics including the then managing director of the

National Hospital Insurance Fund or the CEO Mr. Kerich, they are facing the law in court and it was so bad because Nyongó [former Health CS] convinced the minister for public service to transfer 4.6 billion Kenya money to NHIF when it had no capacity to handle such money, so the money was just going like this (A\_09).

There are a number of important features of these stories from the self-styled “whistleblowers.” First, in the initial story, the providers were simply investigating a curious arrangement and not looking for shortcomings with the new civil servants scheme. This justification for action is surprising because the model of capitation was not well understood and the medical union itself was unhappy about medical cover for its members under NHIF. Second, they were quick to recognize that a scandal existed without seeking clarification from NHIF. Instead, together with COTU, they went directly to the media to announce the fraud. The medical union, it should be noted, was founded on the recommendation and with the assistance of the Chairman of COTU and both organizations’ headquarters are located in the same office building. COTU, as I established earlier in this chapter, was already locked in a bitter dispute over the rate increase with NHIF at this time and was increasingly involved in opposition to the civil servants scheme. According to a former Minister of Health (now called Cabinet Secretary) (G\_05), “*the people in COTU also have insurance companies.*” So, what initially seems odd, that the medical union would contact the media, seems less so when the historical linkages between COTU and the union are understood. Third, the actors paint themselves as the victim of a crime and one in which they are on the side of everyday citizens in battling government corruption. Given the origin of this scandal and the context in which it emerged, these stories of scandal raise many questions.

For most of the actors, this story of scandal was relatively straightforward and sadly familiar in Kenya. As one former MOH director (B\_12) stated, “*It was done too fast, it should have been done a bit slowly. Uh, and I think there are always opportunists. So in Kenya everything one day is something to be made. Everybody does it very quickly. This is the story of scandals in Kenya.*” The view of one NHIF Board member (A\_07) was typical, “*Every way you try to look at it, it’s somebody taking advantage because there was so much money involved.*” Another NHIF Board Member (D\_08) stated, “*The colossal amounts that you talk about in billions will never be recovered.*” When asked whether or not the civil servants scandal was real, a private insurance company director (D\_01) further explained,

*“Absolutely. That I can say with clarity because I also conducted the forensic audit through [X company].”*

It became clear over the course of the interviews, however, that some actors had reservations about the legitimacy of this scandal. As one finance expert (D\_05) explained, *“I maybe take a very extremist view but it’s a scandal that never existed, in the sense that everybody says they lost money, I do the NHIF [X service], so they never lost any money.”* This statement directly contradicted several listed above and when pressed, the individual further explained, *“if you ask any of those doctors, [...] ask him how many clinics do these guys have and how much money have you lost, even ask the minister how much money did you lose, nothing... people get paid to tell you how much money...”* As an external finance expert contracted through NHIF for several years, he implies that he is one of those people who can actually speak to the balances of their accounts.

Instead of outright corruption, several actors privy to the inner workings of NHIF and the private sector suggested that what took place was simply “business wars” between competing service providers. According to one private sector representative (D\_06), *“if a contract doesn’t go to a particular person, the other guy got it through corruption.”* A former Minister of Health explained how the facility accreditation was awarded:

I think it was more me than anything else, so I think it was business wars because originally, these private insurers, like Jubilee insurance company they had wanted to get this business but they quoted higher, they wanted 12 billion to do it as a constitution of the insurance companies. The government couldn’t afford more than 6 billion to the business. So this, so the government floated that and this two firms applied at a price that the government could afford (G\_05).

One finance expert explained how some possibly influenced the accreditation process, a relatively minor infraction as opposed to laundering money through “ghost clinics”:

the biggest problem, what actually happened, again the vested interest came and the biggest problem is two guys Clinix and Meridian decided that they wanted to grab 50% of the membership of the civil service, now they didn’t have enough clinics at that stage to services those guys, they influenced NHIF management and the unions in the civil service to make sure that they have these members (D\_08).

A few actors understood that the civil servants scheme was botched, but not in ways that could be interpreted as flagrant corruption. According to one MOH employee (B\_05), “*We still believe there was something fishy that happened. I want to believe maybe it wasn’t intentional but [...] even if I have a good intention and I do not follow procedure, I could easily get into any form of trouble because it can be interpreted in whichever way.*” As one private sector representative said, the blame for the civil servants scheme debacle rested with both parties:

But, to give someone a contract, where they don't have the capacity to do it, is wrong. And, to accept a contract, where you know you don't have the capacity to do it, is also wrong. [...] So I think both parties had a role to play. One shouldn't have accepted because it didn't have the capacity yet. And the other shouldn't have signed without investigating the capacity (D\_07).

Many actors understood that in Kenya these stories of scandal resonate strongly with the general public, which is why they are so effective, if sometimes inaccurate. One finance expert (D\_05) quipped, “*In this country once a lynch mob comes out, you are dead.*” A private sector representative (D\_06) further voiced sympathy for the plight of public sector workers who are subject to frequent accusations of wrongdoing, “*Because in this country if a civil servant makes a mistake, its corruption. We do not give them allowance for what I call honest mistakes.*” Yet, in light of the previous section on sense-making, this mistake, NHIF’s weak capacity to accredit health facilities, and its lack of regulatory oversight, provided fuel for a scandal which would deeply affect its ability to enact meaningful reform and move closer towards Universal Health Coverage.

### *5.3.3. Corruption is Pervasive and Personal*

As I have discussed in the preceding segments, corruption is a salient feature of political discourse in Kenya. Stories and rumors about corruption abound. Whether describing the inefficiencies of NHIF with innuendos about vested interests or the convoluted drama over the rollout of the civil servants insurance scheme, corruption is a feature of political calculus and an idea that resonates with the wider citizenry in Kenya. Many actors understand corruption to be a reliable explanation for inefficiencies in the health sector. Still others indicated that corruption is a tired idea and that it is employed as a linguistic trump card, so to speak, in order to rally opposition and rouse the court of public opinion against a given policy position. There are many opinions on corruption and its corrosive effect on public sector

stewardship. Yet, of the fifty in-depth interviews I conducted, one stood out above the rest on account of the informant's ability to draw on his life-long experiences to illustrate the extent to which corruption is pervasive in public service.

By way of introducing his stories about corruption, I will attempt to conceal the individual's identity, at risk of sacrificing some of his credibility. Suffice to say that the individual in question is currently an elected official and held several key leadership roles within the ministry of health and other government departments. Throughout the interview, he gesticulated and his voice grew in volume and timbre when discussing corruption. These theatrics, in the context of the interview, were meant to suggest that I was naïve in my questioning of some of the ideational forces at play in the policy process. While he could speak to these, he frequently reflected on values of public sector workers, Kenyan society, and complications of the material world. For example, when asked if the Management Board of NHIF needs to change, he (G\_01) replied, "*yes, but you really have to change the heart of Kenyans.*" He further stated, "*[...] the argument is there is corruption and inefficiency. Well, it's an argument and an excuse, at the same time.*" In this way, he told three stories that weave together his understanding of the "cancer of corruption" and its effects on policy making in the health arena.

As the interview unfolded the respondent grew more candid moving from management practices, to personal experiences, and culture. When describing his experience running programs in the ministry of health, he started:

if you are giving money, my policy in life is if I go into an institution, I don't leave with a single cent that I didn't earn. And my office has to know. And if you try anything else, I will not take it. [...] If you take it behind my back, I don't know. But if I know, you go. So the donor, the partners loved that and it worked a lot of things (G\_01).

This short description of his management practices illustrates the influence that leadership and international stakeholders exert on governance in the health sector. This is illustrated in greater detail by his experiences in piloting a successful primary health care program that received support from the donor community:

It all started with the global fund. Very complex fund. And I told them one thing. I'm not smart enough like you guys to do all this technical work. I just want you to give me nets for mosquitoes control and to give me money for ARVs. I don't even want the money, let somebody else buy the ARVs and bring them. Let UNICEF buy the medicine and bring them. Let WHO buy cotton and bring them. I don't want money because money is the problem. And it worked marvelously and WHO, people couldn't believe it and we moved people from less than 10,000 on ARVs to about 110,000 a month. And UNAIDS and WHO came to check and said is it this real? (G\_01)

This segment is interesting for a couple of reasons. The respondent downplays his role and describes humbling himself to the donors. Similarly, he suggests that his role as an authority figure in the MOH is somehow subservient to donors because of the need to both solicit funding and report on how funds were effectively utilized. He situates the line “*I don't want money because money is the problem,*” in the middle of the brief account so that it is seen as a potential explanatory variable in determining how a problematic situation was resolved. Furthermore, he possibly suggests that outsourcing procurement practices to the international multilaterals is more transparent than conducting them in-house at the MOH.

A few minutes later in the interview, the respondent grew quiet and reflective on his life in public service. He then digressed to tell a story and situate it in his broader life narrative. In this way, he uses storytelling to connect elements of his previous comments on corruption:

**Respondent:** “Let me tell you the cancer of corruption. People, *everybody*, agrees corruption is bad, but faced with the decision on the table, many don't have the strength to say no to corruption, at personal level.”

**Interviewer:** “What makes you different than them?”

**Respondent:** “I don't [know] whether I'm different, but maybe I'm a coward and so when you get me something that I don't think I've worked for, I'll feel bad. I don't feel good. I mean, even if I have it, ok, I'll tell you. I've not told many people this...one time in the government of President Moi, there was this thing that if you went there to visit, then you were given a lot of money and that time we went and we were a large group and when you were leaving, there was a lot of money, it was poured on a table and we were being given 10,000...that money stayed in my house for a long...neither me or my wife wanted to use it because we felt ‘what is it for?’. So I don't know, it's just that, I don't enjoy it, if I didn't work for it or I know it is unfair. I would love a nice big house. I would love a nice big car. I would love all that, but I don't think I would enjoy it if I didn't like

the source of it. My life has been simple, my father was a cook for the colony of...here, and I didn't know the concept of poverty until I was in high school because we were all walking barefoot in the village. Until I went to high school and people had three, four pairs of shoes, I'd say, why they need that much, I had one. And I say, 'Ah, people are different.' Even then, I got a 5-star hotel in New York and sit and sleep there and it's quite fine and I come here and I go in a *matatu* [taxi bus], I don't use a *matutu* much, but I don't think I'll have a problem. It's just the same, I just feel the same, so I don't see..."

**Interviewer:** "So you think you're different than some of the others?"

**Respondent:** "I don't know. Because I really don't know how the others feel. Whether they're also going in those things and not feeling nice, I don't...Whether I'm just incapable of moving the resources to myself, I don't know..." (G\_01)

Finally, the interview participant concluded with a brief depiction of a sector and a society tainted by the corrosive effects of corruption. According to him, corruption operates in the realm of daily practice, where ordinary citizens perpetuate graft. He stated that in the public sector, procurement is a problem because drugs, for example, can sometimes cost up to three times their actual value so that administrators can pilfer the excess. When asked if this happens in NHIF, he responded:

"Everywhere! Whether we are going to a seminar to discuss social health insurance, a bottle of water that is probably costing 20 shillings suddenly is costing 100 shillings, so all our predictions, if you asked me the one thing that this country needs to address to get developing there, it's not even ethnicity, it is the corruption. Unfortunately, it has become the...everybody believes in it, but everybody castigates it.(laughter) So nobody really comes out to say, 'we shouldn't do it.' Because you must start at an individual level, you must refuse it. So if you are in the streets and you refuse to pay the policemen thing, if everybody refuses, they'll stop asking. Sometimes people even tell them, please take this and leave me (G\_01).

This short account of how corruption is baked into the fabric of daily life serves two purposes. It is both an explanation for how the extraordinary becomes ordinary as well as a call to action. He establishes corruption, and measures to combat it, as a priority for Kenyan society to advance.

#### 5.3.4. Path-dependency and the NHIF Act of 1992

Several actors reflected on the fact that the rate increase is symptomatic of an institutional path-dependency created by legislation, namely the NHIF Act of 1992. Two senior and very influential actors told stories about the difficulties of changing legislation in the stakeholder-heavy health arena. The first, an individual who has worked closely with NHIF and has served in a regulatory capacity for multiple state-owned enterprises reported that the NHIF Act suffers from lack of an overarching regulatory framework. The second individual described in detail the difficulties with changing the Act that governs their segment of the health workforce. A closer analysis of each reveals the way in which stories of legislative change or even hypothetical change weave together ideas and values to frame the failure to increase rates in a particular way.

#### The Resistant NHIF Act: 'Vested Interests'

According to the finance expert, the difficulty of changing an Act in the health sector is directly tied to the outsized role of stakeholders in the management of NHIF. When asked if it is difficult to change an Act, he (D\_05) responded, "*It's not hard to change an Act but to change a health act, it's almost impossible.*" When asked why, he answered with a hypothetical:

**Respondent:** Because of the vested interest, the guys...take the providers for example...let's see, for example, you want one week to change the NHIF act, to remove accreditation from NHIF to an independent body, there are guys who NHIF accredits and tells them they are in grade A or in grade B, when they are not in grade A or in grade B, because they want to be getting more money from...NHIF is a gravy train...as soon as you want to do that, they will go to parliament and block it and say no, 'NHIF is the best, why do you want to give to some foreign people?'"

**Interviewer:** These providers or through the employers?

**Respondent:** The providers. No, not the employers. Anything in health fund, anything in NHIF, there is someone who is benefiting, and as soon as you touch that person they will go and fight you, it will be very, it will be tough, you need very strong leadership and you need strong leadership in two places [[Interviewer: within NHIF or?]] no no, ministry, the minister must be very strong and the president must be very clear in his head, if those two are not clear you will do whatever you want to do you will take...it will take you 100 years to get it done (D\_05).

This story is important for four reasons. First, the respondent notes that actors directly involved with the governance of the fund are benefitting from the status quo, in this case, the weak accreditation process within NHIF. This is connected to the above section on sense-making in that he clearly perceives providers to influence the accreditation process that categorizes health facilities into compensatory grades based on service provision. He notes that to them, NHIF is seen as “the gravy train,” for example. Second, this highlights the detailed level of knowledge about the NHIF Act and the provision within it on the part of stakeholders such as the providers groups who occupy a seat on the Management Board and are privy to prevailing policy positions and proposals. Furthermore, it implies that the stakeholders in this capacity are very pro-active in heading off any challenges to their legislated advantages within the existing governance structure and are cognizant of ways to contest change. Third, he suggests that Parliament is the forum in which these exchanges can be contested and that they can be effectively influenced on short notice. It is unclear whether he means the Parliamentary sub-committee on health or Parliament more widely. Fourth, he suggests that the executive branch has powers to override Parliament or establish an agenda that supersedes quibbles over details. In his conception, there is an implied old-fashioned element of autocratic elite rule in which the highest level officials, the President and Cabinet Secretary (aka minister), can enact legislation in more of a top-down manner. In fact, he suggests that timely reform, given the level of “vested interests” is only possible through the sheer might and clear vision of the executive branch.

#### The Resistant NHIF Act: Sectoral Bureaucracy

The second story in which the failure to increase the rates is seen as a limitation of the governing NHIF Act, is told by way of comparison with another act in the health sector, the Nurses Act. This senior policymaker (B\_07) who has spent a career in public service reported, “*Changing Acts, it is the most difficult thing. The Nurses Act that we have, we wanted to review in 1992 it was ready to go to parliament; it did not go until 2011.*” She further clarified that the Act was prepared three years before it was presented to Parliament, so it was actually designed beginning in 1989. She explained the process:

You start, you have a board who think you should have these members to sit. Then it drags...by the time they get the drafters to draft again...redraft...it goes to the Ministry of Health then somebody thinks something is wrong, it comes back, then you re-correct...it goes back...three years are over, another board comes who thinks, ‘no this is not

right you should have done this, recall it,'...it comes back. In '96, as I was in the Ministry of Health it reached the Minister's office. The Minister was asking just for a very small correction...it came back and people started afresh. In 2002, before I came here, there was even a task force that did the Nurses Bill 2002. When I came in 2003, the task force was still working, now reviewing. Then we have another Act and another board and it went and went. So we had in that committee of 2009. Then we decided democracy...too much democracy is not going to help...we are going to the private member's [MP] motion. Because it was disappearing between Nursing Council, Ministry of Health, AG chambers and parliament. So we went through a private member's motion and it went through [...] Enough, 20 years. In fact, when we counted 20 years, and we said it's enough (B\_07).

There are a number of important features in this story that are worth highlighting. On the surface this looks to be a classic case of ineptitude frequently associated with government bureaucracy. In fact, later in the interview, the representative admitted that this situation would be hard to imagine for a private sector corporation. The implication, however, is that nefarious activity on the part of outside influences is often hard to detect. The individual suggested that perhaps decision-makers dragged their feet because the situation was perceived to be of low priority and on the low end of the policy agenda. This story further illustrates that policy contestation often takes place internally on government task forces and sub-committees. This is complicated by a decision-making structure that places a great deal of emphasis on political as opposed to technical considerations in designing policy proposals. Hence changes associated with the preferences of revolving government bodies. The interview respondent implies that inability to change the original act reflects a vacuum in leadership, where multiple voices make it difficult to generate consensus. As a result of "too much democracy" and the significant time period, which elapsed over the proposed legislation, they experimented with a new legislative tactic called "a private members motion." Through this process, a clear case of policy learning seems to have taken place, where the preferences of the nursing body and their desire for reform caused them to find alternative means of advancing legislation.

There are significant differences that are worth noting between these two accounts of legislative change for governing Acts. The first suggests corruption and outright meddling by actors on the periphery of policy design. The second story shows that a sizable degree of contestation and resistance to change is located within the machinery of government itself. Together, the stories show that, while an Act can indeed change, it often takes an

extraordinary amount of time and effort and must involve a degree of leadership to ensure that change corresponds to the prevailing needs of the day. In separate parts of the interviews, both actors confirm that the board structure of NHIF would have to change in order for the NHIF Act to be altered in any significant way.

## **5.4. Conclusions**

### **Sense-making**

The sense-making process for the policy to increase rates for the NHIF was characterized by actors' understandings of NHIF and its perceived disorganization, dysfunction, strategic misalignment, and corruption. Though the identity of the NHIF was distinct and dominated understandings of the decision to increase its rates, there was a sense that the NHIF was symptomatic of an archaic form of post-colonial governance embodied by the 'parastatal'. These are tied to a larger debate that operates across multiple sectors and touches on various aspects of Kenyan life on reforming state-owned enterprise. Actors often made sense of NHIF by alluding to or citing figures associated with a recent external audit that revealed an array of administrative inefficiencies and operational incongruities within the mandatory fund. Some of these issues, such as the composition and dysfunction of the Management Board, the role of the CEO, performance of the organizational workforce, and misguided strategic investments were mentioned in the report. Moreover, many of these ideas appear to have been in circulation prior to the 2012 report and actors quite possibly cite the external evaluation in order to validate their beliefs about the inadequacy of NHIF. In addition to organizational misalignment, many understood that NHIF is engaged in a variety of activities in which it is ill-equipped and precariously positioned to provide with any degree of reliability. This included accreditation of health care providers and, to a much lesser extent, revenue collection. Nevertheless, actors understood the attempt to increase rates as a dangerous move that would exacerbate persistent shortcomings within the organization and reinforce, what many understood to be, a culture of corruption in which public servants receive little oversight and remain unaccountable for mishandling public funds. Finally, policy stasis for the rate increase and wider NHIF reforms were understood to reflect an institutional inertia that exists for public Acts, which are resistant to change in arenas marked by a plurality of stakeholders, such as the health sector.

## Naming

Actors named various macro and micro-level features of the NHIF when discussing the rate increase, selecting for issues of financial stewardship and portraying the organization as categorically misguided. The cumulative effects of the naming process could be interpreted as simultaneously delegitimizing and further politicizing the organization. Due to the technical nature of health financing, actors at times cited exaggerated, outdated, or simply inaccurate information in ways that furthered their arguments. This could be interpreted as a misunderstanding of the data or a strategic deployment of the politics of misinformation. Actors used a variety of names to portray the organization as a wasteful, incompetent, and untrustworthy government enterprise. Though, at the time of interviews, the executive branch and MOH largely maintained an arm's length relationship to NHIF. By using names such as "cash cow", "monster", and "black box", actors understood and sought to convince others that NHIF was incapable of fulfilling its current mandates and unworthy of expansion. Names were also given to the benefits package, in order to trivialize NHIF's current offerings and further undermine the organization's reputation on a technical basis. This feature possibly resonates with actors because NHIF was designed as the National *Hospital* Insurance Fund in order to extend financial protection for inpatient care. In moving to outpatient care, NHIF is understood to be outgrowing its original mandate, an argument made more visible by the naming process. In this way, actors use naming to focus the attention on the identity of NHIF, including its legacy and perceived shortcomings, to prioritize a comprehensive program of organizational restructuring over increasing the parastatal's operating revenues.

## Storytelling

The process of storytelling was utilized to a moderate extent for the NHIF rate increase in ways that employ salient contextual features of the NHIF and its governance shortcomings through stories of scandal, corruption in the health sector, and path-dependent policy stasis. These stories bring to the fore the interaction of a number of powerful policy actors and frame sponsors in the health sector, including unions and representatives of the private for-profit sector. Conflicting accounts of scandal were framed alternatively as "businesses wars" amongst competing health care providers or "ghost clinics" in which payments were made to fictitious entities. This is an example where the lack of clarity or consistency surrounding accounts signals to the researcher that actors are engaged in a strategic framing contest in which participants are recruited through symbolic representation. Regardless, these stories of

scandal reinforce the attitudes of many that, at the very least, something must be wrong with NHIF. Furthermore, this trend extends beyond the rate increase debate and seems to surface in tandem with proposals to increase the size and scope of NHIF, including the move to outpatient care. Finally, stories of graft, which feature regularly in Kenyan political discourse, and the difficulty of altering legislative Acts in the health sector were seen as explanations for the deficit of trust in NHIF and its failure to reform.

### Framing Similarities

Like the user fee removal, analysis of the distinct stages of the framing process for the policy to increase NHIF rates produces a number of similarities across stages. First, the focus of the debate has been centered on the identity of NHIF as an institution as opposed to the actual decision to raise its rates. Moreover, across each stage actors largely understand that there are problems within NHIF that require urgent attention. The organization itself is understood to be highly politicized through its contentious governance structure and its position as a state-owned enterprise. Thus, each of the framing stages works to frame NHIF as an organization that is not capable of expanding, let alone worthy of the increase in revenue and responsibility. By framing the organization as fundamentally flawed and resistant to change, the debate supersedes considerations of increased revenue collection by calling attention to the existence and legitimacy of NHIF as a mandatory insurer. Moreover, the array of powerful actors who are actively engaged at each stage of the framing process demonstrates the intractability of efforts to enact meaningful change within the organization. In this way, each of the stages of the framing process suggests a deeper more divisive frame conflict persists related to understandings of the role of government in risk pooling in the health sector. Analysis of the cross-domain functions of the framing process, therefore, can illustrate the role that conflicting ideas play at multiple levels of abstraction in generating meaning in the policy process.

### Framing Differences

Different analytical insights also emerged through comparison of the three stages of the framing process for the rate increase. For example, while each feature of the process sheds light on the ways in which a revenue collection issue such as the rate increase is framed, only in the naming section, and to a lesser extent, the storytelling section, does risk pooling and

purchasing surface. Moreover, the benefits package is portrayed as inadequate and irrelevant through a process of naming, but is not mentioned in storytelling or directly through analysis of sense-making processes. Also, in the analysis of naming, the fact that NHIF is seen to outgrow its original mandate (and name) raises important questions about the organizational vision and guidance, which arises in analyses of sense-making, and to a lesser extent, storytelling, but in much more indirect ways. Instead, actors seem to make sense of NHIF and its associated problems much more directly through the symbolic representation of the Management Board, which is programmed for contestation and controversy. Storytelling on the other hand suggests a degree of strategic intentionality in which actors use NHIF for instrumental gain and leverage. Furthermore, only through stories of path-dependent political institutions does the analysis get a sense of the legislative difficulties in bringing new policies, even less divisive ones than NHIF reform, to the table. Also, analysis of naming, and its sub-components of selecting and categorizing, illustrates much more tangibly the ability of actors to frame multiple aspects of NHIF in a negative light. In addition to helping understand policy stasis for the rate increase, these observations also reveal much about the various stages of the framing process, their signatures in pluralistic discourse, and the ways in which they emphasize different features of the meaning-making enterprise.

# Chapter 6: Framing The Ngilu Bill

---

## Introduction

This chapter addresses the framing of the 2004 Bill on National Social Health Insurance in Kenya. This attempt represented one of Kenya's most ambitious proposals for overhauling health financing and re-aligning service delivery according to the global pool of health systems research. Despite the amount of time that had elapsed since the passage of the bill, it quickly became clear that given the significance of this bill, analysis of subsequent health financing policies would be insufficient without a solid understanding of what happened at this critical juncture. This bill frequently surfaced, in unexpected ways in conversations with myriad actors interviewed for this study. In addition, there exists no rigorous policy analysis of why the bill failed despite many colorful explanations and theories. This was surprising as it was reported to receive widespread stakeholder support, particularly from the international sector and was one signature away from being signed into law. The bill was championed by its primary sponsor, Charity Ngilu, at the time Minister of Health (now called Cabinet Secretary of Health) and currently the Cabinet Secretary of Lands. With Minister Ngilu's strong and vocal support, the bill was passed unanimously through Parliament in just two weeks. The President, however, refused to sign the bill into law and sent it out for further consultation, where it appears to have been quickly dismantled. All of this makes for an insightful domain for further explanation of the myriad forces that combine to shape the health policy process in Kenya and serve as the backdrop to present debates about UHC.

A number of noteworthy issues arose during the course of data collection. First, features of the 2004 debate were recalled easily; however, the minutia of discursive tactics and strategic ideational positioning was more difficult to remember for multiple study participants. Second, many actors quickly jumped to explanations for why the 2004 Bill failed, which perhaps colored their interpretation of events. This provides an insightful description of how actors understand the issues, but it also could pre-determine the interview as actors frequently attempted to provide explanations to fit their conclusions. I interpreted this to be a positive sign that the subject material was conducive to the elucidation of the sense-making enterprise. Also, this is perhaps a consequence of conducting research on such

an emotional charged debate, one in which actors held strong convictions about the validity of arguments and the implications for the development of the health sector. Third, as I will describe in greater detail in the naming section, actors often referred to the 2004 Bill on National Social Health Insurance as the “Ngilu Bill”. As with the previous chapter on the “Rate increase”, I will also call it the Ngilu Bill simply because that is what it is called by actors in Kenya. It should be acknowledged, however, that despite Minister Ngilu’s significant involvement and even assistance in crafting the bill, this was a product of several individual and collective inputs.

Throughout the course of data collection, I came to understand that the Ngilu Bill was a symbolic form of resistance in the health policy community. For the private sector representatives, it served as a rallying cry and springboard to a sophisticated organizational structure through the formation of the Kenya Health care Federation under the existing Kenyan Private Sector Alliance (KEPSA). For many of the public sector workers who toiled away on the design of the bill and advocated on its behalf, it represented the difficulty of working in a health policy space marked by a plurality of voices where policy measures are often incremental and fragmented. Regardless, this moment in time was pivotal for the Kenyan health system and not only did actors reflect on this dimension, but the very fact that the Ngilu Bill surfaced in so multiple interviews unprompted indicates that it is something that actors still feel compelled to discuss. Moreover, the content of the interview data differs and is somewhat richer than for other topics discussed. I would argue that more than any other policy proposal, successful or otherwise, the 2004 Ngilu Bill casts a long shadow over the health policy arena. The forces that converged during its brief life span reveal much about the nature of Kenya’s health system, its broader policy process, and values espoused by Kenyan society.

By describing the framing process, I hope to illustrate the significance of the Ngilu Bill and provide an explanation for its legislative failure. This includes the ways in which actors understood the content of the bill and their interactions with its stakeholders, the deliberate process of naming salient features of the bill, and storytelling by actors enmeshed in high-level dialogue and decision-making surrounding the bill. Finally, the frame analysis of the Ngilu Bill will show the complicated ways in which disputes during this time persist in altered forms in the current debate around UHC.

## 6.1. Making Sense of the Ngilu Bill

An adequate analysis of the sense-making process for the Ngilu Bill requires careful consideration of the political context in which the frame emerged; therefore, in this chapter I introduce various aspects of the bill as presented in journal articles, a text book on health insurance, and using the content of the bill itself. Actors’ understanding of party and electoral politics were largely tied to their interpretations of the decision-making process and how this prevented the bill from being passed. In this way, a nuanced analysis of the sense-making process will show how multiple forces interact to construct a functional understanding of the Ngilu Bill and its legislative defeat.

**Table 6.1. Ngilu Bill Timeline**

Year	Event
2001	President instructs ministers to develop a plan for creating mandatory National Social Health Insurance (NSHI) for all Kenyans
2001	Delegates adopt resolution for “right to health” in the constitution and task force recommends NSHI
2002	Cabinet adopts resolution for the creation of NSHIF
2002	Minister of Health appoints intersectoral task force to prepare national strategy and Draft Bill on NSHI with private sector input
2003	Economic Recovery Strategy for Wealth and Employment Creation includes measures to transform NHIF into National Social Health Insurance Fund (NSHIF)
2003	MOH requests technical support from GIZ/WHO to assist with implementation once Bill is passed by law
2003	1 <sup>st</sup> technical mission to review strategy and draft bill, which would become parliamentary sessional paper no. 2, 2004
2003	2 <sup>nd</sup> technical mission assess legal aspects of Bill, design of benefits package, provider payment mechanisms, and transition of NHIF to NSHIF
2003	3 <sup>rd</sup> technical mission assess health insurance governance and financial feasibility
2004	4 <sup>th</sup> technical mission assess progress towards implementation, management reforms, and establishment of working group
2004	5 <sup>th</sup> technical mission reviewing progress and developing strategic milestones
2004	6 <sup>th</sup> technical mission assessing financial projections and training with a financial simulations tool
2004	National Assembly debates Bill and passes through Parliament unanimously
2004	President refuses to sign the Bill into law, sent out for further stakeholder input

Adapted from Abuya et. al. 2015

### *6.1.1. The Design of the Ngilu Bill*

The design of the Ngilu Bill emerged from the same discourse around the inadequacy of financial protection from catastrophic health expenditures discussed in previous chapters. This was tied in complicated, yet direct, ways to the debate around user fees and perceived shortcomings with NHIF. Many of the same values and arguments for financial reform helped to define the problem which comprehensive social health insurance sought to address. I build upon these by introducing the various design elements of the Ngilu Bill and interpretations of their intended impacts. This sense-making process provides a crucial background to the strategic positioning and tactical battles that will be presented in the subsequent sections on naming and storytelling.

The design of the Ngilu Bill and the legislative process took place over a period of four years from 2001-2004, as outlined in Table 6.1. This process involved a significant amount of consultation with technical partners within and outside MOH. This included a number of international actors with significant programs of work in health financing in Kenya, including the German Corporation for International Cooperation (GIZ), World Health Organization, and the World Bank. The MOH, spearheaded this effort under a seasoned senior team led by the new Minister of Health, Charity Ngilu. As we shall see, the degree of stakeholder consultation, particularly with respect to the private sector, was seen as a source of controversy. Yet, at least at an early stage, it appears as though all stakeholders were involved in the initial consultations during a series of technical missions organized by MOH. While many actors commented on the perceived problems with the political process, it is important to first gain a better understanding of how actors made sense of various aspects of the Bill itself.

The first salient feature of the Bill was its proposed methods of contribution. The Bill conceived of a diverse financing stream to support a National Social Health Insurance Fund (NSHIF) through a combination of government revenue and earmarked taxes, mandatory contributions from formal sector employees (enhanced through a feature called payroll harmonization), contributions from employers and the self-employed, and through donations or grants. The government was expected to provide sources of revenue through grants and private donations to cover the poor. The self-employed would be subsidized by larger contributions from the formal sector, including both employee and employer contributions. The employee and employer contributions were proposed to be income-rated in an attempt to

fix the outdated “rates” discussed in the previous chapter. It is important to note that many of these contribution mechanisms were already in place in the existing NHIF, including voluntary contributions for informal workers and mandatory contributions from formal workers. What the Bill introduced for the first time was a mandatory contribution from employers and a formal commitment from the government to provide coverage for the poorest.

There were several perceived shortcomings with the revenue collection features of the bill. Many were worried about the earmarked funds from general tax revenue. As one NHIF employee described, some perceived there to be an unacceptably high burden on taxpayers. Though the exact percentage to be earmarked for NSHIF was never established in the Bill, the design occurred at a time when the economy was sluggish and politicians were worried about economic growth prospects. It was further perceived to be an expensive endeavor because government would be responsible for taking care of the poor and indigent. There were also strong arguments in favor of basic primary care being covered by the government, as one former NHIF Board Member (B\_02) noted, *“If this was done, women will deliver, children will be immunized and we will include large aspects of public health into these.”* Similarly, there were concerns about the amount and consistency of funding from development partners. Though, as the same senior health official (B\_02) involved with the design of the Bill pointed out, *“we had proposed that a small percentage of VAT was to go, that is what Ghana did and everybody, development partners, have been very happy and a small portion would have gone to support the indigent.”* Finally, as one economist pointed out, the Bill involved a contribution from employers, which was unprecedented in the health sector, but not in Kenya as the National Social Security Fund involves an employer contribution. Still, the knock-on effects of employer contributions resonated with many the stakeholders. According to one international actor, the private sector and even development partners were concerned that:

The increase would be shared by employee and the employer and even if it's completely passed onto the employee by the employer that it would be some kind of a tax on businesses and that would lead to lower growth (C\_02).

This view was typical and multiple interview participants condensed it into an easily understood narrative that transforms the technical aspects of the bill into something that

makes sense with what they understand to be an important shortcoming of the bill itself. This important sense-making process is exemplified by the following quote from an international finance expert (C\_03), *“I think there was a certain aspect of it, that were not well thought out, I don’t know I have to read it again, I think there were certain parts that were going to hurt the private sector and that’s normally, probably, you don’t want to do that.”* For these reasons, many actors understood that the tax-based mode of increasing revenue for social health insurance and incorporating employer contributions was economically problematic.

In designing the Bill, many understood that a reasonable degree of tension existed around risk pooling. On the one hand, evidence suggested that a larger, more efficient risk pool is optimal for cross-subsidization purposes. On the other hand, many argued that NHIF and its perceived shortcomings would undermine implementation, and that private sector competition was needed to raise standards. Despite its problems, NHIF was proposed in the 2004 Bill to be reformed and expanded into a national *social* health insurance fund (NSHIF). Like the new forms of contributions, this feature of the bill was widely contested. As some actors pointed out, however, the lack of participation from the private sector and the limited scope for private insurance in a national social health insurance program, created a great deal of hostility from private insurers. In this way, the design of risk pooling in the Ngilu Bill contributed to the highly charged positions sponsored by key members of the private sector at the behest of the private insurance industry.

In addition to introducing new revenue streams and clarifying risk pooling, the Bill was to set about key purchasing reforms. Again, the NHIF was seen as the primary vehicle for purchasing, albeit with enhanced regulatory oversight and potentially removing the revenue collection function from NHIF. Though it was not explicitly stated in the 2004 Bill, some actors recommended that a separate entity be established to accredit health care providers. Under the Ngilu Bill, providers would be paid a flat fee per inpatient day and per outpatient visit (though the exact levels were never finalized). In addition to this, cost containment measures were inserted into the purchasing arrangements. A basic package of inpatient and outpatient health services was proposed to cover medical consultation, some specialty care, essential medicines, dental care, referral, and other costs associated with hospitalization. The package was to be approved and modified by the NSHIF Board, although it did not specify the process. While many of the purchasing arrangements in the Ngilu Bill are in place in social health insurance schemes in other countries, this feature of

the Bill was notable as the first time in which NHIF, or rather, the new NSHIF, would move into outpatient care. Indeed, this move, to expand NHIF's mandate and cover services beyond the walls of the hospital was seen as a threat to the private sector (as was discussed previously in Chapter five).

There were at least two perceived shortcomings with the purchasing arrangements outlined in the Ngilu Bill. First, the move to provider payment mechanisms that standardized financial transactions and contributed to cost containment was viewed unfavorably by providers themselves. As this amounted to a form of capitation, the common perception was that, *"they would see their margins cut by having a universal scheme,"* as one former MOH Director (B\_12) explained. According to him, *"Actually they were opposed to capitation. That was one of the things. [...] Even fee-for-service, they didn't want limits on the fees they could charge. It was like a free-for-all."* Several interview participants mentioned that private providers viewed the Ngilu Bill as suspiciously ambitious. As one actor (B\_08) commented, *"...for the private providers, they sort of saw that, in a way, this strategy is trying to build up one huge social health and to drive all others out of business."* Second, the move into outpatient care was seen as a threat to the private sector as the current offering for inpatient services through NHIF was largely seen to be benign. According to one private sector representative (D\_04), *"...they were now going into uncharted waters where they had never been before? They'd never run an outpatient scheme..."* He then described that the Bill was rushed in moving to position NHIF as the purchaser of outpatient services. He continued, *"we needed to have certain things in place, like we needed to have had some data for us to be able to make informed decisions [based] on a pilot outpatient study for example."* In this way, opponents of the Bill, strongly cautioned against providing outpatient coverage through a new NSHIF and at the very least lobbied for more time in determining whether or not it was a feasible strategy. In this way, the new forms of purchasing outlined in the Ngilu Bill, namely, providing outpatient coverage and moving to a capitation model of provider payment, elicited a strong reaction from segments of the private health sector.

### *6.1.2 The Political Economy of the Ngilu Bill*

Before describing a bit about the political context and contestation around the Bill, it is important to note a few observations from the data collection process. Whenever interviews moved into the terrain of the Ngilu Bill, often by the interview participants themselves, the

conversation assumed the tone of an autopsy of sorts. Actors frequently glossed over the details of the Bill and were hard pressed to recall its finer points. Instead, most interview participants immediately began describing what, in their view, went wrong. Because very few participants had formal training in policy analysis, their explanations were overwhelmingly interest-based. The explanations usually followed a particular formula: name the culprit, describe how their perceived interests were threatened by the bill, and allude to the fact that they kept the President from signing it into law. This is important because this Bill supposedly received widespread support, was quickly approved by Parliament, and was literally one signature away from being enacted. There is a great deal of speculation about what or who caused President Kibaki to reject the Bill. This assumed the form of names of officials, interest groups, or even party politics. When I further questioned interview participants about other dimensions to the problems, most actors conceded that these played a role. Oddly enough, as I will attempt to demonstrate throughout this chapter, the actors who were most heavily involved with the Bill attributed success and failure to the discursive tactics employed in a strategic framing contest. For opponents, how they framed various features of the Bill when communicating with Treasury and the President were seen as vital explanations for success. For the architects of the Bill, their shortcomings were largely understood to be shortcomings with the “packaging”, “marketing”, or “communication” of the Bill itself. For this reason, the latter sections on Naming and Storytelling will draw more heavily from the smaller subset of actors who were directly involved with this contested process and have intimate knowledge of the policy debate. In this section (6.1.2), however, I draw from the wider pool of interview participants to describe the array of organizations and individuals who are understood to have played a role in the Bill’s defeat.

A related aspect of political circumstance was the timing of the Bill’s introduction immediately following the administration’s decision to enact universal primary education. Multiple interview respondents questioned whether or not Kibaki and his administration needed sweeping health reform on the heels of universal primary education. According to one former NHIF official (B\_03), *“like one of the greatest projects that he had been able to bring to book was the school, the free education. So he was soaring high on the free education thing.”* Some saw the issue as a technical challenge, as one former MOH Director (B\_02) stated, *“And the issue was that Kenya was introducing free primary education and experts advised that it may be difficult for Kenya to run both free primary education and*

*social health insurance.*” Others in the public sector, however argued that the debate over affordability of the Bill was analogous to previous discussions in the education sector:

I think it just goes back to free education. We also said one time that we can't afford free education remember that? [...] President Moi never believed that we can afford free education, free primary education, what has happened? We decide, we do (B\_11).

It seems clear that the campaign for the Ngilu Bill was at least partially hindered by the political victory and sizable cost of the recently enacted legislation for free primary education.

Charity Ngilu

Undoubtedly, the person who is most associated with the Ngilu Bill was the former Minister of Health, Charity Ngilu. The actual 2004 Bill was formally entitled *The National Social Health Insurance Bill*. As one actor (A\_07) explained, people commonly refer to it as the ‘Ngilu Bill,’ “*because she was just passionate about it, she literally went out of her way to make sure it happens and it's developed.*” As I will show in the Naming section later in this chapter, the very fact that the Bill is commonly referred to as the “Ngilu Bill” is revealing and not inconsequential.

The fact that nobody referred to it as the ‘Kibaki Bill’ was indicative of the level of ownership by Ngilu. This was potentially problematic, as one professional association representative (A\_07) commented, “*that competition was been seen, like she will get too much credit for this.*” Though she was a member of Kibaki’s Cabinet as Minister of Health, she was also somewhat of a political threat. An active Member of Parliament, representing Kitui Central, since 1992, Charity Ngilu ran for President in 1997. Together with Nobel Laureate, Wangari Maathai, she was the first female to run for President in Kenya. Popularly dubbed ‘Mama Rainbow,’ she was somewhat of a media darling by the time she was appointed Minister of Health in the newly elected Kibaki administration of 2003. As another female leader (B\_07) in the health sector commented, subtle forms of sexism may have been at play in Kibaki’s decisions not to enact what was perceived to be his cabinet member’s bill: “*No, politics entered. I think for me I thought, these men, they thought Ngilu was going to get credit or what?*” A political victory on the scale of National Social Health Insurance reform would further elevate Ngilu’s political standing and perhaps position her for the head office

in the elections of 2007. As one industry insider (D\_05) who has worked with Ngilu explained, *“if this thing won, even if it were Kibaki, I wonder, now, will this woman be with me? Can she try and run?”* Some people speculated that the fact that Ngilu and Kibaki were from different political parties (NARC and NAK, respectively) meant that the coalition government had no “unity of purpose” in the early stages of the Kibaki administration. Therefore, not only would a political victory look good for Ngilu, but it would also represent a political win for a rival party. In this way, interview participants suggested that party politics and Ngilu’s ownership of the Bill were at least part of Kibaki’s political calculation in refusing to sign the Bill into law.

Multiple interview respondents commented on favorable personal characteristics of Charity Ngilu that led to political traction for the Bill. For some, Ngilu was seen as an effective leader. According to a trade union representative (A\_09), *“when she took over immediately, Moi left and she was appointed the minister for health, she changed the whole scenario.”* A former health official now working for an international organization (C\_05) further explained her positive attributes, *“She needs and sees what can arouse the public mood, you know she will wake up and tell Kenyans I will provide you with free health care.”* According to another actor (D\_05), *“She is smart, she is streetwise.”* Someone who worked closely with her (G\_01) described her thus as an important policy entrepreneur, *“If she gets a bright idea, first of all she absorbs it quickly, understands it, and then she has a huge capacity to lobby. Yes, so I found, I said, ah, this can work well. So if you have ideas, you feed ideas, she lobbies.”* The fact that over a decade later she is still a cabinet member, currently Secretary of Lands, was also seen as evidence of her political acumen. Even her staunchest opponents admitted that she is not as autocratic as everyone believes. According to a private sector representative (D\_07), *“Ngilu is more into negotiating. [...] And [...] would probably be debating and thinking different lines of possibilities.”* When an opponent was asked if she was personally to blame for the shortcoming, he responded (D\_06), *“No she wasn’t, she wasn’t. What she did was this, when people bring you something and they tell you, everybody is on board, run with it, that is what she attempted to do.”* In fact, another opponent (D\_07) of hers during the debates surrounding the Bill understood her role as an important one, if even in direct conflict to his own, *“I think Ngilu did one thing, she brought health care to the limelight and she actually elevated health as a sector, which was actually quite forgotten for a long time.”* Her charisma and ability to champion a cause she believed in was seen as one explanation for her strong attachment to the 2004 Bill.

In contrast, multiple interview respondents attributed the Bill's failure to Ngilu's character flaws and her autocratic leadership style. According to one journalist (E\_01), "*she was manipulative, she is very opportunistic.*" He further elaborated, "*You know she doesn't put her thinking, she wasn't a good champion, she is very emotional about it and very committed about it.*" Another interview participant (B\_11) further commented on her ability to throw her weight around, "*Yes but the problem, she pushes and then leaves everybody on the floor and the particular, the key decisions-makers were not with her, she doesn't go far, Treasury, The President, if they are not with you, then you don't go far.*" When asking an associate of hers if this is simply the mark of a strong leader, they responded:

No, leadership is making strong decisions but be smart, I would have made a decision by asking, 'what do you think,' but I have already made the decision, but when I came and tell you, 'I have made the decision,' ...you can't... that's being autocratic, now (D\_05).

This presents somewhat of a paradox. Interview participants frequently recalled Ngilu as being the strongest leader of MOH in recent memory. And yet, many reported that her leadership attributes were the downfall of the Bill. Regardless, she is a controversial figure and her impassioned support for the Bill, often on moral grounds, had a polarizing effect on stakeholders privy to the debate.

## Treasury

One of the most frequent explanations for the Ngilu Bill failure was a lack of consultation on three fronts, the Treasury, the private sector, and the World Bank. There was consensus among interview participants that Treasury and the Minister of Finance/Treasury Secretary are highly influential in policy debates. As one former director within MOH (B\_12) stated, "*The whole issue is convincing the Treasury [...] I think when Treasury makes up its mind, it **does** make up its mind.*" Moreover, much of the focus on politics in Kenya tends to view MPs as the primary movers of social policy. As the Ngilu Bill shows, however, Treasury, with its ability to control the government's purse strings, has a key role in setting the policy agenda. As one health official (B\_12) stated, "*So the buy-in was there from the politicians, but there was not enough buy-in from Treasury.*" President Kibaki, as a former Treasury Secretary, was probably also more sensitive to the advice of Treasury officials. As a member

of the Cabinet along with the Treasury Secretary, however, it is unclear why Ngilu would not have resolved these disputes behind closed doors. As one NHIF Board member stated:

Perhaps there should be a little bit discussion at the cabinet level to make the cabinet own it from the beginning because what happened is that Ngilu brought to parliament, did all the right things made sure it passed, but perhaps at the cabinet level it didn't quite get ownership (A\_07).

Several actors reported that the way in which Ngilu and her team consulted Treasury was misguided. This statement by a MOH official (B\_05) is typical: *“Treasury was not part of it. You know, it's like you draft something, eventually you want the president, there is also the Treasury, they were told, ‘hey bring money,’ this is not the way to go.”* Others argued that Ngilu had a history of productively working with Treasury, if strained at times. As one member of her team stated:

She was equipped with a lot of evidence and actually I remember her going to the Treasury one time and she told the Treasury, ‘this is what is happening, the households are putting more money in financing health care. You are neglecting as a duty, you Treasury, as a duty’. And, for the first time if you look at the data, that is when the health sector got a huge increment from Treasury and I can say that was as a result of the way she was packaging. [...] You know what I have learnt with Treasury, you have to go and tell them, ‘if you give me this money, this is what is going to happen and this is how the indicators will behave’. Like I remember package for him immunization, he told them that, ‘if you give me this money, am going to push immunization to this level’. You know those guys in Treasury, they just believe in figures and output or outcome. So I think she was a well-organized politician who knows how to package agenda and get that (C\_05).

Another leader in the health sector (B\_11), who was involved with the Bill, concluded, *“We did consult. There was a bit of a rush to move. We didn't address the concerns, which is the private sector and that's why they killed it along the way.”* Regardless of how Ngilu and her team approached Treasury; however, it appears to be clear that Treasury were unconvinced that the Bill was worth what they viewed to be a sizable investment from government.

Some participants recalled that Treasury saw the Bill as unsustainable and unaffordable. As one NHIF employee (B\_08) stated, *“Yes, but I mean, I think the main issue was now the government, you see when our own Treasury comes out and say this is not sustainable, in the long run its too expensive what would you expect of other people?”*

According to at least one finance expert working for an international organization (C\_05), *“from the Treasury side, [the] point was [...] the poor were supposed to be financed by Treasury and [at] that time, Treasury said they don’t have money [...] so they could see the implication of financing the poor to the budget.”* One actor (D\_05) saw it as a simple disagreement, *“that one again was in my judgment that was the one problem, was the ministry of finance, of the national Treasury, and the ministry of health couldn’t agree, everything [else] was done, everything [else] was agreed.”* As I will show later in this chapter, Treasury was in fact a significant venue for debate and an active participant in shaping the political outcome. While it seems clear from the multiple participants who were involved in pushing the Bill that Treasury was simply against it, few understood why Treasury’s position was so entrenched. According to the private sector representatives who heavily contested the Bill, however, the explanation is simple:

Because they [Ngilu’s team] didn’t go to Treasury first [...] for them they thought all the bases are covered; for us we are covering every base from scratch so we are operating on very different parameters. We knew we were starting off later and therefore we will have to do a lot of work (D\_06).

This version of events was corroborated by a member of Ngilu’s team who reported attending a high stakes meeting at Treasury on a Sunday:

It dawned on me that the ministry of finance guys just didn’t want this thing, too costly for the government, they didn’t want it to go in stages, nothing, they just didn’t want anything about it,[...] I think people had already gone and influenced them (D\_05).

Whether Treasury simply was against the Ngilu Bill on grounds of fiscal responsibility or whether they were persuaded by members of the private sector opposition, the outcome is the same. The lack of support from the Treasury on grounds of sustainability and affordability was a significant consideration in the President’s decisions to reject the Ngilu bill.

### The private sector

Some actors also reported that the private sector was not consulted in the campaign surrounding the Ngilu Bill. According to one private sector representative,

No, we were not consulted, you see [...] it did suit the government to what I normally refer to as the revolving door policy approach whereas if you

talk to one group, to validate part of your thinking, you then took that as an absolute mandate from the private sector to go ahead and implement whatever (D\_04).

This quote raises an important issue as the private sector is diverse and includes an array of actors from medical suppliers, pharmaceuticals, healthcare providers, facilities, and insurance companies. Nevertheless, they are usually considered as a single entity, as evidenced by this quote from an MOH employee (B\_10), *“those people thought that if this system is implemented it will completely put them probably out of business, so they went ahead lobbied against it.”* According to a private sector representative (D\_04), the Kenyan Medical Association (KMA) was seen to represent the entire private sector, *“[KMA...] are regarded as private sector and therefore had a voice. Now not necessarily that the membership were truly consulted and there was a very robust discussion about what the government wanted to do.”* The position of KMA, however, was not understood to be representative of the diverse landscape of actors in the private sector in health. Multiple interview participants saw the private sector as a primary lobbyist against the vague principles of the Bill, as communicated by an MOH leader (B\_11), *“there was an issue, they said you are going to overtax people and all those politics that came along with it, yeah and I think this was a strong private sector lobby that played...killed it.”*

Actors generally stated that the private sector saw the Ngilu Bill as a threat to both private insurance and private health care providers. As one NHIF board member (A\_07) commented, *“particularly people in the private insurance business they felt very threatened and so I think they also put their spanners in the work and make sure that this was never released.”* Others explained the failure as a result of vested interests amongst private providers, such as this quote by a trade unionist (A\_09), *“Because of the private medical practitioners, they did not want that bill to take off, simple they will lose the market.”* There were good reasons for this, as one hospital executive pointed out:

two thirds of the health workforce are employed by the private sector. So when you say you are going to deliver, you are going to expand this access, and you haven't involved the private sector in this discussions, how are you going to structure it (D\_04)?

Furthermore, there were light and heavy interpretations of the role the private sector played in contesting the Bill. As one journalist (E\_01) explained, *“Yeah so and then we had all these*

*guys, the guys running private hospitals and all that, they sounded very very convincing.”*

Others understood the private sector representatives to have had a direct hand, as one former NHIF official (B\_03) claimed, *“They actually drafted the memorandum of which the president rejected. Private sector. And they went with some very key confidants of the president, who advised him to reject it. And that was it.”* In summary, understandings of the role of the private sector and its relations to the policy process are probably best exemplified by the views of a finance expert employed by an international organization:

Those guys [Ngilu’s team] focused on parliament then didn’t get the support of all the stake holders, the private sector was not involved, and the President was linked to the private sector and they tell him ‘it’s a terrible mistake, don’t sign it’ [...] we ignored the local private sector and we completely underrated how powerful they are (C\_03).

An important outcome of the contested politics surrounding the Ngilu Bill was that it served as a rallying cry for the private sector in health. As one leader (D\_06) recalled, *“And that’s now when, the private sector truly came out of the woodwork and said; this is wrong, that’s wrong.”* One of the key opponents of the Ngilu Bill further described the evolving nature of the private sector’s resistance:

KHF [Kenyan Healthcare Federation] was born out of this bill and this created this desire of having a common vehicle which the private sector can work with [...] we have common interests, we need to be involved in advocacy, a bit of lobbying, we never had a platform (D\_07).

The organization’s sophisticated level of communication, and the convening power of the private sector, which was born out of resistance to this bill continues to this day and their influence has even begun to spread beyond Kenya (through the formation of the East African Healthcare Federation, for example).

The World Bank (and other development partners)

The final interest group that was considered to have played a role in defeating the Ngilu Bill was the World Bank (WB). As with much development assistance, WB has invested heavily in a variety of sectors, including health, in Kenya. This lent them authority in policy disputes, as one former NHIF employee (B\_03) commented, *“if it’s the Bank, everybody fears, because the Bank has a way of popping its head in another critical sector.”* This is important because

a sweeping policy measure such as national social health insurance would affect WB's portfolio of work outside of health. For this reason, an academic speculated that the Ngilu Bill would:

substantial[ly] increase government spending and therefore increasing the fiscal deficit, and the only way to finance that gap is through borrowing which has its own adverse consequences whether the borrowing is done internally or its done externally (F\_02).

Some actors understood also that WB was invested in a variety of other health financing and private sector development initiatives that would be adversely affected by the new social health insurance scheme. As one of the Ngilu Bill's architects claimed:

It was a simple thing that we had donors, who were asking a question, if this bill goes through, what is our role? And among the people who were leading that drive was World Bank, DFID, what is our role? So because they had the muscle, they influenced the Treasury to disown the bill, and you see, you can't disown a bill because that bill went to cabinet, the first one there to disown the bill was actually minister for finance then, and he signed that bill when it was going to cabinet but when the parliament passed it, was the first person to disown the bill, ok so you can see, this was a big, big thing and I probably put it on donors led by the World Bank [...] if you are able to mobilize all that funding, what is my role (C\_08)?

Multiple members of Ngilu's team that were present in high level discussions with Treasury and the President, understood that the WB Country Director, Makhtar Diop, a former Minister of Finance from Senegal, was personally responsible for influencing the President's decision. One member who was a consultant elaborated:

because Ngilu didn't want to hear anything about those guys, they wanted to pull a particular direction [...], I remember Diop's team wanted to do pilots before you actually do the thing, they were very scientific, but because Ngilu side-stepped them, they said no, this thing can't work (D\_05).

This level of involvement on behalf of the WB by a country director was seen as disturbing by the handful of insiders on Ngilu's team.

Interestingly, one actor that was part Ngilu's team (G\_01) fondly recalls an interaction with the WB country director in the President's office when debating the Ngilu Bill: *"And the only person who supported me was uh...Sachs of Columbia...([Interviewer:] Jeff Sachs?)...He came here, he insulted Diop in the office and I got embarrassed."* When asked what he said, the interlocutor responded, *"I can't repeat. So he told, 'you guys, when the WB come in and you don't listen to the local people, these are the people who know the problem'."* When asked whether he thought that offended the country director and it made him angry, he responded, *"No, no. Well I think Sachs is just very uh pushy. Jeffrey Sachs is very pushy [...] and I liked him."* He then summarized his interpretation of that crucial meeting thus, *"So the WB wasn't really for it. So, but they were not the big pusher against it. It was Treasury. Whether they were behind Treasury, I don't know. And also the [private health insurance industry]."*

In summary, three organized interest groups who were involved in contesting the Bill were likely to be the Treasury, the private sector representatives, and the development partners led by the World Bank. As the following quote from an international actor succinctly summarizes:

the story goes that the private sector and the world bank went and convinced the ministry of finance that this was affectively huge sort of tax on the private sector employers, and this would lead to lower growth rates and on and so forth, and even though the bill passed in parliament, the President never signed it (C\_02).

This illustrates the shortcomings with interest groups approaches. For example, there is no account of how Treasury changed its mind or the process by which actors decided to pursue Treasury in the first place. It remains unclear what exactly WB did and when. Also, there is no explanation for why The President himself decided not to sign the bill. This leads to a reductionist and simplistic conception of policy change. Rather, having gained a solid understanding of the various ways in which actors interpret and make sense of the complex arena surrounding the Ngilu Bill, the following sections will provide a more nuanced account of how and why the Bill came to be rejected.

## 6.2 Language of the Ngilu Bill

Consensus amongst actors on both sides of the debate exists that the Ngilu Bill was subject to a strategic competition in which discursive tactics were deployed. Those in opposition to the Bill claim, and in some instances boast, of their ability to frame the Bill in such a way as to prevent Treasury and the executive from endorsing it. Similarly, former members of Ngilu's team readily acknowledge the various ways in which they failed to effectively frame the Bill to include an inclusive coalition of supporters. Naming, selecting, and to a lesser extent, categorizing the Bill within the political sphere were important tactics used by both sides of the debate. Personification of the Bill, appeals to affordability and sustainability, and reframing policy measures were important naming processes that contributed to the Bill's defeat. Also, by categorizing the bill as a health sector governance issue and linking the debate to Kenyan conceptions of free enterprise, opponents of the Ngilu Bill were able to position their arguments in way that touched on contested values in Kenyan society. In this way, I will show how naming, selecting, and categorizing are important vehicles for wielding ideas in ways that persuade and explain political behavior in the policy process.

### 6.2.1 *Selecting Charity Ngilu*

One of the first and most curious ways in which actors selected a particular feature of the Bill was by naming it after its primary sponsor, Charity Ngilu. Though it is unclear where exactly or even when the Bill began to be referred to as the Ngilu Bill, this form of personification certainly was not without consequence. Given Ngilu's background, her impassioned support, and her position as one of the first female politicians in Kenya, the Bill was attached to preconceived notions of gender and patronage in the political sphere. Without knowledge of the Bill's specifics, one is free to read into actors' understandings a variety of interpretations based solely on knowledge of the Ngilu public persona. This perhaps partially explains why interview respondents without finance expertise or insider knowledge of the political process that surrounded the Bill's design, still were able to draw conclusions and voice opinions favorably or negatively about the bill. As one high-ranking health official explained:

Probably she could have done it in a different way where the glory is not going to her but am sure it's people just threw spanner into the works of these things and when they call it Ngilu bill when it's supposed to be Kibaki bill, yeah it's part of polarizing others, and so to limit support for it (B\_11).

While it is unclear whether or not opponents of the Bill were responsible for transmitting the Ngilu persona to the Bill, they were at least satisfied with the arrangement. A closer look at the way in which a private sector representative described deliberations is instructive:

Yeah we involved the ministry of finance in this debate and said ok fine this is your budget, alright now this is what Ngilu wants, this is what Ngilu says she wants on top of what you are already taxing Kenyans. So this is taxation, Ngilu doesn't have powers to tax. No minister has powers to tax. So we involved parliament, we said well, so [...] you need to include this in your budget in your budgetary estimates presentation appropriation to parliament and say you need to tax Kenyans or we are going to go to court and Ngilu therefore is competing for the same resources that you are already generating for your other projects now really are you saying that there is that much more left out there? [...] Because the... Ngilu's approach was, which it still is, that you are looking at the formally employed [...] but this what you generated from this group alone was not going to be sufficient to cover and therefore guarantee access to all these (D\_04).

What is interesting to note is the number of times that the actor mentions to Treasury Ngilu's motives. This serves to isolate her from a broader constituency and personalize the debate. The image of Ngilu as a popular female politician is, therefore, symbolic and one that operates on multiple levels. It helps to trivialize the claim that the Bill is a rational, economically feasible policy proposal. As one member of Ngilu's team (D\_05) stated, in the latter stages of the campaign, when the relationship with Treasury turned sour, the dominant narrative became, "*Ngilu is pushing an agenda to make sure that the government runs out of money, she just wants to eat money from the ministry.*" As an international researcher, not privy to the nuance of gender stereotypes in Kenya, I do not feel comfortable making the claim that this directly influenced actors' understandings of the Bill itself. At the very least, the attachment of Ngilu's name to the Bill created a polarizing effect, largely to the benefit of the Bill's opponents.

### *6.2.2 Framing the Ngilu Bill as 'Unaffordable'*

There was a consensus among interview participants that the Bill's adversaries were effective in their characterizations of the Bill as "unaffordable" and "unsustainable." In this way, the Ngilu Bill was reframed as a doomed enterprise. Though there were extensive debates between economists and actuaries within Ngilu's team as to the affordability of the proposal, its proponents worked out various scenarios in which it could be phased in over a period of five years. Despite considerably less financial expertise, the private sector representatives

used their own data to demonstrate to key opinion leaders how they understood the bill to be financially unsound. A journalist for example, drew interesting comparisons between Ngilu's team and the opposition from the private sector:

It wasn't quite well thought out, [...] they did a poor [...] PR job on it, that was one reason, the second reason is the other side were very smart, unlocking a lot of, what seemed to make sense... am talking about the private guys who saw these things are going to affect them, but you know then they gave us numbers, they gave us excel whatever, and said this is what is going to [happen...] of course they were lobbying and...they were also [...] putting their views on the public domain and but they were giving the excel so it was very easy to see the point, and this is just a politician who is shouting more than they are convincing (E\_01).

This argument, that the Ngilu Bill was unaffordable, at least in wake of universal primary education, was one that gained significant traction, again despite the involvement of finance experts in designing the bill. While the affordability frame served to condense the micro-economic concerns into a comprehensible narrative, the reality seems to be that Kibaki himself was concerned about a particular feature of the Bill. A senior health official recalled the exact rationale the President used:

I remember I went to present it to the President and the big thing he asked was who is going to pay for the indigent? Does the government have the money to pay for the indigent? Because somebody has to pay and it was a huge sum of money. And he just said, 'we don't think this is possible, Treasury said so', [...] I just said, 'the government can pay'. It can support and so on. But he was convinced, I think by Treasury and those people, that it's not possible to cover the indigent (G\_01).

One of the reasons why the private sector was convinced that it was unaffordable is that they reframed a particular revenue collection feature of the bill, called "payroll harmonization," in their discussions with powerful interest groups. Since there are more teachers than any other occupation in Kenya, for example, their union (KNUT) enjoys a position of power in negotiations with the state. Previously, teachers received medical allowances, with which they could choose to contribute towards the cost of health care. According to the representatives of the private sector, this was to be consolidated under the Ngilu Bill and was given the ambiguous title of payroll harmonization. He continued:

The Ministry is very good at [...] summarizing everything so that you don't get the full meaning and you know those words have a description [...]

They had not explained properly to the civil servants that payroll harmonization means that we take your allowances and put in this kitty (D\_06).

When asked how the Ngilu team proposed to convince constituents that this was a viable means of recovering costs, he responded, “*They had hoped that once it’s done [...] people will just have to accept whatever was said. So then it became clear, even Ngilu herself did not understand payroll harmonization means taking allowances from civil servants and teachers.*” This oversight by the Bill’s sponsors was apparently uncovered by the private actors in a thorough stakeholder mapping. Next, they used their informal networks to meet with KNUT and explain, “what it means.” Without the support of KNUT, the pool of resources available to finance the Ngilu Bill was considerably lower. This was then relayed in discussions with Treasury and, according to these actors, only later was the Ngilu team aware that a key element of the Bill had been undermined. In this way, the ability of the private sector to reframe payroll harmonization and thus enlist the powerful teachers union into the opposition helped to further the argument that the Ngilu Bill was unaffordable in discussions with Treasury.

### 6.2.3 Framing the Ngilu Bill as ‘Unsustainable’

Similar to the unaffordability argument, was the characterization of the Bill as “unsustainable.” In this way, actors questioned the long-term viability of the Bill and the complex, particular conditions that must be created for it to succeed. One of the Bill’s opponents explained:

So I think what really [...] the argument that won the day with the President was sustainability because [...] you know when you start something like health care delivery you cannot withdraw it and even if you don’t withdraw it, and then you don’t provide health workers, you don’t provide drugs, consumables, it is the same politicians that would start making noise in the parliament (D\_04).

This is an interesting statement used to justify the position because the State was not actually planning on delivering services through the Bill; it was simply going to finance service delivery (largely from the private sector) through pooled prepayment. Nevertheless, this portrayal of the Ngilu Bill as putting the government on the hook, so to speak, for an

indefinite period of time was likely to be considered no light undertaking. Furthermore, as one former MOH official (B\_12) pointed out, the evidence was weak, *“I think what happened was, there wasn't enough evidence at that time in terms of sustainability. Ok, politically it was passed, but nobody had done any economics feasibility study, things like that.”* When I pointed out that the economists and actuaries involved with the Bill had crunched the numbers, he conceded, *“Yes, the chief economist at that time [had] done their homework, but I think they never managed to convince the Treasury.”* In much the same way as concerns about affordability, actors seemed to understand that legitimate sustainability concerns were never adequately addressed by the Bill’s sponsors.

#### *6.2.4 Framing NHIF within the Ngilu Bill as a ‘Monopoly’*

One prominent way in which opponents of the Bill categorized a salient and perceived shortcoming of the Bill was to name the enhanced NHIF as a “legislated monopoly.” During the course of the interviews, this concept, that the proposed policy limited private insurance participation in ways that were damaging to free market principles, surfaced in surprising ways. For example, a former director within MOH sought to downplay the role of the private sector in opposing the bill by explaining:

What they were opposed to was a monopoly. Right? Because private sector didn't want a monopoly for just one fund, right? One scheme. I think that's why they came in. But later they were on board. The question is, private sector does not like monopolies here (B\_12).

According to some actors, the fact that parastatals were “born out of monopoly” made the private sector nervous that the government was reverting back to its populist past. Their arguments in favor of choice and free enterprise were also colored with appeals to modernity and economic progress, as one leader of the private sector (D\_07) exclaimed, *“And it was. A legislated monopoly. We are 2015 for heaven's sake. In those days we used to say we are in the 20th century, come on. We should give people choice.”* Again, because of the presence of economists and finance ministers in key leadership positions, this argument was likely to resonate at a very high level. Even more damaging for proponents of the Bill, by naming the newly formed NSHIF a legislated monopoly, opponents also drew on a legacy of corruption and incompetence associated with NHIF. As one international (C\_02) explained, *“So why would you create a monopoly using an institution that has a terrible track record of delivering services?”* Moreover, the natural extension of naming NSHIF a monopoly was

then to question its constitutionality. This was clear in the description of a planned court action against the Bill by a private sector representative (D\_06), “*It created an organization that would run the autonomous of government. It was actually treasonable.*” According to this individual, in the initial draft of the Bill, which Ngilu quickly amended:

we would have a group of 142 people, who will make a budget that parliament could not change, that the president could not touch, that the cabinet secretary for health [...] could not touch. It was literally treason; we are creating parallel government [...] an institution that was unconstitutional (D\_06).

In this way, by positioning the newly formed NSHIF as an entity that resembled state-sponsored monopoly, opponents of the bill were able to shift the debate to the extreme and thus stifle compromise. This clever way of contesting a specific feature of the Bill also demonstrates the role that naming plays in categorizing the whole Bill as “fundamentally flawed.”

#### *6.2.5 Framing the Ngilu Bill as providing ‘free health care’*

There is some indication that efforts to categorize the Bill as one of “free health care” was problematic. This was potentially framed as such given the recent legislative victory on “free education.” In a moment of self-reflection, one of the architects of the Ngilu Bill admitted to misgivings about the way in which they categorized the Bill:

I think basically two things, one is how we marketed that bill, marketing is very important, because I think we were clear that we want an employer-employee contribution, and we wanted the government to subsidize the premiums for the poor, but then I think political will marketed that thing as a ‘free,’ so people who were supposed to contribute started raising questions, why should I be contributing to pay for this guy? So I think the marketing, although technically the thing was sound, then how we packed it, the marketing of it, I think we could have done better (C\_08).

When pressed to explain an alternative way of framing the Bill, he responded, “*Just say we want to cover all Kenyans, and [...] just say, you know, this is the bill that will ensure that we cover all Kenyans, [...] to ensure that they have got equal access.*” According to this individual, the word “free” is loaded with meaning in Kenyan society, “*free things especially when you are in a country, Kenya, where there is a very big private sector who perceives free*

*things differently, [...] and they fought us hard because of that word free.”* As an astute political actor, albeit on the losing side in this scenario, this individual aptly demonstrated the importance of naming the Bill in ways that garner support while limiting its contestability. In this way, not only did opponents of the Bill successfully employ certain names, but also other names were unsuccessful in building a coalition of support.

### **6.3 Stories of Battle, Stories of Defeat**

On account of the highly charged nature of the debates surrounding the Ngilu Bill, there were at least two forms of storytelling that were commonly employed. The principle actors from the private sector who were involved in countering the Bill frequently told stories of battle in which they were cast as the unlikely victors. On the other side, the Bill’s sponsors often used stories of argumentation and technical struggles, which resembled stories of defeat and loss. In this section, I have drawn on a narrower account of the specifics from a few key actors to show how various elements of storytelling glue the various features of the debate into a larger and more persuasive narrative. This is partially a reflection of the data, as these actors were simply more open and reflective. Nevertheless, by taking a closer look at these instances of “thick description” we can gain a better understanding of the interplay of emotion, ideas, and identity in providing a basis for human behavior in the policy process.

#### **6.3.1. Private Sector Stories of Battle**

Stories of battle were frequently recounted in interviews with private sector representatives who were heavily involved in contesting the Ngilu Bill in 2003 and 2004. In seeking interview participants for this research, it became clear that of the three primary entities in opposition to the Bill, the most accessible were the private sector in health representatives. Given the cyclical nature of funding tied to domestic politics, positions within international development partners are relatively short-term. For this reason, it was virtually impossible to interview international actors employed by the WB or others involved with contesting the Bill. I made repeated requests to Treasury, which were denied through a passive mode of bureaucratic delay and foot-dragging. On the other hand, representatives from private provider organizations who lobbied on behalf of the reset of the private sector were open and proud of their role in contesting the Ngilu Bill. For this reason, the bulk of the stories from

opponents of the Bill, who describe contestation through stories of battle, were drawn from interviews with key individuals from the private sector.

### Building a Campaign

Stories of battle involved the extended narrative of policy struggle as one of discursive and ideational warfare. This involved a host of military terms used to convey the oppositional nature of policy contestation. Though the stories of conflict are seated in a context of interest-laden warfare, the actors also articulated the exact means by which they attempted to persuade key decision-makers, including Treasury and President, throughout the process.

In describing the context and the overall approach to contestation, actors used the symbolic language of war. When asked whether this was a coordinated response, one actor explained:

No we were fighting from the gutters. Me and [Dr. X] were actually in the trenches [...]Yeah (laughter). We were the two main soldiers in the battle and we actually—KHF was born out of this bill and this created this desire of having a common vehicle which the private sector can work with (D\_07).

When asked where the funding came from for this high degree of direct confrontation, he reported, *“So we put up a war chest. We went from place to place from city to city.”* When I interrupted to clarify where the war chest came from, he replied, also further describing how the fundraising was initiated:

My own funds and colleagues who were in the private sector, their funds. So from one institution to the other, we started giving presentations, giving our views on why this bill should not be supported. And we just had a snowball effect of supporters, from manufacturer...(D\_07)

When asked if this was a full-time commitment, he explained, *“Almost! I was actually in charge of [organization X]. At that time, I was CEO and chair and my managers were running it but it took a hell of a lot of my time.”* The other main “soldier” (D\_06) agreed, *“actually that year I spent 30% of my time here; the rest of the time for a whole year I was doing radio interviews, TV interviews, parliamentary committees, meeting World Bank, meeting WHO, meeting GIZ who are very very supportive of the bill.”* As in a war that consists of multiple battles, one of the actors (D\_07) described an intermediate defeat in the following way, *“Almost two to three years and I thought I'd lost it when [...] the bill went for*

*the third reading and it passed in parliament at a record time of 47 MPs.”* Then, as if receiving late intelligence informing him that while he may have lost a single battle, he hadn’t lost the war, he continued:

That was an evening, like seven o'clock, just before December break, and I thought, now we're done. Since it's gone through the third reading and passed, all it needed was the president's signature. Kibaki met me at New Year's Eve... (Interviewer: Just you alone?) Yeah, with all the, whoever was his friend...I went for a break and he recognized me and shook my hand and he told me, "don't worry" and then the next day or the day after he refused to assent to the bill. (Interviewer: In the big meeting with all the stakeholders involved?) Yeah (D\_07).

He then proceeded to explain that he believed the finance minister persuaded the President that the Bill was “fundamentally flawed.” He elaborated, “*The idea was noble, but the way it had been designed and crafted...the devil is in the detail.*” He then voiced his principal argument couched in terms that identify strongly with current debates:

So universal coverage, everyone desires. But, to have a legislated monopoly that would be the only risk pooling entity and will be in charge of claims and collection of premium and show me the numbers, don't add up, just made the whole thing fundamentally flawed (D\_07).

Interestingly, when I pointed out how actuaries and economists had determined that the numbers did work out, he responded in a way that demonstrates just how easy it is to discredit one argument while introducing another at the tail end to shift the terrain of the debate:

So you know, the actuaries are also tricky in terms of how they measure and what they measure, but the fact is that the numbers didn't add up. Somehow there was an urgent drive towards collection but a little bit of a drive of how you're going to spend it (D\_07).

He picked up on this different line of argumentation when asked what they discussed in their meetings with Treasury, “*And of course we gave them our views and they said that if they [NHIF] can't use 100 shillings well, which we provide to them, how are they going to manage a thousand?*” This statement perhaps suggests that governance concerns with NHIF may have been part of Treasury’s political calculus in advising the President to reject the Bill.

## Ideas and Networks of Influence

In the story of contesting the Ngilu Bill, the main actors were able to recall some of the ideas that were wielded in efforts to persuade. This was particularly true in their discussions with the President himself. Interestingly enough, they seemed to identify quite quickly that ideas or “issues” were effective means of persuasion. As one actor explains:

We were there before [Ngilu’s team] and we had a written memorandum with questions. And they had been explained to him, and he had looked into them and implicated. We had distilled the issues; because we realized unless we go issue-based, on the basis of the popularity, we lose hands down, so the only way was to make an operational case and a financial case. To say, this is why this can’t fly. You can’t register 40 million Kenyans in one year. So, because we are looking at operational, can NHIF manage to implement the bill and then economically, can we as a country afford the things that we’re being sold [...] So we went to the president with a political case: the risk of failure. First, we showed it will fail. Then we pointed out what failure would mean politically. And, we indicated why we thought it would fail. It was quite methodical approach. So that is the memorandum that now got sent to parliament as the reason the president rejected that (D\_06).

This story of how the private sector representative “distilled the issues” in an attempt to win the President’s support is interesting for two reasons. First, they presented a very clear, organized, and “methodical” argument. Because each of these touched on distinct domains and were attached to political risks, they were likely to, at the very minimum get the President’s attention. Similarly, this seems to include various elements of the names that operate at micro-level, described in the previous section. Second, this was not the only interview to mention that the President’s dissent was communicated through a memorandum drafted by the private sector and sent to Parliament. Given the level of detail and the specific recollection of events, this claim seems plausible. The implications about the level of involvement of the private sector in decision-making, at the highest office in Kenya, reveals much about Kenyan politics and its neoliberal orientation.

While the ideational features of the attack on the Ngilu Bill are helpful, the venue in which they were aired, the President’s office and through consultations with Treasury, are likewise significant. Again this is couched in competitive language where these actors pitted themselves against the cunning, but slow Ngilu:

So the Treasury has an issue, I [Ngilu] will by pass them [...]The vice president has an issue with it, so I'll [Ngilu] go directly to the MPs because they refused to list it as urgent business for the cabinet [...] in minutes it went to the president yes, who is an economist so fortunately, we had realized that she might do that, so we had gone to the president (D\_06).

When asked how the private sector representatives gained access to a private audience with the President before his own Minister had time to fully consult him on the issue, one interview respondent gave a fascinating account of the exercise of power in Kenya:

being a small country, whether it is village networks of all .....networks or business networks. Actually, I have begun to define power by how many phone calls I am from the president because there are those who can; from the most powerful guy in the land there are those who have his direct number. [...] There are those who are tier two, I think I consider myself a tier two while you have someone you can talk to; whom the president trust explicitly and that person trusts you explicitly so your message gets to the president [...] You went to school with someone, they have known you for a long time, they think you mean well on whatever you said you mean so if you sell them a position, they are able to sell it to the President so we were in the sense privileged to have that kind of arrangement (D\_06).

This level of connection explains much about the kind of access to key politicians the private sector enjoyed, as well as the extent to which they contested the Bill, drawing on all of their resources. To illustrate this point further, the actor explained the informal way in which they were able to gain an audience with the teacher's union in order to reframe payroll cross-subsidization:

So that's basically what happened, we would look and ask who knows the head of the teachers union; I happen to be serving on a board with him someplace else in a school so during a school board meeting I said, 'we need to talk,' and he said, 'in actual fact, we don't have to come to my office, let us go under that tree and talk.' I said, 'it's urgent and important,' he said, 'we'll have time.' So we finished the board meeting, went and talked under a tree. I got an appointment to meet the officials of the union. By the time we went to parliament, the teacher's union was saying these are technical experts and they said this thing can't fly and we believe them and we are not on board (D\_06).

These observations are crucial to this analysis. Traditionally, policy analysis has focused on interest-based modes of policy change, arguing that uncovering these hidden networks reveals insights into why policies evolve and change. While these stories show how the

connections matter, the substance of the conversations and the style of argumentation play at least as large a role. In this way, we know how the private sector actors were able to convince unions, Treasury, and the President himself how to feel about the Ngilu Bill.

## Victory

Finally, the actors commented on the political outcome of victory, again using the language of conflict. *“Basically we killed the Bill,”* as one (D\_06) explained, *“I think we were tired [...] President is the last line of defense. And politically it was very expensive because from there he and madam Ngilu ceased to see eye to eye.”* Like this last statement a number of outcomes of victory were enjoyed. Similar to a military alliance and supporting rebels movements abroad, the principle actors banded together and formed KHF, which has since grown regionally, as one (D\_07) explained, *“We also helped incubate Rwanda and Uganda and we showed Tanzania how the benefits of a unified private sector can be. And now we are moving ahead with East African Health care Federation and using this model in West and Southern Africa.”* Finally, when asked if the defeat of the Ngilu Bill marked the end of these debates, at least one actor, somewhat wearily reported:

No I think the discussions have still gone on. It's in everyone's memory. All these discussions. And then, look at the [current] health care financing strategy for example. If you look at all the amendments during the NHIF bill, Act, or contributions that they're looking at in terms of payroll...are all pieces of that bill and thoughts being seen slightly differently. So it's not completely forgot (D\_07).

These concluding thoughts about the outcome of fighting over the Ngilu Bill are insightful. These stories about the contested process, and the way in which elements are couched in the language of battle demonstrate in a very convincing manner the means by which the President and others were persuaded to reject the Ngilu Bill.

### 6.3.2. *Stories of Defeat*

On the other side of the debate, one of the principle consultants who was hired by the Ngilu team vividly captured the sequence of events and how this affected the policy process. As an initial outsider, this individual claimed to be much less ideologically driven than the rest of the Ngilu team. His role was to look at the numbers and ask, “does this make sense?” He described internal contests within the team about the finer features of the debate, which

largely pitted his staff against economists from MOH. He (D\_05) described this internal struggle thus, “*we even costed it, we debated we argued with [the chief economist], I remember arguing with [him], the whole, almost the whole night, but in the end [...] he agreed this is the number, then we finalized the report, I signed the report.*” He then recalls that they were called into a meeting with Treasury on a Sunday. Before going, they regrouped as a unified team and debated how to approach the process. He continued:

I can’t remember who, I think it was one of the communication guys, he said this thing is very sensitive, once it comes out, because there are so many people fighting, people would want to leak it, so let’s find a way to bring the press in and to look at the right side of it and we slowly leak it out of the press to make sure that the press understands why we are doing, because there is logic to it. After debating Ngilu said no, we can’t do that. That is irresponsible (D\_05).

This is an interesting recollection in so much as it underscores the value of framing and the strategic process by which the Ngilu team attempted to influence public opinion. It also speaks to the integrity, or more pessimistically the naiveté, of Ngilu herself. Regardless, this actor saw this moment as a key turning point in the campaign to win support for the Bill. He picked up the story by describing the circumstances and tone of the meeting:

So we were called in a meeting on a Sunday at the ministry of finance, at Treasury building, we went in, I remember going in at nine, we left at five in the evening, only drinking tea, nothing, we never had lunch, nothing...It dawned on me that the ministry of finance guys just didn’t want this thing, too costly for the government, they didn’t want it to go in stages, nothing, they just didn’t want anything about it, [PS] who is now [...] in the presidents’ office, is the boss now of all civil servants, was then the permanent secretary, it was very clear these guys didn’t want anything. [...] They just said they didn’t have the money (D\_05).

At this point in the interview, I prompted him by reminding him that they had spent a long time arriving at calculations. He agreed, but described Treasury’s entrenched position:

We had calculated it. We had even told them how they could phase it over five-year period, how they could come through, so that the universal health care could come to the country, if you do this year, this is what will happen, you do this, this is what happen like that like that, over five year phasing in period, but the guys were dead against it. They said they didn’t have the money and I think people had already gone and influenced them (D\_05).

It is important to note that in the interview, prior to telling this story, he prefaced by saying this incident was one of the two things that had ever scared him in his life. This helped to personalize the story and illustrate that although he viewed himself as a neutral participant, a hired outside consultant, the consequences of engaging with politics at this level were personally nerve-racking. He continued:

so it was on a Sunday, so we leave the meeting at five, after we left the meeting I said to the guys look, I don't have a good feeling about this, everybody was now going their own direction, everybody was tired and all that, I said to the minister look, madam I don't think this thing...it's a problem, she said no, no, no, we will go to the President and Kibaki is my friend I will go to him. She went to him. That was on a Sunday [...] Monday morning there was nothing in the press, Tuesday morning am driving from home going to the office at that time our offices were in town, first thing I saw was the newspaper headline, Ngilu thing to cost 143 billion, says experts, and I said Shit!, the number was exactly the number which was in the report, exactly what I had given to the report...says experts, fwaaa! I drove into the office, got into the office and I picked up the newspaper, the report including the front page of the report had been photographed in extracts in the newspaper, everything had been leaked by Treasury, it couldn't have been anybody else but Treasury (D\_05).

At this point in the interview, the tone shifted to one of defeat in which he painted the consequence of this betrayal in a predictable light. Albeit, one that demonstrates a sophisticated understanding of the importance of the media and framing in shaping attitudes around the Bill:

From there, the argument was, Ngilu is pushing an agenda to make sure that the government runs out of money, she just wants to eat money from the ministry [...] now we couldn't control, now one ministry is against one ministry...finished. Now it became feeding frenzy, by ten o'clock there are, were five journalists queuing out in my office saying, you know sir we want to talk to you, you know this report of yours, we got it, don't ask us how we got it, what did you mean on page seventeen, you know? It was an absolute nightmare; it was a blow (D\_05).

When pressed to think of what they could have done differently, this interview participant described some of the very tactics employed by the private sector, earlier described in this chapter:

Ministry of health what they should have done is they should have educated people, once they had known the whole thing, take the press and take the employers, employee tell them if you want universal health care it means

this, this, this, we want to do it over five year period it means this, this...it is going to cost like this, like this, they should have taken everybody along and that way then they would have boxed the ministry of finance in. Then even when they release it there is nothing, the press would say but we know, but we know it's good because of this and this, then they will be going back to ask them [...] but when the guys came, they came with a nice juicy report a thing like that, originally signed report, here it is...look they want us to spend this kind of money, we don't have roads, we don't have...it was absolutely nightmare, it was dead (D\_05).

Mirroring his own dramatic tone in reaching the conclusion of his story of defeat, this consultant then illustrated the ways in which this series of events affected and continues to affect Charity Ngilu. This was somewhat novel in the interview data in that so much of the information focused on her character traits that led to her being associated with the Bill and advocating for it, but few reported, or even knew how the Minister stomached this defeat. He described her reaction and the lasting influence of the bill thus:

Ngilu got so angry. She got so dismayed. It was perhaps one of the biggest things she had ever done in her life, and see, for her, it remained a scar. Even now when you see her fighting the ministry of lands...I remember going there [...] to plead with her to assist us on some land issues. After those guys had gone, she said [Mr. X], 'you know this is like the health. I will fight in this ministry straight. I was defeated there but here I will not be defeated.' You can see how scarred she was in her mind (D\_05).

Finally, in describing the aftermath of the defeat of the Ngilu Bill, the interview participant linked this to the current policy agenda in health. Because of his unique level of expertise, he has worked with the current President and the current Secretary of Health in their banking careers, before they moved into government. He reported to be in somewhat consistent communication with the current Secretary of Health and serving as an informal advisor. He is sympathetic to the plight of the current administration to address governance reforms in NHIF, adjust rates, and other incremental measures that resemble the battle over the Ngilu Bill. His following conclusion thus reveals important insights as to the agenda-setting process, and the large shadow that the Ngilu Bill continues to cast over the health sector:

[the Ngilu Bill] became very very difficult. It was hot, very very difficult and since the real unfortunate thing for me, after that failure, even the current Cabinet Secretary I believe when he looks back he knows that, so do you want to go through that? So universal health care is something that is scarred, something that for you to pick it up, you must really have guts, and you must be prepared to fight for it, and the problem is, you don't

know all the corners and everything, so is this the thing you really want to do, or should you just say, ‘I’m cabinet secretary. I have five years. I want to achieve these five things and you do them.’ I mean if I was him, I don’t know...if I was him I would have five things but this would be number five, not number one.

## 6.4. Conclusions

### Sense-making

The sense-making process for the policy to provide national social health insurance demonstrates the way in which actors understood the design features of the Ngilu bill and the array of actors who assumed an active role in promoting or contesting it. As a set of technical issues, actors understood the trajectory of the Ngilu Bill as derivative of its forbearance on the health financing landscape. While the design was consultative, the implications of augmented revenue streams, particularly from ear-marked general taxes and mandatory contributions from employers, were acutely perceived by many as a move to enhance the role of the government in health financing. Similarly, actors made sense of risk pooling through the expanded role of NHIF, which left little room for the private insurance market to compete for customers. While the exact services to be included in the basic package had yet to be determined, actors understood that both inpatient and outpatient care would be covered through a capitated means of provider payment. In addition to the design features of the Bill, actors made sense of the proposal through understandings of the principal agents involved, including the Bill’s primary sponsor, international development partners, Treasury, representatives for the private for-profit health sector, and President Mwai Kibaki. The positions, identities, and relationships of these actors as well as the effectiveness of their tactics were largely understood to operate as explanatory variables in the Bill’s ultimate failure. Chief among these were understandings that Ngilu’s personal characteristics, her relationship to Kibaki, and the lack of stakeholder engagement in championing the Bill, created a charged environment in which the onus of decision-making resided with the chief executive who was subject to tremendous influence from persuasive agents.

### Naming

The naming process for the Ngilu Bill was used in ways that select for perceived shortcomings in the Bill’s design and sponsorship in order to question its legitimacy and categorically position the discourse as one requiring further deliberations about the role of

government in Kenyan society. In the same way that the Affordable Care Act has been dubbed ‘Obamacare’ by opponents in the United States, the 2004 Bill on National Social Health Insurance was renamed the Ngilu Bill by many actors in Kenya. Personification of the Bill achieved two primary aims. First, it sought to create the perception that support for the Bill was limited to a single key champion operating on emotion as opposed to rational calculation. Second, it likely drew on pre-conceived notions about the role of women in Kenyan political life to undermine the Bill’s legitimacy on technical merits. This naming process linked these debates to economic and political considerations by explicitly selecting the Bill’s revenue generation requirements and operational capacity as unaffordable and unsustainable, respectively. In this way, actors with a conservative orientation to expenditure (the Treasury Secretary) and an eye on the political consequences of failure (the President), met the proposal with a fair degree of skepticism. Furthermore, by individually engaging with key constituents at length, the Bill’s adversaries carved out a discursive space in which to reframe certain dimensions of the Bill, including payroll harmonization, in contentious ways. Naming was notable in that both opponents and adversaries seemed to understand that the strategy to identify the proposal with notions of free health care was categorically misguided. This further politicized the Bill and perhaps more importantly, suggested a wider government incursion into the health sector. On this basis, the expanded NSHIF was characterized as a monopoly, which rapidly galvanized a coalition of free enterprise activists. In this way, through a contested process of naming the Ngilu Bill became less about the narrow problems of financial risk protection or access to care and instead represented larger governance considerations in which the role of the State in the daily life of its citizens was questioned. Relying on this logic and its attendant use of the naming process outlined here, the President decided to send the Bill out for further stakeholder consultation where it was promptly dismembered.

### Storytelling

The process of storytelling was utilized to great effect by providing a coherent meta-narrative in which the Ngilu Bill was the subject of a high stakes framing contest. Within this, the opponents of the Bill used discursive strategies to persuade the President of the Bill’s shortcomings. The Bill’s advocates, meanwhile, lost ownership of the issue in the public domain and failed to provide a convincing financial argument. These stories were largely situated in the language of conflict in which participants were engaged in a protracted and

highly charged zero-sum dispute. Stories from sides of the dispute suggest that numbers were a source of conflict, with competing interpretations of measurement standards, data classification, and their meaning, the subjects of intense scrutiny and debate. By reflecting on the policy process for the Ngilu Bill, actors frequently described the persuasive process as one in which framing and the interplay of ideas matter. This includes interactional depictions by the private for-profit representative to explicitly question the financial, operational, and political implications of the Bill in their dealings with Treasury and the President.

Furthermore, the importance placed on framing key concepts early and at strategic intervals in the process was emphasized in the stories actors told. This included attempts to rely on informal and formal networks to gain access to influential decision-makers and attempts to control technical information interpreted by the mass media. Stories of success and failure also illustrate in implicit and tacit ways the strong emotional orientation of entrenched policy positions, which were seen as integral to the Bill's success or failure. Finally, actors understood these stories to explain the Bill's outcome in the context of subsequent policy prospects, and the political obstacles awaiting future health reform measures, such as the user fee removal and NHIF rate increase. This section demonstrates the persuasive effect of stories in gluing together the potent combination of coalitions, strategic positioning, identity construction, and problem definition into a convincing meta-narrative that explains for many the ultimate shortcoming of either the Bill itself or the policy process leading to its failure.

### Framing Similarities

Analysis of the distinct stages of the framing process for the Ngilu bill reveals a number of important common themes across stages. First, the focus on the Bill's financial implications and contested portrayals of the evidence used to make rational financial decisions positioned the Bill in a cloud of uncertainty which was assumed to make Treasury and even some international actors either uncomfortable or defiant. Second, the organization and acuity of the negative response by a coalition of powerful free enterprise advocates positioned the issue in the context of larger governance considerations that extended beyond the health sector. Third, by identifying the Bill with a largely unfamiliar political entity and polarizing personality, opponents were potentially able to draw on tacit understandings of Kenyan political leadership in questioning the Bill's conceptual design and stewardship throughout the process. Fourth, across all stages of the framing process, the centrality of framing itself, largely instrumental or strategic, was understood to have a persuasive influence that explains

the primacy of some ideas over others. Fifth, across all stages the framing of issues, actor identities and relationships, as well as the policy process itself can be understood as socially constructed entities in which actors win or lose at the expense of one another. In this way, analysis of the Ngilu Bill demonstrates a coherent and highly instructive way of assessing the role of framing on the health policy process in Kenya as well as actors' understandings of the Bill's ultimate failure.

### Framing Differences

While important similarities existed across the stages of the process for the Ngilu Bill, emphasis was placed at different levels of abstraction at distinct stages of the framing process. For example, sense-making focused to a large extent on the organizational and institutional dimensions of the Bill as well as the array of actors involved in its sponsorship and contestation. More than for the storytelling and naming processes, actors understood the Bill's primary sponsor, and the political context in which she and the President rose to prominence as important. Furthermore, understanding the Bill as following on the heels of free primary education, which entailed a significant commitment on behalf of the government (and Treasury) also helps to clarify the social dynamics underlying the naming and storytelling processes. The explicit use of Ngilu's name and its adherence to a polarizing political personality, on the other hand, helps to explain the practical or strategic dimensions of the Bill. Also, the manners in which actors wielded and interpreted evidence, to unions, the media, Treasury, and the President in a very direct attempt at portraying the Bill's financial and technical shortcomings, were also more clearly represented in analysis of the naming process. While the storytelling section brought together elements of each of the other sections, some features, such as intentionality and emotional pull, were more clearly demonstrated as playing a role in creating a meta-narrative that explains how actors understood the interplay. Also, in storytelling, there was a greater coherence to portrayals of the process as linear and marked by a defined trajectory, and less of an emphasis on the substantive shortcomings of the Bill itself. In this way, the analysis of differences across the framing stages for the Ngilu Bill reveals less in terms of discrete forms of domain specific information and more about the subtle shift in emphasis in attempts to create meaning in the policy process.

# Chapter 7: Discussion

---

## **Introduction**

This chapter compares the findings from the previous chapters to explore the nature of framing in the Kenyan health policy process and to position these insights in the global pool of knowledge. By critically reviewing and comparing findings from the previous three chapters, I argue that framing is a productive avenue for understanding salient features of contested policy ideas. In the first section, I conduct a comparative analysis of the framing process, including sense-making, naming, and storytelling across the three policy domains. Next, I compare the entities framed, including issues, identities and relationships, and the policy process, in each of the policies. This provides the analytical basis for the third and fourth sections of this chapter in which the relevance of these findings for the UHC movement, health financing in Kenya, and critical policy studies is discussed. In this way, the research presented here seeks to advance the knowledge base for the newly theorized frame-critical policy analysis as well as to generate meaningful insight for Kenyan actors responsible for aligning health financing policy with the growing UHC movement.

## **7.1 Comparing framing processes across policies**

In this section, I compare salient observations of the framing process including sense-making, naming, and storytelling across the three distinct policy domains of user fee removal, the NHIF rate increase, and the Ngilu Bill. By comparing the ways in which the framing process varied across policies, this section sheds light on the policy process in the Kenyan health sector as well as frame-critical policy analysis as an analytical tool. I critically appraise the substantive content of the data to illustrate how data co-generation is intricately tied to meaning making in frame-critical policy analysis. In this way, this section will provide a fuller explanation for understandings of “how” financing policies have been framed in the Kenyan health sector.

## Sense-making

While sense-making varied to a certain degree in the presentation of information across three policy domains, this static conception was more difficult to analytically fragment than naming and storytelling. This was largely attributable to the means of data co-generation as well as the artificial barrier that exists, for analytical purposes, delineating the three policy domains. In actuality, actors understood each policy in relation to one another, as a continually evolving story situated in a particular historical context and populated by a changing milieu of stakeholders. The most accurate way to characterize the differences across policy domains was to conceptualize the sense-making process around the finer details of the bill itself, its technical dimensions, as well as the actors directly involved in championing or opposing it. For example, while the sense-making process for the Ngilu Bill and the rate increase made heavy use of financial concepts of risk pooling and threats to the private insurance industry, there was a shift in emphasis in the role actors played in the process. For the rate increase, actors' understandings of unions and their functions were represented to a larger extent than in the Ngilu Bill which centered more around the agency and personality of a select group of elites. Moreover, the user fee removal was tied in stronger ways to a global political economy of financing actors than either the rate increase or the Ngilu Bill. Professional identity or membership in an epistemic community, on the other hand, seemed to be a common theme throughout analysis of the sense-making enterprise for each of the three policies. Actors made sense of politics and the policy process in slightly different ways across each of the three policies. In the user fee removal, actors attributed political considerations, tied to electoral politics, as a way to make a relatively marginal improvement to revenue collection that would be politically expedient and popular. In the rate increase, politics was seen largely as a function of systemic corruption and inefficiencies as symbolized by the NHIF. The Ngilu Bill was understood as a political drama in which policy elites grappled with incommensurate understandings of the role of government in Kenyan society. Nevertheless, the fragmentation of the Ngilu Bill preceded strong efforts to increase rates for NHIF, which in turn made user fee removal a much more attractive policy pursuit. In this way, sense-making was very much the same across all policy domains and distinct only for analytical purposes.

## Naming

Naming, which included selecting and categorizing, was quite distinct, and to a larger extent than either of the other framing processes, across policy domains. Common to each policy was the suggestive choice of a name for the policy itself. Through the co-generation process this name was adopted for analytical purposes. While the Ngilu Bill and the NHIF rate increase were not “officially” recognized names, the “user fee removal” was most likely derived from a global health finance policy discourse. Nevertheless, the name of the policy itself mattered, regardless of its legitimacy or even accuracy. Selection for the removal of user fees was significantly milder, preferring to focus attention on the marginal benefits of incremental finance measures. Selection for the rate increase focused squarely on the perceived inadequacy and dysfunction of NHIF. Selection for the Ngilu Bill focused on political personification and distorted portrayals of financial shortcomings of the bill. The naming process selected for salient features of the policy or its implications that favored a policy position by a coalition of attuned frame sponsors. For example, by perpetuating dated beliefs about the shortcomings with NHIF, actors pre-emptively warded off certain proposals for reform. Though actors largely used names for instrumental purposes, in the strongest of examples, these were also expressive in so much as actors were able to colorfully expand on the names they used and reflect on the efficacy of symbolic representation. While the analysis identified a number of such explicit metaphors and similes, it also presented more tacit, taken-for granted names that were selected for less obvious features of the policy process. By using names to challenge the methods and means of evaluating risk and financial viability of the Ngilu Bill, actors raised concerns about the validity of their implications. In this way, naming through a process of selection was seen as a key element at the micro-level in framing distinct health financing policies, especially the NHIF rate increase.

There was difficulty, however, in internal boundary definition, where it was often unclear whether a name selected or categorized a salient feature of the policy or the policy process. Moreover, given the variety of functions and shifting priorities of naming through a process of selection, little room was left for categorization. In fact, conceptually the two are quite inter-related, by selecting something, it is categorized as having affinity for sets of things that it is and is not. By categorizing/selecting a revenue collection issue, the efforts to increase rates for NHIF divert attention away from the pressing need to change accreditation processes. Similarly, by categorizing/selecting the expanded NSHIF in the Ngilu Bill as a

monopoly, the debate assumes a democratic tenor in which notions of free enterprise are called into question. While categories certainly existed, there was little by way of the data-co-generation process to sufficiently distinguish between selecting and categorizing. Perhaps for this reason, categorizing in the naming analysis for each policy was significantly shorter than the selecting sections (which were assumed to encompass a more expansive notion of naming dimensions). This will be further explored in the following section on future directions for frame-critical policy analysis.

### Storytelling

Storytelling assumed a number of forms with a variety of intentions across the three policy domains. On the one hand, stories about political participation were used to a mild extent in the analysis of user fee removal. On the other hand, comprehensive accounts of conflict surrounding the Ngilu Bill were used to define the arch of contestation and interpret its ultimate outcome. Stories across all policies shared a strong focus on actor agency in government corruption and political contamination of the health arena. Perceived self-interest was primarily seen to be driving narratives across all three policies, though the form of those constructions and the substance of their persuasive influence differed. For example, in stories of conflict for the Ngilu Bill, a clear focus existed on the ideational basis for affecting cognitive change amongst elite stakeholders. This was perhaps more clear because of the nature of the outcome, namely, one person (the President) was required to make one decision (to sign the bill into law or reject it). For analytical purposes, this was somewhat clearer to investigate and actors were quite engaged in explaining their understandings of the forces that precipitated the momentous decision. This contrasts with the means by which obstructionists have historically prevented the NHIF rates from being increased.

Alternatively, one branch of stories suggests that the path-dependent nature of institutions may lead to policy stasis. At the other extreme stories of user fee removal were vague and less informative. Their simplicity, however, might suggest that the relatively incremental approach to adjusting a persistently annoying feature of revenue collection, that also happens to align with a scientifically sponsored global discourse, made it a prime candidate for successful policy implementation. Though this analysis does not seek to explain why a policy succeeded or failed, some stories, such as those for the Ngilu Bill, are more informative and richly layered, than others. This may reflect the significance of the policy domain, the socio-political context, or the level of involvement and familiarity with the

contours of the discourse on the part of actors responsible for engaging with the researcher in data co-generation. Regardless, storytelling is an important and insightful way of analyzing how actors create meaning in the health finance policy process.

#### Critical Reflection of the Comparative Value of Each Framing Stage

In assessing the three stages of the framing process by the three policy domains some clarity is produced around the nature of insights and their levels of abstraction. While the sense-making process is pervasive, constant, and evolving throughout the life of each policy, it helped to understand the emphasis of distinct policy issues. It was particularly useful for understanding why NHIF and Charity Ngilu were so controversial and why the President of Kenya expended early political capital by addressing a narrow financial nuisance (user fees) in the health sector. It paints a picture, underpinning beliefs and filling in the background of political debate. Through its characterization of actors and their relationship to one another, sense-making has a strong institutional and organizational locus as well.

The naming process was much more discerning of policy domain and specific to particular policy positions. Despite the analytical difficulty of delineating selecting and categorizing, the naming process more broadly was helpful at exploring how certain ideas or entities came to be portrayed in a particular way. By presenting discreet entities, naming operates at a more granular micro-level and there is the possibility for simultaneously cognitive and interactional analyses of naming processes at work in health financing disputes. Thus, naming analysis is the more familiar form of framing that seems to bridge disciplines (linguistics, psychology, sociology, policy studies, etc.) in an attempt to dig into the substance of ideas and their persuasive influence.

Finally, storytelling, while inherently difficult to synthesize for analytical purposes, provides the meta-narrative that positions key features of the policy process into a coherent system of interaction. It was extremely helpful for understanding how and why the Ngilu Bill failed and the palpable vein of corruption that features so prominently in Kenyan political life. The logic and rationale used to espouse particular interpretations of reality are also more easily linked to values held by the storyteller. Nevertheless, the fragmented nature of stories of scandal for the rate increase and the scant description of features of the user fee removal suggest that storytelling is highly dependent upon getting a set of storytellers who are

intimately involved in the debate. While all stories are relevant, some are “thicker” and informed by richer experience with the subject material than others. This is not to say that a first-hand account of policy action is directly more insightful than a second-hand more speculative account, but rather, the first-hand account is likely to be presented in a more detailed, nuanced, and expressive manner. For this reason, the process of data co-generation, including the recruitment of study participants as well as the location of alternative forms of data are highly important for storytelling analysis. In summary, all three phases of the policy process reveal different kinds of insight, and at different levels of abstraction, for the ways in which three distinct finance policies were framed in Kenya.

## **7.2 Comparing the objects of framing across policies**

This section compares the objects of framing across each of the three finance policies. Drawing on Dewulf’s delineation of framing entities (Dewulf et al. 2009), which include the issues, identities and their relationships, and the policy process itself, this section will further elaborate the extent to which certain features of the three distinct policies are represented in the present analysis. This provides insight into the ways in which framing affects understandings of the landscape of the policy terrain, interactions amongst its participants and the ways in which these are linked to broader explanations of the interplay of ideas. Much like the stages of the policy process, these are presented as distinct, static or “frozen” features of the policy for analytical purposes, when in actuality the boundaries between the processes are somewhat less clear (Van Hulst & Yanow 2014). In this way, this section will demonstrate how framing works to create meaning for actors involved in the health financing landscape and provides a basis for subsequent action.

### **The Issues**

As a framing entity, issues varied considerably and were largely specific to the policy domain under consideration. The policies were similar to the extent that the technical features of policy design and the implications of its adoption into law were subject to framing. Similarly, these issues were selected for analysis based on their perceived role in financing health care. Nevertheless, certain issues, such as the constitutionality of the expanded NSHIF in the Ngilu Bill or the shift from cost-sharing to user fee removal were policy-specific. Also, the emphasis of issues differed across policies. Whereas the framing focus on the user fee removal and Ngilu Bill was on technical merit and political expedience, the emphasis on the

rate increase was placed largely on a set of issues associated with the NHIF itself in the policy to increase its rates. Also, the user fee removal and NHIF rate increase were understood to be based on issues of revenue collection whereas the Ngilu Bill was a much more ambitious attempt to overhaul the entire health financing infrastructure. Other issues at play were the responsibility of government to provide for the poor and indigent, which featured more prominently in framing the user fee removal and the Ngilu Bill, but not the NHIF rate increase. Similarly, the rate increase involved a more pronounced understanding of issues related to organizational structure, management capabilities, and accountability than framings of the user fee removal and Ngilu Bill. Alternatively, the NHIF rate increase and the Ngilu bill both involved framing of risk pooling considerations whereas the user fee removal was almost exclusively focused on revenue collection. In addition to issues related to finance, all policies involved practical considerations for rolling out proposed reforms which were seen as relatively feasible for the user fee removable and politically untenable for the NHIF rate increase and the Ngilu Bill. Moreover, actors widely contested issues specific to each policy based on a deeply held values held by themselves as well as perceived values reflected in Kenyan society. In this way, Universal Health Coverage was understood as a means of resolving financial shortcomings in the health sector based on conflicting interpretations of sets of issues related to distinct finance policies.

#### Actor identities and relationships

Actor identities and the relationships they share with one another were also subject to a great deal of framing. To a lesser extent than issues, however, actors framed themselves and others differently across policies. This was also somewhat of an analytical construct in that the identities and relationships operate across policy domains and though some were emphasized more and less in discussions around certain policies, they functioned in much the same way. For example, trade unions and their role in framing the NHIF rate increase were prominently described, but unions also played a significant role in framing the Ngilu Bill. Similarly, the implications of user fee removal were pronounced for health care providers whose unions actively protest the manner in which it has been subsequently implemented. The relationships between unions and other organized interest groups for the NHIF rate increase were more clearly framed in an attempt to illustrate the construction of resistance to an enhanced NHIF. In analyzing the Ngilu Bill, identities of several elites, mostly in the form of political personalities, were central to framing. Alternatively, the user fee removal more

clearly demonstrated the identity of key multilateral organizations and international health economists in policy framings. Relationship framing was more vividly depicted in storytelling, particularly in framing the Ngilu Bill. While the private for-profit representatives were also understood to be more actively engaged and with closer ties to influential decision-makers in the Ngilu Bill, they are virtually absent in depictions of the user free removal. Nevertheless, these identities and relationships form the entire interactional plane in which ideas are framed and subsequently attract sponsorship or resistance. Though presented discreetly for analysis they work together to provide an understanding of how Universal Health Coverage, as a set of interrelated financing priorities, has been framed in Kenya.

### The policy process

The policy process was also the subject of much framing in which actors sought to portray the activity of themselves and others in ways that explained policy success or failure. This was an important distinction. While searching for meaning, actors gravitated toward causal explanations. While rational, interest-based explanations for policy outcomes were pervasive, actors more intimately acquainted with the specifics of a given policy domain seemed to favor ideational explanations. This was most commonly referred to as “packaging” information in ways that persuade. For example, in the Ngilu Bill, the chief architect admitted to mistakenly framing the policy as one of free health care. Similarly, other primary champions and members of Ngilu’s inner team described the fatal misstep of not informing the media and instead allowing Treasury to leak the financial details of the Bill to the press, which forfeited control of the framing process. On the other side, opponents of the Ngilu Bill commented that given widespread public support and sponsorship by Parliament, they were forced to go “issue-based” presenting an ideational case of political, financial, and operational concerns in their dealing with Treasury and the President. This insight, while most vividly portrayed in stories of the Ngilu Bill, existed for other policies as well. Through the attendant use of metaphor to characterize the user fee removal, actors framed the policy process as one in which party consultants were given a platform to introduce new ideas to a receptive audience. Furthermore, for the NHIF rate increase, actors relied on established and at times dated framings of the NHIF in ways that blocked or preempted new ideas from receiving widespread consideration. In these ways the policy process itself was subject to framing in ways that corresponded to the specific features of a given policy proposal.

In addition to framing the policy process in specific policy domains, framing occurred in a variety of settings across tiers of decision-making structures. Throughout the analysis of each policy, actors commonly made reference to a number of technical working groups composed of a diverse array of stakeholders in which the interplay of ideas was an essential part of the policy process. This suggests a formative sequence in which multiple tiers and venues exist for policy deliberation. Oftentimes MOH will be asked to provide a report to the Parliamentary sub-committee on health. Stakeholders deliberate over a variety of issues. These are oftentimes unresolved and a list of policy options is submitted to Parliament for debate. Ideas are then debated and a second round of consultations takes place. For high profile issues, such as the Ngilu Bill, this process is amplified by media framing. The constitutional basis of financing policies is often the subject of court challenges by opponents of a particular policy. Finally, if it survives, it reaches the office of the President, whereby it is either signed into law, or rejected, as was the case in the Ngilu Bill.

The policy process is framed as an ideational process in other domains as well. For example, several actors understood that the pace and timing of policy directives is often developed at cabinet level, where the executive branch prioritizes a number of key intentions. While this is an insular process and access to the interplay of ideas within the cabinet is highly restricted, they can be arrived at through the orders issued to the legislative branch as well as other organs of government. Similarly, the interplay of ideas and the incommensurable differences represented by the Management Board of NHIF is often framed as a key feature of health finance policies. In this way, framing takes place fluidly, in a variety of locations, with an evolving network of actors, and with unpredictable consequences. Nevertheless, it is clear that actors in Kenya largely frame the policy process as one in which ideas are consistently contested by a plurality of actors and based on principles of deliberation characteristic of democratic governance.

In much the same way as stages of the framing process are useful for conceptualizing the interplay of ideas, the objects of framing provide insight into the substance of these interactions. Ideas conceived as a set of issues, identities, relationships, and understandings of process presents the analyst with a nimble set of discursive domains to generate interactional meaning. In this way, each of the entities work together and in concert with policy participants to co-construct a particular interpretation of a problematic policy situation.

By focusing on both the process of framing as well as the objects being framed, an interpretive mode of policy analysis renders both the foreground and background of the debate, as well as the behavior of participants in it, comprehensible.

Thus, this work has demonstrated how the politics of UHC in Kenya are complex and multi-layered. The analysis of framing processes for three distinct policies aligned with UHC illustrates how actors construct meaning through the interplay of ideas. Interpretive analysis of these ideas, and the meaning-making enterprise more broadly, has produced significant insight for the UHC movement in Kenya and frame-critical policy analysis.

### **7.3 Significance for UHC in Kenya**

This study reflects on a highly charged political environment in which the interplay of ideas around UHC carry strong implications for the global movement as well as health financing policy in Kenya. It is important to note that following the principles of constructivist inquiry, this work makes no claims of generalizability or external validity. Rather the transferability of the findings are largely to be determined by the actors responsible for incorporating these insights into practice (Lincoln & Guba 1985). Nevertheless, I believe six observations are salient for, what some have called, the UHC “movement” (Latko et al. 2011; Brearley et al. 2013). The contributions of these findings to the global pool of knowledge, as well as practical recommendations based on the researcher’s interpretation of their significance, are now discussed.

First, this provides much needed analysis on the political process through which UHC reforms are pursued. The UHC literature is clear that political will is a necessary precondition of successful movement towards UHC (WHO 2010; Gwatkin & Ergo 2011; Brearley et al. 2013; McIntyre et al. 2013; Yamey & Evans 2015; Nicholson et al. 2015; Fox & Reich 2015; Reich et al. 2016). Yet, most of the research to date has largely been descriptive (Brearley et al. 2013; McIntyre et al. 2013) or focused on economic dimensions (Knaul et al. 2012; Mills et al. 2012; Balabanova et al. 2013). Only recently have researchers begun to think about ways to adequately study the political process of UHC reforms (Fox & Reich 2015). By introducing a novel conception of frame analysis (Van Hulst & Yanow 2014) to health policy, this work provides a deeper, situated understanding of the political

dynamics at play in a country that has struggled to make substantial progress towards UHC. By focusing on how actors intersubjectively construct meaning in the policy process, this analysis furthers our understanding of an otherwise opaque and problematic situation. In this way, the analysis will provide a valuable contribution to the global pool of UHC knowledge by clarifying why some policies (user fee removal) were successfully adopted and others (the NHIF rate increase) were not. Furthermore, by bringing to the fore a robust, but unsuccessful effort (the Ngilu Bill) to comprehensively align health financing with the UHC movement, this analysis demonstrates the potential consequences of moving too quickly in pluralistic societies. This analysis therefore provides a deeper and more politically aware understanding of the difficulties in moving towards UHC in low-income countries.

Second, in Kenya, as in much of the world, UHC is highly associated with health financing. This study adopted health financing as the principle UHC function of health systems because, at the time of planning, the global movement was still very much driven by the health financing ‘epistemic community’ (Haas 1992) from which it emerged (Bump 2010). A critical mass of financing work placed attention on the equity dimensions of “universal coverage” (Mills et al. 2012; Tangcharoensathien et al. 2011). Key financing actors in leadership positions at global organizations, such as WHO and the Rockefeller Foundation, further developed and promoted this concept (Garrett et al. 2009; WHO 2010; Brearley et al. 2013; Evans et al. 2013; Kutzin 2013). This global frame has been somewhat clarified and augmented over the course of the study with efforts to link UHC to previous global health campaigns such as the Health for All movement and the Alma-Ata Declaration of 1978 (Evans et al. 2013; O’Connell et al. 2013; Kutzin & Sparkes 2016). This seems also to be the case in Kenya, but to a much lesser extent.

The health financing community in Kenya still drives much of the discussion around UHC, but some have begun to shift the focus away from financial protection and towards primary healthcare. This may be an important example of reframing, which policy theorists argue is a key means of resolving intractable policy controversies (Rein & Schön 1993). For reasons identified in this thesis, health financing has been viewed as a problematic policy terrain in Kenya. Whether or not this is the primary motivation for reframing or whether renewed emphasis on primary healthcare simply reflects shifts in the global framing of UHC, is unclear. Similarly, it is unclear how country experience, such as the legacy of health financing contestation in Kenya, has affected the global efforts to extend the UHC frame.

More research on the interface between the global and domestic framing of UHC is needed to clarify the connections between the two. Nevertheless, in Kenya, at the time of this research, health financing continued to dominate discussions of UHC.

Third, a fundamental frame conflict exists over the nature of risk pooling that lies at the heart of health financing debates in Kenya. Frame conflicts, such as these, reflect deeply held and incommensurable value systems, and result in entrenched policy positions (Schön & Rein 1994). On one side, actors, predominately public sector employees and international stakeholders, support efforts by global health advocates such as WHO to increase financial efficiency and equity through the operation of a single large risk pool (McIntyre et al. 2008). On the other side, actors, predominately from the private for-profit sector, claim that the single risk pool in Kenya is a bad one and the only way to clean up their behavior is through competitive market forces. This reflects social vs. libertarian notions of the size and scope of government involvement in Kenyan life (Chan 2016). As I have shown, governance in Kenya is a pluralistic enterprise, with robust participation from the private sector and international stakeholders. In this context, countries that have made strides towards achieving UHC have benefitted from strong executive leadership and political windows of opportunity (Frenk 2006; Atun et al. 2013; Yamey & Evans 2015; Reich et al. 2016). Yet, what this analysis reveals, is that even with strong leadership and a favorable political climate, the way in which debates are framed matters. This perhaps suggests that strong leadership is actually knowing how to effectively frame issues in ways that galvanize large ‘coalitions of interests’ (Schattschneider 1960). In this respect, we can see the value in reframing the UHC movement away from health financing in favor of primary healthcare in Kenya. Indeed, many policy actors who opposed the Ngilu Bill (including private sector representatives), voiced support for small measures that would increase access to care for marginalized socioeconomic groups. In this way, ideas can mobilize politics in ways that subsume the priorities of organized coalitions and free the decision-making process from gridlock.

Fourth, health financing reforms in Kenya that seek to re-balance the regressive health system are primarily incremental in nature. While UHC is explicit in its rejection of a one-size-fits-all approach, many of the countries that have made progress have made small incremental gains over time (Lagomarsino et al. 2012; Balabanova et al. 2013; Maeda et al. 2014). In this respect, the lessons from the Ngilu Bill are instructive. A comprehensive overhaul of the health financing architecture in the country generated intense opposition, at

least in part because of the scale and urgency of the proposed reforms. Furthermore, international experience suggests that more organic, bottom-up movements can help sustain the needed political support for a far-reaching policy measure such as UHC. As Reich et al. (2016) explain: “[in] Brazil and Thailand, social movements had a catalytic role in putting UHC on the political agenda and in encouraging government leadership to adopt and implement reforms”. This is in stark contrast to how several actors understood the rushed, top-down nature that saw the Ngilu Bill ushered through Parliament. In the face of a plurality of participation in the health arena as well as a diverse and market-oriented economy, sweeping changes in the Kenyan health sector are seemingly impossible to enact devoid of significant external political shocks. Instead, as the removal of user fees somewhat demonstrates, the history of health financing in Kenya is marked by smaller, incremental changes that provide less inspiring, but equally salient markers of societal progress.

Fifth, the failure to implement a program of comprehensive change in the health sector potentially reflects underappreciated systems of democratic governance. In other words, what some see as bad for the Kenyan health system might actually be good for Kenyan democracy. While much of this work was focused on elites, its focus on framing reveals much about the deliberative nature of Kenyan politics. In deliberative democracies, there is a deep commitment to cultivating a polity marked by a plurality of values and aims (Dryzek 2000). Compared to some of its regional neighbors, Kenya has made great strides in its ability to strengthen citizen voice in the democratic process (Finkel & Smith 2011). On the one hand, health advocates may argue that the rejection of the Ngilu Bill represents a missed opportunity for health systems strengthening. On the other hand, democracy advocates can point to a sequence of events marked by a system of checks and balances in which the opinion of the ruling elite is subject to extensive deliberation from multiple segments of Kenyan society. For this reason, the analysis suggests that the global health community could be more circumspect in its efforts to further the UHC agenda.

Sixth, health financing debates at the heart of UHC reforms involved the interplay of ideas that draw on underlying values as opposed to evidence-informed policy positions. There are several problems with evidence-based approaches to policy making. Often, research is solicited to lend authority to the preferences of actors and as a symbolic means of demonstrating sound judgement (Boswell 2009). This was particularly present in the use of evidence by the Jubilee Coalition to justify the removal of user fees, but also by the private

sector in opposition to the Ngilu Bill. The outsized role of development partners in using evidence to justify parallel service delivery schemes, financing pilots, and influencing the policy agenda potentially undermined the authority of domestic policymakers, a finding shared by research in Ghana (Vecchione & Parkhurst 2015). Indeed, the global health community is somewhat unique in countries such as Kenya, where actors frequently exercise financial, epistemic, *and* normative power (Shiffman 2014). Epistemic power is pronounced in health financing, which is commonly perceived to be an enterprise germane to economists and actuaries; however, the Kenyan experience demonstrates that decision makers are not altogether financially fluent and struggle to grasp the nuances of data meant to persuade. Instead, evidence assumes a ‘performative quality’ (Smith & Stewart 2015). Though good evidence is used in Kenya, it is also heavily contested and, as elsewhere, must be used to solve problems amidst competing priorities and agendas (Hawkins & Parkhurst 2015). Nevertheless, the Kenyan experience suggests that ideas in the form of evidence can be particularly useful in dealings with Treasury, who, by virtue of being the primary steward of government finances, exercises power and authority in dealings with other branches of government, notably the Executive. As the Ngilu Bill demonstrates acutely, however, evidence can, “inform, but cannot determine policy choices” (Hawkins & Parkhurst 2015).

## Recommendations

In addition to the broader interpretations of this research, this study raises a number of specific insights that are relevant to policymakers and other stakeholders in Kenya. These recommendations, a requested output of the research by interview participants, are based on the researcher’s reading of the data and his interpretation of beneficial policy options. This includes overlapping areas of interest that could be communicated through a form of frame reflection, based on the principles of mediated negotiation (Schön & Rein 1994).

Two areas consistently identified across the spectrum of study participants were the urgent need to define a basic (costed) package of health services and the desire to remove the accreditation process from NHIF (possibly through contracting). By focusing on these two issues first, some of the confusion leading to entrenched policy positions could be alleviated. Though a dynamic costing model was developed by a consultant and individuals within MOH were trained to use it, there currently lacks good costing data and no defined basic package for health services offered by NHIF. If the operations of NHIF are to be augmented,

it will not be able to afford comprehensive care, leaving plenty of scope for private insurance to function as complimentary. Because, at the time of this analysis, NHIF has yet to indicate what it plans to cover at-scale, the private for-profit sector has rejected any measures to enhance NHIF based on guarded suspicions of intended overreach. Similarly, there is a static notion of the benefits package, which is unfounded and represents a potential stumbling block to formulation. As with other countries, this benefits package could explicitly develop a roster of services to be provided at various levels of reimbursement based on facility type and revisited annually or bi-annually. In this way, problems encountered by other schemes, such as the excessive costs of optic and dental care in the civil servants' scheme, could be rectified relatively simply. Moreover, if demand and financial projections allow, more services could slowly be included in the benefits package as an expanded NHIF matures. By enshrining this routine function in legislation, and by appointing an external board (perhaps located at KEMRI), the function of developing the benefits package could be further de-politicized.

Actors understood that the accreditation process within NHIF was deeply flawed and subject to exploitation. By focusing on rectifying accreditation processes, NHIF could free itself from an unnecessary burden and focus on strengthening the fundamentals of the organization. Similarly, by outsourcing this function or expanding the remit of an existing regulatory body to include it, NHIF would benefit from a more thorough and neutral process than the current system of empaneling. This could fix inefficiencies within the system leading to leakage of resources, help repair the image of NHIF, and signal to stakeholders that the government will take regulatory affairs seriously.

Bolstering its public relations department and proactively engaging stakeholders should help the NHIF repair its image. This can take two forms, either a complete re-branding including a name change, or a media blitz that reaches across the country to ingratiate NHIF to its customers. Stakeholders that work with and for NHIF say that perceptions of the organization are based on an outdated and misguided understanding of corrupt practice. For example, though many people claim that NHIF has yet to reveal its financial dealings, the organization has published an account for three years in a row in the largest national newspaper. This suggests that its reputation precedes itself in policy circles, which makes it a relatively easy target for opposition. Instead of consistently defending itself, the organization should place more of an emphasis on proactive media relations and

stakeholder engagement. In this way, NHIF should invest heavily in transforming its image to regain public confidence and trust in the organization.

Similarly, by developing a sustainable long-term plan for addressing the needs of the poorest (and by conclusively defining them) key concerns about the nature of government stewardship would be clarified. Many, including private for-profit advocates, call for investment by the government in covering the indigent. How to finance this investment, possibly through innovative forms of indirect taxation (i.e. sin taxes, extractive industry tax, mobile carrier tax, earmarked value-added-tax, etc.) should be the subject of economic analysis and policy deliberation. On the other hand, by prioritizing issues of revenue collection, such as increasing contributions to NHIF or introducing innovative forms of taxation, in the absence of deliberation, actors are likely to encounter entrenched and impassioned opposition. Carefully shopping for an appropriate venue and nimbly redefining the problem through a process of framing, actors, however, can recruit values and shape preferences across the spectrum of stakeholders to generate momentum for this issue. In this way, this research demonstrates the value of interpretative approaches for understanding the policy terrain and providing insights that assist in informing political behavior and further decision-making.

#### **7.4 Significance for framing research**

In addition to the broader recommendations for the global UHC movement and Kenyan health financing, this research project underscores a number of important recommendations for framing research. To inform the theory and methods deployed here, this project initially sought to assess the scope of framing research as it relates to the health policy process (see Chapter three or Koon et al. 2016). Through the scoping review, a number of gaps were identified with respect to contemporary understandings of framing and the health policy process. First, of the small number of studies identified (n=52), few were conducted in LMICs. Second, only a few health issues, notably tobacco control, obesity, and pandemic influenza preparedness, were well-represented in the literature, leaving other issues, such as health financing, underexplored. Third, there was considerable variation in how framing research was conducted based primarily on disciplinary orientation. Fourth, framing research was relatively variable with respect to the level abstraction at which frames operated. The

gaps identified in this paper served as a foundation for more research into the complicated ways in which framing affects the policy process.

This study addressed these gaps by analyzing the influence of frames in a relatively unexplored domain (health financing) and in a new geographic setting (Kenya). Similarly, this study applied a new methodology based on theoretical advancements (Van Hulst & Yanow 2014) in a particular type of framing research called frame-critical policy analysis (Rein & Schön 1996). Furthermore, the considerations for the conduct of framing research identified through the scoping review were adequately satisfied by the subsequent project (Table 4, p.54). In this way, the research presented here pushes the body of framing research into new territory and helps strengthen its evidence base.

This research demonstrates that interpretivist frame-critical policy analysis can be applied to understand the construction of intersubjective meaning in the policy process across a range of settings and policy issues. This should be carefully distinguished from explanatory theories developed and applied in other epistemological traditions within the social sciences that seek to explain or predict policy failure or success. Instead, frame-critical analysis explores a key feature of the policy process, namely ‘problem definition’ and the development of putative policy responses to the emerging policy problems (Rochefort & Cobb 1994). This aligns with the original conception of ‘problem setting’ (Rein & Schön 1977) and is evidenced by the overwhelming number of instances in this research where ‘policy action frames’ (Schön & Rein 1994) helped to shape understandings of the issue, the actor identities involved, the interpretations of the policy process and the sequence of events. As a narrative-driven form of framing (Braun 2016), frame-critical policy analysis is a valuable means of assessing the role that societal values play in shaping social programs (Rein & Schön 1996).

In this analysis, the newly theorized approach to frame-critical policy analysis, while more dynamic, seems to slightly favor interpretation of actor agency over structural phenomena. This is perhaps attributable to the researcher’s understandings of the phenomenological presuppositions of this work (Yanow & Schwartz-Shea 2006). Frames balance structure and agency because our world is framed by events and experiences and yet we actively frame events and experiences (Gamson et al. 1992). Nevertheless, a fuller explanation of the broader historical and institutional factors that shape policy design was not

accomplished in this analysis. In this respect, perhaps the Schön and Rein (1994; 1996) framework is somewhat underdeveloped. For example, Schön and Rein (1994) argue that frames can be thought of as a hierarchy based on levels of abstraction. In their conception, the middle level, institutional frames, are conceived of as organizations. Though they cite the work of New Institutional scholar (March & Olsen 1989) the examples they use throughout their book and the description of institutional frames do not adequately account for the way institutions *as rules* shape behavior and policy choices (Schön & Rein 1994). It could be argued that, given the primacy of ideas in framing analysis, rules are simply “congealed” ideas (Riker 1980). Still, a fuller analysis of the complex ways in which rules, legislatures, and electoral systems have evolved in Kenya would help contextualize this framing research. Furthermore, despite operating from a different research paradigm new (historical) institutionalist scholarship could help clarify the lineage of incremental policy change in Kenya through the use of analytical metaphors such as policy layering, drift, conversion, and displacement (Mahoney & Thelen 2010). Moreover, accounts that combine framing research with historical institutionalism have been shown to offer convincing interpretations of policy change (Schmidt 2008; Schmidt 2011).

The newly theorized frame-critical analysis was a means of addressing the considerations identified in the scoping review as well as the original Schön and Rein (1994) work. Through analysis of framing as the interplay of ideas, actors were constructed to be frame sponsors that compete and contest in the ‘nested policy arena’ (Schön & Rein 1994). Consequently, frames were both legitimized and discredited through processes of sense-making, naming, and storytelling (Van Hulst & Yanow 2014). These processes seemed to correspond to Schön and Rein’s (1994) different levels of abstraction, with sense-making operating throughout, but particularly in the framing of issues at the policy action level, naming at the policy action and institutional levels, and storytelling at the meta-narrative level. Also, the policies identified in this study emphasized the strengths of the frame-critical approach. For example, user fee removal illustrated the generative effect of sense-making, whereas the NHIF rate increase emphasized the role of naming, and the Ngilu Bill is most thoroughly characterized through storytelling. Across the whole study, however, the researcher found storytelling to be the most insightful and persuasive form of framing. As in the case of the Ngilu Bill, various aspects including actor identities, interpretations of the substantive issues, the policy process, and underlying values were integrated into a narrative that engages and persuades both tacitly and explicitly. More than other stages in the policy

process, storytelling seems to create an emotional and irrational account of policy and political behavior, which has been shown to mobilize politics (Gould 2009).

Another theoretical consideration for frame-critical policy analysis is that Dewulf's conception of the entities framed in the process (2009) resembles conceptions from other forms of framing analysis. In Dewulf's work, the objects of framing are the substantive issues, actor identities and relationships, as well as the policy process itself. In his book *Projections of Power* (2004), Robert Entman, a communications scholar, identifies three related objects of media framing. This includes issues, political actor identities, and events (Entman 2004). Though operating from different epistemologies and disciplines, both Dewulf and Entman seem to agree that issues and actor identities are objects of framing, but offer slightly different interpretations of the third objects, the political process and events, respectively. I would argue that the present analysis demonstrates that the two are not incommensurable. Rather, actors in this study often framed the policy process through their understandings of events. This was particularly evident in the stories actors used to frame the policy process, as in the Ngilu Bill. I posit here that perhaps the unifying feature of both events and the policy process is 'experience'. This somewhat expands the third object of framing, perhaps too much so, but theoretically, 'experience' resonates with the phenomenological basis for interpretive framing. Indeed, 'experience' is closely tied to Schön's celebrated body of work on reflective practice (Schön 1984) and the Dreyfus model of expertise (Dreyfus et al. 1986). In this way, more research into the intersubjective co-creations of experiential dimensions of the policy process might be a fruitful line of inquiry in future frame-critical policy research.

Methodologically, frame-critical policy analysis presented the researcher with a coherent theoretical foundation and an adept set of implied methods. Though interview data is becoming more common in framing research (Hajer & Laws 2006; Dewulf et al. 2009; Hawkins & Holden 2013) it remains less prevalent than secondary sources, such as media coverage. Two other studies that incorporated dimensions of Van Hulst and Yanow's new framing theory; however, also made use of interview data (Metze 2014; Lis & Stankiewicz 2016). The present research project found that interviews were an effective means of generating situated meaning by probing actors and policy issues in greater depth, exploring emerging themes, and identifying framing contradictions and inconsistencies. Though the research was focused on interactional framing analysis, "between the noses" as opposed to

cognitive framing analysis “between the ears” of participants (Dewulf et al. 2009), it was difficult to analyze without transcription that captured linguistic nuance. Similarly, this research would have benefitted greatly from the deconstruction and interpretation of alternative sources of data including legislation and media. Further engagement with the historical basis for social phenomena and their impact on political systems (such as electoral politics) would further extend the reach of frame-critical policy analysis. A more important analytical challenge, however, was the difficulty in adequately distinguishing between categorizing and selecting, as features of the naming process. While Van Hulst and Yanow (2014) provide examples of categorization in their account, it was difficult to analytically interpret the categorization of issues and the policy process in this analysis. Instead, categorization was more easily applicable when simply analyzing actor identities and relationships. Finally, the framing approach employed here found it difficult to interpret “normative leaps”, as conceptualized in the original frame-critical approach (Schön & Rein 1994). According to Schön and Rein (1994, p.26), “[...] stories make the ‘normative leap’ from data to recommendations, from fact to values, from ‘is’ to ‘ought’ [...]” The researcher found this difficult to identify and interpret in the present analysis without extending significantly beyond his evolving understanding of the nuances of health financing and the actors located in the process. These challenges notwithstanding, the present analysis demonstrates the value and relevance of further frame-critical engagement and endorses the marriage of Dewulf’s objects of framing (2009) to Van Hulst and Yanow’s (2014) recent attempts to refine the Schön and Rein theory of the framing process.

In conclusion, this chapter demonstrated the analytical value of focusing the object of social inquiry on the ways in which actors frame discreet health financing policies in Kenya. In so doing, it helped to clarify outstanding questions about the UHC movement, incremental health finance reforms, and policymaking in the Kenyan health sector. Furthermore, this chapter pointed to several theoretical and methodological considerations for the future conduct of frame-critical policy analysis. Finally, the chapter generated understandings that not only contribute to the global pool of knowledge, but also provide decision makers with a number of specific recommendations for ways to realign health financing with the growing UHC movement and strengthen the Kenyan health system.

# Conclusion

---

This study sought to better understand the political dynamics of health financing policies aimed at moving towards Universal Health Coverage in Kenya. More specifically, it asked: 1) *How* do policy-relevant actors frame health financing policy in Kenya? 2) *What* features of health finance and the policy community are framed in this process? 3) *How* does framing help us understand the health policy process in Kenya? In addition to these important questions, the current study was motivated by gaps in the global health literature on the politics of UHC and a lack of understanding of the policy process for global health issues in LMICs.

The global health community suggests that movement toward UHC is contingent upon the successful cultivation of “political will” in domestic policy settings (Lancet 2012; Brearley et al. 2013; Yamey & Evans 2015). Very little research from the global health community, however, has sought to deconstruct this notion and the complicated ways in which politics influences health policy design. By investigating policy dynamics from a different theoretical starting point than traditional health systems researchers, it was possible to move beyond the static concept of “political will” and explore the policy process as a function of structured contestation and political behavior. In this way, this research shows how actors mobilize in support of the idea of UHC, its interpretations, and perceived policy implications. This is instructive as this research both demonstrates the value and shortcomings of ambiguous global policy campaigns. The interplay of domestic politics and international priorities is shown to play a significant role in further entrenching policy conflicts in a country undergoing key governance reforms. By focusing on the framing of policies aligned with the UHC movement in Kenya, this study shows how institutions mobilize around ideas to create an environment in which UHC is an aspiration achieved through incremental policy measures over a long period of time.

This research demonstrates the tacit influence of social values and norms that underpin policy contestation in the Kenyan health arena. In this study, much of the policy controversy as framed by policy actors can be traced to competing value structures and the collective mobilization of perceived interests. Ideas were wielded symbolically and

strategically to organize these values into concrete and executable policy stances. Consensus on principles and disagreement over implementation demonstrated noticeable uncertainty with respect to the direction of a rapidly changing health system. Elite conceptions of society and democratic governance were interpreted in light of political change. In this way, the picture of policymaking in the public sphere is opaque, fragmented along ethnic and class lines, and subject to a significant degree of deliberation. These insights contribute to an environment in which incremental policy measures are increasingly likely to proceed in favor of sweeping reforms.

Though the insights generated by this research fulfilled the broader questions and aims of this study, a number of micro-level or intermediate policy recommendations emerged from the project. These relate primarily to the framing and sequencing of health financing policies in ways that encapsulate the preferences of a broad coalition of stakeholders. By focusing on reframing UHC and by addressing the fundamental frame conflict, this research suggests specific measures which, if prioritized could possibly lead to the resolution of stubborn policy controversies. In this way, the findings from this research carry direct implications and insights for policymakers and practitioners alike.

This project points to a number of domains for further research into the politics of UHC and health financing; the wider application of the policies discussed here; and the role of framing influences in the policy process. More research should be conducted that similarly draws on approaches beyond the realm of traditional health policy to supplant the vague and analytically limited concept of “political will” with a more nuanced and expansive understanding of the political dynamics of key health policy debates. This is particularly true for the global movement around UHC, which places emphasis on the political nature of high profile reforms. More research on the political processes that influence incremental reforms and how these align with UHC is needed. Moreover, efforts to analyze the emergence and evolution of the global UHC frame over time may prove insightful for the study of social movements and collective action in global health. Research on contestation in health financing is greatly needed to move understandings of financing away from rational conceptions of technical policy design. In this way, issues such as the politics of defining basic packages, shifting provider payment to forms of capitation, and introducing innovative forms of taxation would prove insightful and could potentially guide subsequent political behavior for international and domestic actors alike.

Finally, the policies analyzed in this study would benefit from further analysis including the impacts of user fee removal and resilience of the health system to cope with increased demand, the expansion of NHIF through augmented revenue streams and expanded benefits packages, enrollment of the informal sector, efforts to identify and cover the poorest households, and regulation of the insurance industry as well as the health professions. In this way, the research here identifies a number of areas that could benefit from a more nuanced understanding of political dynamics in the health sector.

This study contributes to the body of framing research in health policy by introducing a new form of policy analysis to a relatively unexplored policy space. This has important implications for the global health literature as well as the interdisciplinary framing literature, which has remained at the fringes of health policy analysis to date. The findings of this study will help to better position the global health literature as an important venue for further exploration of framing in the policy process. Similarly, by deploying a new conceptualization of frame-critical policy analysis, a number of conceptual and methodological considerations were identified which point to ways of advancing frame-critical theory. This included a clearer distinction between different features of the naming process, incorporation of dimensions of historical institutionalist scholarship, the role of experience as an object of framing, and clearer ways to account for ‘normative leaps’ in the framing process.

Finally, this research raises a number of key issues and insights, which call for more research into the complicated ways in which framing influences the policy process. It provides a basis for further exploration of the forces that influence health finance policymaking. Also, it suggests a number of important research domains that will further understanding of the UHC movement, its influence, its outcomes, and its interaction with domestic politics in LMICs.

Speaking at the Democratic National Convention on July 27, 2016, US President Barack Obama said, “It’s precisely this contest of ideas that pushes our country forward.” Only by reflecting on our own ideas and the complicated world we live in, can we help to make it better. The messiness of the world represents the messiness of life. Through shared reflection, we can, not only help to clarify the more problematic features of life, but also collectively strive to make the world a more equal and just place.

# References

---

- Abuya, T., Maina, T. & Chuma, J., 2015. Historical account of the national health insurance formulation in Kenya: experiences from the past decade. *BMC Health Services Research*, 15, pp.1–11.
- Agyepong, I.A. & Adjei, S., 2008. Public social policy development and implementation: a case study of the Ghana National Health Insurance scheme. *Health Policy Plan*, 23(2), pp.150–160.
- Akazili, J. et al., 2012. Progressivity of health care financing and incidence of service benefits in Ghana. *Health Policy and Planning*, 27(suppl 1), pp.i13–i22.
- Akin, J.S., Birdsall, N. & De Ferranti, D.M., 1987. *Financing health services in developing countries: an agenda for reform*, Washington D.C.: World Bank Publications.
- Anangwe, A., 2008. Health sector reforms in Kenya: user fees. In M. Sama & V.-K. Nguyen, eds. *Governing Health Systems in Africa*. Dakar, Senegal: Council for the Development of Social Science Research in Africa, pp. 44–59.
- Anon, 2014. Audit exposes loss of Sh4bn in fishy cash deals. *Daily Nation*.
- Anon, 2013a. Joint Learning Network for universal health coverage. , 2013(November 18). Available at: <http://jointlearningnetwork.org>.
- Anon, 2013b. UHC Forward. , 2013(November 18). Available at: <http://uhcforward.org>.
- Anon, 2013c. Universal Health Coverage. , 2013(November 18).
- Appiah, B., 2012. Universal health coverage still rare in Africa. *Canadian Medical Association Journal*, 184(2), pp.E125–E126.
- Armada, F., Muntaner, C. & Navarro, V., 2001. Health and social security reforms in Latin America: the convergence of the World Health Organization, the World Bank, and transnational corporations. *International journal of health services*, 31(4), pp.729–68.
- Aseto, O. & Okelo, J.A., 1997. *Privatization in Kenya*, Nairobi: Basic Books (Kenya) Limited.
- Atun, R. et al., 2013. Universal health coverage in Turkey: Enhancement of equity. *The Lancet*, 382(9886), pp.65–99.
- Balabanova, D. et al., 2013. Good Health at Low Cost 25 years on: lessons for the future of health systems strengthening. *The Lancet*, 381(9883), pp.2118–2133.
- Bartlett, F.C., 1932. *Remembering: A Study in Experimental and Social Psychology*,

- Cambridge: Cambridge University Press.
- Bateson, G., 1972. *Steps to an Ecology of Mind: Collected Essays in Anthropology, Psychiatry, Evolution, and Epistemology*, Chicago: University of Chicago Press.
- Baumgartner, F.R. & Jones, B.D., 1993. *Agendas and Instability in American Politics*, University of Chicago Press.
- Beland, D., 2007. Ideas and Institutional Change in Social Security: Conversion, Layering, and Policy Drift. *Social Science Quarterly*, 88(1), pp.20–38.
- Béland, D., 2009. Ideas, institutions, and policy change. *Journal of European Public Policy*, 16(5), pp.701–718.
- Béland, D., 2005. Ideas and Social Policy: An Institutional Perspective - Béland - 2005 - - Wiley Online Library. *Social Policy & Administration*, (1), pp.1–18.
- Béland, D., 2010. Policy change and health care research. *Journal of Health Politics, Policy and Law*, 35(4), pp.615–641.
- Béland, D. & Cox, R.H., 2011. *Ideas and Politics in Social Science Research*, Oxford: Oxford University Press.
- Bennett, C.J., 1991. What is policy convergence and what causes it? *British journal of political science*, 21(2), pp.215–233.
- Bennett, S., Ozawa, S. & Rao, K.D., 2010. Which Path to Universal Health Coverage? Perspectives on the World Health Report 2010. *PLoS Med*, 7(11), p.e1001001.
- Berger, P. & Luckmann, T., 1967. *The social construction of reality: A treatise in the sociology of knowledge*,
- Bernard, H.R., 2011. *Research Methods in Anthropology* 5th ed., Plymouth, UK: AltaMira Press.
- Bevir, M. & Rhodes, R.A.W., 2003. *Interpreting British Governance*, London: Routledge.
- Billig, M., 2001. Arguing. In W. P. Robinson & H. Giles, eds. *The New Handbook of Language and Social Psychology*. Chichester, UK: John Wiley and Sons, pp. 241–251.
- Blyth, M., 2002. *Great Transformations: Economic Ideas and Institutional Change in the Twentieth Century*, Cambridge: Cambridge University Press.
- Blyth, M.M., 1997. “Any More Bright Ideas?” The Ideational Turn of Comparative Political Economy. *Comparative Politics*, 29, pp.151–207.
- Borghesi, J. et al., 2013. Promoting universal financial protection: a case study of new management of community health insurance in Tanzania. *Health Research Policy and Systems*, 11(1), p.21.
- Boswell, C., 2009. *The Political Uses of Expert Knowledge: Immigration Policy and Social*

- Research*, Cambridge University Press.
- Braun, K., 2016. Between representation and narration: analysing policy frames. In F. Fischer et al., eds. *Handbook of critical policy studies*. Cheltenham, UK: Edward Elgar Publishing Limited, pp. 441–461.
- Brearley, L., Marten, R. & O’Connell, T., 2013. *Universal Health Coverage: A commitment to close the gap*, London, UK: Rockefeller Foundation, Save the Children, UNICEF, WHO.
- Bull, H., 1977. *The Anarchical Society: A Study of Order in World Politics*, New York: Columbia University Press.
- Bump, J.B., 2010. *The long road to universal health coverage: a century of lessons for development strategy*, Rockefeller foundation.
- Cacciatore, M. a., Scheufele, D. a. & Iyengar, S., 2016. The End of Framing as We Know It ... and the Future of Media Effects. *Mass Communication and Society*, 19(1), pp.7–23.
- Campbell, J.L., 2002. Ideas, politics, and public policy. *Annual review of sociology*, pp.21–38.
- Campbell, J.L., 2004. *Institutional Change and Globalization*, Princeton: Princeton University Press.
- Carrin, G. et al., 2007. Health financing reform in Kenya - assessing the social health insurance proposal. *S Afr Med J*, 97(2), pp.130–135.
- Chan, M., 2012. Address. In *65th World Health Assembly*. Geneva, Switzerland: WHO.
- Chan, M., 2016. Making Fair Choices on the Path to Universal Health Coverage. *Health Systems & Reform*, 2(1), pp.5–7.
- Checkel, J., 1993. Ideas, institutions, and the Gorbachev foreign policy. *World Politics*, 45(2), pp.271–300.
- Chong, D. & Druckman, J.N., 2007a. Framing public opinion in competitive democracies. *American Political Science Review*, 101(4), pp.637–655.
- Chong, D. & Druckman, J.N., 2007b. Framing theory. *Annu. Rev. Polit. Sci.*, 10, pp.103–126.
- Chuma, J. et al., 2009. Reducing user fees for primary health care in Kenya: Policy on paper or policy in practice? *Int J Equity Health*, 8, p.15.
- Chuma, J., Mulupi, S. & McIntyre, D., 2013. *Providing Financial Protection and Funding Health Service Benefits for the Informal Sector: Evidence from sub-Saharan Africa*, London, UK: RESYST.
- Chuma, J. & Okungu, V., 2011. Viewing the Kenyan health system through an equity lens: implications for universal coverage. *Int J Equity Health*, 10, p.22.
- Coalition, J., 2013. *Transforming Kenya: securing Kenya’s prosperity*, Nairobi, Kenya:

Jubilee Coalition.

- Cobb, R., Ross, J.-K. & Ross, M.H., 1976. Agenda building as a comparative political process. *The American political science review*, 70(1), pp.126–138.
- Cox, R.H., 2001. The social construction of an imperative: Why welfare reform happened in Denmark and the Netherlands but not in Germany. *World Politics*, 53(April), pp.463–98.
- Dahl, R.A., 1961. *Who governs?: Democracy and power in an American city*, New Haven, CT: Yale University Press.
- Dahlgren, G., 1994. The political economy of health financing strategies in Kenya. In L. C. Chen, A. Kleinman, & N. C. Ware, eds. *Health and Social Change in International Perspective*. Boston, MA: Harvard University Press, pp. 444–470.
- Deloitte, 2011. *Strategic Review of the National Hospital Insurance Fund - Kenya*, Deloitte.
- Dewulf, A. et al., 2009. Disentangling approaches to framing in conflict and negotiation research: A meta-paradigmatic perspective. *Human Relations*, 62(2), pp.155–193.
- Dilthey, W., Makkreel, R.A. & Rodi, F., 1989. *Introduction to the Human Sciences*, Princeton University Press.
- Dolowitz, D.P. & Marsh, D., 2000. Learning from abroad: The role of policy transfer in contemporary policy-making. *Governance*, 13(1), pp.5–23.
- Dorfman, L., Wallack, L. & Woodruff, K., 2005. More than a message: Framing public health advocacy to change corporate practices. *Health Education & Behavior*, 32(3), pp.320–336.
- Dreyfus, H.L., Dreyfus, S.E. & Athanasiou, T., 1986. *Mind Over Machine: The Power of Human Intuition and Expertise in the Era of the Computer*, New York: Simon & Schuster.
- Druckman, J.N., 2010. Competing Frames in a Political Campaign. In B. . Schaffner & P. J. Sellers, eds. *Winning with Words: The Origins and Impact of Framing*. New York: Routledge, pp. 101–120.
- Druckman, J.N., 2004. Political Preference Formation: Competition, Deliberation, and the (Ir)relevance of Framing Effects. *American Political Science Review*, 98(4), pp.671–686.
- Druckman, J.N., 2011. What’s it all about? Framing in Political Science. In G. Keren, ed. *Persepctives on Framing*. New York: Psychology Press, pp. 279–301.
- Druckman, J.N., Kuklinski, J.H. & Sigelman, L., 2009. The unmet potential of interdisciplinary research: Political psychological approaches to voting and public opinion. *Political Behavior*, 31(4), pp.485–510.

- Dryzek, J.S., 2000. *Deliberative democracy and beyond: liberals, critics, contestations*, Oxford University Press on Demand.
- Eckstein, H., 1960. *Pressure group politics: the case of the British Medical Association*, Stanford University Press.
- Edelman, M., 1977. *Political language*, New York: Academic Press New York.
- Edelman, M.J., 1988. *Constructing the Political Spectacle*, Chicago: University Of Chicago Press.
- Edelman, M.J., 1985. *The symbolic uses of politics*, Urbana: University of Illinois Press.
- Edwards, D., 1997. *Discourse and Cognition*, SAGE Publications.
- Elder, C.D. & Cobb, R.W., 1983. *The political uses of symbols*, New York: Longman New York.
- Ensor, T., 2008. Universal Coverage in Developing Countries, Transition to. In H. K. Heggenhougen, ed. *International Encyclopedia of Public Health*. Oxford: Academic Press, pp. 441–452.
- Entman, R.M., 1993. Framing: Toward clarification of a fractured paradigm. *Journal of communication*, 43(4), pp.51–58.
- Entman, R.M., 2004. *Projections of Power: Framing News, Public Opinion, and U.S. Foreign Policy*, Chicago: University of Chicago Press.
- Epstein, C., 2008. *The Power of Words in International Relations: Birth of an Anti-Whaling Discourse*, Cambridge: MIT Press.
- Evans, D.B. & Etienne, C., 2010. Health systems financing and the path to universal coverage. *Bulletin of the World Health Organization*, 88(6), pp.402–403.
- Evans, D.B., Hsu, J. & Boerma, T., 2013. Universal health coverage and universal access. *Bulletin of the World Health Organization*, 91, p.546–546A.
- Evans, D.B., Hsu, J. & Boerma, T., 2013. Universal health coverage and universal access. *Bull World Health Organ*, 91.
- Finkel, S.E. & Smith, A.E., 2011. Civic Education, Political Discussion, and the Social Transmission of Democratic Knowledge and Values in a New Democracy: Kenya 2002. *American Journal of Political Science*, 55(2), pp.417–435.
- Fischer, F., 2003. *Reframing Public Policy: Discursive Politics and Deliberative Practices: Discursive Politics and Deliberative Practices*, Oxford: Oxford University Press.
- Fischer, F. & Forester, J. eds., 1993. *The Argumentative Turn in Policy Analysis and Planning*, Durham, NC: Duke University Press.
- Fischer, F. & Gottweis, H. eds., 2012. *The Argumentative Turn Revisited: Public Policy as*

- Communicative Practice*, Durham, NC: Duke University Press.
- Flyvbjerg, B., 2001. *Making social science matter: Why social inquiry fails and how it can succeed again*, Cambridge, UK: Cambridge University Press.
- Fox, A.M. & Reich, M.R., 2015. The Politics of Universal Health Coverage in Low- and Middle-Income Countries: A Framework for Evaluation and Action. *Journal of health politics, policy and law*, 40(5), pp.1023–60.
- Fraker, A., Hsiao, W.C. & Institute, T.W.B., 2007. Kenya: designing social health insurance. In W. C. Hsiao & P. R. Shaw, eds. *Social health insurance for developing nations*. Washington DC: The World Bank, pp. 43–60.
- Fraser, N., 1989. *Unruly Practices: Power, Discourse, and Gender in Contemporary Social Theory*, Minneapolis: U of Minnesota Press.
- Freidson, E., 1970. *Professional Dominance: The Social Structure of Medical Care*, New Brunswick: Transaction Publishers.
- Frenk, J., 2006. Bridging the divide: global lessons from evidence-based health policy in Mexico. *Lancet*, 368(9539), pp.954–961.
- Gains, F., 2011. Elite ethnographies: potential, pitfalls and prospects for getting “up close and personal.” *Public Administration*, 89(1), pp.156–166.
- Gamson, W.A. et al., 1992. Media images and the social construction of reality. *Annual review of sociology*, pp.373–393.
- Gamson, W.A., 1992. *Talking Politics*, Cambridge: Cambridge University Press.
- Gamson, W.A. & Lasch, K.E., 1983. The political culture of welfare policy. In S. Spiro & E. Yuchtman-Yaar, eds. *Evaluating the Welfare State: Social and Political Perspectives*. New York: Academic Press, pp. 397–415.
- Gamson, W.A. & Modigliani, A., 1987. The Changing Culture of Affirmative Action. In R. Braumgart, ed. *Research in Political Sociology*. Greenwich, Conn: JAI Press Inc., pp. 137–177.
- Garrett, L., Chowdhury, A.M.R. & Pablos-Méndez, A., 2009. All for universal health coverage. *Lancet*, 374.
- Ghaffar, A. et al., 2016. Where is the policy in health policy and systems research agenda? *Bulletin of the World Health Organization*, 94(April), pp.306–308.
- Giddens, A., 1993. *New Rules of Sociological Method: A Positive Critique of Interpretative Sociologies*, Stanford, CA: Stanford University Press.
- Giedion, U., Alfonso, E.A. & Diaz, Y., 2013. *The Impact of Universal Coverage Schemes in the Developing World: A Review of the Existing Evidence*, Washington DC: World Bank.

- Gilson, L. et al., 2011. Building the field of health policy and systems research: social science matters. *PLoS Med*, 8(8), p.e1001079.
- Gilson, L., 1988. *Government health care charges: is equity being abandoned?: a discussion paper*, Evaluation and Planning Centre for Health Care, London School of Hygiene and Tropical Medicine.
- Gilson, L. et al., 2001. Strategies for promoting equity: experience with community financing in three African countries. *Health policy*, 58(1), pp.37–67.
- Gilson, L., 1997. The lessons of user fee experience in Africa. *Health Policy and Planning*, 12(4), pp.273–285.
- Gilson, L. et al., 2003. The SAZA study: implementing health financing reform in South Africa and Zambia. *Health Policy Plan*, 18(1), p.31.
- Gilson, L. & McIntyre, D., 2005. Removing user fees for primary care in Africa: the need for careful action. *BMJ*, 331(7519), pp.762–765.
- Gilson, L. & Raphaely, N., 2008. The terrain of health policy analysis in low and middle income countries: a review of published literature 1994-2007. *Health Policy and Planning*, 23(5), pp.294–307.
- Gilson, L., Russell, S. & Buse, K., 1995. The political economy of user fees with targeting: developing equitable health financing policy. *Journal of International Development*, 7(3), pp.369–401.
- Gitlin, T., 1980. *The Whole World is Watching: Mass Media in the Making & Unmaking of the New Left*, Berkley: University of California Press.
- Goffman, E., 1974. *Frame Analysis: An Essay on the Organization of Experience*, Cambridge: Harvard University Press.
- Goldman, E.F. & Swayze, S., 2012. In-Depth Interviewing with Healthcare Corporate Elites: Strategies for Entry and Engagement. *International Journal of Qualitative Methods*, 11(3), pp.230–243.
- Gottret, P. & Schieber, G., 2006. *Health financing revisited: A practitioner's guide*, Washington DC: The World Bank.
- Gottret, P., Schieber, G.J. & Waters, H.R., 2008. *Good Practices in Health Financing: Lessons from Reforms in Low and Middle-Income Countries*, Washington D.C.: The World Bank.
- Gould, D.B., 2009. *Moving Politics: Emotion and ACT UP's Fight against AIDS*, Chicago: University of Chicago Press.
- Government of Kenya, H.S.P., 2009. Kenya National Health Accounts 2005/2006.

- Green, A., 2007. *An introduction to health planning for developing health systems* 3rd ed., Oxford, UK: Oxford University Press.
- Green, J.L. & Thorogood, N., 2009. *Qualitative Methods for Health Research* 2nd ed., SAGE Publications.
- Gusfield, J.R., 1981. *The Culture of Public Problems: Drinking-Driving and the Symbolic Order*, Chicago: University of Chicago Press.
- Gwatkin, D.R. & Ergo, A., 2011. Universal health coverage: friend or foe of health equity? *The Lancet*, 377(9784), pp.2160–2161.
- Haas, E.B., 1990. *When Knowledge is Power: Three Models of Change in International Organizations*, Berkeley: University of California Press.
- Haas, P.M., 1992. Introduction: Epistemic Communities and International Policy Coordination. *International Organization*, 46(1), pp.1–35.
- Hafner, T. & Shiffman, J., 2013. The emergence of global attention to health systems strengthening. *Health Policy and Planning*, 28(1), pp.41–50.
- Hajer, M. & Laws, D., 2006. Ordering through discourse. *The Oxford handbook of public policy*, pp.249–266.
- Hall, J.A., 1993. Ideas and the Social Sciences. In J. Goldstein & R. Keohane, eds. *Ideas and Foreign Policy: Beliefs, Institutions and Political Change*. Ithaca: Cornell University Press, pp. 31–56.
- Hall, P.A., 1993. Policy Paradigms, Social Learning, and the State: The Case of Economic Policymaking in Britain. *Comparative Politics*, 25(3), p.275.
- Hall, P.A., 1997. The role of interests, institutions, and ideas in the comparative political economy of the industrialized nations. *Comparative politics: Rationality, culture, and structure*, pp.174–207.
- Harvey, W.S., 2010. Methodological approaches for interviewing elites. *Geography Compass*, 4(3), pp.193–205.
- Hawkesworth, M., 2012. From policy frames to discursive politics: feminist approaches to development policy and planning in an era of globalization. In F. Fischer & H. Gottweis, eds. *The argumentative turn revisited: public policy as communicative practice*. Durham, NC: Duke University Press, pp. 114–148.
- Hawkins, B. & Holden, C., 2013. Framing the alcohol policy debate: industry actors and the regulation of the UK beverage alcohol market. *Critical Policy Studies*, 7(1), pp.53–71.
- Hawkins, B. & Parkhurst, J., 2015. The “good governance” of evidence in health policy. , pp.1–18.

- Hay, C., 2011. Ideas and the Construction of Interests. In D. Béland & R. H. Cox, eds. *Ideas and Politics in Social Science Research*. Oxford: Oxford University Press, pp. 65–82.
- HPP/Kenya, 2013. *Taking the pulse: what Kenyan presidential candidates promised on health and why it matters*, Washington DC: Futures Group, Health Policy Project.
- HSPH, 2013. Peter Anyang' Nyong'o, former Minister of Medical Services for Kenya. *Decision-making: Voices from the field*.
- Huber, J.H., 1993. Ensuring access to health care with the introduction of user fees: a Kenyan example. *Social science & medicine*, 36(4), pp.485–494.
- Van Hulst, M. & Yanow, D., 2014. From policy “frames” to “framing”: Theorizing a more dynamic, political approach. *The American Review of Public Administration*, pp.1–21.
- Husserl, E., 1931. *Ideas: General introduction to pure phenomenology*, London: Allen & Unwin Ltd.
- Iyengar, S., 1991. *Is anyone responsible?: How television frames political issues*, Chicago: University of Chicago Press.
- James, C.D. et al., 2006. To Retain or Remove User Fees? *Applied health economics and health policy*, 5(3), pp.137–153.
- Jamison, D.T. et al., 2013. Global health 2035: a world converging within a generation. *The Lancet*, 382(9908), pp.1898–1955.
- Jenson, J., 1989. Paradigms and Political Discourse: Protective Legislation in France and the United States Before 1914. *Canadian Journal of Political Science/Revue canadienne de science politique*, 22(2), pp.235–258.
- Jerit, J., 2009. How predictive appeals affect policy opinions. *American Journal of Political Science*, 53(2), pp.411–426.
- Jerit, J., 2008. Issue Framing and Engagement: Rhetorical Strategy in Public Policy Debates. *Political Behavior*, 30(1), pp.1–24.
- Jilo, R., 2010. Court halts new NHIF rates. *Daily Nation*.
- Jobert, B. & Muller, P., 1987. *L'Etat en action: Politiques Publiques et Corporatismes*, Paris: Presses Universitaires de France.
- Juma, V., 2011. New charges set NHIF up for war with employers. *Business Daily*.
- Kahneman, D. & Tversky, A., 1984. Choices, values, and frames. *American psychologist*, 39(4), pp.341–350.
- Kahneman, D. & Tversky, A., 1979. Prospect Theory: An Analysis of Decision Under Risk. *Econometrica*, 47(2), pp.263–292.
- Katzenstein, P.J., 1996. *The Culture of National Security: Norms and Identity in World*

- Politics*, New York: Columbia University Press.
- Kenya, G. of, 1986. *State Corporations Act*, Kenya.
- Kenya, G. of, 2008. Vision 2030: Sector Plan for Health 2008-2012.
- Kingdon, J.W., 1984. *Agendas, alternatives, and public policies*, Boston: Little Brown.
- Knaul, F.M. et al., 2012. The quest for universal health coverage: Achieving social protection for all in Mexico. *The Lancet*, 380(9849), pp.1259–1279.
- Koon, A. et al., 2013. Embedding health policy and systems research into decision-making processes in low- and middle-income countries. *Health Research Policy and Systems*, 11(1), p.30.
- Koon, A.D., Hawkins, B. & Mayhew, S.H., 2016. Framing and the health policy process: a scoping review. *Health Policy and Planning*, 31(6), pp.801–816.
- Koon, A.D. & Mayhew, S.H., 2013. Strengthening the health workforce and rolling out universal health coverage: the need for policy analysis. *Global Health Action*, 6.
- Kutzin, J., 2001. A descriptive framework for country-level analysis of health care financing arrangements. *Health policy*, 56(3), pp.171–204.
- Kutzin, J., 2012. Anything goes on the path to universal health coverage? No. *Bulletin of the World Health Organization*, 90, pp.867–868.
- Kutzin, J., 2013. Health financing for universal coverage and health system performance: concepts and implications for policy. *Bull World Health Organ*, 91.
- Kutzin, J. & Sparkes, S.P., 2016. Health systems strengthening , universal health coverage , health security and resilience. *Bulletin of the World Health Organization*, 94(9980), p.165050.
- Lagomarsino, G. et al., 2012. Moving towards universal health coverage: health insurance reforms in nine developing countries in Africa and Asia. *The Lancet*, 380(9845), pp.933–943.
- Lakin, J. & Magero, V., 2012. *Healthy Ambitions? Kenya's National Hospital Insurance Fund (NHIF) must become more transparent if it is to anchor Universal Health Coverage*, Nairobi, Kenya: International Budget Partnership.
- Lakoff, G., 2004. *Don't Think of an Elephant!: Know Your Values and Frame the Debate*, White River Junction, VT: Chelsea Green Publishing.
- Lakoff, G., 2006. *Thinking Points: Communicating Our American Values and Vision*, New York: Farrar, Straus and Giroux.
- Lakoff, G., 2006. *Thinking Points: Communicating Our American Values and Vision*, New York: Farrar, Straus and Giroux.

- Lancet, T., 2012. The struggle for universal health coverage. *The Lancet*, 380(9845), p.859.
- Latko, B. et al., 2011. The growing movement for universal health coverage. *Lancet*, 377.
- Laws, D. & Rein, M., 2003. Reframing practice. In M. Hajer & H. Wagenaar, eds. *Deliberative policy analysis: understanding governance in the network society*. Cambridge: Cambridge university press, pp. 172–208.
- de Leeuw, E., Clavier, C. & Breton, E., 2014. Health policy – why research it and how : health political science. *Health Research Policy and Systems*, 12(55), pp.1–10.
- Leftie, P., 2013. Uhuru’s Madraka Gifts. *Daily Nation*.
- Levin, I.P. et al., 1998. All frames are not created equal: A typology and critical analysis of framing effects. *Organisational Behaviour and Human Decision Processes*, 76(2), pp.149–188.
- Leys, C., 1996. *The Rise & Fall of Development Theory*, Bloomington: Indiana University Press.
- Lieberman, R.C., 2002. Ideas, institutions, and Political Order: Explaining Political Change. *The American political science review*, 96(4), pp.697–712.
- Lilleker, D.G., 2003. Interviewing the Political Elite: Navigating a Potential Minefield. *Politics*, 23(3), pp.207–214.
- Lincoln, Y.S. & Guba E., 1985. *Naturalistic Inquiry*, London: Sage Publications Ltd.
- Lis, A. & Stankiewicz, P., 2016. Framing shale gas for policy making in Poland. *Journal of Environmental Policy & Planning*, (February).
- Maeda, A. et al., 2014. *Universal health coverage for inclusive and sustainable development: a synthesis of 11 country case studies*, World Bank Publications.
- Mahoney, J. & Thelen, K., 2010. A theory of gradual institutional change. In *Explaining institutional change: Ambiguity, agency, and power*. Cambridge: Cambridge University Press, pp. 1–37.
- Majone, G., 1989. *Evidence, Argument, and Persuasion in the Policy Process*, New Haven: Yale University Press.
- March, J.G. & Olsen, J.P., 1989. Rediscovering institutions: The organizational basis of politics.
- March, J.G. & Olsen, J.P., 1984. The new institutionalism: organizational factors in political life. *The American political science review*, pp.734–749.
- Mathauer, I., Schmidt, J.O. & Wenyaa, M., 2008. Extending social health insurance to the informal sector in Kenya. An assessment of factors affecting demand. *Int J Health Plann Manage*, 23(1), pp.51–68.

- Mattingly, C., 1998. *Healing Dramas and Clinical Plots: The Narrative Structure of Experience*, Cambridge: Cambridge University Press.
- Mbugua, J.K., Bloom, G.H. & Segall, M.M., 1995. Impact of user charges on vulnerable groups: the case of Kibwezi in rural Kenya. *Social science & medicine*, 41(6), pp.829–835.
- McIntyre, D. et al., 2008. Beyond fragmentation and towards universal coverage: insights from Ghana, South Africa and the United Republic of Tanzania. *Bulletin of the World Health Organization*, 86(11), pp.871–876.
- McIntyre, D. et al., 2013. Promoting universal financial protection: evidence from seven low- and middle-income countries on factors facilitating or hindering progress. *Health Research Policy and Systems*, 11(1), p.36.
- McIntyre, D. et al., 2013. Promoting universal financial protection: evidence from seven low- and middle-income countries on factors facilitating or hindering progress. *Health Research Policy and Systems*, 11.
- McIntyre, D. & Kutzin, J., 2012. Revenue collection and pooling arrangements in financing. In R. D. Smith & K. Hanson, eds. *Health systems in low- and middle-income countries*. New York, NY: Oxford University Press Inc., pp. 77–101.
- McIntyre, D. & Mills, A., 2012. Research to support universal coverage reforms in Africa: the SHIELD project. *Health Policy and Planning*, 27(suppl 1), pp.i1–i3.
- McNamara, K.R., 1998. *The Currency of Ideas: Monetary Politics in the European Union*, Ithaca: Cornell University Press.
- Meessen, B. et al., 2011. Removing user fees in the health sector: a review of policy processes in six sub-Saharan African countries. *Health Policy and Planning*, 26(suppl 2), p.ii16-ii29.
- Metze, T., 2014. Fracking the Debate: Frame Shifts and Boundary Work in Dutch Decision Making on Shale Gas. *Journal of Environmental Policy & Planning*, pp.1–18.
- Mills, A. et al., 2012. Equity in financing and use of health care in Ghana, South Africa, and Tanzania: implications for paths to universal coverage. *The Lancet*, 380(9837), pp.126–133.
- Mills, A., 2014. Health care systems in low- and middle-income countries. *The New England journal of medicine*, 370(6), pp.552–7.
- Mills, A. et al., 2012. Progress towards universal coverage: the health systems of Ghana, South Africa and Tanzania. *Health Policy Plan*, 27.
- Mills, C.W., 1956. *The Power Elite*, London: Oxford University Press.

- MMS/MPH, 2009. Kenya household expenditure and utilization survey report 2007.
- MMS/MPH, 2012. Sessional paper no. 7 of 2012 on the policy on Universal Health Coverage in Kenya M. of P. H. Ministry of Medical services, ed.
- MOHa, 2014. *Kenya Health Policy 2014-2030*, Nairobi, Kenya
- MOHb, 2014. *Health Sector Human Resources Strategy 2014-2018*, Nairobi, Kenya
- Mooney, G.H., 2012. *The Health of Nations*, Zed Books.
- Moses, S. et al., 1992. Impact of user fees on attendance at a referral centre for sexually transmitted diseases in Kenya. *The Lancet*, 340(8817), pp.463–466.
- Munge, K. & Briggs, A.H., 2013. The progressivity of health-care financing in Kenya. *Health Policy and Planning*.
- Munguti, R., 2010. New hospital fund rates blocked. *Daily Nation*.
- Mwabu, G., Mwanzia, J. & Liambila, W., 1995. User charges in government health facilities in Kenya: effect on attendance and revenue. *Health Policy and Planning*, 10(2), pp.164–170.
- Mwabu, G.M., 1986. Health care decisions at the household level: results of a rural health survey in Kenya. *Soc Sci Med*, 22(3), pp.315–319.
- Mwangi, T., 2013. Dying to live: Kenya's search for universal healthcare A. Marriott, ed. *Global Health Check*, 2014.
- Ndii, D., 2015. Why Uhuru's parastatal reform was doomed to fail. *Daily Nation*.
- Nicholson, D. et al., 2015. *Delivering Universal Health Coverage a Guide for Policymakers*,
- Nisbett, R.E. & Ross, L., 1980. *Human inference: strategies and shortcomings of social judgment*, Englewood Cliffs, NJ: Prentice-Hall.
- North, D.C., 1990. *Institutions, Institutional Change, and Economic Performance*, Cambridge, UK: Cambridge University Press.
- Nyikuri, M. et al., 2015. Crises and Resilience at the Frontline-Public Health Facility Managers under Devolution in a Sub-County on the Kenyan Coast. *PloS one*, 10(12), p.e0144768.
- O'Connell, T., Rasanathan, K. & Chopra, M., 2013. What does universal health coverage mean? *The Lancet*, 383(9913), pp.277–279.
- Olson, M., 1965. *The logic of collective action: public goods and the theory of groups*, Harvard University Press.
- Omondi, G., 2013. 42 parastatals to be dissolved under new reforms plan. *Business Daily*.
- Orenstein, M.A., 2008. *Privatizing pensions: The transnational campaign for social security reform*, Princeton: Princeton University Press.

- Ostrom, E., 1990. *Governing the commons: The evolution of institutions for collective action*, Cambridge university press.
- Otieno, S., 2012. Cotu, FKE oppose new NHIF rates . *The Star*.
- P4H, 2012. *Kenya Draft Health Financing Strategy - Report of an External Review*, Providing for health, Social Health Protection Initiative.
- Pan, Z. & Kosicki, G.M., 1993. Framing analysis: An approach to news discourse. *Political communication*, 10(1), pp.55–75.
- Parsons, C., 2003. *A Certain Idea of Europe*, Ithaca: Cornell University Press.
- Peters, B.G., Pierre, J. & King, D.S., 2005. The Politics of Path Dependency: Political conflict in historical institutionalism. *The Journal of Politics*, 67(4), pp.1275–1300.
- Petrocik, J.R., 1980. Issue Ownership in Presidential Elections, with a 1980 Case Study. *American Journal of Political Science*, 40(3), pp.825–850.
- Putnam, L.L. & Holmer, M., 1992. Framing, reframing, and issue development. In L. L. Putnam & M. E. Roloff, eds. *Communication and negotiation*. London: Sage Publications, Inc, pp. 128–155.
- Rabinow, P. & Sullivan, W.M. eds., 1987. *Interpretive Social Science: A Second Look* 2nd ed., Berkley: University of California Press.
- Rasmussen, A.C., 2011. Contraception as Health? The Framing of Issue Categories in Contemporary Policy Making. *Administration & Society*, 43(8), pp.930–953.
- Reich, M.R. et al., 2016. Moving towards universal health coverage: Lessons from 11 country studies. *The Lancet*, 387(10020), pp.811–816.
- Rein, M. & Schön, D., 1996. Frame-critical policy analysis and frame-reflective policy practice. *Knowledge and policy*, 9(1), pp.85–104.
- Rein, M. & Schön, D., 1977. Problem setting in policy research. In C. H. Weiss, ed. *Using Social Research in Public Policy Making*. Lexington, Mass.: Lexington Books, pp. 235–251.
- Rein, M. & Schön, D., 1993. Reframing policy discourse. In F. Fischer & J. Forester, eds. *The argumentative turn in policy analysis and planning*. Duke University Press.
- Ridde, V. & Morestin, F., 2011. A scoping review of the literature on the abolition of user fees in health care services in Africa. *Health Policy and Planning*, 26(1), pp.1–11.
- Ridde, V., Robert, E. & Meessen, B., 2012. A literature review of the disruptive effects of user fee exemption policies on health systems. *BMC Public Health*, 12(1), p.289.
- Riker, W.H., 1980. Implications from the Disequilibrium of Majority Rule for the Study of Institutions. *The American political science review*, pp.432–446.

- Rivera, S.W., Kozyreva, P.M. & Sarovskii, E.G., 2002. Interviewing Political Elites: Lessons from Russia. *Political Science & Politics*, 35(4), pp.683–688.
- Rocheftort, D. & Cobb, R., 1994. *The politics of problem definition: Shaping the policy agenda*, Lawrence: University Press of Kansas.
- Rorty, R., 1992. *The Linguistic Turn: Essays in Philosophical Method*, University of Chicago Press.
- Rothman, a J. & Salovey, P., 1997. Shaping perceptions to motivate healthy behavior: the role of message framing. *Psychological bulletin*, 121(1), pp.3–19.
- Ryan, G.W. & Bernard, H.R., 2003. Techniques to Identify Themes. *Field Methods*, 15(1), pp.85–109.
- Sabatier, P.A. & Jenkins-Smith, H.C., 1993. *Policy change and learning: an advocacy coalition approach*, Boulder: Westview Press.
- Saussure, F. De, 1959. *Course in General Linguistics* T. P. Library, ed., New York: Columbia University Press.
- Savedoff, W.D., 2008. Conclusions: Lessons from governance trends for developing countries. *Governing Mandatory Health Insurance*, p.203.
- Savedoff, W.D. et al., 2012. Political and economic aspects of the transition to universal health coverage. *The Lancet*, 380(9845), pp.924–932.
- Savedoff, W.D. & Gottret, P.E., 2008. *Governing Mandatory Health Insurance: Learning from Experience*, World Bank Publications.
- Schattschneider, E.E., 1960. *The Semisovereign People: A Realist's View of Democracy in America*, Englewood Cliffs, NJ: Prentice Hall.
- Scheufele, D., 1999. Framing as a theory of media effects. *Journal of Communication*, 49(1), pp.103–122.
- Scheufele, D.A. & Iyengar, S., 2012. The State of Framing Research: A Call for New Directions. In K. Kensk & K. H. Jamieson, eds. *The Oxford handbook of political communication theories*. New York: Oxford University Press, pp. 1–27.
- Scheufele, D.A. & Tewksbury, D., 2007. Framing, agenda setting, and priming: The evolution of three media effects models. *Journal of Communication*, 57(1), pp.9–20.
- Schmidt, V.A., 2008. Discursive institutionalism: The explanatory power of ideas and discourse. *Annual Review of Political Science*, 11(1), pp.303–326.
- Schmidt, V.A., 2011. Reconciling ideas and institutions through discursive institutionalism. In D. Béland & R. H. Cox, eds. *Ideas and Politics in Social Science Research*. Oxford: Oxford University Press, pp. 47–64.

- Schmidt, V.A., 2002. *The Futures of European Capitalism*, Oxford: Oxford University Press.
- Schön, D.A., 1971. *Beyond the stable state*, New York: Random House.
- Schön, D.A., 1984. *The Reflective Practitioner: How Professionals Think In Action*, New York: Basic Books.
- Schön, D.A. & Rein, M., 1994. *Frame reflection: Toward the resolution of intractable policy controversies*, New York: Basic Books.
- Schutz, A., 1962. *Collected Papers: The problem of social reality. Volume I*, The Hague: Martinus Nijhoff Publishers.
- Schutz, A., 1967. *The Phenomenology of the Social World*, Evanston: Northwestern University Press.
- Schwartz-Shea, P. & Yanow, D., 2012. *Interpretive Research Design: Concepts and Processes*. D. Yanow & P. Schwartz-Shea, eds., New York: Routledge.
- Sheikh, K. et al., 2011. Building the field of health policy and systems research: framing the questions. *PLoS Med*, 8(8), p.e1001073.
- Sheikh, K., George, A. & Gilson, L., 2014. People-centred science: Strengthening the practice of health policy and systems research. *Health Research Policy and Systems*, 12(1), pp.1–8.
- Shiffman, J., 2009. A social explanation for the rise and fall of global health issues. *Bulletin of the World Health Organization*, 87(8), pp.608–613.
- Shiffman, J., 2007. Generating political priority for maternal mortality reduction in 5 developing countries. *Am J Public Health*, 97(5), pp.796–803.
- Shiffman, J., 2014. Knowledge, moral claims and the exercise of power in global health. *Int J Health Policy Manag*, 3(6), pp.297–299.
- Shiffman, J., 2016. Networks and global health governance: Introductory editorial for *Health Policy and Planning* supplement on the Emergence and Effectiveness of Global Health Networks. *Health Policy and Planning*, 31(suppl 1), pp.i1–i2.
- Sil, R. & Katzenstein, P.J., 2010. *Beyond Paradigms: Analytic Eclecticism in the Study of World Politics*, Basingstoke: Palgrave Macmillan.
- Smith, K.E., 2013a. *Beyond Evidence Based Policy in Public Health: The Interplay of Ideas*, Palgrave Macmillan.
- Smith, K.E., 2014. The politics of ideas: The complex interplay of health inequalities research and policy. *Science and Public Policy*, 41(5), pp.561–574.
- Smith, K.E., 2013b. Understanding the Influence of Evidence in Public Health Policy: What Can We Learn from the "Tobacco Wars"? *Social Policy & Administration*, 47(4),

- pp.382–398.
- Smith, K.E. & Stewart, E., 2015. “Black magic” and “gold dust”: the epistemic and political uses of evidence tools in public health policy making. *Evidence & Policy*, 11(3), pp.415–437.
- Snow, D.A. et al., 1986. Frame alignment processes, micromobilization, and movement participation. *American sociological review*, pp.464–481.
- Snow, D.A. & Benford, R.D., 1988. Ideology, frame resonance, and participant mobilization. *International social movement research*, 1(1), pp.197–217.
- Stone, D., 2008. Global public policy, transnational policy communities, and their networks. *Policy studies journal*, 36(1), pp.19–38.
- Stone, D., 2012. *Policy paradox: the art of political decision making* 3rd ed., London: W.W. Norton & Company Ltd.
- Tangcharoensathien, V. et al., 2011. Health-financing reforms in southeast Asia: challenges in achieving universal coverage. *Lancet*, 377(9768), pp.863–873.
- Tangri, R.K., 1999. *The Politics of Patronage in Africa: Parastatals, Privatization, and Private Enterprise*, Trenton: Africa World Press.
- Tannen, D., 1993. *Framing in discourse*, Oxford: Oxford University Press.
- Tannen, D. & Wallat, C., 1987. Interactive frames and knowledge schemas in interaction: Examples from a medical examination/interview. *Social psychology quarterly*, 50(2), pp.205–216.
- Travis, P. et al., 2004. Overcoming health-system constraints to achieve the millennium development goals. *Lancet*, 364, pp.900–906.
- Tsofa, B., Molyneux, S. & Goodman, C., 2015. Health sector operational planning and budgeting processes in Kenya—“never the twain shall meet.” *The International Journal of Health Planning and Management*, p.n/a--n/a.
- Tuchman, G., 1978. *Making news: A study in the construction of reality*, New York: Free Press.
- Tversky, A. & Kahneman, D., 1981. The framing of decisions and the psychology of choice. *Science*, 211(4481), pp.453–458.
- UN, 2015a. Agenda Items 13 (a) and 115 - Draft Resolution. In *Sixty-ninth session*. p. 35.
- UN, 2015b. Sustainable Development Goals: 17 Goals to Transform Our World. Available at: <http://www.un.org/sustainabledevelopment/health/>.
- UNDP, 2015. *Human Development Report 2015: Work for Human Development*, New York.
- Vassall, A. & Martinez-Alvarez, M., 2012. The health system and external financing. In R. D.

- Smith & K. Hanson, eds. *Health systems in low- and middle-income countries*. New York, NY: Oxford University Press Inc., pp. 193–217.
- Vecchione, E. & Parkhurst, J., 2015. The use of evidence within policy evaluation in health in Ghana: implications for accountability and democratic governance. *European Policy Analysis*, 1(2).
- Victora, C., Saracci, R. & Olsen, J., 2013. Universal health coverage and the post-2015 agenda. *The Lancet*, 381(9868), p.726.
- Walt, G., 1994. *Health Policy: An Introduction to Proces and Power*, Johannesburg, SA: Witwatersrand University Press.
- WB, 2013. Universal Health Coverage Study Series. *UNICO*, 2014(January 18). Available at: <http://www.worldbank.org/en/topic/health/publication/universal-health-coverage-study-series>.
- Weber, M., 1946. The social psychology of the world religions. In H. H. Gerth & C. W. Mills, eds. *From Max Weber*. London: Routledge.
- Weiss, J.A., 1989. The Powers of Problem Definition : The Case of Government Paperwork. *Policy sciences*, 22, pp.97–121.
- Weyland, K., 2005. Theories of policy diffusion lessons from Latin American Pension Reform. *World politics*, 57(2), pp.262–295.
- WHO, 2010. *Health Systems Financing: the path to universal coverage*, Geneva: World Health Organization.
- WHO, 2013a. Notes from Proceedings May 20-28, 2013. In *66th World Health Assembly*. Geneva: The World Health Organization.
- WHO, 2013b. *Research for Universal Coverage*, Geneva: World Health Organization.
- WHO, 2013c. *Universal Health Coverage: Report by the Secretariat*, Geneva: WHO.
- Yamey, G. & Evans, D., 2015. Implementing pro-poor universal health coverage: Lessons from country experience. In *Bellagio workshop policy report*.
- Yanow, D., 1999. *Conducting interpretive policy analysis*, SAGE Publications, Incorporated.
- Yanow, D., 1996. *How does a policy mean?: interpreting policy and organizational actions*, Washington DC: Georgetown University Press.
- Yanow, D., 2007. Qualitative-interpretive methods in policy research. *Handbook of public policy analysis: Theory, politics, and methods*, pp.405–415.
- Yanow, D. & Schwartz-Shea, P., 2006. *Interpretation and method: Empirical research methods and the interpretive turn*, London: ME Sharpe Inc.

# Appendix A: Ethical Approval

## A.1. Local Institutional Review Board



Amref Health Africa in Kenya

REF: AMREF-ESRC P112/2014

17<sup>th</sup> June 2014

Adam Koon  
London School of Hygiene and Tropical Medicine  
Tel: +1 202 578 1816  
Email: [Adam.Koon@lshtm.ac.uk](mailto:Adam.Koon@lshtm.ac.uk)

Dear Mr. Koon,

**RESEARCH PROTOCOL: THE POLITICS OF UNIVERSAL HEALTH COVERAGE IN KENYA (P112/2014)**

Thank you for submitting your protocol to Amref Health Africa Ethics and Scientific Review Committee.

This is to inform you that the ESRC has reviewed and approved your above protocol. The approval period is from 18<sup>th</sup> June 2014 to 18<sup>th</sup> June 2015.

The approval is subject to compliance with the following requirements:

- a) Only approved documents (informed consents, study instruments, advertising materials etc) will be used.
- b) All changes (amendments, deviations, violations etc) are submitted for review and approval by AMREF ESRC before implementation.
- c) Death and life threatening problems and severe adverse events (SAEs) or unexpected adverse events whether related or unrelated to the study must be reported to the ESRC immediately.
- d) Any changes, anticipated or otherwise that may increase the risks or affect safety or welfare of study participants and others or affect the integrity of the research must be reported to AMREF ESRC immediately.
- e) Submission of a request for renewal of approval at least 60 days prior to expiry of the approval period (attach a comprehensive progress report to support the renewal).
- f) Clearance for export of biological specimens must be obtained from AMREF ESRC for each batch of shipment.
- g) Submission of an executive summary report within 90 days upon completion of the study. This information will form part of the data base that will be consulted in future when processing related research studies so as to minimize chances of study duplication and/or plagiarism.

In case of any clarification or query, please do not hesitate to contact the ESRC Secretariat ([esrc.kenya@amref.org](mailto:esrc.kenya@amref.org)).

Yours sincerely,

A handwritten signature in black ink, appearing to read "M. Karama", written over a light blue horizontal line.

Prof. Mohamed Karama  
ESRC Chair, Amref Health Africa in Kenya  
CC. Dr. Meshack Ndirangu, Deputy Country Director and ESRC Vice Chair, Amref Health Africa in Kenya

Dr. David Ojaka, Programme Manager Research Advocacy and Business Development, Amref Health Africa in Kenya

## A.2. LSHTM Institutional Review Board

### London School of Hygiene & Tropical Medicine

Keppel Street, London WC1E 7HT  
United Kingdom  
Switchboard: +44 (0)20 7636 8636

[www.lshtm.ac.uk](http://www.lshtm.ac.uk)

LONDON  
SCHOOL of  
HYGIENE  
& TROPICAL  
MEDICINE



### Observational / Interventions Research Ethics Committee

Mr Adam Koon  
Research Degree Student  
GHD/PHP  
LSHTM

15 May 2014

Dear Mr. Koon,

**Study Title: The Politics of Universal Health Coverage in Kenya: An Interpretive Analysis of Political Priority for Revenue Collection Policies**

**LSHTM ethics ref: 8245**

Thank you for your application of 15 April 2014 for the above research, which has now been considered by the Observational Committee.

#### Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation, subject to the conditions specified below.

#### Conditions of the favourable opinion

Approval is dependent on local ethical approval having been received, where relevant.

#### Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document Type	File Name	Date	Version
Protocol / Proposal	Koon Interview Guide DRAFT 4 - 28.2.14.doc	28/02/2014	2
Protocol / Proposal	LSHTM IRB Protocol - 28.3.14.docx	28/03/2014	1
Information Sheet	AMREF ESRC Sample Consent Form.doc	28/03/2014	1

#### After ethical review

Any subsequent changes to the application must be submitted to the Committee via an Amendment form on the ethics online applications website. All studies are also required to notify the ethics committee of any serious adverse events which occur during the project via an Adverse Event form on the ethics online applications website. At the end of the study, please notify the committee via an End of Study form on the ethics online applications website. Ethics online applications website link: <http://leo.lshtm.ac.uk>

Yours sincerely,

**Professor John DH Porter**  
Chair

[ethics@lshtm.ac.uk](mailto:ethics@lshtm.ac.uk)  
<http://www.lshtm.ac.uk/ethics/>

---

Improving health worldwide

# Appendix B: Consent Form

---



## Ethics & Scientific Review Committee

### Informed Consent Form

<b>Study Title</b>	The Politics of Universal Health Coverage in Kenya
<b>Investigator(s)</b>	▪ Adam Koon, Susannah Mayhew, Jane Chuma
<b>Study Sponsor(s)</b>	
<b>Collaborators</b>	Kenya Medical Research Institute – Wellcome Trust, London School of Hygiene and Tropical Medicine

**This Informed Consent Form has two parts:**

- **Information Sheet (to share information about the study with you)**
- **Certificate of Consent (for signatures if you choose to participate)**

**You will be given a copy of the full Informed Consent Form**

#### **Part I: Information Sheet**

The Kenya Medical Research Institute – Wellcome Trust (KEMRI-WT) and London School of Hygiene and Tropical Medicine are doing research on the politics of universal health coverage (UHC) in Kenya. We are giving you this information because we would like you to participate in our research project. If you prefer not to participate, you are free to choose to do so. You will continue to receive health services the way that you normally would, with no negative impact. We want to make sure that you have all the information that you need before you decide. Members of our team are here to help you understand more about the project. If you do not understand any of the words or ideas that you see on this form, please ask us to explain the information to you. You can talk to anyone from our team whom you feel comfortable with about the research.

#### **Why is this Project Important?**

This project is important because Kenya is embarking on an ambitious finance strategy to move towards universal health coverage (UHC). Little is known about how political considerations influence the decision-making process for health financing policies in low-income countries. This study is of particular significance as a growing international movement is pushing for UHC as one of the successors to the UN's millennium development goals after 2015. Also, many low-income countries are looking to each other for lessons on how to navigate the political process for UHC.

- The purpose of this study is to see why some health financing policies to support UHC receive political priority and others do not.

### **Who Can Participate?**

You are being invited to take part in this research project because we feel that your experiences with designing, influencing, or supporting health financing in Kenya will help to illuminate the process by which this takes place.

### **Participation is Your Choice**

Your participation in this research is completely voluntary. You will make the choice about whether you will participate or not. If you choose not to take part, you will continue to receive all of the services that you usually get in your community and nothing will change.

### **What Is Involved in this Project?**

This is a qualitative research project that will use well-established interpretive methods including analysis of documents as well as in-depth semi-structured interviews with those participating health financing in Kenya.

- Approximately 50 open-ended interviews will be conducted with health financing stakeholders from a variety of organizations at their place of work.
- Interview questions will elicit responses that reveal how participants interpret a variety of health concepts and the policymaking process more generally. Participants do not have to answer all questions.
- Interviews will take place over a period of 7 months from May – December 2014.
- All interviews will be anonymously transcribed, coded, and analyzed using qualitative data analysis software immediately after conducting the interview.
- Preliminary findings will be presented in a workshop to which participants will be invited in 2014. An additional workshop to disseminate the findings will be conducted approximately one year after this study has been completed.
- If changes are made to the study or new information becomes available, you will be informed
- The research data (anonymous transcripts) will be destroyed 10 years after the study is complete.

### **How Long will the Project Last?**

This study takes place over May 2014 – May 2015.

### **What are the Risks?**

There is a risk that you may share some personal or confidential information by chance, or that you may feel uncomfortable talking about some of the topics in this study. However, we do not wish for this to happen. You do not have to answer any question or take part in the survey if you feel the question(s) are too personal or if talking about them makes you uncomfortable.

### **What are the Benefits?**

There will be no direct benefit to you, but your participation is likely to help us find out more about the politics of universal health coverage in Kenya.

### **How will we Protect your Information and Confidentiality?**

The research being done in the community may draw attention and if you participate you may be asked questions by other people in the community. We will not be sharing information about you to anyone outside of the research team. The information that we collect from this research project will be kept private. Any information about you will have a number on it instead of your

name. Only the researchers will know what your number is and we will lock that information up with a lock and key. It will not be shared with or given to anyone outside of our project.

### **What will Happen with the Results?**

The knowledge that we get from this research will be shared with you and your community before it is made widely available to the public. Each participant will receive a summary of the results. There will also be small meetings in the community and these will be announced. Following the meetings, we will publish the results so that other interested people may learn from the research.

### **Can I Refuse to Participate or Withdraw from the Study?**

You do not have to take part in this research if you do not wish to do so. If you choose not to participate, you will continue to receive all of the normal services that you usually get and nothing will change. If you wish to stop participating in the study after you begin, you can stop at any time by telling someone on our project team. If you choose to stop taking part, you will continue to get all of the normal services that you usually get in your community.

### **Who Can I Contact?**

If you have any questions, you can ask anyone from our team now or later. If you have questions later, you may contact Adam Koon, +254 (0)723 405 096, adam.koon@lshtm.ac.uk. If you have questions about your rights as a research participant, you may contact:

The Research Officer  
AMREF Kenya  
Wilson Airport, Lang'ata Road  
Office Tel: +254 20 6994000  
Fax: +254 20 606340  
P.O Box 30125-00100  
Nairobi, Kenya

### **Do you have any questions at this time?**

**Part II: Certificate of Consent**

**I have read the above information, or it has been read to me. I have had the opportunity to ask questions about it and any questions I have been asked have been answered to my satisfaction. I consent voluntarily to be a participant in this study.**

<b>Print Name of Participant</b>	[at least forename and surname]
<b>Signature of Participant</b>	
<b>DD/MM/YYYY</b>	

***If visually impaired, physically impaired, mentally impaired or illiterate***

**I have witnessed the accurate reading of the consent form to the potential participant, and the individual has had the opportunity to ask questions. I confirm that the individual has given consent freely.**

<b>Print Name of Participant</b>	[at least forename and surname]
<b>Thumb/Foot print of Participant</b>	
<b>Signature of Witness</b>	[A literate witness must sign and should be selected by the participant and MUST have no connection to the research team.]
<b>DD/MM/YYYY</b>	

**Statement by the researcher/person taking consent**

**I have accurately read out the information sheet to the potential participant, and to the best of my ability made sure that the participant understands that the following will be done:**

- 1. A member of the research team will visit the participant at least once.**
- 2. At the visit the participant will complete a one-hour interview.**
- 3. The participant's information will be kept confidential.**

**I confirm that the participant was given an opportunity to ask questions about the study, and all the questions asked by the participant have been answered correctly and to the best of my ability. I confirm that the individual has not been coerced into giving consent, and the consent has been given freely and voluntarily.**

**A copy of this ICF has been provided to the participant.**

<b>Print Name of Researcher/person taking the consent</b>	[Adam Koon]
<b>Signature of Researcher/person taking the consent</b>	
<b>DD/MM/YYYY</b>	

# Appendix C: Interview Guide

---

**Participant Information** Could you tell us/me about your work experience?

1. Sex \_\_\_\_\_
2. Organization \_\_\_\_\_
3. Designation \_\_\_\_\_
4. Department \_\_\_\_\_
5. No of years in current position \_\_\_\_\_
6. Date of Interview \_\_\_\_\_

## BACKGROUND

Part 1: **I would like to begin by asking you a few background questions.**

### **1a: Can you tell me about your organization?**

What are your organization's main responsibilities?

Does your organization work with other organizations?

### **1b: How do you view the role of your organization in the health sector?**

## UNIVERSAL HEALTH COVERAGE

Part 2: **Now, can I ask you some questions about Universal Health Coverage in Kenya?**

### **2a: What does the term "universal health coverage" mean to you?**

Where did you first hear the term?

In what context is it typically used here in Kenya?

How frequently is it being used here in Kenya?

Do you think this term is becoming more frequently or less frequently used in Kenya?

### **2b: Do you think that universal health coverage has the same meaning for other health policy actors?**

Who are these actors?

How would they interpret UHC?

What are the effects of these different interpretations of UHC?

### **2c: Do you think that policy actors agree/disagree with how universal health coverage should be achieved?**

What do different people agree/disagree about?

Why do you think they agree/disagree?

Can you give me specific examples?

### **2d: Do you think universal health coverage should play a role in health policy in Kenya?**

How so?

Should it inform finance policy decisions?

How should stakeholders be involved in supporting or not supporting it?

## USER FEES

Part 4: **Now, I would like to learn more about two specific policies in Kenya.**

### **4a: What is your view of the recent decision to remove user fees from public health facilities and dispensaries?**

Do you think this is a good thing or a bad thing? Why?

How will this affect your work?

Does anyone stand to benefit from the policy change?

Will anyone be negatively affected by this decision?

### **4b: Why do you think this decision was made?**

**4c: In an ideal world what in your view would have been the correct decision with regard to user fees at these access points?**

**4d: Are the interests of your organization met by the recent decision?**

In what ways?

Does this positively or negatively affect your work?

**4e: Do you think that debates around Universal Health Coverage influenced this decision?**

Why/why not? How did it or did it not influence the decision

NHIF RATE INCREASE

**Part 5: Now I would like to know more about the recent attempt to increase the contribution rate to the National Hospital Insurance Fund.**

**5a: What is your view of the recent attempt to raise the contribution rates for the NHIF?**

Do you think this is a good thing or a bad thing? Why?

How will this affect your work?

Will anyone benefit from the policy change?

Will anyone be negatively affected by this decision?

**5b: Why do you think this attempt has stalled?**

**5c: In an ideal world what, in your view, would be the correct decision with regard to the NHIF contribution rates?**

**5d: Are the interests of your organization met by the recent decision not to increase the rate?**

How? Are there indirect ways?

Does this positively or negatively affect your work?

**5e: Do you think that debates around Universal Health Coverage influenced this decision?**

Why/why not? How did it or did it not influence this process

POLICY PROCESS

**Part 6: Now, I would like to learn more about how health policy is made in Kenya.**

**6a: How do you think your organization is viewed by (other) policymakers?**

Are they correct to see it in this way?

**6b: To what extent should your organization be involved in the policy process?**

What can your organization contribute that others cannot?

**6c: Are your views on the policies we just discussed sought by policymakers?**

If **Yes** – by whom, how, when?

If **No** – do you attempt to engage with (other) policymakers yourself?

**6d: Do you communicate your views to policymakers or ministers of parliament?**

How do you engage with these people?

Are they responsive to this?

What do you aim to achieve in speaking to these people?

**6e: Do you engage with any (other) particular organizations or individuals in the policy process?**

Which ones?

How do you engage with them?

Why do you speak to these people/organizations?

What is your aim?

How effective are these mechanisms in articulating your position to policymakers?

**6f: Are you involved in the formal mechanisms of policymaking?**

In what way?

At what point in the legislative process?

What contribution do you make through your involvement in this process (consultation submissions, evidence to committees, etc.)?

**6g: Are there any other, less formal ways in which you engage policymakers or politicians?**

Why do you engage policymakers in this way?

Does this enable you to effectively articulate your views to policymakers?

How are you able to do this?

**6h: Do you know which other organizations are involved in the policy process in the health sector?**

Which organization do you think ought to be involved?

**6i: Could your involvement be improved in any way?**

**6i: How do you attempt to communicate your views to the media, and the public more generally?**

**6i: What message do you aim to convey about your organization?**

What message do you aim to convey about universal health coverage?

**6i: Why is it important for you to communicate this message?**

## EQUITY

Part 3: Now, for the last part, I'd like to explore the idea of equity in health.

**2a: What does the term "equity" mean to you?**

Do you think other policymakers/stakeholders use it this way?

**3a: What role do you think equity plays in the Kenyan health sector?**

Why/ why not?

Is there (dis)agreement about this?

If so, who agrees or disagrees?

Do you think this debate extends to the public?

**3b: Do you think that equity should be a consideration in the health sector?**

**3c: Do you think equity should be a consideration within health financing debates and policies in Kenya?**

In your view was there any discussion of equity in either the user fees or the NHIF debates in Kenya?

If **YES**, which actors promoted health equity in these policy debates?

How were these actors able to use equity to generate support for policy positions?

If **NO**, why do you think this was not part of the discussion for these policies?

**3d: What other factors should be considered in the health sector?**

How do these considerations compare to equity?

## CONCLUSION

**Is there anything else you would like to add about the issues we have discussed and your role in the policy process?**

**Are there any other people either within or outside your organization with whom it would be beneficial for me to speak?**

**Would you be willing to be contacted again if I need to clarify anything in the future?**

**Thank you very much for participating in this interview. It takes time to participate in these surveys and discussions about health financing and we very much appreciate your valuable time.**

## Appendix D: Kenyan Health Systems Data

Basic demographic and health information is presented in Chapter one. Appendix D provides more detail on the Kenyan health system, with a particular emphasis on health financing. The information was condensed into multiple tables that efficiently summarize key financing data relative to the information presented in this thesis. These tables are not numbered as they are only briefly referred to in the text.

In Kenya, the government employs 1,080 medical doctors and consultants while faith-based organizations (FBOs) and NGOs employed a total of 653 (MOHb 2014). There were a total of 17,075 nurses (including B.Sc. Nursing) working in government facilities and 5,832 in FBOs/NGOs (MOHb 2014). Kenya has many fewer dentists, with 151 working in the government and 61 working in FBOs/NGOs (MOHb 2014). The government employs 277 pharmacists while FBOs/NGOs employ 52 (MOHb 2014). These health workers employed by the government and FBOs/NGOs were largely concentrated in the Rift Valley (12,879), Central (8,752) and Nairobi (8,752) (MOHb 2014). The following figure (adapted from MOHb 2014) demonstrates that a slight majority of health facilities are in the private sector.

Public/Private Health Facilities in Kenya, 2013

	Facilities (N)	Proportion (%)
Ministry of Health	3,965	42.9
Other Public Institution	438	4.7
Faith Based Organization	1,053	11.4
Private Institutions and Private Practice	3,500	37.8
Non-Governmental Organizations	293	3.2
<b>Total:</b>	<b>9,249</b>	<b>100</b>

This study focused on reforms within the National Hospital Insurance Fund (NHIF) because it is the largest, most influential, and widely discussed of insurer. For a historical overview of the NHIF and relevance to the broader health system, please see Chapter five and Table 5.1 at the beginning of the chapter. Currently, NHIF membership is mandatory for all public and private sector employees and informal workers can voluntarily contribute. The scope of NHIF is somewhat limited, as it covers exclusively inpatient services, despite the fact that outpatient services were intended to be covered in the original NHIF act of 1998 (J. Chuma & Okungu, 2011). Coverage includes up to 280 inpatient days per year per member (and beneficiary, such as spouses and children). Although there is some variation, as indicated in

the table below, all government facilities cover any illness condition and maternity care. Those enrolled in NHIF further benefit from designated health centers and referral/teaching hospitals that waive copayments (see table below from Deloitte 2012)

### NHIF Benefits Coverage, 2010

Facility type	Category	In patient	Surgical	Others	Facilities (#)	Beds (#)	Min. Reimbursement	Max. Reimbursement
<b>Government</b>	A	Yes	Yes	Yes	162	20,319	600	2,400
<b>Private and Mission</b>	B	Yes	Co-pay	No	176	11,491	800	2,400
<b>Private</b>	C	Daily rebate for bednights only	No	No	140	6,059	600	2,100
<b>Others</b>	N	Daily rebate for bednights only	No	No	167	6,446	200	1,700
<b>Totals</b>					645	44,315	200	2,400

Despite the potential of NHIF, problems persist that impede Kenya's march toward UHC (for more detail see Chapters one and five). Coverage of informal sector workers remains low which is important because the informal sector is large (approximately 6-7 million) and enrollment of this group is needed for cross-subsidization (Chuma & Okungu 2011; Mathauer et al. 2008). See table below from Deloitte 2012.

### NHIF Background Statistics, 2010

Deloitte's NHIF Fact Sheet: 30 June 2010	
Number of members	Total: 2.8 million Formal sector: 2.3 million Informal sector: 0.5 million
Number of members + dependents	6.6 million (17% of tot. pop.)
Total contributions received (KSh.) in FY 2010	KSH. 5.7 billion
Total benefits paid out in FY 2010	KSH. 3.1 billion
No. of branches	31
No. of window / satellite offices	44
No. of employees	1,629
No. of providers in NHIF network	645 hospitals (98% of Kenya hospitals)
No. of claims in FY 2010	303,000
Amount of average claim (KSh.)	10,000

Also, it is widely considered that all contributions to the NHIF are grossly inadequate as they have not been revised to account for inflation or the rising cost of medical care since NHIF's inception (Chuma & Okungu 2011; Munge & Briggs, 2013). During the study time period formal sector employees were expected to pay through monthly payroll deductions based on a progressive distribution of ability to pay (30 to 320 Kenyan Shillings (KSH) although it is unclear whether or not this was occurring (Chuma & Okungu 2011). Monthly payments were fixed for informal sector employees who voluntarily contribute 160 KES (1.9 USD) per household, per month (NHIF, 2013). Following an external audit from Deloitte in 2012, new rates were proposed that would more accurately reflect economic and medical inflation. These rates were adapted and modified slightly by NHIF for higher income earners after data collection ended. The table below is adapted from the Deloitte report and includes the new rates, which are publically available on the NHIF website. As the table shows, these are reasonable adjustments in light of the higher estimates based on inflation.

NHIF Rates (March 19, 2017 exchange rate: 1 KSH = .01 USD)

Gross Income Bracket (KSH)	Monthly Contributions During Study (KSH)	Monthly Contribution Inflation Adjusted (KSH)	Deloitte 2010 Proposed Monthly Contribution (KSH)	New Monthly Contribution 2016/2017 (KSH)
1,000 - 1,499	30	364	150	150
1,500 - 1,999	40	486	150	150
2,000 - 2,999	60	729	150	150
3,000 - 3,999	80	971	150	150
4,000 - 4,999	100	1,214	150	150
5,000 - 5,999	120	1,457	150	150
6,000 - 6,999	140	1,700	300	300
7,000 - 7,999	160	1,943	300	300
8,000 - 8,999	180	2,186	400	400
9,000 - 9,999	200	2,428	400	400
10,000 - 10,999	220	2,671	400	400
11,000 - 11,999	240	2,914	400	400
12,000 - 12,999	260	3,157	500	500
13,000 - 13,999	280	3,400	500	500
14,000 - 14,999	300	3,643	500	500
15,000 - 19,999	320	3,885	600	600
20,000 - 24,999	320	3,885	750	750
25,000 - 29,999	320	3,885	850	850
30,000 - 34,999	320	3,885	1,000	900
35,000 - 39,999	320	3,885	1,000	950
40,000 - 44,999	320	3,885	1,000	1,000
45,000 - 49,999	320	3,885	1,000	1,100
50,000 - 59,999	320	3,885	1,500	1,200
60,000 - 69,999	320	3,885	1,500	1,300
70,000 - 79,999	320	3,885	1,500	1,400
80,000 - 89,999	320	3,885	1,500	1,500
90,000 - 99,999	320	3,885	1,500	1,600
100,000 & Above	320	3,885	2,000	1,700

## Appendix E: Scoping Review Sources

Author	Year	Journal	Country	Type	Method	Data Source	Health Issues	Frames	Contestation	Affect on the policy process
<b>A. C. Rasmussen</b>	2011	Administration & Society	United States	Policy Studies	Interpretive Policy Analysis	Legislative testimony, letters, and written statements	Reproductive health - Contraception	Inclusive frames (2): Medical, gender/class based equity Exclusionary frames (3): market-based, religious, elective/immoral procedure	Yes	Yes
<b>A. C. Saguy and K. W. Riley</b>	2005	Journal of Health Politics, Policy & Law	USA	Sociology	Case Study	Document reviews, in-depth interviews, participant observation	NCDs - Obesity	(fat acceptance group) “body diversity”, (anti-obesity group) “risky behavior” “disease”, “epidemic” both use “illness	Yes	Some
<b>A. Sardell</b>	2014	Book	USA	Political Science	Comparative Case Study	Interviews, Documents, building on previous research	Financing - Health Insurance Reform	(3) preventable/solvability, cost-effective, human capital	Yes	Yes

<b>A. E. Doan and K. Kirkpatrick</b>	2013	Policy Studies Journal	USA	Political Science	content analysis, cross-sectional logit analysis	4 newspapers	Infectious Disease - HPV	politics, public health, economic, morality	Yes	Some
<b>A. Iannantuono and J. Eyles</b>	2000	Environmental Management	Multiple	Policy Studies	Frame-critical policy analysis	International Joint Commission Reports	Environmental Health	Multiple, by level of framing: action frames - managing ecosystems, changing human behavior	Yes	Yes
<b>A. Iannantuono and J. Eyles</b>	1997	Social Science & Medicine	Canada	Policy Studies	Semiotic Schemata	Achieving Health for All - Policy Document	Health Systems	Various components labeled as signs or codes	Little	Some
<b>A. J. Peters, F. T. M. Van Driel and W. H. M. Jansen</b>	2013	Journal of the International AIDS Society	Global	Health Policy	Discourse Analysis	Policy Documents for 16 organizations	Infectious Disease - HIV/AIDS	Sexuality (main) - also gender, reproductive rights, sexual rights	Yes	Yes
<b>A. Kamradt-Scott</b>	2012	Global public health	Global	International Relations	Comparative Case Study:	Interviews with individuals in orgs., document analysis	Infectious disease - influenza	Evidence-based medicine as an emergent frame	Some	Some

<b>A. Kamradt-Scott and C. McInnes</b>	2012	Global public health	Global	International Relations	Comparative Case Study:	Interviews with individuals in orgs., document analysis	Infectious disease - influenza	Security		Yes	Yes
<b>A. L. Esperance</b>	2013	Ph.D. Thesis	Multiple	Policy Studies	Interpretive Policy Analysis	Documents, Interviews, Newspapers	Reproductive health - Assisted Reproductive technologies	(6) Moral, Medical, Administrative, Legal, Family-building, Experience-based		Yes	Yes
<b>A. L. Roth, J. Dunsby and L. A. Bero</b>	2003	Social Studies of Science	USA	Sociology	Frame Analysis, Content Analysis	572 selected at random from 96,755 FDA individual comments	Substance Misuse - Tobacco control	Original FDA frames: (1)master frame: science (1) diagnostic frames: preventable illness (FDA), (3) prognostic frame: reducing access, reducing appeal, educating youth about health risks; Various counter-frames (5)-scientific, ideological, economic, political, procedural (all with sub-frames)		Yes	Yes

<b>A. Ofori-Birikorang</b>	2010	Ph.D. Thesis	Ghana	Media Studies	Ethnographic Content Analysis	Media analysis of 4 major newspapers 2005-2007, small n (6) interviews	Financing - National Health Insurance Reform	7 main news frames (Politics, community&development, corruption, social apathy/Disenchantment, core NHIS issues, health, business) with 26 sub-frames	Yes	Yes
<b>A. S. Fogarty and S. Chapman</b>	2012	BMC Public Health	Australia	Health Policy	Content Analysis, Frame Analysis	Newspaper articles over months	Substance Misuse - Alcohol control	(10) News media frames supportive of adv. restrictions (5) and not supportive of adv. restrictions (5)	Some	Some
<b>A. S. Fogarty and S. Chapman</b>	2011	Drug Alcohol Rev	Australia	Health Policy	Content Analysis, Frame Analysis	329 Newspaper articles over 24 months	Substance Misuse - Alcohol control	2 in favor of alcopops tax (consumption reduction, loophole) and 2 against (substitution, revenue raising)	Some	Some
<b>B. Hawkins and C. Holden</b>	2013	Critical Policy Studies	UK	Policy Studies	Frame-critical policy analysis	35 Interviews and document analysis	Substance misuse - Alcohol	Multiple - problem restricted to a minority vs. societal problem, reframing by advocates of public order to a public health issue, pricing vs. anti-pricing prescriptions	Yes	Yes

<b>C. C. David, J. M. L. Atun and A. G. M. La Vina</b>	2012	Population Research and Policy Review	Philippines	Policy Studies	Textual discourse analysis, semantic neural network analysis	Legislation from 21 years (168 documents from House, 113 documents from Senate)	Reproductive health - demography	“development” Population management, reproductive health, vs. “abortion” “moral values” anti-familyplanning/anti-abortion	Yes	Yes
<b>C. Johnson</b>	2010	Global Public Health	Honduras	Health Policy	Latent Content Analysis	Documents from PAHO, WHO, WB, USAID, Honduran MOH	Health Systems	Economic liberalization, distributional equity,	Yes	Unclear
<b>C. L. Menashe and M. Siegel</b>	1998	Journal of Health Communication	USA	Media Studies	Signature Matrix	Newspaper articles (80 randomly selected from set of 179)	Substance Misuse - Tobacco control	Of 11 tobacco interest frames, 10 tobacco control frames (arguments) - 6 industry frames and 4 advocate frames dominated (each mapped to select few core principles/values)	Yes	Some
<b>D. A. Rohlinger</b>	2002	The Sociological Quarterly	USA	Sociology	Content analysis	print media	Reproductive health - decision making	(2) abortion framed as (constitutional) right vs. morality	Yes	Yes

<b>D. Goss</b>	1996	Scandinavian Journal of Management	UK	Sociology	Frame Analysis	Policy Documents	Infectious Disease - HIV/AIDS	Defensive - threat to organizational success, constructive - medical problem	Some	Some
<b>D. Noy</b>	2009	Social Problems	USA	Sociology	Frame analysis, network analysis, media content analysis, Participatory action research	Documents, Interviews, Media, participant observation	Social Determinants - Homelessness	Master frames (4): individual, systemic, social control, bureaucratic failure shared Diagnostic - individual, structural; divergent Prognostic -	Yes	Yes
<b>D. Reubi</b>	2012	Global Public Health	Global	International Relations	Comparative Case Study:	Interviews with individuals in orgs., document analysis	Substance Misuse - Tobacco control	Human rights	Yes	Yes
<b>D. T. Studlar</b>	2008	The Review of Policy Research	USA	Political Science	Systematic historical analysis	Unclear	Substance Misuse - Tobacco control	Public health, political economy, morality; good vs. evil, "social hygiene", "tax grab" (re-frames)	Yes	Yes

<b>E. S. Kolker</b>	2004	Sociology of Health & Illness	USA	Sociology	Frame analysis	congressional testimony and media accounts (unclear specifics)	NCDs - Cancer (breast)	reframing breast cancer from “private problem” to “public health problem” activists used (3) culturally resonant frames: BC as epidemic, BC as gender equity problem, BC as threat to families	Some	Yes
<b>G. L. Jenkin, L. Signal and G. Thomson</b>	2011	Obesity Reviews	New Zealand	Health Policy	Case Study, Signature Matrix	31 written and oral submissions to the NZ Parliamentary Inquiry on obesity	NCDs - Obesity	Table 3 Many frames for both camps organized by position (7), causal roots (6), solutions (3), and core values (2 w/8sub-frames): market justice vs. social justice	Yes	Some
<b>J. Adams, V. Braun and T. McCreanor</b>	2010	Gay and Lesbian Issues and Psychology Review	Multiple	Psychology	Discourse and Social Psychology	Gov. docs, stakeholder reports	Inequalities - LGBT health	(2) Biomedical, biopsychosocial	Yes	Little
<b>J. O. Parkhurst</b>	2012	Evidence & Policy: A Journal of Research, Debate and Practice	US	Health Policy	Discourse Analysis	28 interviews, documents, texts	Infectious disease - HIV/AIDS	Sexuality, Morality	Yes	Yes

<b>J. O. Parkhurst and M. Vulimiri</b>	2013	Global Public Health	Global	Health Policy	Review	Unclear, cervical cancer literature	NCDs - Cancer (Cervical)	NCDs umbrella, women's right and health, co-morbidity of HIV/AIDS	Yes	Some
<b>J. R. Daw, S. G. Morgan, P. A. Collins and J. Abelson</b>	2014	Journal of Health Politics, Policy & Law	Canada	Health Policy	Content analysis	3 Newspapers 1990-2010, coded by problem frame and policy solution (selection 686 articles)	access to medicines - expansion of drug/pharmacy benefits in national plan	problem frames: values-related (w4 sub-frames), cost-related (w4sub-frames), other policy solutions (3sub-frames) Policy options (8sub-frames), barriers to policy (6sub-frames)	Yes	Yes
<b>K. A. Dodge</b>	2008	American Psychologist	USA	Psychology	Strategic frame analysis	Unclear	Violence	superpredator, moral defect, quarantine, man as computer, corrective surgery, vaccine, chronic disease	Yes	Some

<b>K. E. Smith</b>	2013	Social Policy & Administration	UK	Policy Studies	Review	Document review: Historical overviews of tobacco wars, journal supplement, systematic reviews	Substance Misuse - Tobacco control	(3) “health-oriented”, vs. free personal choice, economic Newer frame for reducing health inequalities	Yes	Yes
<b>K. Inoue and G. S. Drori</b>	2006	International Sociology	Global	Sociology	Organizational and policy assessment	Unclear	Global Health governance	-4 international health as charity, professional activity, means for development, basic human right	Little	Little
<b>L. Andress</b>	2007	Ph.D. Thesis	UK	Political Science	Signature matrix, discourse analysis	Media, newspapers	Social Determinants	44 different frames	Yes	Some
<b>L. C. Esmail and J. C. Kohler</b>	2012	Globalization and Health	Canada	Policy Studies	Content analysis, critical realist evaluation	Parliamentary Committee transcripts and legislative review	Access to drugs	Multiple categorized under goals: liberty, equity, efficiency, security	Yes	Yes

<b>L. Redington</b>	2009	Ph.D. Thesis	United States	Health Policy	Mediated thematic analysis	Transcripts from 4 congressional hearings over 4 years, 100 documents, 10 in-depth interviews	Access to drugs and medications	(4) ODA Reform as Economics and Access, Patient Relief, Rules of Participation, Congressional Action	Yes	Yes
<b>L.-K. Tynkkyne n, J. Lehto and S. Miettinen</b>	2012	BMC health services research	Finland	Health Policy	Frame Analysis , Signature Matrix	Interviews , individual and group	Financing - strategic purchasing	(5)rational reasoning, pragmatic realism, promoting diversity of providers, benefits for the municipality, good for local people.	Yes	Yes
<b>M. Moret-Hartman, P. D. Knoester, Y. A. Hekster and G. J. van der Wilt</b>	2006	Health Policy	Netherlands	Health Policy	Argumentative Policy Analysis / Case Study	Interviews (very small number approx. 8)	Health systems - service delivery (prescribing practices)	Specific policy frames > 16, organized in a interpretive matrix by judgement toward solutions, problem definition, Background theory, and preferences	Little	Some

<b>M. S. R. Berger</b>	2013	Ph.D. Thesis	United States	Policy Studies	Comparative case Study	32 in-depth interviews, papers, newspaper articles, legislative testimony	Substance Misuse - Injection drug use	Moral, Political, Scientific, Other (lesser)	Yes	Yes
<b>M. Woodling, O. D. Williams and S. Rushton</b>	2012	Global public health	Global	International Relations	Comparative Case Study	Interviews with individuals in orgs., document analysis	Infectious Disease - HIV/AIDS	frame shift from “AIDS to development” to “AIDS and development”	Yes	Yes
<b>O. D. Williams</b>	2012	Global public health	Global	International Relations	Comparative Case Study	Interviews with individuals in orgs., document analysis	Access to medicines	Dominant economic framing vs. counter frames of human rights, negative consequences for access, undermining global public goods, and negative impact on development	Yes	Yes
<b>O. E. Firbank</b>	2011	Journal of Aging Studies	Canada	Policy Studies	Frame-critical policy analysis	Textual analysis, mostly documents and government papers	Population health - Geriatrics	Moral. Frame emergence, shift, and re-framing over long periods of time 4 stages listed as “Dominant institutional action frames” and “dominant policy frames” Table 1	Some	Yes

<b>R. N. Oronje, J. Crichton, S. Theobald, N. O. Lithur and L. Ibisomi</b>	2013	Ph.D. Thesis	Kenya	Policy Studies	Comparative case study	54 in-depth elite interviews, participant observation, content analysis, document review	Reproductive health - Sexual and reproductive health	4 over-arching narratives )SRH as a moral, cultural, medical, and human rights narrative...multiple frames included within each narrative	Yes	Yes
<b>S. Frickel</b>	2004	Social Problems	Global	Sociology, Social Movements	Frame analysis	Documents and 27 in-depth interviews	Environmental Health - Toxicology	Frame Extension and frame amplification, also translation (chemical risk became genetic hazard)	Some	Some
<b>S. Kwan</b>	2009	Sociological Inquiry	USA	Sociology	Frame Analysis, Signature Matrix	42 documents selected from articulator websites	NCDs - Obesity	(3) Cultural frames: medical, social justice, market choice then multiple sub-frames embedded within the framing matrix attributable to each and their reasoning, positions, policies, etc.	Yes	Some
<b>S. M. Driedger and J. Eyles</b>	2003	Social Science & Medicine	Canada	Policy Studies	Frame Analysis	36 Key informant interviews, Media analysis of newspapers	Environmental Health - water quality	Voluntary vs. involuntary risk or “chlorination disinfection saves lives” with 3 sub-frames “luxury of the first world” “balancing risks” “single bad actor vs. complex mixture” vs. “chlorine byproducts cause cancer”	Yes	Yes

<b>S. Paterson and C. Marshall</b>	2011	Journal of Canadian Studies	Canada	Policy Studies	Frame Analysis	Newspapers	Health Systems - Workforce (Midwifery)	Ontario (3): progress (metaframe), legal, boundary (issue frames); Quebec (1): boundary	Yes	Yes
<b>S. Rushton</b>	2012	Global Public Health	Global	International Relations	Comparative case Study:	Interviews with individuals in orgs., document analysis	Infectious Disease - HIV/AIDS	public health security/safety, economic re-framing to a single human rights based frame	Yes	Yes
<b>T. Abraham</b>	2011	Political Studies	Global	International Relations	Historical media analysis	Media	Infectious Disease - Avian Influenza	Security	Little	Some
<b>T. Blackman, B. Harrington, E. Elliott, A. Greene, D. J. Hunter, L. Marks, L. McKee and G. Williams</b>	2012	Sociology of Health and Illness	UK	Health Policy	Comparative case study	197 in-depth interviews	Health Inequalities	Politics, Audit, Evidence, Treatment	Yes	Yes

<b>T. Garvin and J. Eyles</b>	2001	Social science & medicine	Multiple	Health Policy	Case Study	15 interviews, policy document analysis	NCDs - Cancer (skin)	Table 1 - communicator, text, receiver, culture - Narratives (problem and solution) all in 3 countries	Yes	Some
<b>Y. Ibrahim</b>	2007	Crossroads	Singapore	Policy Studies	Content analysis	Press release of government positions during crisis	Infectious Disease - SARS	War - rhetorical=gov., action frame= policymakers	Some	Yes

