Framing Universal Health Coverage in Kenya: An Interpretive Analysis of the 2004 Bill on National Social Health Insurance

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ABSTRACT

In 2004, President Mwai Kibaki of Kenya refused to sign a popular bill on National Social Health Insurance into law. Drawing on innovations in framing theory, this research provides a social explanation for this decision. 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, 2014-2015. The frame-critical analysis focused on how actors engaged in 1) sensemaking, 2) naming, which includes selecting and categorizing, and 3) storytelling. We demonstrated that actors' abilities to make sense of the Bill were largely influenced by their own understandings of the finer features of the Bill and the array of interest groups privy to the debate. This was reinforced by a process of naming, which selects and categorizes aspects of the Bill, including the public persona of its primary sponsor, its affordability, sustainability, technical dimensions, and linkages to notions of economic liberalism. Actors used these understandings and names to tell stories of ideational warfare, which involved narrative accounts of policy victory and defeat. This analysis illustrates the difficulty in enacting sweeping reform measures and thus provides a basis for understanding incrementalism in Kenyan health policy.

INTRODUCTION

In 2004, President Mwai Kibaki of Kenya refused to sign a Bill on National Social Health Insurance into law. It was promptly dismantled and, over a decade, the oldest health insurance agency in Africa - Kenya's National Hospital Insurance Fund (NHIF) – become mired in allegations of corruption and organizational disfunction (Künzler, 2016). This would prove pivotal in the development of the Kenyan health system. This paper seeks to understand the forces that shaped the President's decision.

Research of this nature is needed to inform future policy processes and mitigate negative consequences. Nevertheless, health policy research in low- and middle-income countries (LMICs) has engaged in only a limited way with politics (de Leeuw *et al.*, 2014). This is particularly true for research on universal health coverage (UHC) (Rizvi *et al.*, 2020). More research is needed to understand policy processes such as policy diffusion (Gautier *et al.*, 2018) and the mobilization of ideas in health financing (Chemouni, 2016). Thus, some have called for a new generation of social protection research, using approaches such as framing analysis, to account for complex social processes in LMICs (Jawad, 2019). This research addresses these concerns by using an interactive form of framing theory,

derived from critical policy studies, to provide a social explanation of the causes and consequences of policy failure in Kenya's quest for UHC.

Over the last decade, global health advocates have rallied around a campaign to promote Universal Health Coverage (UHC), or complete access to quality, affordable health care (WHO, 2013). This led to the inclusion of UHC in the post-2015 development agenda where it features prominently in the UN's Sustainable Development Goals (UN, 2015a, 2015b). According to former Director General of the World Health Organization (WHO), Margaret Chan, UHC "is the single most powerful concept that public health has to offer" (Chan, 2012).

UHC scholars argue that "political will" or "political commitment" is a necessary precondition of successful movement towards UHC (Balabanova *et al.*, 2013; Nicholson *et al.*, 2015; Yamey and Evans, 2015). 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). Only recently have researchers studied the sociopolitical process of UHC reforms (Fox and Reich, 2015; Harris, 2017; Sparkes *et al.*, 2019). By introducing a conception of framing analysis (van Hulst and Yanow, 2016) 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 (Barasa *et al.*, 2018). Focusing on how meaning is constructed intersubjectively in the policy process furthers our understanding of an otherwise opaque and problematic situation.

The research presented here addresses this gap by using framing theory 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 policy-relevant insights into the health financing policy process in Kenya through a framing analysis of the 2004 Bill on National Social Health Insurance. Actors often referred to this Bill as the "Ngilu Bill", after its primary champion Charity Ngilu, then Minster of Health (a position now called Cabinet Secretary of Health). For this reason, we refer to it as the "Ngilu Bill" throughout this paper.

THEORY AND METHODS

Critical policy studies is a branch of scholarship that examines decision-making in political settings and the practices of policy analysis (Fischer et al., 2016). A key focus of inquiry

is on the social construction of knowledge (Berger and Luckmann, 1967) following principles of interpretation (Taylor, 1971) in order to render value-conflicts understandable. In this vein, "frame-critical policy analysis" was developed in the 1990s to analyze, and potentially resolve, protracted policy controversies that arise from competing worldviews (Rein and Schön, 1996). Donald Schön and Martin Rein (1994) defined policy frames as "taken-for-granted assumptional structures… derived from generative metaphors… effecting the transition from statements of fact to judgements of value" (viii). They called this transition the "normative leap" (Ibid).

Van Hulst and Yanow (2016) shifted the analytical focus of framing analysis from the static concept of 'frames' to the more dynamic focus on 'framing' as an active process, whereby the act of framing involves 'sense-making,' 'naming' (i.e. selecting and categorizing), and 'storytelling'. In this way, they provide an account of frame analysis that focuses less on frames and more on the *process* of framing (van Hulst and Yanow, 2016). In this article, we consider the interactive process through which UHC was framed at a key juncture in Kenya.

The concept of framing has been used in variety of disciplines to understand the health policy process (Koon *et al.*, 2016).

This article deploys a constructivist account of framing as developed by van Hulst and Yanow (2016). Following Mead (1934), Goffman (1959), and Weick (1995), van Hulst and Yanow (2016) conceptualize framing as a process of *sensemaking*, involving the intersubjective construction of meaning among policy actors. Through the process of selecting, naming, and categorizing, actors "highlight some aspects of a policy discourse while occluding and even silencing others" (Van Hulst & Yanow 2016; p.100). *Naming* refers to the features of this selection that must be communicated, often through specific rhetorical and symbolic devices, such as metaphor (Lakoff and Johnson, 1980). While naming is central to Schön and Rein's theory (1994), Van Hulst and Yanow incorporate the concepts of *selecting* and *categorizing* into their framework.

According to Van Hulst and Yanow (2016), the process of *selecting* constructs a problematic policy situation so that it concerns certain actors in a particular way. *Categorizing*, meanwhile, gives meaning to objects, events, acts, and actors often through their association with and differentiation from other social objects and practices(van Hulst and Yanow, 2016). Drawing on Rein and Schön's earlier work on 'problem-setting' (Rein and Schön, 1977) and Deborah Stone's concept of 'causal stories' (Stone, 1989), Van Hulst and Yanow (2016) identify

storytelling as a key component of the framing process that allows actors to situate various aspects of an issue into a broader narrative, helping to explain the emergence or resolution of a persistent policy problem. In this way, ideational features of framing take on a less static, more dynamic, and politically interactive means of negotiating meaning in the policy process (van Hulst and Yanow, 2016).

We used four distinct data-collection methods. First, we used academic literature on the health sector, policy studies and relating to Kenya. Second, we examined published reports, position papers and government documents identified throughout the research process. Third, we conducted semi-structured in-depth interviews. These interviews, their 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. This was captured through field notes (our fourth dataset) that accompanied each interview. Since 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 are not directly cited.

A total of 50 interviews were conducted by X from May 2014 to

March 2015 in Nairobi, Kenya. Interview participation was developed through an iterative snowball method (Bernard, 2011) of identifying principal actors based on relevant documents and knowledge of their involvement in health policy discussions. Study participants were recruited via email, phone calls, and personal contact. The consent form used for this study was required by the local IRB, X.

Interview participants were either leaders, high-ranking members, or financing experts within their respective organizations (see Table 1). At the expense of specificity, we have anonymized quotes from study participants, utilizing broad professional categories. Saturation was largely achieved and few individuals, other than a former Minister of Health/current Governor of Kitui County (Charity Ngilu) and former President Mwai Kibaki, were noticeably absent from this cohort. All interviews were recorded, transcribed, thematically coded, and emerging themes analyzed using Dedoose analytical software. We used the Van Hulst and Yanow (2016) frame-critical configuration as an analytical framework. Peer-debriefing was pursued by presentation of findings at X as well as international scientific conferences. Member-checking was enabled through presentation of preliminary findings to study participants.

[TABLE 1: Study Participants]

The Institutional Review Boards of X in Kenya and X in X approved this study.

RESULTS

Sensemaking

The sense-making process for the Ngilu Bill requires careful consideration of the political context in which the frame emerged. Actors' understanding of party and electoral politics were tied to their interpretations of how decision-making processes prevented the bill from being passed. Analysis of the sensemaking process shows how multiple forces provided a platform to construct a functional understanding of the Ngilu Bill and its legislative defeat.

Sensemaking: The Ngilu Bill

The design of the Ngilu Bill and the legislative process took place over a period of four years from 2001-2004 (see Table 2). This process involved significant consultation with technical partners within and outside the Ministry of Health (MOH), including international actors such as the German Corporation

for International Cooperation (GTZ), World Health Organization (WHO), and the World Bank Group (WBG). The MOH, led the effort under a seasoned senior team led by the new Minister of Health, Charity Ngilu. As we will demonstrate later, the degree of stakeholder consultation, particularly with respect to the private for-profit medical community, 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. The principle components of the Bill involved changes in revenue generation, risk pooling, and purchasing (Carrin *et al.*, 2007).

[Table 2. Ngilu Bill Timeline] Adapted from (Abuya *et al.*, 2015)

The Bill proposed significant changes to **revenue generation**. It outlined diverse contributory streams to provide health insurance 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. Some actors worried about garnering the earmarked funds from general tax revenue, and some anticipated a high taxpayer burden. Though the exact

percentage to be earmarked for NHIF was never established in the Bill, the design occurred during a period of economic uncertainty. The Bill was perceived to be expensive because government would be responsible for ensuring financial protection of the poor. Although there were strong arguments in favor of basic primary care being covered by the government, there were concerns about the amount and consistency of funding from development partners. The Bill involved a contribution from employers, which was unprecedented in the health sector, but not in Kenya; the National Social Security Fund (NSSF) requires employer contributions, for example. Still, the knock-on effects of employer contributions resonated with many stakeholders, as (development partner_02) explained, "*[…]even if it is completely passed onto the employee it would be […] a tax on businesses and lead to lower growth.*" Thus, 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, a reasonable degree of tension existed around **risk pooling**. A problematic dilemma over the quantity and size of risk pools was debated. While evidence suggests that a larger more efficient risk pool is optimal for cross-subsidization purposes (WHO, 2010), many argued that NHIF and

its perceived shortcomings would damage prospects for implementation and that competition would raise standards as well as provide an avenue for private sector participation. Despite its problems, NHIF was proposed in the 2004 Bill to be reformed and expanded into a national social health insurer (NSHIF). Like the new forms of contributions, understandings of this feature of the bill were widely contested. As many actors pointed out, however, the lack of participation from the private for-profit health sector and the limited scope for private insurance in a national social health insurance program, created hostility from private providers and insurers. The design of risk pooling in the Ngilu Bill therefore influenced the highly charged positions sponsored by key members of the private for-profit health sector.

Purchasing reforms in the Bill also provoked contestation. Again, the NHIF was seen as the primary vehicle for purchasing, albeit with enhanced regulatory oversight. Though it was not explicitly stated in the 2004 Bill, many 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). This was notable because 1) the move to provider payment mechanisms that standardized financial

transactions and contained costs (capitation) was viewed unfavorably by both public and private providers who worried about getting paid less; and 2) the move into outpatient care was seen as a threat to the private for-profit health sector because the current offering for in-patient services through NHIF was largely viewed as benign. A basic package of in-patient 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 NHIF Board though it did not specify the process, which was concerning to (private sector _04), "*(NHIF) were now going into uncharted waters where they had never been before. They'd never run an outpatient scheme…"* Thus, purchasing reforms, including changes to provider payment mechanisms and enhanced benefits, were understood to increase the legitimacy of NHIF at the expense of the private for-profit health community.

Sensemaking: the policy process

Study participants focused much of their attention on describing the policy process for the Ngilu Bill. The explanations usually followed a particular formula: name the culprit, describe how their interests were threatened by the Bill, and allude to what 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. Speculation about what or who caused President Kibaki to reject the Bill included naming officials, interest groups, and party politics. Those 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 "issues" when communicating with the Ministry of Finance (the National Treasury) and the President were seen as vital explanations for success. For the architects of the Bill, their shortcomings were understood to be shortcomings with the "packaging", "marketing", or "communication" of the Bill itself.

Sensemaking: Actors and relationships

Central to this understanding of the policy process is the identity of its key actors. This includes the Treasury, the private for-profit health sector, and development partners, especially the World Bank but in particular the relationship between the Former Minister of Health (now called Cabinet Secretary), Charity Ngilu, and President Kibaki. The social process of sensemaking constructs a particular understanding of the motivations and interactions of each.

The fact that nobody referred to the Bill as the 'Kibaki Bill' was indicative of Madam Ngilu's level of ownership. Though Ngilu was a member of President Kibaki's Cabinet as Minister of Health, she was also a political threat. An active Member of Parliament, representing Kitui Central since 1992, Charity Ngilu was one of the first two women to run for President in Kenya. Popularly dubbed 'Mama Rainbow,' she was appointed Minister of Health in the Kibaki-led coalition administration of 2003. Actors inferred that out of sexism, jealousy, or strategic electoral considerations, President Kibaki failed to support Ngilu's aggressive legislative push in 2004, straining an already fragile relationship. For example, according to (government_07), "[…]*politics entered. I think for me, I thought, these men, they thought Ngilu was going to get credit[…]".* Thus, many understood party politics and Ngilu's ownership of the Bill were part of Kibaki's political calculation in refusing to sign the Bill into law.

These political circumstances were complicated by the timing of the Bill's introduction immediately following the administration's decision to enact universal primary education. "*Experts advised that it may be difficult for Kenya to run both free primary education and social health insurance*," (government_02). Multiple respondents also questioned whether

the Kibaki administration *should* have expended political capital on sweeping health reform on the heels of universal primary education. In this way, the campaign for the Ngilu Bill was at least partially hindered by the recent political victory, and sizable cost of the enacted legislation for free primary education.

A frequent explanation for the Ngilu Bill's failure was incomplete support from the Treasury. While Parliament shapes social policy, Treasury, with its control over the government's purse strings, receives special attention from the Executive Branch. "*The whole issue is convincing the Treasury [...] I think when Treasury makes up its mind, it* ***does*** *make up its mind* (government_12)". Furthermore, President Kibaki, as a former Minister of Finance, was understood to be particularly sensitive to economic guidance. Still, it is unclear why internal, cabinet-level disagreement (between MOH and Treasury) persisted within the Kibaki administration. Ultimately, the lack of support from the Treasury on grounds of fiscal responsibility were seen to influence the President's decision to reject the Ngilu Bill.

The Ngilu Bill's failure emboldened a group of medical entrepreneurs representing the private for-profit health sector.

The private for-profit health sector is diverse and includes an array of interests from medical suppliers, device manufacturers, pharmaceuticals, providers, health facilities, and insurance companies. At minimum, the Ngilu team's consultations did not capture this diversity. Instead they focused on recruiting the endorsement of providers through the Kenya Medical Association (KMA). Respondents suggested that this was likely due to the fact that KMA's leadership has historically consisted of private providers and KMA occupies a key position on the NHIF Board of Directors. But, in hindsight, their influence was more limited than presumed by the Bill's sponsors.

Finally, a select group of development partners, led by the (WBG), was influential. While on the one hand some development partners assisted with the technical design of the reform, others expressed uncertainty about its implications. According to (development partner_03), "*It was a simple thing that we had donors, who were asking a question, if this bill goes through, what is our role?*" Some present in high level discussions with Treasury and the President, understood that an influential former Minister of Finance from Senegal at WBG cast doubt on the macro-economic consequences and scientific basis for such reforms. Regardless, this involvement by development partners

was discouraging to health advocates and seen as a key link in the President's line of reasoning.

In summary, sensemaking across actors and organizations provides a descriptive account of the technical dimensions of the Ngilu Bill, actor identities and relationships, and the policy process surrounding the Ngilu Bill. However, we still need to understand how and why actors behaved – or changed their minds – as they did. The following sections on Naming and Storytelling add depth and nuance to the account of how and why the Bill came to be rejected.

Naming, Selecting and Categorizing

Naming, selecting, and to a lesser extent, categorizing are all important tactics used by both sides of the debate. Personification of the Bill, appeals to affordability and sustainability, and reframing policy measures, were all 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.

Naming: Selecting Charity Ngilu

Though it is unclear where or when actors began using the shorthand "Ngilu Bill," this form of personification among policy actors was notable for rechanneling the symbolic power of Charity Ngilu. Given Ngilu's background, her impassioned support, and her position as one of the first female politicians in Kenya, the Bill was likely attached to preconceived notions of gender and patronage in the political sphere. This tactic served to isolate the primary champion from a broader constituency and trivialize the debate. In so doing, it undermined the sponsors' claim that the Bill was a rational, economically feasible policy proposal. At the very least, the attachment of the Ngilu persona to the Bill had a polarizing effect.

Framing the Bill as unaffordable

The Bill's adversaries were effective in their characterizations of the Bill as "unaffordable" and "unsustainable." Though there were extensive technical debates within Ngilu's team as to the affordability of the proposal, its architects derived scenarios for phasing it over five years. Despite considerably less financial expertise, key private for-profit health sector representatives used their own "data" to demonstrate to opinion leaders how they understood the Bill to be financially unsound.

According to (journalist_01), Ngilu's team "*did a poor […] PR job on it*," and opponents, "*[…] gave us numbers, they gave us excel (spreadsheets),"* warning against the Bill's economic implications.

While the affordability frame served to condense the macro-economic concerns into a comprehensible narrative, it's possible that Kibaki himself was concerned about cost. Ignoring counter explanations from the Bill's architects, President Kibaki deferred to Treasury.

Opponents also reframed a particular revenue collection feature of the Bill, called "payroll harmonization," in their discussions with powerful interest groups. Because teachers occupy the largest segment of the formal economy, for example, their union (KNUT) enjoys a position of power in negotiations with the state. Teachers' medical allowances were to be consolidated under the Ngilu Bill. Some argued MOH was vague on this point. This strategic framing opportunity was reportedly uncovered by private for-profit actors in a thorough stakeholder mapping. Next, they used informal networks to meet with KNUT and explain "what it means" (see storytelling section). Without KNUT support, the Ngilu Bill was perceived as financially unsound. This was then relayed to Treasury unbeknownst to the

Ngilu team. "*By the time we went to Parliament, the teacher's union was saying […] this thing can't fly and […] we are not on board,*" (private sector_06). Hence, the ability of the private sector to reframe payroll harmonization and persuade KNUT to join them strengthened their position when lobbying to Treasury ahead of the Ngilu team.

Framing the Ngilu Bill as unsustainable

The Bill also was characterized as "unsustainable." In this way, actors questioned the long-term viability of the Bill and the complex conditions that must be created for it to succeed. Obscuring the provision and financing of health services, the Bill's opponents argued that it established unrealistic expectations for material investments in health service delivery platforms, with steep political consequences for failure. This portrayal likely resonated, regardless of its veracity (the Ngilu Bill envisioned financing, not delivering services). In much the same as concerns about affordability, respondents seemed to understand that legitimate sustainability concerns were never adequately addressed by the Bill's sponsors.

Framing NHIF within the Ngilu Bill as a "Monopoly"

Opponents of the Bill also categorized one of its salient and perceived shortcomings by naming the enhanced NHIF as a

"legislated monopoly." Some actors understood that the proposed policy limited private insurance participation, threatening free market principles. According to some, the fact that parastatals were "born out of monopoly" made the private for-profit health sector nervous that the government was reverting back to its populist past. Their arguments in favor of choice and free enterprise were therefore colored with appeals to modernity and economic progress. A logical extension of naming NHIF a monopoly was to question its legitimacy. This was clear in the description of a planned court action against the Bill, "[…]*It was literally treason, we are creating parallel government […] an institution that was unconstitutional*," (private sector_06). By naming the newly formed N(S)HIF a legislated monopoly, opponents also drew on a legacy of corruption and incompetence associated with NHIF. According to (private sector_07) during consultations, "*They* [Treasury] *said that if they [NHIF] can't use 100 shillings well […] how are they [NHIF] going to manage a thousand."* In this way, opponents of the Bill were able to shift the debate to the extreme and thus create more room for favorable compromise.

Framing the Ngilu Bill as providing "free healthcare"

Some indicated that sponsors' efforts to categorize the Bill as one of "free healthcare" were problematic. This was framed as

such given the recent legislative victory on "free education." In a moment of self-reflection, architects of the Ngilu Bill admitted to misgivings about how political operatives in the team "marketed" the Bill as "free healthcare," which raised many questions about fairness of financial contribution. According to (development partner_08), "*Although technically the thing was sound, then how we packed it, the marketing of it, I think we could have done better.*"

This demonstrates the importance of naming the Bill in ways that garner support while limiting its contestability. Not only did opponents of the Bill successfully portray polarizing dimensions(through personification with Ngilu, characterizing NHIF as a "legislated monopoly", and the Bill as unaffordable and unsustainable), but also other names were unsuccessful in building a coalition of support (such as "free healthcare"). Furthermore, naming works synergistically with sensemaking, approaching the "normative leap" suggested in the original conception of frame-critical policy studies. Looking at the emotional and cognitive work of storytelling, however, provides a more complete view of the policy process.

Storytelling

The highly charged nature of the debates surrounding the Ngilu Bill revealed at least two forms of storytelling illustrating the exercise of power and change in the policy process: 1) stories of resistance and 2) stories of betrayal. The principle actors from the private sector involved in countering the Bill frequently told stories of resistance in which they cast themselves as unlikely victors. This included militarized accounts of conflict to highlight agency in the policy process, as well as emotional validation to explain implications for future policy. On the other side, the Bill's sponsors told stories of betrayal in which they were naïve victims of a bitter policy dispute. This included painful depictions of betrayal to account for agency in the policy process, as well as emotional frustration to explain its effects on subsequent agenda-setting. In this section, we show how various elements of storytelling "emplot" (Mattingly, 1998) features of the debate into a larger and more persuasive narrative. By taking a closer look at these instances of "thick description" (Geertz, 1973) we can gain a better understanding of the interplay of agency, emotion, ideas, and identity in providing a basis for human behavior in the policy process.

Stories of resistance

In describing the context and overall approach to contestation, some actors used the symbolic language of war in telling stories of resistance. This conveyed urgency and desperation, weaving a narrative arch from characterizing participants, generating revenue, and forming alliances, to engaging media and politicians. In the story of contesting the Ngilu Bill, actors readily acknowledged that ideas were wielded in efforts to persuade. This was particularly true in discussions with the President (see Table 3).

The narrative (encapsulated by private sector_06 in Table 3) of how the private for-profit representative "*distilled the issues*" in an attempt to win the President's support is notable for two reasons. First, the actor presented an urgent, 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. This narrative incorporated cognitive elements of names mentioned previously like "unsustainable" and "unaffordable". Second, (as confirmed by multiple interview respondents) this account explicitly locates the source of the President's written dissent: a memorandum drafted by private for-profit health representatives and forwarded directly to Parliament.

This process required actors to tap hidden networks of power and influence. As (private sector_07) explained, "*Actually, I have begun to define power by how many phone calls I am from the President […] I think I consider myself a tier two.*" The actor then explained the informal way opponents were able to gain an audience with KNUT in order to reframe payroll harmonization as an effort by MOH to take money from teachers.

The outcome of this conflict was characterized in several ways. First, politically it was expensive as Ngilu and Kibaki "*ceased to see eye to eye*," (private sector_06). Second, it polarized participants in the policy process, which led to a period of intense policy stasis and scandal over the next decade. Third, private for-profit opponents of the Bill banded together and formed a professional association, supporting similar counter-movements in Rwanda, Uganda, Tanzania, and further afield in West and Southern Africa.

Finally, stories cast doubt as to whether the Ngilu Bill truly failed or simply fragmented into smaller policy positions. For example, actors point to recent debates over provisions in the national health financing strategy as evidence that "[…] *the discussions have still gone on. [The Ngilu Bill] is in*

everyone's memory […] So it's not completely forgotten,"

(private sector_06).

Public Sector Stories of Betrayal

Stories of betrayal explain how the narrative and thus public support was ceded in the policy process. Their accounts of betrayal are all the more painful because they embarked on an elaborate process of generating public support, stakeholder endorsement, and internal consensus. Similarly, the Ngilu team believed in their cause and described their authentic pursuit of policy change. For example, early in the process, the team was divided as to whether they should "get ahead" of a sensitive report detailing the cost of the Ngilu Bill. According to (private sector_05), Ngilu herself claimed that leaking to the press was "irresponsible" and that Kibaki was a friend of hers. Accounts such as these underscore the value of framing and the strategic process by which the Ngilu team attempted to influence public opinion.

Actors told stories of betrayal on multiple fronts, including by Treasury, KNUT, Kibaki, private for-profit providers, and development partners in the policy process. Of these, a meeting with Treasury was considered to be particularly critical. The

Ngilu team met with Treasury on a Sunday; they spent all morning debating the bill and were met with resolute disagreement by Treasury officials. Revealing an affinity for issue framing, the team concluded that this was a lost opportunity as somebody had already been to Treasury and persuaded them. Perhaps more damaging, the confidential report debated between Treasury and the Ngilu team was leaked to the press, which caused the Bill's advocates to lose control of the narrative. It became a "feeding frenzy" of journalists, and the narrative shifted to Cabinet level in-fighting which pitted ministries against one another. In this public dispute, Ngilu herself was portrayed as reckless and financially irresponsible.

These stories carry important repercussions. First, they illustrate how stories of betrayal damaged the relationship between Ngilu and Kibaki. Second, the stories account for the ways in which Ngilu herself became angry, dismayed, and even "scarred" by betrayal. Third, they explain how this affects agenda-setting for current efforts to move towards UHC in Kenya (see Tables 3 and 4).

This narrative informs how storytelling functions in policy processes. In describing the political fallout from the Ngilu Bill, a participant linked this to the current policy agenda in

health, illustrating a "normative leap" characterized by Schön and Rein (1994). Because of his unique expertise, this finance expert claimed to have worked years ago in the banking industry with the current President, Uhuru Kenyatta, as well as the Cabinet Secretary of Health (at the time of his interview). He claimed to occasionally offer informal advice to the new Cabinet Secretary. His concluding thoughts (see quote from "private sector_05" in Tables 3) reveal important insights as to the agenda-setting process, and the large shadow that the Ngilu Bill casts over the health sector.

DISCUSSION and CONCLUSIONS

This article provides much needed analysis of the political process through which UHC reforms are pursued. The use of framing theory provides an important account of developments in the health policy process recognizing the ways in which social structures shape actors' behavior and choice but at the same time are subject to change as a result of human agency (Gamson *et al.*, 1992). The UHC literature is vague on the importance of agency in the policy process; countries that have made strides towards achieving UHC have benefitted from strong executive leadership and political windows of opportunity (Atun *et al.*, 2015; Reich *et al.*, 2016). Yet, what this analysis reveals, is

714 that even with strong leadership and a favorable political
715 climate, framing matters. Moreover, our research suggests that
716 strong leadership is actually knowing how to effectively frame
717 issues in ways that galvanize large 'coalitions of interests'
718 (Schattschneider, 1960), which in turn shapes the political
719 environment.
720
721 Our research contributes to theoretical advances around the role
722 of agency by framing scholars in critical policy studies.
723 Research on Dutch coastal management has demonstrated the
724 utility of deconstructing the sensemaking process in framing
725 (Aukes *et al.*, 2018). Reimagining Kingdon's "policy
726 entrepreneur" (Kingdon, 1984) as an interpretive actor, Aukes et
727 al. (2018) argue that unusually influential policy actors define
728 problems in others' terms, take risks, and engage in a variety
729 of framing interaction mechanisms to enhance their epistemic
730 community. We found that private for-profit actors in our study
731 were tacitly understood to be interpretive policy entrepreneurs.
732 They actually reframed the Ngilu Bill as the problem instead of
733 the solution, and maintained policy stasis by defining the
734 political risks in clear terms to the President (see Tables 3
735 and 4). Moreover, they detailed professional risks in pursuing
736 aggressive political action, often relying on military tropes
737 (see Table 4). Through a process of "frame accommodation"

738 (Dewulf and Bouwen, 2012), President Kibaki forwarded the
739 memorandum drafted by these interpretive entrepreneurs to
740 Parliament to explain his dissent. The experience caused these
741 individuals to form a professional association, and "incubate"
742 comparable organizations in neighboring countries, thus
743 enhancing the epistemic community.
744
745 We argue, however, that the interpretive entrepreneur model is
746 incomplete. We found that naming (including processes of
747 selecting and categorizing) as well as storytelling have a
748 unique and persuasive effect in conjunction with sensemaking.
749 By focusing specifically on sensemaking, the interpretive policy
750 entrepreneur does not have a clear discursive basis for defining
751 problems in others' terms or taking risks. In addition to this,
752 it seems that entrepreneurship mediated by framing interactions
753 would do more than simply enhance the epistemic community. Our
754 research suggests that policy, as a social construct, is
755 reconstituted as a result of framing, as are actors' identities
756 and relationships with one another. More interpretive research
757 on framing is needed to further our understanding of complex
758 phenomena around agency and its role in the policy process.
759
760 Through framing, our research provides rare insight into the
761 politics of emotion in agenda-setting research. This is

762 consistent with theoretical developments in critical policy
763 studies that call for an analytical shift from subjective
764 accounts of what emotions *are* to collective interpretations of
765 what emotions *mean* in the policy process (Durnová, 2018). For
766 example, in explaining fallout from the Ngilu Bill, the final
767 storyteller links emotional pain to specific priority-setting
768 guidance (see Table 3). In this way, Rein and Schön's normative
769 leap (from what *is* to what *ought to be)*, is symbolically
770 amplified by emotion. Reconstructing experience in this way,
771 lends authenticity to a particular interpretation of the
772 "political spectacle" (Edelman, 1988), a finding consistent with
773 UHC research on health workers in Kenya (Koon *et al.*, 2017).
774 Furthermore, appeals to emotions such as anger or anxiety are
775 relatively unaffected by evidence (Stucki and Sager, 2018), a
776 point demonstrated by the Ngilu team's inability to persuade
777 based on technical guidance.
778
779 In this respect, we demonstrate how health financing debates
780 draw on underlying values as opposed to evidence-informed policy
781 positions. Often, research is solicited to lend authority to
782 the preferences of actors and as a symbolic means of
783 demonstrating sound judgement (Boswell, 2009). This was
784 particularly present in the use of evidence by the private
785 sector in opposition to the Ngilu Bill. 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 and Stewart, 2015). Nevertheless, the Kenyan experience suggests evidence crafted to mobilize ideas can be particularly useful in dealings with Treasury, who, by virtue of being the primary steward of government finances, is a uniquely persuasive frame sponsor. As the Ngilu Bill demonstrates acutely, however, evidence can, "inform, but cannot determine policy choices" (Hawkins and Parkhurst, 2015).

Finally, our research proposes that health financing reforms are often incremental in nature, making them particularly sensitive to reconstruction and reinterpretation. We argue, for example, that the Ngilu Bill didn't fail, but rather was fragmented into several smaller policy positions, some of which have recently been legislated (Barasa *et al.*, 2018). In fact, many of the countries that have made progress toward UHC 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 was

highly contested, at least in part because of the scale and urgency of the proposed reforms. Moreover, a plurality of actors in the health arena as well as a diverse and market-oriented economy, make sweeping changes in the Kenyan health sector seemingly impossible to enact devoid of significant external political shocks. Instead, recent experience (Barasa *et al.*, 2018) illustrates how health financing in Kenya is marked by smaller, incremental changes that provide less inspiring, but equally salient markers of social progress.

Limitations

This study had several limitations. First it relied heavily on semi-structured interviews with key informants about a policy process several years ago. Because interviews were conducted several years after the Ngilu Bill was contested, some stakeholders worked hard to recall vividly their experiences. Second, this research would have benefitted from the deconstruction and interpretation of alternative sources of data including legislation and news 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. Third, we had difficulty in adequately distinguishing between categorizing and selecting, as features of the naming process. These

834 challenges notwithstanding, the present analysis demonstrates
835 the value and relevance of further frame-critical policy
836 analysis.
837
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Table 1: Description of Participants

Interview Participants	Number
Government employees (NHIF and MOH)	12
Development Partners	11
Professional associations and unions	9
Private for-profit health sector	8
Politicians (MPs and Senators)	5
Academics	3
Journalists / Editors	2
Total	**50**

Table 2. 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 NSHI
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 GTZ/WHO to assist with implementation once Bill is passed by law
2003	1st technical mission to review strategy and draft bill, which would become parliamentary sessional paper no. 2, 2004
2003	2nd technical mission assess legal aspects of Bill, design of benefits package, provider payment mechanisms, and transition of NHIF to NSHIF
2003	3rd technical mission assess health insurance governance and financial feasibility
2004	4th technical mission assess progress towards implementation, management reforms, and establishment of working group
2004	5th technical mission reviewing progress and developing strategic milestones
2004	6th 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

Table 3. Framing the Ngilu Bill

Framing Dimensions		
Sensemaking	Bill's financing provisions: revenue collection, pooling, purchasing; Policy process: public deliberation over expansion of social services; Actor identities and relationships: Minister Charity Ngilu, President Mwai Kibaki, Treasury (Ministry of Finance), MOH, Private for-profit providers, Development partners (particularly the World Bank & GIZ)	
Naming	"*Ngilu* Bill", "(legislated) monopoly", "unaffordable", "unsustainable", "free healthcare"	
Storytelling	Resistance – Conflict (action), validation (emotion) normative leap exemplar (action) "We were there before [Ngilu's team] and we had a written memorandum with questions. […] 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 it operationally - 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 a methodical approach. So that is the memorandum that now got sent to parliament as the reason the president rejected it." (private sector_06)	Betrayal – Deception (action), frustration (emotion) normative leap exemplar (emotion) "[The Ngilu Bill] 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], […] 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." (private sector_05)

1009 Table 4. Storytelling elements
1010

Symbolic Storytelling Devices	Exemplars for Agency	Exemplars for emotion
Conflict	fighting from the gutters trenches soldiers battle war chest killing last line of defense	Happy Exhausted Relief Expensive Tired Concern Unified
Deception	Executive backchanneling Leaking to news media Doubt Issue reframing – payroll harmonization Narrative control Feeding frenzy Inter-ministry value conflict	Dismay Angry Nightmare A blow Scar Concern Fear

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