
Social security reforms in Kenya: Towards a workerist or a citizenship-based system?

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Abstract With social security provisions in Kenya remaining under-reported in the more recent literature, this overview covers recent reforms in key areas of the country's social security system. In the health sector and in old-age pension provision social security is still mainly workerist (biased toward those in formal employment), and attempts to expand coverage have had limited effect only – cash transfer programmes, for instance, have been expanded but in practice they do not universally cover the entitled categories. Thus, although the Kenyan social security system now has a considerable pro-poor social assistance component it remains biased toward those in formal employment, to the benefit of the highest income quintile.

Keywords coverage, social policy, provident fund, social insurance, social assistance, Kenya, Africa

Introduction

Recent attempts to situate Kenya within a comparative social security framework have produced divergent results. According to Wood and Gough (2006, p. 1703), Kenya is part of the “actual or potential welfare state regimes ... with high state commitments and relatively high welfare outcomes”. Later in the same work, however, the authors characterize the entire region of sub-Saharan Africa as an “insecurity regime” (Wood and Gough, 2006, p. 1706). Elsewhere, Abu Sharkh and Gough (2010, p. 40) have situated Kenya in cluster E for the year 1990, without

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further describing the characteristics of the countries classified in that group. A decade later, in 2000, Kenya belonged to cluster D, described as “middle-income countries with relatively high spending on health and education, moderately good welfare impacts and high literacy but with very low life expectancy”. Later in that article, this cluster was called a “Failing Informal Security Regime: High Morbidity” (Abu Sharkh and Gough, 2010, p. 48). Rudra (2007) does not include Kenya in her cluster analysis; neither does Seekings (2013) in his.

The focus of this contribution is not concerned with looking at the selected variables that led to the inconsistent results of the cluster analyses reported above, but rather with presenting an overview of social security provision in this interesting case. Despite papers published in the 1970s and 1980s (Musiga, 1974; Witzsch, 1981; Fuchs, 1985; Neubert, 1986; Mullei, 1988), the provision of social security in Kenya has been somewhat under-reported in the recent literature. Moreover, since the contribution of Gsänger (1994), there have been important changes in the Kenyan social security system, especially in the last few years. Based on a review of the relevant literature and regular fieldwork conducted in Kenya since 2006, this article thus attempts to characterize key areas of social security by asking the question “who gets what and how?” (Seekings, 2013, p. 16).

As a theory-driven framework, we draw on Seekings’ (2008, 2013) proposition to distinguish between citizenship-based regimes and workerist regimes. Citizenship-based regimes, which focus more generally on universal rights, developed out of an earlier pauperist focus on social assistance for the poor. From this perspective, the state, and not employment, is central to solidarity and social security is decommodified and more concerned with redistribution. In sub-Saharan Africa, again according to Seekings (2008, 2013), pauperist regimes were common, with the classical example of food aid. Non-contributory social assistance is central to this type of regime, both in its pauperist and citizenship-based forms. Workerist regimes, which are more common outside of sub-Saharan Africa, focus on social insurance (in contrast to social assistance) and especially on formal economy workers, thus benefiting the middle groups of society. With a focus on social insurance, employment is central and a locus of solidarity, with little or no decommodification and little redistribution. Seekings (2008, p. 27) acknowledges that, in practice, elements of the two approaches are frequently combined. Consequently, his statement that workerist regimes are more common outside of sub-Saharan Africa does not mean that social insurance is absent from this region, but that more public expenditure in sub-Saharan Africa flows into citizenship-based and pauperist forms of social assistance. While the state-centrist approach of Seekings neglects other providers of social security, it provides a heuristically useful distinction.

The distinction also helps to situate Kenya within wider, global social policy trends and in turn informs the discussion on these. The workerist approach with its focus on

contributory social insurance embedded in a tripartite and thus corporatist setting has been championed by the International Labour Organization (ILO) for many years. From the 1950s to the 1970s, inspired by modernization theories, it was generally assumed that the countries of the Global South would follow the model of the Global North and develop from agricultural societies to industrial societies (So, 1990; Deacon, 2007). The informal “sector” was seen as a transitional phenomenon that was supposed to disappear with the integration of the population into the formal labour market where it would be fully covered by social insurance. However, since the 1970s, this assumption has been called into question. It was challenged by the increasing influence of the Bretton Woods institutions, the International Monetary Fund and the World Bank, and the persistence of the informal economy in the context of the structural adjustment programmes promoted by these institutions. In this context, the notion of residual “safety nets” was popularized, including measures such as targeted cash transfer programmes for the poorest.

More recently we have witnessed a parallel social policy trend to move away from this selective and residual approach to social protection towards a more universal focus on social human rights. This re-discovery of the social human rights of citizens was reinforced by the Millennium Development Goals, but also by developments in the ILO, which became more concerned also with the needs of the poor beyond the formally employed (Deacon, 2007; Leisering, 2009).¹ These developments reflect a core social policy debate about whether provisioning should be universal or selective through targeting (Mkandawire, 2005). Regardless, based on different ideological assumptions, different international organizations currently champion non-contributory forms of social assistance, especially cash transfers, and emphasize their contribution to poverty reduction (Leisering, 2009; Hanlon, Barrientos and Hulme, 2010). The Kenyan case also helps to answer the neglected question as to whether this shift has led to a reduction in the importance of social insurance in that country.

This article reveals diverse dynamics with both citizenship-based and workerist elements of social security in Kenya. The new Constitution, as discussed in the next section, includes social rights and is thus citizenship-based. In the health sector, as we discuss, social security is still mainly workerist. Several attempts to shift the National Hospital Insurance Fund system towards a citizenship-based health insurance have failed to date, but citizenship-based social security has expanded somewhat with the declaration of “free maternity”. Old-age provision, the focus of the following section, is persistently workerist: certain workers are privileged with a non-contributory retirement scheme, while another group of workers have been covered by a contributory provident fund (albeit that this fund is moving to

1. In 2012, this culminated in the adoption of the ILO Recommendation concerning national floors of social protection, No. 202 (2012).

become a contributory pension scheme). Attempts to expand old-age provision to the informal economy have had limited effect. In the subsequent section, the focus is placed on the expansion of cash transfer programmes. These, however, do not provide universal coverage to the entitled categories. As we conclude, any meaningful description of social policy reforms must address the level of effective coverage. Although the social security system in Kenya has a bias toward (male) employment in the formal economy (especially in the civil service), to the benefit of the highest income quintile, there is also a considerable pro-poor social assistance component. Overall, despite a certain shift towards non-contributory forms of social assistance as advocated by different international organizations, the role of social insurance continues. This suggests that while the frameworks of workerist and citizenship-based social security are useful at the level of specific instruments of social security, they are less useful for describing a complex regime.

From a workerist to a citizenship-based approach in the health system?

Kenya's independence constitution was mainly concerned with defining its polity and protecting individual freedoms and fundamental rights following the proclamation of the Republic of Kenya in 1964. Social rights, however, were not recognized. It is thus remarkable that the 2010 Constitution of the Republic of Kenya included an article (Art. 43) on economic and social rights (Republic of Kenya, 2010). For the health sector, the new constitution guaranteed the right "to the highest attainable standard of health, which includes the right to health care services, including reproductive health care" (Art. 43 (1) a). The right to health care was reinforced explicitly in article 53, which defines the rights of children. The new constitution thus is clearly citizenship-based. This change, however, was not at the centre of public attention, which focused rather on the political aspects of the new constitution, such as the devolution of functions to county level and other provisions seeking to curtail presidential power. Devolution also concerned aspects of the health sector however – according to the Fourth Schedule, lower level health facilities and ambulance services were declared functions and powers of the counties.

In reality, the right to health care is rather hypothetical, as financial and non-financial barriers to health care persist. Currently only limited parts of the population have some form of health insurance. For 2010, the *Kenya Social Protection Sector Review* lists 2.7 million contributing members of the National Hospital Insurance Fund (NHIF), but five pages later only 367,886 contributing members are listed (Republic of Kenya, 2012a, p. 13, p. 18). The first number probably refers to membership in the formal economy and the second to membership in the informal economy. This assumption is made plausible by a report prepared for the World Bank and the Government of Kenya by Deloitte Consulting (2011, p. 19),

which cites a membership of 2.3 million in the formal economy and 0.5 million in the informal economy. Including the dependants of this total of 2.8 million members, an estimated 6.6 million Kenyans, or 17 per cent of the total population of 38.6 million (2009 census), are covered by the NHIF. However, it is clear that in the very country that “can boast the oldest compulsory insurance scheme in the whole of Africa” (Koltermann, 2004, p. 14) for formal economy workers, the vast majority of Kenyans have no health insurance.

After the National Rainbow Coalition government came to power in 2002, there was an attempt to broaden health insurance coverage by making it compulsory after a transition period. While the contributions of the poorest Kenyans would be financed with tax money, others would pay a flat-rate contribution, and half of the contributions of employees would be paid by their employers (Koltermann, 2004, p. 15). The conception of this new National Social Health Insurance Fund (NSHIF), which was supposed to replace the NHIF, was developed on the advice of the World Health Organization (WHO) and the *Deutsche Gesellschaft für Technische Zusammenarbeit* (GTZ).² A corresponding Act was passed by parliament in December 2004, but it was never signed into law by President Mwai Kibaki. Independent sources in Kenya repeatedly attributed this to the resistance of the private insurance sector, which feared losses.³ There was also pressure against the NSHIF from the Treasury and from donors pushing for limited state spending (Hornsby, 2012, p. 737). Furthermore, organizations that represented employees – including many health professionals and teachers belonging to the middle class – opposed the reform, preferring the possibility of choosing private insurance coverage with tax relief (Maupeu, 2012, p. 60).

In turn, the creation of a National Health Insurance Scheme was included in Vision 2030, the country’s development programme (Republic of Kenya, 2008, p. 18). Nonetheless, a second attempt to shift the current strongly workerist health insurance system towards citizenship-based health insurance failed in 2008 in the context of post-electoral violence and a Government of National Unity. Citizenship-based social security was somewhat expanded with the declaration of “free maternity” by newly-elected Kenyan President Uhuru Kenyatta in 2013 (Künzler, 2014). However, achieving universal coverage has been limited by uneven access to health facilities. Consequently, as regards levels of maternal and child mortality, there are huge gaps between the rich and poor and across different regions (Otieno and Kibet, 2013, p. 22). Furthermore, in October 2015 a revival of the Health Insurance Subsidy Programme was announced, which, with the support of the World Bank, targets 23,000 households of elderly and disabled people in all

2. Other donors are clearly in favour of a more dominant role for the private sector. US AID, for example, supported a World Bank (2010) assessment that favoured private-sector investment in the health sector. There are thus conflicting views in the donor community.

3. The Kibaki family is assumed to be among the shareholders of companies in this sector.

counties. Currently, discussions over the concept of “Universal Health Coverage” continue in Kenya.

Currently, NHIF membership remains compulsory only for salaried employees. The contributions of these workers are deducted automatically from their pay cheques and calculated on a graduated income-based scale. There have been several unsuccessful attempts by the government to raise the NHIF contributions in the last few years. The most recent proposal suggested contributions ranging from KES 150 to KES 2,000 per month.⁴ After trade unions threatened strike action and went to court to stop the increases, a compromise was negotiated and new monthly contributions, which also cover the provision of some outpatient services, came into force on 1 April 2015 (see Table 1).

Contributions are neither progressive, regressive or, indeed, linear. There is a minimum contribution of KES 150 for monthly incomes lower than KES 6,000. As a proportion of income, the highest contribution level is paid by workers with earnings in the income bracket just above the minimum income, while the lowest is paid by middle- and high-income brackets, up to the maximum contribution of KES 1,700 for monthly incomes higher than KES 100,000. The NHIF contributions thus favour workers with higher incomes. Contributions are paid only on the salary portion of income, which means that “allowances, which can make up to half or more of most government employees income, are exempt” (Fraker and Hsiao, 2007, p. 53). The number of salaried employees evading contributions to the NHIF is difficult to assess, but has been estimated at 2 per cent by the NHIF board chairman (Jamah, 2014, p. 18). Self-employed workers and informal economy workers can join the scheme on a voluntary basis for a monthly contribution of KES 500, which also covers immediate dependant family members (i.e. nuclear families).

However, not all health expenses are covered by the NHIF. Furthermore, there are substantial co-payments. These health expenditures heighten the risk of falling into poverty (Otieno Ajwang’, 2013, p. 236). The reimbursement process is cumbersome and prone to fraud and abuse. Furthermore, the NHIF does not cover many of the health facilities that are mainly accessed by poor people, who are not reimbursed for the expenses they incur even if they are NHIF members. Finally, over many years only a small part of the budget was paid out to members in the form of benefits, while most went to cover excessive administrative costs and dubious investment projects (Koltermann, 2004, p. 14; Fraker and Hsiao, 2007, p. 52 f.). Only recently has the NHIF started to pay out more than half of its budget as benefits. The perception of paying contributions without getting benefits in return contributes to the Kenyan population’s lack of trust in the NHIF. Adding to this is an ongoing series of corruption scandals, untransparent deals, and confusion over the sacking and reinstatement of senior management.

4. KES = Kenyan shillings. In October 2015, EUR 1.00 = KES 110 approx.; USD 1.00 = KES 100 approx.

Table 1. *New contribution rates for the NHIF, as of 1 April 2015*

Gross income in KES	Monthly contribution in KES
0–5,999	150
6,000–7,999	300
8,000–11,999	400
12,000–14,999	500
15,000–19,999	600
20,000–24,999	750
25,000–29,999	850
30,000–34,999	900
35,000–39,999	950
40,000–44,999	1,000
45,000–49,999	1,100
50,000–59,999	1,200
60,000–69,999	1,300
70,000–79,999	1,400
80,000–89,999	1,500
90,000–99,999	1,600
100,000 and above	1,700

Note: KES = Kenyan shillings.

Source: NHIF.

For civil servants and their nuclear families, including up to three children, the NHIF administers a special medical scheme that covers inpatient and outpatient medical services in accredited hospitals, including some mission and private hospitals. It also provides optical and dental coverage and, for the principal member, life insurance and coverage for burial expenses, graduated according to wage groups. The scheme is funded partly by the monthly medical allowance given over directly to the scheme and partly by additional government funds. Thus, taxpayers de facto additionally support the health expenses of an already rather privileged group. The effects of the structure of Kenyan taxes on gender and economic inequalities would merit a more profound analysis. However, it seems reasonable to assume that the redistribution associated with tax-funded programmes burdens the vast group of the poor, albeit not necessarily the rural poorest who have a higher level of self-sufficiency. This is supported by the overall finding of Munge and Briggs (2014) concerning regressive health-financing in Kenya.

In addition to that provided for civil servants, the NHIF offers similar schemes to other professional groups in the formal and informal economies. Employer-based health insurance may also be managed by private insurance companies. “In 2007, there were 14 private insurance companies offering health insurance in Kenya, with membership of about 600,000 people” (less than 2 per cent of the population), including individual Kenyans insured by general insurance companies. Owing to the high cost of premiums, there is a bias towards wealthier and urban Kenyans (Chuma and Okungu, 2011, p. 6). However, this rather rich group benefits from tax relief and is thus subsidized by poorer taxpayers who cannot afford private health insurance.

Recently, several private insurance companies have started to compete with the NHIF for the informal economy market by offering low-cost health insurance products. They use different sales channels (e.g. mobile money, banks) to collect monthly contributions ranging from KES 300 to KES 1,000 for schemes with different coverage packages (inpatient and outpatient benefits, life cover, funeral expenses, paid sick days). However, trust in the private insurance sector in Kenya is somewhat limited given that several private health insurance schemes have collapsed since the 1990s (World Bank, 2010, p. xv). In the informal economy, in which women and younger Kenyans are over-represented, there are other forms of micro-insurance whose premiums are close to the lower range of low-cost private insurance. Since their introduction in 1999, about 38 Community Based Health Insurance (CBHI) schemes have emerged, whose members’ contributions cover 470,550 beneficiaries, as recent data from the Kenya Community-Based Health Financing Association show.⁵ Beyond these CBHI schemes, there are other micro-insurance initiatives.

To sum up, the vast majority of Kenyans are still not covered by any health insurance. Social security in the health sector is still mainly workerist; in principle, but not in practice, all formal economy workers are covered. NHIF contributions favour workers with higher incomes and these workers also tend to be covered by private insurance more often than low-income or informal workers. Several attempts to shift the workerist hospital insurance system towards citizenship-based health insurance have failed; that aside, citizenship-based social security has expanded at the national level with the declaration of “free maternity”.

Persistent workerist old-age provision

Old-age provisions are also dominated by workerist insurance. The core scheme is a non-contributory programme for civil servants (Civil Service Pension), including

5. See CBHF program at <www.kcbhfa.org>.

teachers.⁶ “The Scheme provides a pension of 2.5 per cent of final basic salary for each year of service on retirement from service” (Raichura, 2008, p. 12). After 30 years of service, the pension thus equals 75 per cent of the basic salary. In recent years, the number of retired civil servants and the costs of the scheme have grown considerably. In 2010, there were 209,384 pensioners covered, and government had to pay more than KES 26 billion (Republic of Kenya, 2012a, p. 5, p. 15), equal to 1 per cent of GDP (Republic of Kenya, 2012a, p. 15). In the 2014–2015 budget, KES 45.9 billion is designated for pensions, as tens of thousands of civil servants are now due to retire after the retirement age was raised from age 55 to age 60 in 2009 (Nyabiage and Some, 2014, p. 10). According to Seekings (2013), social insurance refers to nominally contributory programmes to pool risks, such as that of longevity risk. The Civil Service Pension follows the workerist logic of social insurance, even if the contributions are paid by government and not by the insured worker.

Given the increasing financial burden for government of the Civil Service Pension, over the years there have been attempts to convert it to a contributory scheme (Dau, 2003, p. 34). According to article 6(1) of the Public Service Superannuation Act No. 8 of 2012 (Republic of Kenya, 2012b) all civil servants must contribute 7.5 per cent of their monthly pensionable emoluments. This is complemented by a government contribution of at least 15 per cent of monthly payroll, according to article 6(2). However, as of August 2015, the act has still not been implemented. There is concern that by shifting part of the burden of pension financing onto the civil servants, the full implementation of a contributory pension scheme might trigger protests by these public employees, who are well organized. Were the Act to come into effect, competence for the authorization of retirement benefit payments would be with the Board of Trustees of the Public Service Superannuation Fund.

According to the Retirement Benefit Authority (RBA, 2014), in addition to public-sector pension schemes, Kenya has 1,232 retirement schemes run by fund managers. This figure means that nine out of ten companies in Kenya do not have such a scheme. In 2012, these schemes held assets of KES 381.6 billion, which is more than double the assets of the state-run National Social Security Fund (NSSF) (RBA, 2012, p. 5). More recent data from the RBA homepage indicate shrinking assets of the NSSF and growing assets of other funds.⁷ Most of these schemes are organized by companies for their employees or by Savings and Credit Co-operative Societies; however, there are also schemes for individuals that are generally established by private insurance companies. The information in the RBA’s 2014 report is not complete, but these individual schemes probably represent only a

6. A discussion of other schemes, such as those for the armed forces, the National Youth Services, local government employees, and various parastatals, is beyond the scope of this article.

7. See <www.rba.go.ke>.

few per cent of total assets. Some of the schemes run by private companies target the middle classes, who strongly mistrust the public NSSF and have a strong preference for private insurance and possess the means to act accordingly (Maupeu, 2012, p. 60). However, private insurance companies are increasingly also targetting the informal economy, which makes up 80 per cent of the labour force (Kwena and Turner, 2013, p. 79).

The Mbaao Jua Kali Pension Scheme, for example, a public-private partnership, requires daily contributions of KES 20 (*mbaao* is slang for 20 shillings), which can be paid by mobile phone transfer either daily, weekly, monthly, or even annually. Launched in June 2011, the Mbaao Scheme ambitiously targeted enrolling a million members within the first year (by July 2011, it had 42,000 members). By March 2014, the Scheme's 53,200 or so members had saved KES 75.8 million (Waitathu, 2014, p. 3), but contributors have neither tax incentives nor matching contributions from government or employers (Kwena and Turner, 2013). Similar to a provident fund, contributors can draw their savings as a lump-sum payment. However, this can be done without penalty after as little as a year, and thus the Mbaao Scheme might be a tool for short-term saving rather than a form of old-age provision. An incentive for membership might be that the account can serve as a mortgage (Kwena and Turner, 2013, p. 94). It is too early to judge the impact of this scheme; however, it clearly shows the growing interest of the private sector in the informal economy, the financial potential of which, typically, has been underestimated.

The pillar of old-age protection in Kenya with the widest membership coverage is the NSSF, which focuses on formal economy workers. The NSSF was established as a national provident fund: a contributory scheme in which the employee and the employer each contribute 5 per cent of monthly earnings, up to a maximum (Dau, 2003, p. 29). In 2009, out of 2.1 million wage employees, 1.1 million were NSSF members (Republic of Kenya, 2012a, p. 26 f.). That small firms with one to four employees are also obliged to contribute to the NSSF has bolstered membership by 100,000. The number of salaried employees or employers evading the NSSF is unknown, but evasion is "rampant" according to a previous managing trustee, Tom Odongo (2013). Attempts to include the self-employed on a voluntary basis have had limited success; 57,000 self-employed members were included in 2012.

Distrust in the NSSF is quite generalized, as is officially acknowledged: "the public's confidence in the Fund's ability to deliver on its mandate is generally low" (Republic of Kenya, 2012a, p. 12). A general perception is that social protection is an excuse for officials to pillage. Previously, the administrative costs of the NSSF absorbed up to 77 per cent of total contributions (Republic of Kenya, 2012a, p. 20); billions of shillings of the contributors' money have been lost in dubious investment deals, and managers have been sacked and summoned to court with astonishing frequency. Unsurprisingly, trade unions, the Federation of Kenya Employers, and governmental audit institutions denounce such irregularities.

Contributors are confronted with being refused access to benefits, delaying tactics and late payments (Hakijamii Trust, 2007, p. 5). The lump-sum payments made at retirement age are very low, devalued by inflation and low interest rates, and are too small to provide adequate social protection in old age: “Between 2005 and 2010, the NSSF paid out, on average, 38,000 claims per year ranging from KES 50,000 to KES 200,000” (Republic of Kenya, 2012a, p. 64). Rather than a social insurance system based on solidarity and cross-subsidization, the NSSF is viewed as an instrument for forced savings by formal economy workers; a conception based on the idea that the country needs domestic savings to finance development projects.

These conceptual shortcomings are well known, and the last two decades have seen repeated attempts to reform the old-age benefits system (e.g. Gsänger, 1994, p. 9). In 2013, the then newly-elected President Kenyatta spoke in favour of expanding old-age protection: “We will champion the rights of all Kenyans, preserving and defending them ... by extending the right to social protection. ... We will expand the state pensions system so that all our citizens enjoy dignity in old age” (*Standard*, 2013, p. 39). With the adoption of the National Social Security Fund Bill in 2013 (Republic of Kenya, 2013), the NSSF was changed from being a provident fund scheme with lump-sum payments into a two-tier (Tiers I and II) pension scheme offering monthly pension payments until death, with an option to receive part of benefits as a lump-sum payment. Under the Bill, the NSSF also provides insurance against disability, grants money for funeral expenses, and workers in the informal economy can join the scheme voluntarily.

The proposed higher contributions triggered much public discussion, and the contribution system is more complicated. There is an upper earnings limit linked to the national average earnings in Kenya, which is currently fixed at KES 18,000.⁸ Pension contributions are not deducted from earnings above this limit, and are thus regressive. The pension contribution, collected by the Kenya Revenue Authority, was set at 12 per cent of earnings, with the employee and employer both contributing 6 per cent. Employees’ contributions are to be directly drawn from salary and wages. There is a lower earnings limit linked to the minimum wage, currently fixed at KES 7,000 in 2015 (KES 8,000 in 2016; KES 9,000 in 2017). Contributions relating to earnings below the lower earnings limit are to be accredited to the Tier I account, and those above (and up to the upper earnings limit) to the Tier II account. It is possible to opt out of Tier II for a registered private retirement scheme. The system’s design essentially excludes low-income earners from Tier II and privately managed retirement schemes, but it does include civil servants who now contribute.⁹

8. This will rise to twice the national average earnings in 2016; progressing to three times in 2017 and four times in 2018 (SSA and ISSA, 2015).

9. An amendment of the First Schedule of the NSSF Act exempted civil servants from Tier II contributions.

The government intended to introduce the new contributions a few weeks after gazetting the new Law on 27 December 2013, but put the Law (Act No. 45 of 2013) on hold until the beginning of June 2014 to allow employers more time to adjust their payroll systems. In the first half of 2014, several trade unions, including those of civil servants, threatened strike action and went to court to block the new contributions, which have still not come into effect.

Furthermore, it was not clear how the transition from the old fund to the new one is going to be organized, what the tax allowable limits will be, and where the Fund's money will be invested. Consequently, the new NSSF is hedged with considerable uncertainty, including the vexed question of its distributional effects. Central to this is the question of whether taxpayers' money will be used to pay for pensions, or for losses incurred by the NSSF due to mismanagement and corruption. Furthermore, workers with higher salaries are privileged in the sense that they can opt out to join registered private schemes, which are generally seen as better performing than the NSSF. In this sense, the NSSF is not based on a solidarity principle, and it does not provide old-age protection for the poorest citizens.

Expanding a citizenship-based regime with cash transfer programmes?

In line with the wider trend across the Global South, Kenya has introduced cash transfer programmes (Alviar et al., 2012, p. 9).¹⁰ The *Kenya Social Protection Sector Review* (Republic of Kenya, 2012a, p. 28) lists two food transfer programmes, five unconditional cash transfer programmes, and one mixed food/cash programme.¹¹ The *Review* states that transfer programmes are geographically overlapping, small, fragmented, and poorly coordinated (Republic of Kenya, 2012a, p. x). In contrast to cash transfers in other African countries (Devereux and White, 2010), besides donors, the Government of Kenya is also an important funder. However, the programmes are partly implemented by donors. The total spending on what are called "safety nets" equalled 0.80 per cent of GDP in 2010 (Republic of Kenya, 2012a, vii); however, 39 per cent of these expenditures were overhead costs. The use of the notion of "safety nets" is noteworthy. Popularized during the 1990s by the Bretton Woods institutions in the context of structural adjustment policies, it echoes a "residual or liberal social policy" (Deacon, 2007, p. 28).

10. Interestingly, the Orange Democratic Movement (ODM, 2007) made in its unsuccessful 2007 electoral manifesto an explicit reference to cash transfer programmes in Brazil, South Africa, and Malawi when proposing an *Usawa Programme* for very poor households. However, the ODM did not specify whether the proposed programme was conditional or not.

11. This survey does not cover short-term programmes or cash transfers by private charities such as GiveDirectly.

A closer look at major cash transfer programmes allows for a better understanding of recent developments in this sector. Concerning the Cash Transfer for Orphans and Vulnerable Children (CT-OVC), Alviar et al. (2012, p. 9) report a lower number of beneficiaries for 2011 than the government report indicates. The CT-OVC began with a donor-funded pilot programme in 2004, which was then approved by Cabinet, integrated into the national budget, and expanded. It targeted families with at least one orphan or vulnerable child, defined as “a household resident between 0 and 17 years old with at least one deceased parent, or who is chronically ill, or whose main caregiver is chronically ill” (Alviar et al., 2012, p. 11). Beneficiaries were told that the monthly cash payment of KES 2,000 was for the care and protection of the child, but there were no punitive sanctions for using the money differently. For the first step, districts were chosen according to poverty levels and HIV prevalence. Then a list of potential households was compiled by community members. Finally, enumerators visited the households and selected the poorest for the programme.¹² It is therefore important to note that the programme does not cover all people living below a certain absolute poverty level. The poor living in less poor regions were excluded. The beneficiaries could access the cash at branches of the parastatal Postal Corporation of Kenya (PCK) on appointed days and had to present their identity cards (Donovan, 2013, p. 9). The administration of the programme required much time and resources, and it was vulnerable to fraud.

... the partnership with the PCK was considered a marked improvement upon a previous iteration that relied on local chiefs in rural areas to distribute envelopes of cash – a practice unsurprisingly marked by bias and patronage. And although both the head of the OVC and a World Bank representative suggested they were decently assured of the current systems reliability, the potential of fraud had motivated a shift toward an electronic payments infrastructure that used biometric fingerprinting to identify recipients (Donovan, 2013, p. 10).

The Hunger Safety Net Programme (HSNP) is the first government-led programme in Africa that from inception was conceived with an electronic delivery mechanism. Households covered received unconditional bi-monthly transfers of KES 4,600, electronically delivered into bank accounts at the private Equity Bank (Vincent and Cull, 2011, p. 46). As a mechanism to avoid fraud, beneficiaries used a biometric smart card to access their cash at small businesses whose owners were appointed as Equity Bank agents (Donovan, 2013, p. 4). These businesses were more widespread and approachable than Equity Bank or PCK branches, and had

12. Interestingly, a list with the names of the beneficiaries can be freely downloaded from <www.labor.go.ke>.

an incentive for the procurement of cash. The chip on the smart card contains the account information, so that agents need not be constantly online. The payment devices were battery powered and recharged with solar panels. The chip furthermore contains the information required to verify the identity of beneficiaries by scanning their fingerprints. This was seen as more feasible than using PIN identification or ID cards (Donovan, 2013, p. 13). Among the problems reported were the lack of IDs for registration, failure of the fingerprint scanners used for enrolment due to the climatic conditions, problems with the software used to means test potential beneficiaries, the limited capacity of beneficiaries to reach an agent, and damaged fingerprints (Donovan, 2013). The registration of a secondary recipient improved access, but it also increased the potential of fraud.¹³ The HSNP was intended to be expanded to 1.5 million households (Vincent and Cull, 2011, p. 46), and the aspiration of its programme officials was to institutionalize rights-based social security (Donovan, 2013, p. 4).

The most recent step that has seen the expansion and consolidation of cash transfer programmes, with the exception of the HSNP, was made in February 2014 with the introduction of the Inua Jamii Cash Programme, which was enlarged in January 2015. It targets more than 200,000 persons aged 65 or older and living in extreme poverty, and 27,200 persons with severe disabilities, 253,000 orphans and vulnerable children, and finally, 10,000 poor urban households (Ongiri, 2014). Beneficiaries will receive an unconditional monthly cash transfer of KES 2,000, notwithstanding the erosion of buying power. The money will be transferred on an M-Pesa mobile phone account and made accessible via 40,000 agents across the country. During the official launch, the CEO of the company that runs M-Pesa promised to provide mobile phones for beneficiaries who were without. Delivering cash transfers through M-Pesa had been reasonably successful in a short-term emergency cash transfer project funded by the NGO, Concern Worldwide (the Kerio Valley Cash Transfer, or KVCT) (Vincent and Cull, 2011, p. 42). Interestingly, in contrast to the HSNP, where PIN authentication was not deemed feasible (Donovan, 2013, p. 13), the PIN used for M-Pesa does not appear to cause problems. M-Pesa is the most widely accessible way of transferring cash at present. Mobile network coverage and agent numbers are increasing, but market penetration is lower in rural areas. Besides convenience of access, cost efficiency is also among the advantages of this approach (Vincent and Cull, 2011). In January 2014, operational costs were budgeted at 15 per cent of the total cash transfer programme budget (Wafula, 2014b, p. 2). At present, the new Inua Jamii Cash Programme is still not very well known among the population.

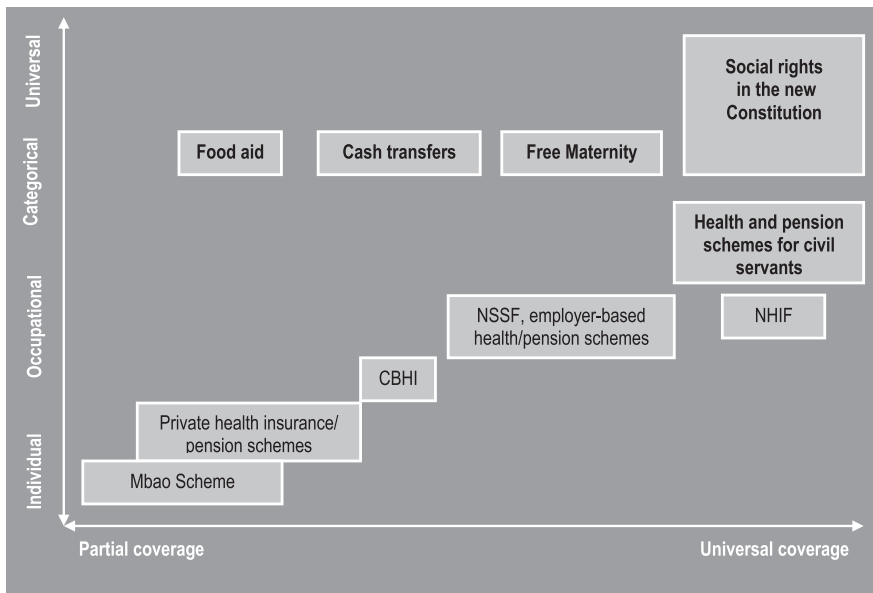
13. Fraud was an issue in the domain of disability grants, where an audit in 2013 revealed KES 120 million lost to 1,400 ghost recipients (Wafula, 2014a, p. 1), which is two-thirds the number of beneficiaries in 2010.

To finance this recent expansion of cash transfers, a loan of KES 21.8 billion was provided by the World Bank. It is therefore important to bear in mind that the programme is not funded by donors; the loan has to be repaid with a low rate of interest. Also, pro-poor tax-funded programmes may redistribute in favour of the poorest of the poor, but they are a heavy burden on the poor. It is also important to note that cash transfers do not universally cover the entitled categories, and fulfilling certain criteria does not bestow any legal entitlement to a cash transfer, even if article 43(1) of the new constitution grants every person the right to social security and freedom from hunger (Republic of Kenya, 2010). Furthermore, distribution of the cash transfer has moved away from the means testing applied in the pilot phase to a formula where a considerable share of the money is equally distributed to all constituencies (Wafula, 2014b), after which a highly-politicized Constituency Social Assistance Committee decides on beneficiaries. Absent a comprehensive legal framework, it is questionable whether there is proper means testing. Poverty, furthermore, is not equally distributed in all constituencies, so that this formula benefits the richer constituencies. In other words, a poor person in a comparatively richer constituency is considerably more likely to receive a cash transfer than a poor person in a comparatively poorer constituency.

Discussion and conclusion

So, how might we address the initial question as to who gets what and how in key areas of social security provision in Kenya? It has been discussed that cash transfers do not universally cover the entitled categories. Citizenship-based social security has somewhat expanded, however, with the declaration of “free maternity”; but not all entitled women are reached. In turn, for workerist social security, there is considerable evasion of the NSSF by formal economy workers and their employers. Consequently, a meaningful description of social policy reforms has to include the level of effective coverage. A second central dimension is whether individuals, members of occupational groups, members of certain categories or all citizens are entitled to social security. Following Seekings (2008), this dimension can be called the mode of solidarity. If we conceive of these two dimensions as a continuum and not as “either or”, the diverse landscape of social security in Kenya can be summarized as in Figure 1.

Ideally, citizenship-based social security would be at the top on the right, and workerist social security would be at the middle on the right. In reality, in Kenya, there tend to be categorical rather than citizenship-based elements of social security, with varying degrees of coverage. At this level, there are some pro-poor redistribution effects. Individual tools of social protection target both formal and informal economy workers, but they have low coverage. Schemes for low-income workers, such as the Mbao Scheme, have no distributional effect. Due to its tax exemption, private health insurance

Figure 1. *Mode of solidarity and coverage of social security instruments in Kenya.*

Note: Bold text in boxes = non-contributory for beneficiaries.

Source: Compiled by the author.

distributes towards the upper classes rather than benefitting the poor. However, the most privileged group at the moment consists of civil servants. They are universally covered by health and pension schemes whose contributions are paid by government. Indeed, the money spent on the civil service pension equalled 1 per cent of GDP in 2010 (Republic of Kenya, 2012, p. vii). Total expenditure on contributory schemes such as the NHIF and NSSF were 0.48 per cent of the GDP, while spending on “safety nets” was 0.8 per cent of GDP. Therefore not only does more money go towards social insurance, but the Kenyan social security system has a bias towards (male) employment in the formal economy, especially in the civil service.¹⁴ Beneficiaries of social insurance programmes in Kenya (including health insurance and pensions) are mostly in the highest income quintile, while those who benefit from cash transfer programmes are highly concentrated in the lower and also the middle income quintiles.¹⁵

This coexistence of workerist social insurance, targeted “safety nets” and (attempted) citizenship-based social security in Kenya is to a certain extent not new, but goes back to the immediate post-independence period at least. The most important policy document

14. The new constitution aims at balancing employment with social rights. However, as long as unpaid care work, for example, is not entitling to social protection and mainly performed by women and women are underrepresented in the formal sector, the employment bias will continue.

15. See World Bank ASPIRE database: The atlas of social protection indicators of resilience and equity <<http://datatopics.worldbank.org/aspire/>>.

just after independence was Sessional Paper No. 10, proposed by the government and adopted by the Kenyan Parliament in 1965. This document stated that “the declared aim of the Government is to provide medical and hospital services, old age and disability benefits, free and universal primary education, benefits for the unemployed, and financial aid to all who need and merit it for university work” (Republic of Kenya 1965, p. 30). Highly influential in shaping this document was Tom Mboya, who as Minister for Labour in 1962 introduced the Industrial Relations Charter and with it the tripartite structure that characterizes the NSSF. Just after independence, Kenya introduced workerist social security (NSSF, NHIF, Civil Service Pension Scheme), but also citizenship-based free health care which had colonial precedents. Based on these past decisions and depending on the respective political context, changing global policy models have been selectively adopted and adapted in Kenya since then.

Non-contributory forms of social assistance as advocated by different international organizations have become more popular in recent years, but social insurance has persisted nonetheless. Indeed, as acknowledged by Seekings (2008, p. 27), there is a combination of workerist and citizenship-based elements. The frameworks of workerist and citizenship-based social security are somewhat useful at the level of specific instruments of social security, but not for describing a regime. The “disjointed set of welfare policies” observed in Kenya confirms Kasza’s (2002, p. 271) conclusion that “few national welfare systems are likely to exhibit the internal consistency necessary to validate the regime concept, and that policy-specific comparisons may be a more promising avenue for comparative research”.

Furthermore, for a comprehensive framework, we have to include care provision as another element of social security in addition to social insurance and social assistance which characterize the workerist and citizenship-based frameworks. A comprehensive framework would also include civil society and households as providers of social security. Such a framework could also systematically embrace indigenous forms of social security and take a step towards focusing on welfare regimes instead of welfare state regimes.

For informed speculation about the future direction of social security reforms in Kenya it is reasonable to assume that workerist and citizenship-based social security will continue to co-exist. Given the powerful domestic constituencies interested in workerist social security (workers in general and civil servants and teachers in particular), an expansion of benefits is more likely than a significant expansion of the group of beneficiaries. In contrast, politicians might have an incentive to expand cash transfers to uncovered regions without necessarily expanding them to universally cover the entitled categories, as this might reduce their potential for local-level patronage. Together with their own initiatives, especially in maternal health, government can depict these co-existing policies as moves towards securing the social rights enshrined in the constitution, thus gaining domestic and international legitimacy and at the same time appeasing powerful political stakeholders. This might continue as long as the question of financing these

policies is solved by incurring debt and, to a certain extent, transferred to the next generations as a result.¹⁶

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16. Kenya’s external debt was relatively constant from 2001 to 2007, but started to grow under Kibaki’s second term and more than tripled from 2009 to 2015.

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