

**Same objective, different paths :**  
**An analysis of Universal Health Coverage policies in Benin and Senegal**

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## Introduction

Over the last few years, Universal health coverage (UHC) has become a central objective of the international agenda for social protection, development and health. Described by M. Chan, former Director-General of the World Health Organization (WHO), as “the most powerful concept that public health has to offer”<sup>2</sup>, the objective of UHC has been adopted by several assemblies (World health assembly, 2005; United Nations General Assembly, 2012) and raised as a target of the Sustainable Development Goals (SDG 3:8).

UHC is commonly defined as ensuring that “all people obtain the health services they need without suffering financial hardship when paying for them”<sup>3</sup>. Comparing it to the “refrain of Health for All”, O’Connell, Rasanathan, & Chopra (2014) have highlighted that the “imprecision of these three terms hinders discussions around key policy questions”. Nauleau, Destremau, & Lautier considered UHC as a « frame of objective » (*référentiel d’objectif*)<sup>4</sup> of public policy, “that aims to establish new configurations of actors and objectives, at the global scale, according to an ethical and weakly normative consensus” (2013 : 145). Similarly, Kutzin pointed out that “unless the concept is clearly understood, [it] can be used to justify practically any health financing reform or scheme” (Kutzin, 2013 : 602).

Indeed, the path to achieve UHC is little marked out. Moving towards UHC implies to reduce out-of-pocket payments, by promoting prepayment and pooling mechanisms. However, there is no “one-size-fits-all approach to achieving UHC” (World Bank & World Health Organization, n.d.). WHO suggests that “all countries must make choices and trade-offs”, adding that “simply adopting elements from a menu of options, or importing what has been shown to work in other settings, will not be sufficient. Health financing strategy needs to be home-grown” (World Health Organization, 2010 : 12-90).

This broad definition of the objective of UHC, combined with the shared conception that social protection is a national matter as well as the absence of “one-size-fits-all approach”, provides

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<sup>2</sup> <http://www.who.int/dg/speeches/2015/universal-health-coverage/en/>

<sup>3</sup> [http://www.who.int/features/qa/universal\\_health\\_coverage/en/](http://www.who.int/features/qa/universal_health_coverage/en/)

<sup>4</sup> This concept comes from the cognitive approach of public policy developed by Jobert & Muller (1987).

national governments with room of manoeuvre to design their national policies. This contrasts with the “travelling models” that abound in Global Health (Olivier de Sardan, Diarra, & Moha, 2017) and it leads to different strategies being adopted and implemented from one country to another.

However, UHC is a highly political matter and involves different national and international stakeholders with competing interests and ideas. Many factors influence the formulation process and adoption of strategies to achieve UHC. This contribution aims to provide a comparative analysis of the formulation process and design of UHC policies in Benin and Senegal, and attempts to answer several questions: How is the concept of UHC understood and translated in the national arena of two West-African countries that have quite similar health history and challenges? What are the commonalities and differences between the Beninese and Senegalese strategies to achieve UHC? How can the ‘3I’ (institutions, interests and ideas) of public policies analysis shed light on these processes and choices?

This research is based on a revue of the literature and several socio-anthropological field missions in Benin and Senegal undertaken between 2014 and 2018. We conducted key stakeholders’ interviews in both countries. The recorded interviews were fully transcribed and are being coded with Nvivo 10<sup>5</sup>. The *verbatim* used in this paper are translated from French to English.

Our theoretical approach is inspired by different references that imply going beyond “monocausal models” in the analysis of public policy and policy change (Béland, 2010a). Palier and Surel (2005) suggest that the “3I” (institutions, interests and ideas) should be taken into account in a complementary manner and that an inductive approach should allow us to rank the influence of these three dimensions *ex post*. Fox and Reich (2015) developed a theory-based framework organized around four policy cycle stages and four variables (interests, institutions, ideas and ideology) that can guide us in the study of UHC reforms. Finally, Shearer, Abelson, Kouyaté, Lavis, & Walt (2016) reconciled policy network analysis with institutions, interests, and ideas.

In the first section, we briefly introduce the Beninese and Senegalese current reforms to achieve UHC, so as to set the context. We then successively propose an analysis of the influence of institutions, ideas and interests on both reforms or some of their distinctive features.

### Same objective, different paths: an overview of UHC strategies in Benin and Senegal

The objective of UHC has first been set at the national agendas of both countries around 2007 and 2008. Despite having quite similar histories in terms of social security and health financing reforms, Senegal and Benin chose different paths on their way to achieve UHC.

In Senegal, the objective of UHC was first translated into the “expansion of Senegalese health risk coverage national strategy” under Wade’s Presidency, but most of the strategies formulated in this plan were materialized after the election of President Macky Sall in 2012. The UHC

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<sup>5</sup> *Work in progress*

programme, called *Couverture Maladie Universelle*, was launched in 2013 around three main lines: (1) reforming the health planning institutions (*Institutions de Prévoyance Maladie*, IPM) that cover workers in the private sector; (2) reforming and expanding user fees exemption policies, with a new policy aimed at children under 5 years old; (3) expanding health coverage through community-based insurance (CBHI) schemes in the context of decentralization (*Décentralisation de l'Assurance Maladie*, DECAM project).

Based on the catchline “One local authority, one community-based health insurance scheme”, CHBI schemes were created and restructured all around the country. The contributions of their members are either half subsidized by the state (50% from 7.000 FCFA) or fully subsidized (for people identified as vulnerable or extremely poor). The members of CBHI schemes are entitled to a “basic package” managed by local CBHI as well as a complementary package managed by CBHI unions at the department level. However, new initiatives aimed at expanding coverage were launched in 2018, such as CMU for pupils, that covers a downsized package in exchange for a contribution of 1.000 FCFA per year.

According to the CMU-Agency’s report (2017), at the end of 2016, the coverage rate was estimated at 46.8% of the population, all schemes combined. 671 CHBI schemes were officially recognized, covering 16% of the population. However, nearly two third of members enrolled in CBHI schemes were fully subsidized by the state, which highlights the persistent challenge to enrol the population and convince them to pay for health insurance without mandatory contribution.

In Benin, process of thought on UHC began in 2008 and led to the official launch of a programme called Universal Health Insurance Scheme (*Régime d'Assurance Maladie Universelle*, RAMU) in 2011. This programme was intended to cover the whole population through a national agency (*Agence Nationale de l'Assurance Maladie*, ANAM) that was established in 2012. However, RAMU was never really implemented, and its failure is commonly attributed to its politicization, that got the upper hand on the technical aspects. In December 2015, the national assembly still adopted a law establishing RAMU as a compulsory scheme that would gradually cover all Beninese.

Following the election in March 2016, the newly elected President Patrice Talon announced his decision to revoke RAMU, in order to implement a new project called Insurance for the strengthening of human capital (*Assurance pour le Renforcement du Capital Humain*, ARCH). It aims to develop social protection for the informal workers and vulnerable populations around four branches: health insurance, retirement planning, microcredit and occupational training. Health insurance is the key component in this project, as it would be mandatory, would replace exemption policies, and would also imply a reform of social security schemes for civil servant and private sector workers. The project intends to exempt extremely poor people from contribution, as well as to partly subsidize the rest of the population living below the poverty line.

A National Agency for Social Protection (ANPS) would be in charge of the implementation of ARCH project, but, in accordance with the President’s will to stimulate public-private partnerships, its management would most probably be delegated to an insurance company. However, in 2018, the ARCH project is still at the formulation stage, as the implementation has

been postponed several times. The steering committee created for the project has been turned into a technical unit that works in close collaboration with the President. The information disseminated about the project is scarce and the coalitions needed to make this project happen seem more and more uncertain.

### Fragmented reforms, path dependency and the role of institutions

In Benin and Senegal, the social security schemes aimed at public servants and the workers in the private sector have been inherited from the colonial period and were institutionalized after independence with the idea that coverage would expand alongside formalized employment. However, this transition never happened, and formalized employment even tended to decrease subsequent to structural adjustment programs. Hence, institutionalized social security schemes only covers a minority of relatively privileged people, while the majority of the population has to rely on interpersonal solidarity or scattered initiatives such as community-based health insurance to deal with out-of-pockets payments (Baumann, 2010). Evidence also points to the fact that some people have to borrow money or sell assets to be able to pay for health services (Kruk, Goldmann, & Galea, 2009), when they do not simply give up on care.

UHC reforms are primarily aimed at *expanding* coverage to the population excluded from social security schemes (Alenda, s. d.), with a focus on equity of access for the poorest of them. New schemes are especially designed to cover workers from the informal sector as well as “indigents” and are added to the pre-existing social security institutions. In Senegal, this is the case with the DECAM project that aims to cover the “informal and rural sectors” through CBHI schemes, in parallel with IPM’s reform and the preservation of separated schemes for public servants and retired people. In Benin, the ARCH project is also primarily aimed at informal workers and destitute people, while the state and private companies would subscribe to an insurance company for their workers and assignees. Cross-subsidisation between schemes is planned as a tax on private insurance that would directly finance the ARCH project.

These reforms lead to a fragmented health financing landscape that rests (among others) on the distinction between formal and informal employment. The emphasis on expanding coverage, strengthened by political pressure to achieve what has been promised, also leads to more and more fragmentation and sedimentation (Bierschenk & Olivier de Sardan, 2014), as new initiatives or schemes are created, such as the CMU for pupils in Senegal. This fragmentation contrasts with international recommendations. The 2010 WHO report, for example, states that “multiple pools, each with their own administrations and information systems, are also inefficient and make it difficult to achieve equity. Usually, one of the pools will provide high benefits to relatively wealthy people, who will not want to cross-subsidize the costs of poorer, less healthy people” (WHO, 2010 : xv).

These fragmented reforms can be understood through the study of institutions and, more specifically, through the phenomenon of *path dependency* that means that “past policies also set up institutions that can place countries on a certain path, which is subsequently difficult to change” (Fox & Reich, 2015 : 1023). As this CMU-agent describes it:

*It could be the best option, to have one unique fund that manages health insurance. But Senegal has the distinctive feature to be one of the rare countries to have implemented a health insurance system since 1975. [...] We had IPM and we had to supplement the system with what is missing. That's the difference. So people have thought, CBHI schemes already existed in Senegal, but it was not really developed. And we considered that, for the excluded ones from the formal system, CBHI could be a good model, don't they? A good lever to cover them. That's it<sup>6</sup>.*

However, this institutional analysis also needs to take into account interests, as institutions shape them, and “radical change is rare largely because of the vested interests that policies create over time” (Béland, 2010b : 105). In Senegal, for example, some authors noticed that “trade unions represented in the bipartite social institutions for the formal sector in Senegal determined the scope of the reform by vetoing fundamental changes that would affect their own position” (Fonteneau, Vaes, & Van Ongevalle, 2017 : 25). During the negotiations of the national health financing strategy in 2017, one task force was about “resource pooling” and de-fragmentation. According to one CMU-agent:

*These are difficult questions because it affects interests. [...] One very complicated question in this group was the management unit of the different schemes. Some people insisted so that the creation of a unified institution to be at very long-term. We decided to be pragmatic<sup>7</sup>.*

The decision, as written in the Plan, was to adopt a “progressive process” with the creation of two different units for the formal and informal sectors (Ministère de la Santé et de l'Action Sociale, 2017). As Fox and Reich affirm, “incrementalism is often a by-product of veto-ridden systems” (2015 : 1039). The same kind of resistances have been encountered in Benin:

*Maybe it will progress towards one universal basic scheme, but people have benefits they are not ready to lose. There are possibilities of extraordinary resistances, and a risk that ARCH would never start. [...] Even between us, we had virulent debates<sup>8</sup>.*

The existence of social security institutions have lock-in effects because they shape decision-makers’ “perception on what is possible to achieve” (Fox & Reich, 2015) and restrain their room of manoeuvre. This leads to UHC policies described by Fonteneau *et al.* as “a rather minimalist interpretation of universalism and redistribution”, with “a strong emphasis on expanding coverage” (Fonteneau *et al.*, 2017 : 23). These results are not new nor specific to the cases of Benin and Senegal. Soors, De Man, Ndiaye, and Criel noticed that “where efforts are made towards harmonisation, this happens to be an extremely difficult task, which is essentially political as it is conditional on bringing in line a range of actors with different interests and power stakes. [...] Evidence suggests that to make progress towards UHC more successful by harmonising and eventually unifying risk pools, technical support has to be complemented by political support and capacity building” (2015: 14-15). However, this would require going beyond “the anti-political machine” (Ferguson, 1990).

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<sup>6</sup> Interview with CMU Agent, Sénégal, 29/03/2016.

<sup>7</sup> Interview with CMU Agent, Sénégal, 11/09/2017.

<sup>8</sup> Interview with project management team members, Benin, 15/03/2018.

## The role of ideas on the institutional architecture of UHC reforms

Benin and Senegal have made completely different choices regarding the institutional architecture of their UHC reforms. On the one hand, Senegal has opted for a voluntary decentralized coverage that rests upon community-based health insurance schemes as well as user fees exemptions. On the other hand, the Beninese successive authorities opted for compulsory health coverage, based on centralized schemes. The cognitive approach of public policy is probably the most relevant approach here, as ideas have played a major role in the decision for one or another path. According to (Fox & Reich, 2015 : 1034), “the design of health reform is influenced by the policy ideas that are present at a given historical moment and the actors (often behind the scenes) that are actively promoting those models”. However, this does not preclude any influence of interests or institutions.

The influence of ideas, combined with the analysis of actors’ networks (Shearer et al., 2016), is especially perceptible in the choice of CBHI schemes as the main instrument to expand coverage in Senegal. Indeed, a coalition of national and international actors emerged around CBHI schemes, alongside the multiplication of projects and the creation of a national expertise on this field. CBHI schemes were progressively structured and their leaders and national and international partners advocated in favour of the “DECAM” model:

*We built CBHI networks in the different regions, and we understood that we also had to meet and exchange in order to speak as one voice. [...] Secondly, we built alliances with technical and financial partners really soon. [...] Then, we had to elaborate proposals in the sense of expanding health coverage. First, the CBHI development plan. Then, the national strategy for the expansion of health coverage. [...] We were in a process of negotiation, influence and induction towards the ministry of Health. [...] During the 2012 presidential elections, we also had to influence the candidates. One of them said: ‘If you elect me, I’ll accomplish universal health coverage’. At the end of the process, he got elected. [...] The inter-ministerial council approved our proposal.<sup>9</sup>*

This coalition of actors also benefited from the skills and status of Senegalese experts of CBHI working for Abt Associates, an executive agency of the American health programme, who formulated and promoted the DECAM project and acted as “policy entrepreneurs” (Fox & Reich, 2015 : 1027):

*The national strategy for health coverage expansion was nearly a work from USAID through Abt, which is the executive agency. This work has been conducted with all stakeholders.<sup>10</sup>*

*The elaboration and management of all this [DECAM] project, it was his work. He was the project team leader. He was the mastermind.<sup>11</sup>*

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<sup>9</sup> Senegalese CBHI representative at the international conference organized by the International Association of Mutual Benefit Societies (AIM), Abidjan, March 2-4 2016.

<sup>10</sup> Interview with CMU-Agent, Sénégal, 02/03/2016

<sup>11</sup> Interview with Abt Associate representative, Sénégal, 29/11/2017.

In several national strategic documents, CBHI schemes are described as the most “pertinent” instrument, therefore “matching solution to the specific problem” (Fox & Reich, 2015) of the expansion of health insurance coverage to the rural and informal workers in Senegal. The proponents of CBHI schemes also regularly use the example of Fandène as evidence, as this scheme was the first one to be implemented in Senegal and still operates (Gollock, Haddad, & Fournier, 2015).

This coalition of actors in favour of CBHI schemes also stands out in the conflict that opposed them to the proponents of the Belgian-Senegalese pilot project that developed professionalized insurance schemes, called UDAM (*Unité départementale d'assurance maladie*), in two Senegalese departments. This alternative model of CBHI schemes, that is also owned by the community but whose management is delegated to a professional team, has been the subject of multiple conflicts among partners (Abt Associates and the Belgian Development Agency) and within the CMU-Agency. Besides interests and interpersonal disputes, this conflict seems to strengthen the ideational analysis, as one contentious feature relates to community-management of the scheme:

*A delegated management, in which there were no more community participation... Against that, we must defend ourselves, we will not agree because... I mean, that's something else than a CBHI !<sup>12</sup>*

At the end of the UDAM pilot-project, no consensus had been found between both models and future prospects were uncertain. However, the coalition of actors in favour of CBHI schemes has declined over the last couple years, due to mixed results in terms of voluntary subscription at the operational level, but also after the unfortunate death of three of leaders of this coalition and, alongside, senior position staff transfers. As a result, the “UDAM” design, as well as socio-professional health insurance schemes, seem to be better considered as alternative models to boost the coverage rate, whereas CBHI schemes try to preserve their status.

In Benin, the coalition around CBHI schemes is weaker and less structured. Moreover, the formulation process and design of successive reforms (RAMU and ARCH) has been under the supervision and significant influence of the President and technocrats. The influence of President Talon’s ideas is particularly prominent in the ARCH project, that has been described as “*his societal project. It was already his idea as a presidential candidate. He deeply thought about social protection*”<sup>13</sup>.

The project is developed by a management unit composed of technocrats, which matches the idea of “a team of well-inspired and skilled leaders” emphasized by the President (Presidence de la République du Bénin, 2016: 20). Similarly, the President’s will to develop public-private partnerships (PPP) results in the plan to delegate the management of the new social protection Agency to the private sector, probably through an insurance company. His societal project also implies to “strengthen human capital” in a productive way, far from state handouts:

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<sup>12</sup> Interview with CBHI leader, Senegal, 07/04/2016.

<sup>13</sup> Interview with project management team members, Benin, 15/03/2018.

*Billions have been injected to fight poverty and, paradoxically, poverty has increased. When we analysed this situation, we noticed a lack of synergy between actions. [...] And so, in his proposal, in his societal project, he [the President] had planned to implement social protection for the poorest, that would include a significant package of services, that would be administered to each poor person so that we would be assure that he would get out of his poor situation. So that there would be no more wasted micro-credit, or a caesarean section program, and then we don't know who is benefitting from it, is it the poorest or the richest? And so, from this point forward, he wants to make sure that those who would be targeted as poor could exactly benefit from this assistance, and then, we will be able keep a close eye on them.<sup>14</sup>*

The President's idea of good governance and strong reforms is also reflected in the will to implement mandatory health insurance:

*Due to the mandatory feature of health insurance, people will have no choice. We are currently planning a bunch of mechanisms to compel them<sup>15</sup>.*

This contrast with the perspectives of Senegal, where mandatory insurance is much debated. This CMU-Agent, for example, considers that:

*It is useless to say that it is mandatory if we are not able to implement it. [...] If you say that it is mandatory, there will be countless suspicions. [...] People already think that they pay too many taxes and that the State doesn't contribute for them. We will be called a dictatorial regime<sup>16</sup>.*

According to the management team members in Benin, the repeated postponements of the ARCH project are partly explained by the will of the President to launch a highly-developed project whose technical preparation would contrast with the haste and politicisation of RAMU. However, the project has also been delayed by the lack of agreement with key actors such as insurance companies and the technical and financial partners, from which 90% of the financing is expected. This leads us to the analysis of "interests".

### Interest and strategic advocacy around UHC reforms

Interests have already been analysed through their embedding to institutions and ideas. As mentioned before, institutions shape interests, and interests can match values and ideas. However, the analysis of interest *per se*, through the action of strategic groups, is instructive as well. According to Fox and Reich, "decisions regarding how to finance a health system may be particularly contentious due to the redistributive quality of these decisions" (2015 : 1034). Besides, UHC policies mobilize a lot of resources that can be fought for. Conflicts have been encountered in both countries regarding the supervision of UHC policies, for which different ministry or agencies competed:

*At first, there were frictions. We even thought that UHC would leave the ministry of Health to be lodged in the Delegation [of Social Protection and National Solidarity]. There were lots of fights. Why was it such a sensitive subject? Because the Delegation*

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<sup>14</sup> Interview with project management team member, Benin, 31/03/2017.

<sup>15</sup> Interview with project management team member, Benin, 31/03/2017.

<sup>16</sup> Interview with CMU-Agent, Senegal, 11/09/2017.



*was managed by Macky Sall's son-in-law. [...] The CMU-Agency became a big 'room' inside the ministry of health 'house' and it caused conflicts. [...] The agency got a 'gold mine', and some people think that they are losing some of their prerogatives<sup>17</sup>.*

In Benin, while RAMU was supervised by an agency lodged at the ministry of Health, the ARCH project has been moved to the ministry of social action:

*This is the best arrangement. The ministry of health is supposed to sell health services, and cannot be the purchaser and the seller at the same time. So, it must be accepted that another institution be the purchaser<sup>18</sup>.*

However, various informants are concerned about this relegation of the ministry of health, alongside significant internal governance reforms, as it seems to generate major frustrations and could lead to the boycotting of the ARCH project at the implementation stage.

Other stakeholders advocate to gain or maintain their position depending on their interests. As mentioned before, CBHI schemes and their partners have been lobbying in Senegal so as to be the main actor in UHC reforms. While an ideational analysis puts forwards shared values and visions underpinning this coalition of actors, this can also be analysed as protecting their interests, as they obtain many resources and power positions from this situation. They are currently advocating so that the UHC bill explicitly mentions CBHI schemes, as these have been removed in the latest draft in favour of a more generic term. In Benin, CBHI schemes also closely follow the progress of the ARCH project, in order to position themselves at the operational level.

As the ARCH project plans to remove of exemption policies, some resistances have also appeared from the actors in charge of their supervision and implementation:

*We can't develop health insurance and, at the same time, implement exemption schemes. When the inventory of existing mechanisms has begun, there was a wave a panic. It is sure that a lot of institution will disappear. Some pressure has been put on us, that's clear, but we have no choice. This is a question of political will<sup>19</sup>.*

These institutions seem to have less power and influence than social security's ones, as they fail to impose their interests, thereby proving that "path dependency" can be overcome under certain circumstances.

The example of insurance companies in Benin is interesting as well, as they had withdrawn from the negotiation and formulation process of the RAMU, as they considered it to be politicized and could not see any interest for them in this process:

*The only problem, unfortunately, is that, at the governance level, there is a problem. It has been politicized too much. Even the choice of the men [leaders], the choice of the governance structure of RAMU, it is a mistake. We don't need public servants; we need to call for applications. [...] It should be private. And that's what we told them. We said,*

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<sup>17</sup> Interview with Abt Associate representative, Sénégal, 29/11/2017.

<sup>18</sup> Interview with project management team member, Benin, 31/03/2017.

<sup>19</sup> Interview with project management team member, Benin, 15/03/2018.

*for us, this is simple, we wished for [...] an institution managed by private board of directors.*<sup>20</sup>

Their wish has been fulfilled with the ARCH project, as it is planned to delegate the management of the new agency to the private sector, most probably an insurer. However, some agreements still have to be reached on important matters, such as management costs and the legal framework.

*There is a huge gap between RAMU and ARCH. [...] As they involved the private sector, we expressed our will to manage. However, we still don't have an agreement on several points*<sup>21</sup>

*The option has been agreed with the insurers, but I must admit that we have not discussed the commission yet.*<sup>22</sup>

The relation between states and international organizations can also be analysed through the concept of interests, although vertical interdependencies have their own “rules of the game” that cannot be ignored. Similarly, the role played by multilateral organizations in the emergence, conceptualization and diffusion of the idea of UHC is obviously important. However, the momentum around UHC has provided national state with the opportunity to benefit from important international financing, as many partners are willing to support this objective. Moreover, as Béland noticed, “health care systems [...] are known as a competitive ‘market-place for ideas’” (2010a : 622) and this is particularly true regarding UHC reforms, where multiple influences can be found. This has already been illustrated by the example of the conflict between the DECAM and UDAM projects in Senegal, which were supported by Abt Associates and the Belgian Development Agency. Some partners are also promoting and supporting the same kinds of strategies in both countries, such as the World Bank that supports the targeting processes of the poorest. If the national party often complains about the lack of synergy, alignment and harmonization between international partners, in both country, some of these partners felt like the state took advantage and, in some case, even caused this, as a strategy to draw as many funds as possible.

Finally, the concept of interests allows us to question the perception and interests of the citizens about these reforms. While the interests of the public servants and formal workers are powerfully protected by unions, as it has been mentioned before, the main beneficiaries – as these reforms primarily aim to expand coverage to the informal and rural sectors - are poorly represented in the formulation processes. Indeed, most stakeholders involved in the negotiations benefit from other health insurance schemes. They assume that those concerned by the strategies they develop will be interested in it. As highlighted by Warin, “non-desire is unthought-of. This is due to the representation of protecting state: protecting, notably because he knows better than no one to define the social demand” (Warin, 2012 : 12). However, during casual talks with citizens in both countries, we regularly noticed a relative indifference to these policies, that are described as distant “*political matters*”. Some vulnerable households, entitled

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<sup>20</sup> Interview with insurance companies' representative, Benin, 04/04/2014.

<sup>21</sup> Interview with insurance companies' representative, Benin, 16/03/2018.

<sup>22</sup> Interview with project management team member, Benin, 15/03/2018.

for free health care, decided not to have recourse to it. In Senegal, several people also stated that they were not interested in CBHI membership due to the fact that they mostly have recourse to private or uncontracted providers. This demonstrates the advantages of taking into consideration the beneficiaries' opinion, including their possible disinterest and the reasons underpinning "non-demand" (Warin, 2016), so as to develop relevant policies.

## Conclusion

This contribution intended to analyse the national translation of the broad and ambitious objective of UHC, based on the policy formulation processes of two West-African countries, Benin and Senegal. Despite quite similar health histories and challenges, these countries have chosen different paths on the road to UHC, but they also have common features. Through the concepts of institutions, interests and ideas, we tried to explain these differences and similarities.

Our analysis points out the relevance of a complementary use of these concepts, as they shed light on different facets of UHC reforms. The contribution successively considered each of the '3Is' and the possible explanations that they provide about the formulation process of UHC reforms. However, we also intended to show how these concepts combine and supplement each other, using an inductive method that does not presuppose of the primacy of one of them, but tries to develop complex and multi-causal explanations, as suggested by Palier and Surel (2005).

As any social protection reform, UHC strategies are highly technical and political matters, and they involve multiple stakeholders with competing interests and ideas. They are also developed in a context that matters, as the rules of the game and strategies previously adopted shape the perception of what is possible and advisable to do. Our study of UHC reforms in Benin and Senegal finally corroborates that these reforms are the product of "aggregation logics", "progressively elaborated during repeated interactions" and that the adopted reforms are "those who arrange the different interests at stake due to their polysemy, the fact that there are subjected to divers possible interpretations" (Palier & Surel, 2005 : 18). Indeed, the broad and consensual conceptualization of the objective of UHC, its "polysemy", is what makes it so "powerful", but also results in incremental reforms and fragmented or "sedimented" systems that contrast with the universalistic goal.

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### Abstract

Over the last few years, Universal health coverage (UHC) has become a central objective of the international agenda for social protection and health, but no consensus has emerged on how to achieve it. This situation provides national governments with room of manoeuvre to design their national policies. However, much factors influence the formulation process and adoption of these strategies, such as institutions, interests, ideas and networks. On the one hand, Senegal has opted for a voluntary decentralized coverage that rests upon community-based insurance schemes as well as user fees exemptions intended for socio-demographic categories of population. On the other hand, the Beninese successive authorities opted for compulsory health coverage, based on centralized scheme(s), with the RAMU adopted during Y. Boni's Presidency soon to be replaced by the ARCH project designed under P. Talon's government. However, some features are also common in both countries, such as fully subsidized contribution targeted at the poorest households. Based on literature review and key stakeholders' interviews, this contribution aims to provide a comparative analysis of the formulation process and design of UHC policies in Benin and Senegal, by looking at the influence of institutions, interests, ideas and actors' networks, as suggested by Shearer, Abelson, Kouyaté *et al.* (2016). Although path dependency and decision taking processes are determining aspects of the strategies' adoption, the role of interests and ideas, as well as the groups and epistemic communities defending them, have to be taken into account to understand why some option have been chosen above others. Vertical interdependencies are also decisive, as international organizations are key actors of the process, providing technical and financial assistance to these countries. However, the variety of available and sometimes competing international partners gives national authorities some opportunities to negotiate projects and support. All these factors converge to explain why different paths are followed to pursue the same objective of UHC.

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