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Removing user fees for health services: a multi-epistemological perspective on access inequities in Senegal

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Abstract

Plan Sésame (PS) is a user fee exemption policy launched in 2006 to provide free access to health services to Senegalese citizens aged 60 and over. However, analysis of a household survey evaluating PS echoes findings of other studies showing that user fee removal can be highly inequitable. 34 semi-structured interviews and 19 focus group discussions with people aged 60 and over were conducted in four regions in Senegal (Dakar, Diourbel, Matam and Tambacounda) over a period of six months during 2012. They were analysed to identify underlying causes of exclusion from / inclusion in PS. These point to three steps at which exclusion occurs: (i) not being informed about PS; (ii) not perceiving a need to use health services under PS; and (iii) inability to access health services under PS, despite having the information and perceived need. We identify lay explanations for exclusion at these different steps. Some lay explanations point to social exclusion, defined as unequal power relations; poor access to PS was seen to be caused by corruption, patronage, poverty, lack of social support, internalised discrimination and adverse incorporation. Other lay explanations do not point to social exclusion, for example: poor implementation; inadequate funding; high population demand; incompetent bureaucracy; and PS as a favour or moral obligation to friends or family. Within a critical realist paradigm, we interpret these lay explanations as empirical evidence for the

presence of the following hidden underlying causal mechanisms: lacking capabilities; mobilisation of institutional bias; and social closure. However, social constructionist perspectives lead us to critique this paradigm by drawing attention to contested health, wellbeing and corruption discourses. These differences in interpretation lead to subsequent differential policy recommendations. This demonstrates the need for the adoption of a “multi-epistemological” perspective in studies of health inequity and social exclusion.

Keywords

Senegal; Africa; social exclusion; older people; universal health coverage; user fees; inequity; epistemology

1. Introduction

The struggle for universal health coverage

It is now widely accepted that user fees increase poverty and inequity and reduce utilisation of needed health services (World Health Organization, 2010). In light of this, World Health Organization (WHO) member states have committed to achieving universal health coverage (UHC), so that all people have access to quality needed health services and are protected from financial hardships of health care costs (WHO, 2005). This commitment has been reaffirmed by the Sustainable Development Goals (UNGA, 2015).

Among current UHC policies, one common strategy is tax or donor-funded exemptions from user fees for health services for vulnerable groups (such as indigents) and priority interventions (such as maternal and child health). At least 14 countries in sub-Saharan Africa (SSA) have introduced this policy (Richard, 2013; Ridde et al., 2015; Yates, 2009). However, although user fee removal can successfully increase utilisation of exempted services, it has been marred by poor implementation (Ridde et al., 2012).

One problem has been a lack of equity. In Ghana, Senegal and Sierra Leone, for example, removing user fees increased the proportion of women delivering in health facilities across the socioeconomic gradient. However, the richest 20% of women were still around twice as likely to give birth in a health facility compared to the poorest 20% after the policy change. Furthermore, removing

user fees was statistically significantly associated with greater increases in facility deliveries among women with a secondary education (8.6 additional facility deliveries per hundred live births) compared to women with no education (only 4.6 additional facility deliveries per hundred live births) (McKinnon et al., 2015). Surprisingly though, few studies have sought to understand the underlying *causes* of inequity in access to publicly funded user fee exemptions. Worryingly, UHC policy documents remain largely silent on this issue (Olivier de Sardan & Ridde, 2015; Ridde, 2015). This has prevented the development of effective policy responses. One objective of this study is to address this gap in the empirical literature by analysing causes of inequity in access to free health care following a policy of user fee removal in Senegal. In doing so, we also aim to achieve a second, linked, objective of exploring how choice of epistemology affects interpretation of results and subsequent policy development. This also addresses an important gap in the literature on UHC and public health more widely (Wainwright & Forbes, 2000). Our main argument is that the researcher's choice of epistemological paradigm for the interpretation of empirical evidence leads to subsequent differential policy recommendations for the reduction of inequity. This has important implications for the growing field of evidence-based health policy.

A user fee exemption policy: Plan Sésame in Senegal

Total expenditure on health in Senegal is low, at 6% of GDP in 2011 compared to the SSA average of 6.5%. Private expenditure on health as a percentage of total health expenditure is 41.7%. This is lower than the average for SSA (54.9%), but

high compared to other world regions. 78.5% of private expenditure on health in Senegal is spent directly out-of-pocket as user fees (World Health Organization, 2013). As in many SSA countries, the reliance on user fees is the result of several decades of health system restructuring, incorporating austerity measures imposed under structural adjustment and decentralisation under the Bamako Initiative (Foley, 2010). As part of its strategy to reach UHC, Senegal has introduced a set of user fee exemptions targeting specific diseases and vulnerable population subgroups (MSAS, 2007). However, as elsewhere, these initiatives are poorly implemented (Soors et al., 2010) and health service providers often continue to charge fees.

This study analyses one Senegalese government-funded user fee exemption named “Plan Sésame” (PS), launched in 2006. PS aims to provide free access to publicly provided health care services to Senegalese citizens aged 60 years and over – an estimated 5.9% of the total population. It covers the costs of consultations, diagnostics, essential drugs, and hospitalizations. Older people who want to benefit from this exemption are required to present a national ID card at the point of service. PS is largely funded by taxation but has suffered from insufficient funding by the state (Leye et al., 2013; Mbaye et al., 2013).

Evaluations of PS suggest great inequity in access to these limited funds. In a survey of 2,933 households in Senegal, Parmar et al (2014) find that only 48% of people aged 60 and over were “enrolled” in PS, i.e. both aware of PS and in possession of a national ID card that is needed to prove their age in order to access the Plan. Since 89% of older people had a valid ID card, it was lack of

information about PS that accounted for the low enrolment rate. Having the following characteristics all statistically significantly ($p < 0.01$ or $p < 0.05$) increased a person's odds of enrolment: being male, being a household head, having formal education, living in an urban area, being relatively wealthy, belonging to the majority ethnicity, being a member of sociocultural associations, being married or not living alone, relatively high political and civic participation, perception of living in a safe neighbourhood, having access to information channels (TV or radio) and hospitalisation in the last year. Furthermore, only 10.5% of the target population was found to have ever used PS to access free health care (Ndiaye et al., 2014). Utilisation was also highly inequitable, with wealthier, formal sector people being significantly ($p < 0.01$) relatively more likely to use PS (Ba et al., 2015).

However, although this type of multivariate quantitative analysis is useful for understanding *patterns* of inequality, it does little to reveal the underlying *causal mechanisms* to explain *why* some social groups experienced inequity (Wainwright & Forbes, 2000). The hypothesis proposed, but ultimately untested, by Parmar et al (2014) is that social exclusion causes inequitable access to PS. They adopt Popay's definition of social exclusion as a: "*dynamic, multidimensional processes driven by unequal power relationships interacting across four main dimensions – social, political, economic and cultural – and at different levels including individual, household, group, community, country and global levels*" (J. Popay et al., 2008, p. 2). Popay and colleagues understand these unequal power relationships to be embedded in social structures, but do not provide a theory of power. Rather, they call for more research into

understanding the forces driving exclusionary processes in specific societies. Popay (1998) argues this needs to be done by exploring explanations derived from lay knowledge and cultural practice in the context of a specific time and place. Our study responds to Popay's call and complements the quantitative study with qualitative data collected as part of the same research project, to uncover underlying causes of the patterns of inequity identified (Creswell, 2009).

Yet, we heed critiques of the positivistic use of solely empirical data from mixed methods studies to determine causes of social exclusion and the plea for more theoretically-oriented research (Hickey & du Toit, 2013). Health scholars are increasingly calling for the use of alternative or complementary epistemological approaches to positivism (Dao & Mulligan, 2016; Gilson et al., 2011; Lacouture et al., 2015; Marchal B et al., 2012 ; Muntaner et al., 2015; J. Popay et al., 2008; Wainwright & Forbes, 2000). Gilson has identified two main knowledge paradigms that have been applied by health policy and systems researchers as alternatives to positivism: critical realism and relativism, incorporating social constructionism and interpretivism (Gilson, 2012; Gilson et al., 2011). We have opted to compare two particular branches of critical realism and social constructionism respectively. They are particularly useful for this study as they incorporate clearly distinct and contrasting understandings of causality and power relations.

Critical realist and social constructionist approaches to understanding causes of inequity

Critical realists argue that measuring the relationship between observed variables and lay knowledge forms the empirical basis for the identification of *hidden or unobservable generative mechanisms*. The observed patterns or events can be compared to other contexts in order to identify underlying reoccurring mechanisms (Bhaskar, 1975). Bhaskar, the initiator of this epistemological movement, distinguishes between three domains: the real, actual and empirical. The domain of the real refers to unobservable generative mechanisms that are independent of humans to exist and act. The domain of the actual refers to events that take place, such as policy interventions. The domain of the empirical refers to what is observed or sensed by human beings (Bhaskar, 1975). Bhaskar's emphasis on uncovering real underlying causal mechanisms is compatible with Marxist theory and other approaches which entail a relational conception of society, where both individuals and social structures are causally efficacious, and interact through time (M. L. Smith & Seward, 2009).

Critical realism was developed in response to not only the perceived limitations of positivism, but also to those of social constructionism. In this paper we focus mainly on social constructionism as expounded by Burr (2015). In this case it is proposed that there is no reality that can be objectively identified by researchers. Rather, it is argued that knowledge is created and sustained through daily practice; that social constructions, in the form of discourse, sustain some forms of practice and exclude others; and that this process entails power and resistance (Burr, 2015). This branch of social constructionism takes a Foucauldian approach, arguing that there exist various *regimes of truth*, but that one regime is no more correct than another (Burr, 2015). Rather than thinking about causal

mechanisms as an interaction between two pre-existing entities (i.e. the self (psychology) and social phenomena (social structures)), social constructionists tend to think a person is always actively constructing the social world at the same time as being constrained by society (Burr, 2015). This approach suggests that no deterministic, underlying mechanisms causing inequity can be objectively identified by researchers. Because of this, critical realists accuse social constructionists of being unable to ground their research in a political or moral stance.

Few studies in the health field explicitly distinguish between the three main epistemological paradigms (positivism, relativism and critical realism), or explain their rationale for adopting one epistemology instead of another (Wainwright & Forbes, 2000). We argue that this is a major limitation, as choice of epistemology determines how empirical results can be interpreted. This in turn is likely to determine policy recommendations. These are crucial issues, given the increasing interdisciplinarity of health research and concurrent diversification of epistemologies used. We argue that the various epistemologies do not have to be at odds, as there are likely to be useful insights garnered from each approach. Rather, health policymakers and researchers need to become more literate in - and perhaps even adopt - each other's epistemologies in order to strengthen health research and policy development. This can be described as a "multi-epistemological" approach.

2. Methods

A total of 34 semi-structured interviews (SSIs) and 19 focus group discussions (FGDs) with people aged 60 and over were conducted by a team of professional fieldworkers over a period of six months during 2012. For the SSIs, older people were selected from the household survey that was conducted across four regions in Senegal (Dakar, Diourbel, Matam and Tambacounda), which preceded the qualitative study. These regions were selected to ensure variety in terms of rural/urban population, poverty and access to healthcare. For further details of the survey methodology see (Parmar et al., 2014). For the SSIs, purposive sampling was used (Palys, 2008) to represent a variety of profiles according to whether they had: been informed / not informed of PS; used / not used health services in the last year; received / not received a user-fee exemption under PS. This sampling strategy was necessary due to the small number of people in the household survey that had received a user-fee exemption under PS. The sampling procedure also aimed to cover a wide range of social and demographic characteristics, in order to incorporate maximum variation of perspectives on the causes of social inclusion/exclusion, covering: formal and informal sectors; gender; urban/rural residence; social status; and vulnerability. Interviews lasted 30 minutes on average. The 19 FGDs with people aged 60 and over were conducted in the same regions as the SSIs and were also selected to cover variations in the profiles and socioeconomic and demographic factors listed above. This allowed data triangulation with the SSIs. FGDs lasted one hour on average and were each made up of around 12 people. Sample size of the SSIs and the number of FGDs was determined by the data obtained and data collection continued until saturation.

In order to explore the relationship between social exclusion and PS, a wide range of topics was included in the SSI and FGD interview guides: socioeconomic status; perceptions of ageing; social and family support; health and access to health care; knowledge, use and perceptions of PS. All SSIs and FGDs were of a focused, open-ended type and were conducted in local Senegalese languages, recorded, transcribed using verbatim transcription and translated. Informed consent was obtained. The authors analysed all transcripts using NVivo10, in order to identify lay explanations of causes of exclusion from / inclusion in PS. The interview guides and background literature were used to develop a coding frame to deductively code the data. Inductive coding (Glaser, 1967) was then performed in order to add relevant codes to the coding frame. As new codes emerged all transcripts that had been previously coded were read again and new codes added. Both authors independently coded the transcripts and the coding was then consolidated and merged.

In sum, using a concurrent transformative strategy design (Creswell, 2009), the qualitative research aimed to make sense and progressively deepen the household survey results (Ba et al., 2015; Parmar et al., 2014) and develop new understandings beyond the quantitative analysis. Ethical approval was obtained from the National Ethics Committee for Research in Health, Senegal [674/MSAS/DS/DER].

3. Results and Discussion

We identified fifteen common explanations (from the perspective of the interviewees) of inclusion in or exclusion from PS across the SSIs and FGDs. These are presented in detail in Tables S1 and S2 (see Supplementary file) [INSERT LINK TO ONLINE FILE TABLES S1 AND S2](#). This section is structured according to explanations for exclusion of older people from PS at three important steps, which emerge from fifteen lay explanations of inclusion in or exclusion from PS: (i) not being informed about the PS policy; (ii) not perceiving a need to use health services under PS; and (iii) inability to access health services under PS, despite having the information and perceived need. The explanations at each step are often interconnected. For each step, we first present the empirical results, which refer to both the SSIs and FGDs unless otherwise stated. Then we interpret the results using a critical realist and /or social constructionist epistemological paradigm. According to the critical realism paradigm, similar mechanisms are likely to operate in many different contexts, albeit with different results depending on the context. We therefore draw on mechanisms identified in the existing critical realist literature. We contrast and critique this approach using a social constructionist lens, drawing mainly on ethnographic literature. Finally, we explore how the different epistemological lenses affect policy implications.

(i) Causes and policy implications of not being informed about PS

The qualitative results help to explain why around half of Senegalese older people were unaware of the existence of PS. They provide a richer set of

explanations than the patterns of inequity observed in the survey alone (Parmar et al., 2014). Some older people who had benefited from PS several times thought PS functioned well and that good information dissemination was key to its success. These people said information about PS was readily available through the radio, television, religious and cultural ceremonies and directly from health service providers (Table S1) [INSERT LINK TO ONLINE FILE TABLES S1 AND S2](#). In contrast, other older people pointed to a lack of knowledge of PS in the population, which they attributed to the government's incompetence. These older people pointed to the inadequate government information campaign, arguing that not everyone listened to the radio or watched television, the main dissemination channels used by the government to advertise PS. These older people argued that more and better-targeted information about PS was needed, suggesting the use of town criers and door-to-door visits (Table S1) [INSERT LINK TO ONLINE FILE TABLES S1 AND S2](#).

A third perspective was that poor information dissemination was not due to incompetence, but rather was intentional on the part of the government and health workers. These older people argued that the deliberate withholding of information had the purpose of enabling the embezzlement or selective distribution of PS funds by the government and health workers (Table S2) [INSERT LINK TO ONLINE FILE TABLES S1 AND S2](#). These results in part echo the correlations from the quantitative analysis, pointing to a lack of social networks and access to television and radio as important barriers to accessing information about PS. However, they also point to an explanation for social exclusion not identified in the survey, namely corruption. This is addressed in more depth in

section (iii) below. Our results raise a second important issue not addressed by the quantitative analysis; they require the researcher to analyse diverging lay perspectives. In this case, the same information dissemination campaign was viewed as not exclusionary, unintentionally exclusionary and intentionally socially exclusionary by different informants.

A critical realist perspective is useful for interpreting these empirical results, by identifying causal mechanisms and explaining the diverging perspectives of the interviewees. Kabeer's (2000) framework of causes of social exclusion is especially pertinent. Kabeer adopts a critical realist approach (Olsen, 2004). One of the main generative mechanisms of social exclusion proposed by Kabeer (2000) is Weber's concept of "social closure". This is defined as the way in which *"social collectivities seek to maximize rewards by restricting access to resources and opportunities to a limited circle of eligibles"* (Parkin, 1979) in (Kabeer, 2000, p. 92). This involves monopolisation of certain opportunities based on group attributes, such as race, language, social origin and religion. Institutions cause exclusion when they deliberately discriminate in their laws, policies or programmes. This mechanism provides a strong causal explanation for the results regarding deliberate withholding of information about PS, echoing calls for increased realist attention to social class as a causal mechanism in health inequalities studies (Muntaner et al., 2015).

In contrast, unintended or subconscious discrimination, termed "mobilisation of institutional bias", is another commonly occurring generative mechanism of social exclusion. Kabeer (2000, p. 91) draws on Lukes (2005) who in turn refers

to Bachrach and Baratz who define it as “*a predominant set of values, beliefs, rituals and institutional procedures (“rules of the game”) that operate systematically and consistently to the benefit of certain persons and groups at the expense of others*”. Analysis of this mechanism calls for the researcher to look beyond people’s subjective explanations and seek an objective perspective to reveal processes of domination. This mechanism provides a strong causal explanation for the unintentional exclusion caused by the government’s use of television and radio as the official channels to disseminate information about PS, by default privileging people from relatively high socioeconomic groups who were more likely to own or have access to these goods.

One policy implication of these critical realist interpretations is the need to diversify PS information dissemination channels and target lower socioeconomic groups. Another important implication is the need to eliminate or reduce discriminatory practices of health and political personnel. However, this interpretation and resulting policy implications are put into question by further complexity in the results of our study; we found that on one hand, older people with no information about PS did not necessarily want this information; and on the other hand, discrimination in the distribution of PS funds was at times perceived to be desirable and even moral. These further contradictions are explored in the following subsections, with social constructionism emerging as a useful analytic tool to reconcile the findings.

(ii) Causes and policy implications of perceiving no need for health services under PS

A complex issue raised in the results is differential subjective, internalized perceptions of health, wellbeing and medicine, and how these perceptions relate to social exclusion from accessing PS. These issues were not addressed by the quantitative study.

Some older people reported never falling sick and therefore never needing to use PS (Table S1) [INSERT LINK TO ONLINE FILE TABLES S1 AND S2](#). A few interviewees argued that some older people believed traditional medicine to be more effective than allopathic, suggesting this was why they didn't access PS (Table S1) [INSERT LINK TO ONLINE FILE TABLES S1 AND S2](#). Other older people were fatalistic about their lack of access to PS, some attributing it to God's will (Table S1) [INSERT LINK TO ONLINE FILE TABLES S1 AND S2](#). Others spoke of a lack of support within the household to reach health service providers but accepted this as a natural attribute of old age. These subjective perceptions led to a lack of demand for information about PS and for the use of health services under PS. However, the older people with these views did not perceive themselves to be socially excluded from PS. On the other hand, some interviewees argued that some older people convinced themselves they did not have the right or need to access health care, so as not to be disappointed by their lack of access (Table S2) [INSERT LINK TO ONLINE FILE TABLES S1 AND S2](#).

A critical realist interpretation might attribute some of these results to psychological adaption, or "internalised discrimination" in the population studied. Sen's capability approach (2005) is useful for understanding

internalised discrimination as a cause of exclusion from PS. The approach has been argued to be critical realist since it focuses on the combination and interaction of individuals' capacities and their relative position vis-à-vis social structures that provide reasons and resources for particular behaviors (M. L. Smith & Seward, 2009). The capability approach shifts our attention from access to health care facilitated by people's knowledge of PS policy (the instrument or permission) and its requisite level of public funding (the means), to whether people are *actually able* to access free health care under PS.

Sen understands internalised discrimination to be a cause of people's differing actual achievement of developmental ends, since "*our desires and pleasure-taking abilities adjust to circumstances, especially to make life bearable in adverse situations*" (Sen, 1999, p. 62). The capability approach deals with this by rejecting individual preferences as foundations for evaluating wellbeing due to their endogenous or adaptive nature, opting instead for an objective set of measures such as whether people have access to health care, education, can protest, vote, etc.

A capability approach therefore identifies internalized discrimination as a causal mechanism for the lack of perceived need for access to PS among those who were likely objectively to be in (biological) need of health services (using objective measures of health would be needed to identify specific cases). Policy implications of this interpretation point to the need for improved health literacy among Senegalese older people, as a prerequisite for them to claim their right to

PS. Such policies have been proposed by WHO under the concept of “active ageing” (WHO, 2002)

However, this aspect of the capability approach has been critiqued as a paternalistic “false consciousness” argument that allows researchers and policy-makers to discount the meanings that underpin poor peoples’ decisions and actions (Deneulin & McGregor, 2010). Following this argument, educating older people about their need for publicly funded health services may perpetuate, rather than undermine, unequal power relations. From a social constructionist perspective, wide disparities between objective and subjective perceptions of ageing have been documented, suggesting avoidance of disability or chronic physical illness are not predictive of subjective successful ageing (Martinson & Berridge, 2015). Our study and other evidence from Senegal (Macia et al., 2015) similarly finds that older people were highly preoccupied with issues other than physiological health and access to health care, such as poverty and changes in social values.

Scholars have applied social constructionist epistemology to policy studies in order to analyse how discourses construct perceived realities. They find that changes in discourse regarding the social position of groups, achieved for example through media narratives or policy entrepreneurs, can shift these groups from low to high political power and help them benefit from public policies (Pierce et al., 2014). Following this social constructionist paradigm, in terms of policy implications, rather than educating older people to subjectively prioritize their health status, PS could be used as political platform from which to

claim the wider (non-medical) rights of older Senegalese citizens, regardless of their perceived need for health services. Further research is needed to explore this.

(iii) *Causes and policy implications of not accessing health services under PS, despite having the information and perceived need*

A third category of older people identified in the SSIs and FGDs were those who both knew about PS and perceived a need to utilise allopathic health services, but were nevertheless unable to access free services at the point of use under PS. Older people's explanations for this lack of access varied greatly but can be divided into two broad subcategories; (i) explanations that did not perceive there to be social exclusion at play (Table S1) [INSERT LINK TO ONLINE FILE TABLES S1 AND S2](#); and (ii) explanations in which PS was seen as socially exclusionary (Table S2) [INSERT LINK TO ONLINE FILE TABLES S1 AND S2](#). Again, the qualitative results help to explain the quantitative results, adding depth and a more nuanced understanding.

In terms of the first subcategory (no social exclusion) (Table S1) [INSERT LINK TO ONLINE FILE TABLES S1 AND S2](#), many pointed to lack of government funding relative to the high levels of demand for health services among Senegalese older people as the main reason for lack of access; in this case older people *wanted to use PS* but it was argued that there was simply not enough funding to cover all of Senegal's older population. In this case there was

exclusion but it was perceived as unintentional and no power relations were seen to be at play.

In the first subcategory there were also older people who *chose not to use* PS. There were many possible reasons given for this. One was that some older people were wealthy and therefore preferred to pay for private health care. Extreme poverty could in theory also result in a choice not to use PS, as some very poor older people were supposed to have access to social welfare. Some older people had access to alternative sources of funding for health care through a community-based health insurance scheme. Other informal solidarity mechanisms also sometimes replaced the need for PS. Another explanation was disillusionment among some older people who had heard that PS was dysfunctional or complex to use, for example due to the requirement to obtain a referral letter, and as a result had decided not to try to access it.

A further group in this subcategory was people who *were included* in PS but social exclusion was not perceived to be at play. In Senegal, IPRES (*L'Institut de prévoyance retraite du Sénégal (The Pension Insurance Institute of Senegal)*) provides free medical coverage to formal sector pensioners and their families. However, the IPRES centres did not offer a comprehensive set of health services; IPRES subscribers were therefore sometimes referred to other facilities, often public hospitals. Previously these services were paid for out-of-pocket. However, PS extended IPRES medical coverage to selected contracted public hospitals outside of its own provider network, funded by its own pension contributions. Furthermore, IPRES pensioners could also access the central government funded

services of Plan Sesame at other hospitals, by presenting their national ID card instead of their IPRES card. Many IPRES members in the SSIs and FGDs talked about successfully using PS. This explains the finding of the quantitative results that utilization of PS was higher among older people who had worked in the formal sector. This was interpreted in the quantitative study as indicative of social exclusion. Yet in the SSIs and FGDs, these people did not view themselves to be benefiting from unequal power relations and informal sector people did not accuse them of such. Many formal sector pensioners did not see themselves as privileged, complaining of serious financial problems due to their families relying on income from their pensions for survival due to high levels of youth unemployment. Furthermore, they often complained of the same social exclusion from PS as informal sector older people (e.g. financial barriers, bureaucratic barriers and patronage (see below)).

Finally, many older people stated that PS is only available to those who have a friend or relative working at a hospital; this was seen as a way of informally rationing limited resources (Table 1) [INSERT LINK TO ONLINE FILE TABLES S1 AND S2](#). Several participants described this process as the “*system camarade*” (“buddy system”). This meant that by default, many of those who used PS were from high socioeconomic groups, since health workers and their friends and family were usually from those groups. This could help to explain the quantitative results and be interpreted as indicative of social exclusion. However, under the “buddy system”, access to PS was organised through prevailing social norms around affective relations; these were in general viewed in the SSIs and FGDs as beneficent, desirable and moral and not socially exclusionary.

Furthermore, local state officials who practiced the “buddy system” were perceived to be under great financial pressure to ration free care due to poor financial practices at the central state level.

Within the second subcategory of explanations (i.e. the perceived presence of social exclusion) (Table S2) [INSERT LINK TO ONLINE FILE TABLES S1 AND S2](#), as mentioned above, some older people expressed the view that corrupt doctors and other local state employees intentionally denied patients access to PS as they were diverting the funds allocated to the PS programme for their own benefit. Others argued that the central state administration was corrupt and had misappropriated the funds for PS. Others suggested that the cause of poor PS rollout was that it had become politicised and opponents of the government ruling party had blocked it. These explanations point to social exclusion, as lack of access was perceived to be caused by unequal power relations.

A further major way in which social exclusion was seen to affect access to PS was through patronage (Table S2) [INSERT LINK TO ONLINE FILE TABLES S1 AND S2](#). Several people reported that they had successfully accessed PS due to their elite status. This system of social networks was described by some interviewees as the “*bras longue*” (“long arm”), perceived by many to be part of a wider system of patronage and corruption in Senegal. In several FGDs, it was reported that people who were not part of the “long arm” system were excluded from accessing PS. This may explain the finding of the household survey that being a member of sociocultural associations and relatively high political and civic participation was indicative of better access to PS. People clearly differentiated

between the “long arm” system and the “buddy system” as two different types of social networks; even those who denounced the “long arm” system approved of the “buddy system”. This nuanced understanding is missing from the quantitative results, which do not distinguish between the two systems. Also missing are the mixed feelings about the “long arm” system; some of the privileged people who benefited from it did so reluctantly and said they believed it was morally wrong. This can be seen as adverse incorporation into to PS.

In almost all FGDs and in many interviews, it was apparent that (ironically) money was needed to access free care under PS. One reason was to cover the costs of travel to the hospital. Another reason was due to the poor design of the policy. People pointed out that even though the hospital fees are covered by PS, the scheme did not cover out-patient prescriptions. Money was also required to access PS due to the need to provide under-the-table payments. Some believed that using PS had led to worse quality care than if user fees had been paid. Furthermore, money was said to be needed to afford nice clothes so as to dress appropriately for a hospital visit, in order to give the impression to health workers that you expect to be well taken care of. A lack of economic capital could also be seen as an indirect cause of exclusion from PS due to shifting social values which held wealth to be a source of respect. Participants of almost all FGDs said that values in Senegal had changed and elders were no longer respected. They often pointed to the example that people no longer gave up their seat for them on the bus – this was an additional barrier to accessing health services.

Many complained that using PS entailed a great deal of time consuming bureaucracy, traveling long distances to obtain referrals, getting up very early in the morning in order to get to do so and to beat the long queues, queuing for hours, being sent from one hospital / office to another, and so on. Being sick and elderly made this especially arduous. Once the appointment had been made, waiting times to receive the service could be several months. This resulted in adverse incorporation into PS. These problems were exacerbated among older people who lived in remote rural areas (reflecting the quantitative results regarding urban / rural differences in access).

Arduous bureaucratic procedures also disproportionately affected those who lacked assistance from their children to accompany them to hospital or care for them. Some elders described these intra-household dynamics as being caused by unequal power relations. For old men, a lack of social support could occur because they had lost power in the household due to their lack of financial income. Others saw the exclusion of old men as part of a wider shift in social values, caused by the empowerment of women and children through modern education.

Sen's capability approach (1999) is again useful for interpreting these empirical results in order to identify underlying causal mechanisms from a critical realist perspective. This interpretation of our results is supported by a recent realist review of user fee removal in SSA (Robert et al., 2017). Sen provides five underlying reasons why people may not actually achieve developmental ends (in our case accessing PS), despite having the means to do so (in our case albeit

limited public funding and information). The first is “*environmental diversity*”. We found this to reduce people’s capability to access PS, due to the lack of health service provision in rural areas, with resulting high travel costs to urban health facilities and bureaucratic procedures that exacerbated the problem. Sen’s second reason is “*personal heterogeneity*”. This also differentially affected people’s ability to access services under PS; those with greater physical impairments found geographic barriers more difficult to overcome. This points to a need for policies to redress geographic barriers to health care; these are extensively elaborated in the international literature, especially in terms of expanding primary health care (World Health Organization, 2008). Our results point to a further need for less arduous bureaucratic procedures in PS that do not discriminate against people living in remote areas.

Sen’s third reason is “*differential distribution of resources and capabilities within the family*”. In our study this caused an inability to access PS by older people who lacked support of other household members. Intra-household discrimination is at the core of Sen’s analysis, especially as regards women. Robeyns (2003) has described this an “ethically individualistic” approach which “*rejects the idea that women’s well-being can be subsumed under wider entities such as the household or the community, while not denying the impact of care, social relations, and interdependence between family or community members*” (p. 65). The same could be argued as regards older people in this study. Policy implications include the need for social assistance and transportation for older people who cannot rely on family members to accompany them to hospital.

The fourth reason is “*variations in social climate*”. The use of PS to extend coverage by IPRES members could be categorized as such, since people covered by IPRES were already familiar the health system; they therefore operated in a different social climate to people in the informal sector. This inequity would be resolved if access problems for the informal sector were reduced. Alternatively, IPRES members could be excluded from accessing PS services funded by general taxation.

Our results on the “long arm” and “buddy system” suggest individuals without certain types of social networks lacked the capacity to access PS. Street-level bureaucrats such as health workers and administrators unofficially perpetuated exclusion by reflecting the prejudices of their society through their position, by requiring different criteria for accessing PS, in this way institutionalising discrimination. This has been documented in other literature on user fee exemptions (Ridde et al., 2012) and on the Senegalese health system (Foley, 2010; Jaffre & Suh, 2016) and can be categorized as an example of Sen’s fifth reason; “*differences in relational perspectives*”.

Kabeer’s framework provides further insights; the “long arm” system can be interpreted as a form of social closure, as health workers were accused of deliberately discriminating against people who were not part of the elite patronage system. The “buddy system”, on the other hand, could be an example of the mobilisation of institutional bias. People who used the “buddy system” believed their actions were moral. However, one could argue that in fact they were perpetuating social exclusion without intent, since friends and families of

health workers were likely to be from relatively privileged socioeconomic groups. Relatively good access to PS by IPRES members could be another example of mobilisation of institutional bias, as they did not perceive social exclusion to be at play.

Those who were not party to the “long arm” or “buddy” systems relied on under-the-table payments to access PS. This reflects evidence that the poor are relatively more prone to having to pay bribes to government officials in health and other public sectors in Africa (Justesen & Bjørnskov, 2014). This was likely to exacerbate inequity.

Jaffré and Olivier de Sardan (2003) point to the historical legacy of the “practical norms” underpinning these types of corruption and discrimination in the public sector in Senegal and West Africa more widely. These norms were originally adaptations developed by colonisers in order to transcend the public / private boundaries of the bureaucracy imported from Europe. They show ethnographically how these practical norms continue to be passed from one generation of health workers to the next, as newly qualified personnel were berated by their seniors if they deviated from them. They conclude that medicine in West Africa suffers from an “ethical deficit”.

Policy recommendations typically proposed to redress these types of corruption include monitoring, auditing, financial and non-financial incentives and sanctions, advocacy workshops and training (Vian, 2008). However, these tend to have limited success. Olivier de Sardan rather recommends an open and

honest discussion about ethics in health service provision (Olivier de Sardan & Ridde, 2015) in the “language of truth”, without the “doublespeak” that he argues is common in administrations and interactions with donors (Jaffré & Olivier de Sardan, 2003). Similarly, Sen (1999) argues each society should determine which capabilities public policy should promote, through a process of public reasoning or public discussion. However, this critical realist approach has been critiqued as idealistic, as it underestimates the power that lies behind the meanings that can be brought to bear in processes of public reasoning and deliberation (Deneulin & McGregor, 2010).

In contrast, a social constructionist analysis questions whether a consensus or “language of truth” of this type is possible. For example, cases of adverse incorporation (Hickey & du Toit, 2013) put into question whether inclusion into PS was desirable, as PS was argued by some older people to provide poor quality of care relative to paying for services with user charges. In terms of corruption, social constructionists question whether it would be possible, or even desirable, for all stakeholders in the PS system to definitively denounce the “long arm” and “buddy” systems. These systems were seen by many as the only way to survive in a failing health system, while the “buddy system” was widely perceived as moral. There are numerous similar sociological and anthropological examples of the social constructedness of corruption in SSA (D. J. Smith, 2007) and internationally (Granovetter, 2007).

Eschewing a single definition of corruption, in an ethnography of professional associations in the construction industry in Tanzania, Koechlin (2013)

conceptualises corruption as an “empty” signifier that is filled with different meanings at different times, alternately enabling and preventing social actors to articulate wider democratic claims. She interprets corruption “*as a discursive representation that creates the possibility of public spaces and discursive interaction*” (p. 87). In her case study, anti-corruption discourses are eventually appropriated and transformed by the state and, ironically, used to disempower the very actors seeking to make democratic claims. Indeed, it has been argued that anti-corruption measures and discourses may obscure the core problems of politics and ethics (Bukovansky, 2006). Thus, from a social constructionist policy perspective (Pierce et al., 2014), Senegalese older people should only seek to establish consensus on corruption in the health system if this discourse is likely to improve their social position and power relations. If strategies that accept corruption were more likely to yield positive results in terms of older people’s empowerment, then these would be viewed as more effective. In other contexts, social constructionist scholars have observed that socially excluded citizens can appropriate and transform powerful medicalizing discourses that initially seek to obscure their wider political rights, in order ironically to argue for those very rights (Fassin & Rechtman, 2009). Further research is needed to explore this policy approach in the context of PS.

4. Conclusions

Three main hidden generative causal mechanisms of social exclusion from PS are identified in this study. One is lack of capabilities, entailing the combination and

interaction of individual-level capacities and individuals' relative position vis-à-vis social structures. The two further, more specific causal mechanisms are mobilisation of institutional bias and social closure, whereby social exclusion is caused by conscious or subconscious discrimination. These three causal mechanisms are rarely acknowledged in research and policy literature on user fee removal or UHC.

Several recommendations for PS are derived from this critical realist analysis, including the need to: ensure sufficient funding; diversify information dissemination channels; improve health education among older people; redress geographic barriers to health care; simplify or remove bureaucratic procedures; assistance and transportation for older people to reach health facilities; possibly disallow eligibility for IPRES members; improve quality of care; change discriminatory attitudes and corrupt practices of health and political personnel through monitoring, auditing, financial and non-financial incentives and sanctions, advocacy workshops and training and / or truthful public debate about the ethical deficit in health service provision. However, reforming PS in these ways is likely to be difficult, as many of these recommendations imply a need for wider health system reform. Indeed, the barriers to accessing PS were in many cases similar to pre-existing barriers to accessing health services in general (e.g. poor geographic access, corruption) (Foley, 2010). Rather than removing these existing barriers, PS often exacerbated them or created new ones such as lack of information and a bureaucratic referral process. A different approach to UHC may therefore be needed to underpin the above-mentioned health system reforms; instead of removing user fees for a comprehensive

benefit package targeted at specific population subgroups (as in the case of PS and other user fee exemptions in Senegal), the government might consider removing fees for a basic package of essential health services for the entire population. This has been the approach taken in Mexico, for example (Jamison et al., 2013). This alternative approach to UHC is comparatively administratively simple, as a separate referral and financing system would not be needed for each exempted population subgroup. It would also be easier to inform the population about the policy, as all citizens would have the right to access the same benefit package.

We also employ a social constructionist perspective whereby the idea of a universal or “true” causal framework for inequity in PS is rejected. Rather, the contested nature of health, wellbeing and corruption discourses in PS is seen as part of an inevitable ongoing process of power and resistance that sustains certain forms of knowledge and practice. Policy implications deriving from this analysis suggest older people may benefit from appropriating and transforming discourses in PS, in order to improve their social position and power relations, and exercise their rights as Senegalese citizens in both medical and non-medical spheres. For example, rather than educating older people to subjectively prioritize their health status, PS might be more successfully used as political platform from which to strategically claim the wider (non-medical) rights of older Senegalese citizens, regardless of their perceived need for health services. Similarly, rather than attempting to reduce corruption, strategies that accept corruption might in practice be more effective in promoting older people’s empowerment. Such appropriation and transformation is likely to be

challenging, but it has been documented in various contexts in relation to the medicalization of politically excluded populations (Fassin & Rechtman, 2009). These strategies are quite different to the policy implications deriving from the critical realist analysis. Researchers and policymaker therefore need to be aware that choice of epistemological paradigm determines interpretation of causes of inequity and subsequent policy recommendations for implementing UHC. In practice this requires adopting a multi-epistemological approach to commissioning, designing and / or interpreting research on inequity, as in our study. Lack of attention to these epistemological issues in evidence-based policymaking may be one of the reasons why in Senegal, as elsewhere in LMIC, UHC policies are not experiencing widespread success.

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Removing user fees for health services: a multi-epistemological perspective on access inequities in Senegal

Highlights

- Uses qualitative methods to explain and deepen findings of a household survey
- Finds that a user fee exemption often exacerbated barriers or created new ones
- Identifies causal mechanisms for social exclusion from user fee exemptions
- Compares social constructionist and critical realist approaches to causality
- Argues that epistemological perspective determines policy implications