Working Paper Series 2016

No.16-177

What causes inequity in access to publicly funded health services that are supposedly free at the point of use? A case of user fee exemptions for older people in Senegal

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Abstract

Plan Sésame (PS) was launched in 2006 to provide free access to health services to Senegalese citizens aged 60 and over. As in many countries, this user fee exemption is marred by inequitable implementation. This study seeks to identify underlying causal mechanisms to explain *how and why* some people were relatively less likely to have access to publicly funded health care. Explanations identified in focus group and interview data are organised into four themes: (i) PS as a poorly implemented and accessed "right" to health care; (ii) PS as a "privilege" reserved for elites; (iii) PS as a "favour" or moral obligation to friends or family members of health workers; and (iv) PS as a "curse" caused by adverse incorporation. These results are analysed through critical realist and social constructivist epistemological lenses, in order to reflect on different interpretations of causality. Within the critical realist interpretation, the results point to a process of social exclusion. However, this interpretation, with its emphasis on objective reality, is contradicted by some local, subjective experiences of inequality and corruption. An alternative social constructionist interpretation of the results is therefore explored; it is argued this may be needed to prevent relatively powerful actors' versions of the truth from prevailing.

Keywords

1. Introduction

The struggle for universal health coverage

It is now widely accepted that user fees for health care, introduced in many low and middle-income countries (LMIC) during structural adjustment in the 1980s and 1990s, increase poverty and reduce health care utilisation (World Health Organization 2010). In light of this, in 2005 World Health Organization (WHO) member states committed to achieving universal health coverage (UHC) to ensure that all people have access to quality needed health services and are protected from the financial hardships of health care costs (WHO 2005). This commitment has been reaffirmed by numerous reports, declarations and targets, including the Sustainable Development Goals (United Nations General Assembly 2012). Even the World Bank has backtracked on its policy of user charges, declaring in 2001 that *"Out-of-pocket payments for health services – especially hospital care - can make the difference between an household being poor or not"* (Claeson, Griffin et al. 2001) and more recently that *"Even tiny out-of-pocket charges can drastically reduce their use of needed services. This is both unjust and unnecessary"* (Kim 2013). However, although many LMIC have implemented financing mechanisms to initiate progress towards UHC, evidence on their effectiveness shows mixed results at best, with many studies indicating that many UHC policies have failed to reach their objectives (Spaan, Mathijssen et al. 2012).

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) form a key pillar of national UHC policy in many LMIC, including in sub-Saharan Africa (SSA) (for example health systems in Benin, Burkina Faso, Burundi, Ghana, Kenya, Liberia, Lesotho, Mali, Niger, Nigeria, Senegal, Sierra Leone, Sudan and Zambia have all introduced user fee exemptions) (Yates 2009, Richard 2013, Ridde, Agier et al. 2015). Internationally, user fee removal has had some success; in some cases it has been found to increase utilisation for the exempted services, but in many cases it has been marred by poor implementation (Ridde, Robert et al. 2012).

This study focuses on a user fee removal policy in Senegal. As in most LMIC, 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% (World Health Organization 2013). This is relatively low compared to the average for SSA (54.9%), but high compared to East Asia and Pacific (32.4%) and Europe and Central Asian regions (24.6%) (World Health Organization 2013). 78.5% of private expenditure on health in Senegal is spent directly out-of-pocket as user charges (World Health Organization 2013). Out-of-pocket expenditure is the main source of funding for ambulatory care and drugs, while government funding is focused on hospital care (Ministère de la Santé 2005).

In order to reduce these high levels of out-of-pocket spending, Senegal has introduced a set of user fee exemptions targeting a variety of different

population groups and health conditions: deliveries and caesarean sections; antiretroviral drugs; anti-TB drugs; severe malaria in children and pregnant women; the elderly; and indigents) (MSAS 2007). However all these initiatives are experiencing difficulties with implementation (Soors, Devadasan et al. 2010), as health service providers continue to charge fees to supposedly exempted patients or for supposedly exempted services.

This study analyses the difficulties implementing one of these policies, Plan Sésame (PS). PS is a user fee exemption policy launched in Senegal in 2006 which aims to provide free access to publicly provided health care services to all Senegalese citizens aged 60 years and over – an estimated 5.9% of the total population of the country. PS has received insufficient funding by the state (Leye, Diongue et al. 2013, Mbaye, Ridde et al. 2013). This has led to the implicit rationing of the limited resources which are made available only to some of the target population and only some of the time, often at the discretion of local health managers and service providers (termed "street level bureaucrats" in some literature (Walker and Gilson 2004). Implicit rationing is common in publicly funded health services (Ham and Coulter 2001) and has even been advocated as a means of enhancing equity (Mechanic 1997) in high income country contexts. However, in Senegal, implicit rationing of care provided under PS has not affected the target population equally; an evaluation of PS suggests great inequity in access the limited funding for free health services.

In a recent survey of 2,933 households in four regions of Senegal, Parmar et al (Parmar, Williams 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 an ID card that is needed to prove their age in order access the Plan). Having the following characteristics all statistically significantly increased a person's odds of enrolling in Plan Sesame: 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 population was found to have ever used PS to access free health care (Ndiaye, Ba et al. 2014). Utilisation was also highly inequitable, with wealthier, urban, formal sector people being more likely to access free health care under PS than their poorer, rural, informal sector counterparts (Ba, Dkhimi et al. 2015).

These findings echo those of other studies of user fee exemptions in LMIC – for example in Ghana, Senegal and Sierra Leone removal of maternity fees at the point of service increased facility deliveries across the socioeconomic gradient, but it did not reduce inequalities defined by household wealth and may have even contributed to a widening of educational inequalities (McKinnon, Harper et al. 2015); although in contrast in Burkina Faso no inequity in access to exempted services was identified (Ridde, Agier et al. 2015).

Understanding the causes of inequalities in health and access to health care: theoretical debates

The quantitative analysis of PS described above (Parmar, Williams et al. 2014), as with other regression analyses of health inequalities, is conducted in the positivist tradition of constructing 'objective' realities or prototypes based solely on observable phenomena. However, this type of analysis does little to reveal the underlying causal mechanisms that might explain *why* some social groups experience inequity (Popay 1998, Wainwright and Forbes 2000, Hickey and du Toit 2013). Recent developments within positivist research seek to integrate survey or experimental data with psycho-social theories to explain inequality in the health field, notably in the fields of social epidemiology (Kawachi, Kennedy et al. 1997, Wilkinson and Marmot 2006). Yet social epidemiological studies have been critiqued as being ultimately inadequate for understanding causes of health inequalities due to: lack of validity of survey data; lack of evidence to support the claim to universality of the proposed relationships between social status, internal psychological dynamics, culture and health; and the lack of analysis of dynamic relationships between social classes in terms of power relations such as exploitation (Forbes and Wainwright 2001, Muntaner, Ng et al. 2015).

The health field is increasingly engaging with the idea that the positivist disciplines that dominate in public health (such as biomedicine and epidemiology) are useful for understanding *patterns* of health inequality (for example the powerful finding that income distribution is positively correlated with negative health outcomes) but are inadequate for explaining the *causes* of health inequality (Wainwright and Forbes 2000) and the complex social and political phenomena occurring in health systems (Gilson, Hanson et al. 2011). These critiques have increasingly led to calls in the health field for the use of alternatives or complementary approaches to positivism, such as interpretivist, social constructivist and critical realist philosophies of science (Wainwright and Forbes 2000, Gilson, Hanson et al. 2011, Muntaner, Ng et al. 2015).

The hypothesis proposed by Parmar et al (2014) to explain the patterns of inequity observed in their results is that social exclusion causes the inequitable access to PS. Following the WHO's Social Exclusion Knowledge Network, they define social exclusion as*: "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"* (Popay 2008). The purpose of this present study is to explore their hypothesis and identify whether unequal power relationships are indeed the cause of the observed inequity, and if so, how and why they occur. Following Popay (1998), one important way in which we seek to address these limitations of quantitative surveys of health inequalities is by exploring explanations derived from lay knowledge and cultural practice in the context of a specific time and place. In doing so we adopt a commonly employed methodology in social science to uncover underlying causes of patterns identified in quantitative studies; "mixing methods" (Creswell 2009). We complement the quantitative data from the Parmar et al study with qualitative data collected as part of the same research project (the EU funded research project "Health Inc"
http://cordis.europa.eu/result/rcn/58135_en.html).

As such, the approach taken in this paper takes lay knowledge as its starting point. Yet, we argue this is not enough. We heed Hickey and de Toit's critique of mixed methods research in their analysis of social exclusion and adverse incorporation, where they argue that "*causality is not something that can be positivistically uncovered by empirical research alone. Neither the correlations generated through statistical analysis of quantitative data nor the descriptive accounts of poor people themselves can on their own be claimed to reveal transparently the causal mechanisms through which poverty (or any other social state or process) is created, maintained or reduced."* They argue that because *"poverty is embedded within and reproduced by broader societal processes",* studies of the causes of social exclusion require "*comparative, historicised and theoretically-oriented forms of research"* (Hickey and du Toit 2013).

Qualitative research on health and health systems is often conducted in interpretivist and social constructionist traditions, within the disciplines of medical anthropology and medical sociology. This can produce the type of comparative, historicised research called for by Hickey and du Toit. In contrast to positivism's concern with the identification of objective truths, interpretivism and social constructionism aim to *"socially construct detailed pictures of human activity, contextually, to capture the social meaning of that activity as it is defined by the cultural and sub-cultural tendencies of a given social group by the participants"* (Wainwright and Forbes 2000). Simply put, social constructionist philosophy opposes positivism and the idea that the nature of the world can be revealed by empirical observation alone; it counters the notion of universal human social or psychological traits, instead emphasising cultural and historical specificity; it argues that knowledge is created and sustained through daily practice; and it argues that social constructions sustain some forms of practice and exclude others and that this process of sustaining and excluding entails power and resistance (Burr 2015). Indeed, social constructionism *"distances itself from causal and deterministic models of psychology and social phenomena and prefers theoretical models emphasising the interrelatedness and inseparability of these"* (Burr 2015)*.* Furthermore, social constructionists argue that any attempt to think or talk about the real world is necessarily mediated by discourse and that it is therefore impossible to objectively identify the "real"[1] (we return to the issue discourse below).

However, the social constructionist approach seems ill-suited to exploring the social exclusion hypothesis set out earlier. This is largely because the social exclusion concept seeks to provide a general comparative, or even universal, framework that can explain inequity in a multiplicity of contexts, as explained by Popay: *"Diversity in the meanings attached to the concept of social exclusion should not be allowed to mask the commonality of exclusionary processes around the world and their fundamental expression, in terms of inequalities in human dignity, human rights and human health"* (Popay 2008). Similarly, echoing wider

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[1] Contrary to the often caricatured portrayal of constructionism, most social constructionists do not deny that a "real" world may exist beyond the discourses that socially construct it (Burr 2015).

critiques of interpretivism and social constructionism (Sayer 2000), Wainwright and Forbes argue for the need for studies of health inequalities to take into account *"broader social forces which may be beyond the consciousness of those (study) participants"* (Wainwright and Forbes 2000). As such, this paper primarily adopts critical realism[2], the other main epistemological approach that has the potential to produce the type of research called for by Hickey and du Toit. Critical realism has increasingly been promoted and adopted in health systems and public health research (Wainwright and Forbes 2000, Lacouture, Breton et al. 2015, Molnar, O'Campo et al. 2015, Muntaner, Ng et al. 2015), including in relation to user fee removal (Robert, Ridde et al. 2012). Like social constructionists, critical realists reject the notion that measuring the relationship between observed independent and dependent variables in a positivist fashion can reveal causal mechanisms. As such, the two epistemological approaches have a lot in common. Yet, unlike social constructionists, critical realists do believe there is a reality that can be objectively identified. For this reason, critical realism is sometimes (simplistically) described as the "third way" between positivism and interpretivism (Wainwright and Forbes 2000).

For critical realists, the observed actions and spoken explanations of actors (research "subjects") are important for different reasons than in the case of social constructionism. Critical realists argue that lay knowledge forms the empirical basis for the identification of *mechanisms*. The observed patterns can be compared to other contexts in order to identify those mechanisms that are reoccurring. As such, critical realism is a philosophy of science that locates causal relationships at the level of generative mechanisms rather than at the level of events (Bhaskar 1975). In order to understand causality in social science, critical realists typically argue it is necessary to identify *hidden or unobservable* mechanisms; these mechanisms are real but cannot be observed empirically. Critical realists therefore distinguish between three domains: the real, actual and empirical. The domain of the real refers to 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, such as changes that are observable (Bhaskar 1975). When activated, unobservable mechanisms will always generate outcomes; outcomes (unlike mechanisms) can potentially be observed empirically but in practice may not be observable as they may not be activated in a particular context, or may be activated at the same time as other mechanisms that obscure their effect.

Social constructionist and critical realist theories respectively can, in simple terms, be broadly linked to two distinct theories of power. Given the centrality of

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[2] Critical realism is one of many types of realism (Mahoney 2001, Gross 2009). The various strands of realism have much in common, but one major area of disagreement is on the issue of methodological individualism. Realists such as Hedström and Swedberg (1998) are methodological individualists; in contrast critical realists such as Bhasker (1975) argue that causal mechanisms need not be developed using a rational actor individual level analysis; rather social structures such as power relations can constitute generative mechanisms (Gross 2009). This paper adopts the latter approach, as the results of the study point to the importance of social structures as a causal mechanism, as explained in the Discussion section.

power in the concept of social exclusion to be explored in this paper, it is important to reflect briefly on these theories here, although the short discussion cannot do the issue justice; a more extensive exploration of power dynamics is undertaken in the discussion section. Social constructionists' analysis of power relations typically derives from the notion that *"discourses can be employed to keep people willingly in a condition of oppression by obscuring power relations"* (Burr 2015). In this sense, social constructionists are interested in unpacking ideologies, but their approach arguably tends to differ from the Marxist tradition of "false consciousness". Whereas Marxists and Neo-Marxists tend to believe there exists a real, material world in which a dominant class exploits others, but that people do not recognise and challenge this reality because it is obscured, social constructionists tend to take the Foucauldian approach that no such underlying reality can be discerned; rather they argue that there exist various "regimes of truth" where 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 in terms of a dialectical process and *"the person as being both agentic, always actively constructing the social world, and constrained by society to the extent that we must inevitably live our lives within the institutions and frameworks of meaning handed down to us by previous generations"* (Burr 2015)*.* In contrast, critical realists argue that social structures established by discourse constitute hidden or unobservable, yet real, causal mechanisms that exist outside of this discourse. Critical realists' emphasis on uncovering real underlying causal mechanisms is arguably more compatible with Marxist / Neo-Marxist theory and the false consciousness concept (although not all realists are necessarily Marxists). Both approaches have strengths and limitations: simply put, social constructionists are accused of being unable to ground their research in a political or moral stance and of therefore failing to promote empowerment; critical realists on the other hand are accused of "stopping conversations" by limiting what others can say, or who can be heard (Burr 2015).

Few studies of inequalities in health or health care access explicitly distinguish between these three epistemological styles underpinning social science (positivism, social constructionism and critical realism), explain their rationale for their adoption of one instead of another, or attempt to draw on the strengths of more than one of them (Wainwright and Forbes 2000). This study seeks to address this gap. By taking epistemological and ontological issues into account, this paper critically reflects on causality and power relations primarily through a critical realist lens - and highlights its strengths and weaknesses as compared to the other two epistemological styles in relation to understanding inequitable access to PS. The results of this study are discussed with reference to similar patterns of exclusion in other contexts and the wider critical realist literature on poverty and exclusion, in particular Sen's capability approach (Sen 2001) and Kabeer's social exclusion framework (Kabeer 2000). Although the mechanisms identified are found to be helpful in explaining the causes of inequity in access to PS, it is argued they ultimately fail to account for the multiple and contested understandings of phenomena that existed among interviewees. This is especially the case as regards understanding the role of corruption in the health

system. Following a social constructionist line of reasoning (Burr 2015), it is argued that a better understanding of often conflicting multiple realities may be needed to resolve the problems of Plan Sesame and UHC policy more widely.

2. Methods

Semi-structured interviews (SSIs) and focus group discussions (FGDs) were conducted over a period of six months during 2012 in order to find out *how* and *why* some types of elderly people are excluded from or included into Plan Sesame. A total of 34 SSIs with individual older people (aged over 60) were conducted across four regions in Senegal. Elder interviewees were drawn from the household survey which preceded the qualitative study and were purposively selected to represent a variety of profiles according to whether they had: been informed / not informed of Plan Sesame; had used / had not use health services in the last year; and had received / had not received a user-fee exemption. Other sociodemographic characteristics were also taken into account to obtain a range of interviewees (eg urban/rural; gender; formal/informal sector; socioeconomic group). Sample size was determined by the data obtained and data collection continued until saturation. The interviews lasted 30 minutes on average. Many of the interviewees were sick and very old, making it difficult to maintain a very long conversation.

A further nineteen FGDs with people aged over 60 were selected in each region studied in the HH survey. They were selected purposively to cover a wide range of social and demographic characteristics that may be related to the causes of social inclusion / exclusion: formal and informal sectors, gender, urban/rural, social status in the community, those who are in vulnerable situations (e.g. suffering from disabilities, members of "casted" groups) etc. In Dakar the FGDs took place in one neighborhood only (Pikine) due to the large size of the city. The FGDs lasted around one hour on average and were made up of around 12 people. Most were single sex. In several cases, FGD participants were drawn from local community associations. This meant that the participants in each group were familiar with each other and a free flowing discussion was generated among people who were used to debating with each other.

The SSI and FGD interview guides contained the following topics: social and economic status; perceptions of the ageing process; 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 performed qualitative data analysis of all transcripts applying both deductive and inductive coding using NVivo10 software. The interview guides, background literature and project objectives to study social exclusion were used to develop the coding frame. Wave one of the coding used this frame to deductively code the data. In wave two, 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 the new code added where appropriate.

Parent and child codes were linked using tree nodes. Both authors independently coded the transcripts and the coding was then consolidated and merged. Throughout the analysis, reflexivity was taken into account and the position of the authors in the interpretation of the data was taken into account. Results from the SSIs and FGDs are presented together.

In sum, using a concurrent transformative strategy design (Creswell 2009), the qualitative strand of the research aims to make sense of, and progressively deepen the results of, the quantitative household survey results (Parmar, Williams et al. 2014, Ba, Dkhimi et al. 2015), using deductive coding. Additionally the qualitative data are used to develop new understandings beyond the quantitative analysis using a second inductive wave of coding.

3. Results

Fifteen separate, although often interlinked, causes of inclusion in or exclusion from PS were identified across the two qualitative datasets. We also identified "parent" codes, which regroup the 15 causes of exclusion or inclusion into four broad categories: PS as "a right", "a privilege", "a favour", or "a curse". The results are presented under these four themes.

Before commencing with the main results, it is import to note that as a general observation, almost all the older people interviewed complained about having illnesses and disabilities. Many were quite fluent in describing their conditions, often elaborating on symptoms and diagnoses of chronic conditions like hypertension, heart disease and diabetes. Other common complaints were loss of sight, hearing and memory, as well as general aches and pains. Some also mentioned the difficulty of preventing the onset or minimising the severity of chronic diseases due to changes in their lifestyle brought about by modernity, such as a high salt and high fat diet.

Another general observation was that across almost all interviews and FGDs people reported a lack of resources to satisfy their basic needs, including needs in the domain of health. This was often the case even for higher socioeconomic groups. Almost all also complained of barriers to accessing health care imposed by user fees.

However, some interviewees had managed to alleviate some of these health problems and financial access barriers by using PS and through other means, while others had not. Explaining these differences is the objective of the following analysis.

3.1 PS as a poorly implemented and accessed right to health care

This theme groups together perceptions that PS is a right that is available to all older people in Senegal in principle, but not in practice as some people do not access this right either because of poor government implementation, because of

personal choice, or because of individual / household level difficulties. According to this view, the government is well intentioned but may be too inept or lacking in resources to deliver PS to some of those who are eligible. Others may fail to access care for idiosyncratic reasons that are beyond the responsibility of the state. Under this theme, no social exclusion was identified by interviewees. In their opinion, solving these problems would therefore not necessarily require changes in power relations or a fundamental redesign of the policy – in general interviewees seemed to think that simply better implementation, entailing a bigger budget and more information dissemination, could rectify the lack of access to PS.

Inclusion in PS as a result of making a rightful claim on the state

Several interviewees explained their ability to access free health care under PS as a result of making a rightful claim on the state based on their prior contributions:

I have used Plan Sesame… I had heart disease, they did a radiograph. I was told that I had to pay 30,000 CFA[3]… when I took bill … the man … said do you know how much this radiography normally costs? I said "No"! He said it cost 100,000 CFA. I told him "Why are you telling me that?" …. He said … "It's just that I want you to be thankful to the Government". I said, "Do you know how long I've been paying taxes? Even one percent of what I've paid in taxes does not amount to that"… (FGD, Association of District Delegates, Dakar)

Many of the older people who had not accessed PS, across various sectors and socioeconomic groups including informal sector workers, also expressed the view that they felt they had a right to access free health care and that the state should implement the scheme better so they could exercise this right.

Exclusion from PS caused by a lack of information

Some people pointed to the inadequate government information campaign as a cause of exclusion from PS. According to this view, more and better-targeted information about PS could enhance implementation.

It is… a communication problem because some do not listen to the radio or television. So they should have involved the town criers (FGD, Artisans, Diourbel)

They should do as it is done in censuses, entering homes… If they had proceeded in this manner, more people would know Plan Sesame. (FGD, Women's income generation group, Diourbel)

In contrast, some people who had benefited from PS several times with no problems thought PS functioned well and that information was key to its success:

When you go to the main hospital , you will find 100 people at the desk using PS because people talk about it on television, radio and even in ceremonies. In case of

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[3] 1,000 CFA is equivalent to around €1.50.

*illness, if you go to the clinic you will be given all the necessary information… you
can pass information to friends to use it too.* (FGD, female members of a CBHI
scheme, Dakar)

Exclusion from PS due to lack of government funding

Some pointed out that the lack of access to PS was caused by an insufficient
allocation of funding for the scheme by the central government.

*The (central government) administration owes billions to the hospitals, but the
administration cannot pay and the hospital must pay its employees and make
savings. The government then went on to say they will not pay (for PS). Also on
their side (the hospitals) say they will no longer accept the Plan. That's the
problem.* (FGD, men who attend public community meetings (les « Grand-Place
»), Dakar)

Others suggested that PS ran out of resources due to too much demand:

*There was a time when the hospital made a call to take care of the elderly for free .
But there was a rush and a lot of older people were not treated* (FGD, Women's
income generation group, Diourbel)

Exclusion from PS due to an incompetent bureaucracy

Many people expressed their frustration with the perceived red tape involved in
accessing PS, which required a referal letter from the health centre:

*I saw an elderly person who tore up the papers he had been given to benefit from
Plan Sesame. He did it because he was tired of the scheme making him go back and
forth* (FGD, CBHI scheme of the Agricultural Cooperative Insurance, Diourbel)

Self-exclusion from PS

The coding analysis suggested that some people who knew about PS chose not
use it. There were many possible reasons for this. One was that some older
people were wealthy and therefore preferred to pay for private health care:

Most users of Plan Sesame are poor because rich people do not need (it). (FGD,
Women's income generation group, Diourbel)

An example was one of the interviewees (EPA-C-DK-8), an elderly woman whose
husband had been in the army and who had lived in France who said that she
knew about but had not used PS, as she didn't need it. She said she was
supported by a large, wealthy family, as she had many children, some of whom
lived and worked abroad and sent remittances, while other relatives in Senegal
were working in the formal sector and provided her with funds to access health
care privately.

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 alternative forms of social protection, such as social welfare. However, although social services did in theory provide access to free health care, in practice access was often difficult due to bureaucracy and corruption (see below).

Many interviees said they used traditional medicine because they could not afford to pay user fees at allopathic providers (see below). However some said that older people *preferred* traditional medicine to allopathic, suggesting that in those cases, not using PS was a choice:

Sometimes some old people believe in traditional medicine more than hospitals; in terms of hospitals , people are afraid of operations, which sometimes go wrong and lead to death. (FGD, Artisans, Diourbel)

However in general traditional medicine was not perceived to be a good alternative to allopathic health care; many people complained that traditional medicine was of poor quality while others pointed out that it cannot treat modern diseases, suggesting they thought that preference for traditional medicine was ill-informed:

If you treat hypertension with traditional medicine, it will not heal (FGD, Women's association, Matam)

Some older people had access to alternative sources of funding for health care through a community-based health insurance scheme. They said their insurance provided financial protection from the cost of health care, yet many also reported using PS quite extensively. Other informal solidarity mechanisms also sometimes replaced the need for PS:

I had an accident. The whole neighborhood contributed and they gave me the money for the purchase of the prescription. You know, that's pure solidarity. (FGD, men who attend public community meetings (les « Grand-Place »), Dakar)

Finally, there was considerable disillusionment among patients who had heard that PS was dysfunctional and, as a result, did not even attempt to access it. For example, an elderly widow living a rural village in the Matam region (EPA-E-MT-20), who had worked in the informal sector, said that she had heard about PS by word of mouth but had been told that it did not function so had not tried to use it. She reported having considerable unmet need; she was sick with several illnesses and could not afford treatment.

Exclusion from PS due to a lack of social support at the household level

In general, helping elderly relatives was seen as a moral duty and households were perceived as a site of reciprocal social relations between generations:

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(When in difficulty) you do not call your… brother, but rather your father or grandfather… So if you do not support him, who is in turn going to help you? (FGD, Association of District Delegates, Dakar)

However, some elderly people reported difficulties in accessing care because they lacked assistance from their children to accompany them to hospital or care for them. This could act as a barrier to accessing PS. The interviews suggested that support within the family broke down for many reasons, several of which were not related to socioeconomic inequalities. Some said that older people who lacked support had only themselves to blame, as they had not fulfilled their own filial duties:

A wise saying is that you reap what you sow. I mean, those who are elderly and who do not have support at home, it is because… when they were young , they did not care for or respect their parents. They end up paying for that when they are old. (FGD, Association of people living with a handicap, Diourbel)

Sometimes the causes of a lack of social support were difficult to ascertain from the interviews:

Interviewee: … You need to have money to go to hospital or have someone to take you. And I have no one who can take me to the hospital… At the beginning my son took me, but he doesn't anymore.
Interviewer: Why?
Interviewee: Honestly, I don't know why… If I had someone who could take me there I'd go, but I have no one who can take me. (FGD, Association of handicapped women, Dakar)

There could be several interpretations of this dialogue. The woman may know why her son didn't take her, but may not be willing to explain in the FDG. Or she may not know and may not be able to discuss the reasons with her son. This illustrates that some "causes" of lack of access to PS relate to intimate aspects of people's lives which they are not willing to reveal to researchers. The interviewees expressed this on several occasions, for example:

For all that is said, there are still many other things; we just told you the essentials but there are things that a person lives with and never dares to speak about… (FGD, Association of District delegates, Dakar)

3.2 PS as a privilege reserved for elites

This theme brings together codes that identify conscious or subconscious discrimination by those in charge of implementing PS as the cause of exclusion from PS, from the perspective of the interviewees and/or the authors. According to this view, PS is perceived to mainly to benefit privileged people and social groups, either through misappropriation of resources or selective distribution of resources. From this perspective, accessing PS entailed a (mostly failed) struggle over resources by less powerful groups vis-à-vis more powerful social groups

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who controlled PS resources. In order to succeed in this struggle, social structural changes such as empowerment of the less powerful and explicit redistribution of health care resources from more to less wealthy would be needed. Because of this requirement, the design of the PS policy itself was seen to be inadequate, as it did not make provisions for such social structural changes and redistribution.

Exclusion from PS due to misappropriation of PS funds by health workers and other state employees

Many interviewees expressed the view that doctors and other state employees were misappropriating the funding allocated to the PS programme:

They have not communicated about Plan Sesame. Doctors do not talk about it. Social workers do not talk about it. District leaders do not talk about it. They do not because they monopolize the benefits. They hide Plan Sesame. (FGD, Association of people living with a handicap, Diourbel)

Many interviewees perceived doctors' corruption to be the source of poor implementation of PS:

President Abdoulaye Wade has certainly put forward the idea (of PS) but it is the people who must implement it that do not do it well, namely the doctors… Only money interests them, if you give them their 50 000frs they will look after you. If you give them nothing they will not treat you. (FGD, men who attend public community meetings (les « Grand-Place »), Dakar)

Corruption was perceived to occur not only in relation to PS but also in relation to other forms of health care user fee exemption:

You know as well as I do that cesareans are free, but they (midwives / doctors) still bill our wives … there are… people who pay and then the state subsidizes the cesarean section. (FGD, Association of people living with a handicap, Diourbel)

The social center puts you in touch with the social department of a hospital but with the back-and-forth you finally get tired and give up. Sometimes they give you a prescription and you go to the pharmacy. But it's a scam. You present your prescription at the pharmacy, they give a paracetamol tablet and you're told that they don't have the rest. Yet they get reimbursed for the prescription as if they gave you all the drugs. (FGD, Association of people living with a handicap, Diourbel)

Doctors were thought to practice fraud by inducing demand:

Interviewee: Sometimes he (a doctor) prescribes you something knowing that there is no hope of recovery . You're wasting your money.
Interviewer: Why do they do this?
Interviewee : The health service providers have no pity. Life is hard. (FGD, Women's income generation group, Diourbel)

In other contexts medical personnel were found to be behaving correctly while other types of state personnel were blamed for the lack of access to PS:

They must appoint someone to take care of PS, especially for disseminating information. At the Diourbel clinic, there is someone like that. They do a really good job, they even went into rural areas to inform the elderly… But this message was not passed on. Even with the neighborhood delegates it is the same… they do not spread the word, not even to their wives. (FGD, CBHI scheme of the Agricultural Cooperative Insurance, Diourbel)

One group had approached local politicians and bureaucrats to air their grievances about misappropriation of funds for free health care for the disabled, (a separate policy from PS), without success:

The Chief District Medical Officer hides things. The Regional Chief Medical Officer hides things. I'll give you an example, (the government)… issued a decree which stipulates that the disabled shall have the right to free care; when I asked the Chief Regional Medical Officer… he replied that it was true, but that he did not try to broadcast it. (FGD, Association of people living with a handicap, Diourbel)

In contrast, most interviewees who complained about misappropriation of government funds for PS did not report making an official complaint, rather accepting the local corruption as unavoidable and seeking alternative avenues to fund their health care:

"If the subsidy (for PS) gets here, it is the people who are in charge of that subsidy that will take it, to the detriment of others. We only get the information. That's what they do to us, but it doesn't change what I do. If there are subsidies that fail to reach beneficiaries, that's their issue, because on my side, there are good people who will come to my rescue." (FGD, Association of handicapped women, Dakar)

Others did not blame local state officials for the lack of access to PS, observing that these officials were themselves under great financial pressure to ration free care due to poor financial practices at the central state level. Several dysfunctions at the central state level were discussed. Some argued that the central government had the capacity to fund PS but was being neglectful participants in the FGDs pointed out that HIV and polio information campaigns seemed to be well funded and implemented, and that the lack of funding for PS must therefore be deliberate. Some suggested that the cause of poor PS roll-out was that it had become politicised and opponents of the government ruling party had blocked it. Others argued that the central state administration was corrupt and had misappropriated the funds for PS, as they did for social funding in general:

…when distributing aid the state gives it to the powerful who take half before distributing the rest. So that the aid does not reach us… this aid must be directly distributed to the populations concerned. (FGD, Association of town criers (traditional communicators), Diourbel)

In Matam, some argued that PS lacked resources because the funding for the programme did not reach their region under decentralisation:

I do not know if the government is against Matam… even if there is aid allocated for the regions, Matam is omitted (FGD, Association of retired civil servants, Matam)

Inclusion into PS due to membership of insurance for formal sector retirees

There was evidence in the interviews that certain types of privileged patients did manage to benefit from PS. One such type were formal sector retirees. 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. However, 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. For example, a widow who was a member of IPRES (EPA-A-DK-1) was happy to have received an operation to treat her goitre for free through PS, saying the cost of the treatment would normally have been 400,000 CFA. However, membership of IPRES was not a guaranteed route to accessing free care under PS, illustrated by the same widow who still had unmet need for health care:

Interviewer: What you can suggest to improve Plan Sesame?
Interviewee: They could help me to have an operation for my eyes, because 500 000 CFA, that's expensive… If I had the operation, we would have to pay that amount…
If eyes were part of PS, that would be a good thing.
Interviewer: Have you asked if eyes are part of it?
Interviewee: No, I have not asked them.

This problem of lack of information about the benefits of PS echoes the results in the previous section on PS as a poorly implemented and accessed right to health care – even relatively privileged people such as those with formal sector pensions did not necessarily have good access to PS. Additional barriers experienced by IPRES members are discussed below.

Exclusion from PS due to lack of patronage

Throughout the SSIs and FGDs, people generally complained of a patronage system in Senegal:

"Everywhere in Senegal… in all meeting places, offices etc., only rich people and those who have networks get the privileges and are treated well." (FGD, retired formal sector, Dakar)

Access to free health care was seen by many to be part of this wider system of patronage. Even some IPRES members, who had relatively good access to PS, complained about patronage:

The implementation of PS is a bit suspect. There is a partisan management that dare not speak its name. When you have someone who knows you, he supports you; if by bad luck nobody knows you, you are not supported. This is what I found. (FGD, Retired IPRES members (formal sector), Tambacounda)

A man who had received a free hernia operation under PS also complained of discrimination:

The referral forms (for PS)… (should be) entrusted to serious people because sometimes you come, they tell you that they have run out of their forms, while this is not the case. You see people who come next to whom they do give the forms. So there is a bias and the doctors should not do that. (FGD, men who attend public community meetings (les « Grand-Place »), Dakar)

Several people reported that they had successfully accessed PS due to their elite status:

I've used PS two times … I know a manager, a medical director who told me, " Sir , I'll do Plan Sesame for you." Twice in the past, but with difficulty. The guy told me that "we will do it for you because you're the boss". (FGD Association of retired state officials, Diourbel)

Some people who did not wield political power or have material resources to offer in exchange for patronage, could nevertheless possess extensive hierarchical social networks which helped them to obtain access to PS. For example, one interviewee (EPA-C-DK-9), a homeless indigent elderly imam of noble caste was temporarily living in a Quranic school and relied on alms to survive. He was, however, able to use PS thanks to his social networks, as he knew a doctor who helped him gain access. This system of social networks was described by some interviewees as the *"bras longue"* (long arm):

Having a "long arm" is to have someone to help you or assist you, to help you to obtain papers for example. (FGD, Association of taxi drivers of Tambacounda)

The "long arm" system was seen as a form of corruption:

…in the operation of Plan Sesame, it is as if there is a scam, a case of "long arms". (FGD, Association of taxi drivers of Tambacounda)

In several FGDs, it was reported that people who were not part of the "long arm" system were excluded from accessing PS, as observed for example by the imams in Tambacounda:

We see elderly people coming to the mosque with their medical bills, they are over 60 years old, yet they come to seek our help with the payment. We ask why they did not... use Plan Sesame, and they tell us "we would need a "long arm" to benefit".

People from all socioeconomic groups complained of not being able to access PS due to the "long arm" system, including formal sector pensioners. In one FGD an interviewee explained that he had a "long arm", which he used to assist people to obtain the necessary papers and negotiate access to PS on their behalf:

Most of the elderly people from rural areas , it is when they get here to Tamba that they are informed (about how PS works). Often, it's my brothers who ask me to accompany them to the hospital to guide them... some come without their ID card...they remain without care for three to four days while their ID card arrives. On the arrival of the identity card, I accompany them to the hospital to help them regularize the papers for the treatment... (FGD, Association of taxi drivers of Tambacounda)

It is unclear from this quotation if the interviewee performed this service free of charge or whether an informal economy had developed around PS, where people with "long arms" were hired as intermediaries to facilitate access.

There were mixed feelings about the "long arm" system, even among many of those who benefited from it. For example a village chief with a large social network and relatives living abroad who sent him remittances (EPA-C-TC-25) had used PS several times but said he felt it was morally wrong that he had accessed free care through the "long arm" system. Some retired formal sector workers, despite complaining about the "long arm" system, actually had benefited from it, in terms of access to PS. Others stated they thought these social inequalities were "natural":

Inequalities come from divine will. There are people who are high up, others low down and the rest in the middle. This is fundamental. (FGD, CBHI scheme of the Agricultural Cooperative Insurance, Diourbel)

Exclusion from PS due to lack of financial resources

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 hosptial. 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:

PS only facilitates small expenses, such as buying tickets which cost between 500 and 1000 F. This is helpful for a truly elderly person. But if you go and pay a ticket for 1000 or 500 F and then they prescribe medications worth 30-40 000F, there you

have problems paying the whole lot. In that case, there is no more social assistance. They (PS) just need to cover the whole lot. (FGD, Association of taxi drivers of Tambacounda)

Many informal sector interviewees complained of living in serious poverty, with no secure source of income. In contrast, the widow mentioned above (EPA-A-DK-1) was able to benefit from PS in part because she had funds to pay for the diagnostic tests (46 200CFA) and to take a taxi to the hopsital. She had several sources of funds: her deceased husband had been wealthy and left several houses to their six children, her daughter in law lived abroad and sent remittances, she had a pension and she was also able to work, until recently running a small tailoring business. When she started losing her sight, she was able to hire a tailor. She was also able to pay a maid to take care of her.

Money was also required to access PS due to the need to provide under-the-table payments:

The inequalities (in access to PS) are caused by… the types of relationships that doctors have with some patients. They favour certain people, those who use money to corrupt, to see the doctor. (FGD, Association of town criers (traditional communicators), Diourbel)

Money was also said to be needed to afford nice clothes so as to dress apporpriatley for a hopstial visit, in order to give the impression to health workers that you expect to be well taken care of.

Lack of financial resources to pay for access to PS affected both formal and informal sectors. Many formal sector pensioners complained of serious financial problems due to their families relying on the income from their pensions for survival. This was a source of great stress for many:

Pensions must be reviewed because they are insufficient. The day we receive our pension, is that day that we feel sicker; all our pathologies awaken from hibernation. We spend all day arbitrating between paying for bills and food. (FGD, Retired IPRES members (formal sector), Tambacounda)

Some pensioners said they didn't actually receive the pension payments that were owed to them by the state:

You see I have filed my papers but do not think I got something… I filled in all the papers, paid the postal checks, I paid even the papers of the court, but I still cannot recover my dues, and I'm tired. (FGD, Association of retired civil servants, Matam)

Participants of almost all FGDs complained about youth unemployment – even many IPRES members who had retired from formal sector jobs said they need to support their adult children financially, because their children could not find work. This explains why even formal sector IPRES members were not necessarily able to access PS due to a lack of funds.

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 or listened to their advice or instructions, as illustrations of this deteriorating respect. Some argued that the cause of this was that economic wealth has overtaken age as a marker of respect:

Today, people respect only those who are rich, whether they are an elder or not. (FGD, Artisans, Diourbel)

When asked for the cause, several interviewees blamed the capitalism system:

We are in a capitalist system which means that only wealthy people are respected. (FGD, Artisans, Diourbel)

This stands in contrast to the results reported in the previous theme where people without financial resources could nevertheless access PS due to their social influence and status. Similarly, others pointed out that financial resources alone were not enough to access PS, and that social support within the domestic sphere was also necessary (as discussed above):

Sometimes you're from a wealthy family, but the elderly person does not benefit from the help of his family. That happens. (FGD, Women's income generation group, Diourbel)

Exclusion from PS due to unequal power relations within the household

Some elders described 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:

The worst thing that happens to us is due to our wives. You made your way together with someone when times were good, but now that we're ugly and old, they avoid us... Now that we have nothing left, no strength, we are no longer important. (FGD, Association of District Delegates, Dakar)

The members of the Agricultural Cooperative Insurance of Diourbel 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. They also felt that elders suffered from poverty due to sacrifices they made for the young:

... when poverty is rife , it is the elderly who have small children who will feel it the most because they will sacrifice themselves for their children to survive. (FGD, CBHI scheme of the Agricultural Cooperative Insurance, Diourbel)

Exclusion from PS due to a lack of awareness of right to free health care or of the need for health care

Many interviewees were fatalistic about their lack of access to PS. They accepted their inability to access free health care, which was not perceived as a right:

Interviewer: What do you expect of the government in terms of health care? Interviewee: The government? In terms of health care, I expect the government to help us, that's what I think. If it helps me in terms of health care, I will take it, if it does not help me, I accept it and say, well it's me who cannot afford it. (FGD, female beggars, Dakar)

In some cases people expressed a religious fatalism, accepting the lack of access as God's will:

Interviewer: What can the government do to help (you to access health care)? Interviewee: Just help us! We are here, we are poor, we do not have the means. If it (the government) comes to our aid that's good. Anyone who is in power and that helps us is good. Whoever does not help us, we also know that it was God who decided. Yes, we will pray for every person that God put here, and if he does not do it (help), we shall say that God has decided it... (FGD, female beggars, Dakar)

These cases were interpreted by the authors as an example of social exclusion from PS, even though the interviewees did not necessarily perceive it as such. The ability to subjectively ascertain ones own need and right to access health care is a complex issue that is elaborated in the discussion section of this paper. This complexity was also illustrated by some interviewees who believed that some older people convinced themselves they did not need to access health care, so as not to be disappointed with the lack of financial access:

In Senegal, when you get sick you are told that you are old, it is old age that awaits you, whereas in fact you need treatment. Instead of going to the hospital, you prefer to stay home under the pretext that it's just old age... But to go to the clinic you need money, whereas we have nothing. Therefore, the one who should take you to the hospital will be content just to say that it is just old age. (FGD, female members of a CBHI scheme, Dakar)

3.3 PS as a favour or moral obligation to a friend or family member

This sub-section groups together a third set of perceived causes of exclusion from or inclusion in PS. Many interviewees stated that PS is only available to those who have a friend or relative working at a hospital. This meant that many those who used PS were elites, as health workers, and their friends and family, were usually from relatively high socioeconomic groups. As such, this cause could conceivably be included in the sub-section above which focuses on PS as a privilege. However, underprivileged people could gain access to PS under this theme, as the prevailing mechanism facilitating access was friendship and family networks rather than (or in addition to) patronage, hierarchical social networks, or financial resources. As such, under this theme, access to PS is organised through prevailing social norms around affective relations; these were in general viewed as beneficent, desirable and moral.

Inclusion in PS due to being a relative or friend of a health worker

There was a perception that health workers used PS and other user fee exemptions to provide free health care to their families and friends:

You will never see a doctor or midwife use their own money (as user fees) to take care of their own father or mother (FGD, Association of people living with a handicap, Diourbel)

Many interviewees talked about accessing PS with the help of a family member or friend:

I go to the Principal Hospital without difficulty because someone there is the son of my brother. Usually when I go there, I called in advance and ...he will help me so that I will not have any difficulty... I got hospitalized for two months, when I had to leave the care was valued at about 700.000f (€1,067) but I didn't pay anything ... If I had to pay, I would have died, because I do not have the money. All my wives, if they have problems, they go to the hospital and they are looked after... they pay nothing... (FGD, Association of District Delegates, Dakar)

Several participants described this process as the "*system camarade*" ("buddy system"), which was viewed as innate, or "God-given":

The "buddy system" has always existed. God created it... You will see a patient who has a doctor friend.... He feels ill, he called the doctor. The doctor will make an effort and go to see him at home. Sometimes, he will give him medication before leaving. This is the "buddy system"... if you're ill, you will go somewhere where you have a friend. (FGD, Artisans, Diourbel)

People differentiated between the "long arm" system and the "buddy system" as two different types of social networks:

Interviewee: X is a doctor, he was born and grew up here. He knows he has older brothers here who have seen him grow. That is why everyone will tell you that "I thank Dr X".
Interviewer: Does he take care of you?
Interviewee: Yes, but it is not a case of the "long arm", he is a friend... This is a network and the "long arm" is another network. (FGD, Association of District Delegates, Dakar)

Even those who denounced the "long arm" system, were glad to benefit from the "buddy system":

Interviewee: If you're not like them (the main Imam and the head of the district), you will not be able to have (PS) papers easily...
Interviewer: Have you ever tried to get the papers?
Interviewee: I've never tried because I know I will not get them, I am poor. But Dr X is like a son to me, and he helps me a lot. If I go to him without money he gives me

medicine anyway. (FGD, men who attend public community meetings (les «
Grand-Place »), Dakar)

As such, the "buddy system" was not seen as a form of corruption; rather, it was
perceived as acceptable, or even moral, for a health worker to give access to free
health care under PS to a close friend or relative.

3.4 PS as a curse

This theme puts into question whether accessing PS was necessarily desirable.
Many of those who accessed PS reported that they did so on adverse terms. As
such, although people seemed to be included, in that they did receive free care,
there were various costs such as poor quality of care, opportunity costs due to
long waiting times or high associated financial costs (see above), all of which
caused them to doubt the value of PS, and in some cases to cease using it
altogether.

Inclusion with long waiting times

Formal sector retirees complained that using PS entailed a great deal of time
consuming bureaucracy, traveling across town to obtain referrals, getting up at
4am 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. Once the service was received,
under the table or official co-payments were often requested, even though the
service should have been delivered free of charge. These problems were not
unique to PS; the formal sector retirees made similar complaints about using
IPRES.

Inclusion with poor quality of care

Quality of care could be poor; one man spoke of his wife dying, having been, in
his opinion, discharged from hospital too early after being in a coma for four
months. Some believed that using PS could lead to worse quality care than if user
fees were paid:

*The elderly person who shows up at the hospital with their own resources is taken
care of more carefully than the one that came to use PS. The one who pays directly
is better taken care of.* (FGD Association of retired state officials, Diourbel)

4. Discussion: How and why were people excluded from accessing free health care under the PS programme?

The results present a complex range of different causal explanations for the
inequity in access to PS observed in the household survey. Many of the

explanations were countervailing, contradictory or contested. Some of the causes, such as the "long arm" system, seemed to be driven by the types of unequal power relationships that underpin the definition of social exclusion (Popay 2008), but others, such as the "buddy system", widely perceived by interviewees as morally sound, did not. Although interviewees distinguished between the two systems, there was conceptually a great deal of overlap between them and it could be argued that based on a Weberian model of bureaucracy, the "buddy system" was unethical despite interviewees' subjective perceptions.

Some people said they did not expect free access to health care and were fatalistic about their lack of access to PS, while others were angered by the lack of access and complained about it to government authorities, albeit to no avail. Here again, it is possible to question the perspective of the interviewees, and argue that the fatalistic attitude was a form of false consciousness (Rosen 1996). In some cases, a person was both included and excluded in PS; for example they had successfully accessed PS once, but did not again, despite having unmet need. Or, they were included in PS, but on adverse terms (Hickey and du Toit 2013). In other cases, people did not know why they were excluded from accessing PS, or were unwilling to fully explain the causes of exclusion to the interviewer. Meanwhile some people blamed corrupt doctors and nurses for some patients' inability to access PS, while others said health workers' selective implementation of PS was caused by corruption among local or national government officials.

This Discussion section seeks to reconcile these differences in perspective or understanding across the fifteen various causes of inclusion in or exclusion from PS using a critical realist epistemological framework. However, as we proceed, we are also open to the possibility of the need to adopt a more social constructionist approach, as we recognise that causality is a long-debated and ultimately unresolved issue in social science and that no one framework is likely to provide a comprehensive explanation for complex social phenomena such as the one presented in this paper, and in health systems research more widely (Gilson, Hanson et al. 2011). According to the critical realist paradigm, the same mechanisms are likely to operate in many different contexts. We therefore sought to identify mechanisms in the existing critical realist literature and apply them to our data. In reviewing the critical realist literature on inequity, poverty and social exclusion, the work of two scholars, Amartya Sen and Naila Kabeer, seems to be especially pertinent to explaining our results. Of particular relevance is their engagement with the "agency-structure" debate in social science (i.e. whether social structures or individuals have primacy in shaping human behaviour) and also their interpretation of the "false consciousness" argument. We then move to a more historically oriented and contextual interpretation of the results, drawing again on the existing literature. Here the work of Olivier de Sardan and colleagues is used to explain how and why certain causal mechanisms emerged and persist in the Senegalese health system. Yet, as the analysis progresses, it becomes apparent that there are limitations in the critical realist interpretations of our data. At the end of this section, the social constructionist literature on corruption is therefore employed to address some of these limitations.

In sum, in the following paragraphs, the results of this study are linked to causal mechanisms and debates identified in the wider political, sociological, anthropological and economic literature, in order to explain how and why certain types of people were excluded from accessing PS.

Sen's capability approach

We start with the capability approach, pioneered by Amartya Sen (2005), which focuses on developmental ends rather than means by distinguishing between *"(i) whether a person is actually able to do things she would value doing, and (ii) whether she possesses the means or instruments or permissions to pursue what she would like to do" (Sen 2005).* In the context of PS, the capability approach shifts attention from the means to access health care facilitated by the PS policy and people's knowledge of it (the instrument or permission) and its requisite level of funding (the means), to whether people are actually able to use it to access free health care (the ends). Sen (1999) argues that people have varying needs and will therefore require different levels of resources in order to achieve the same standard of living. He gives five reasons why people may not achieve developmental ends, despite having the means to do so: (1) personal heterogeneity (physical and biological differences between human beings); (2) environmental diversity (differences in physical environments); (3) variations in social climate (different social contexts); (4) differences in relational perspectives (differences in customs that cause different requirements for achieving the same capability); and (5) differential distribution within the family (the same resources may not produce the same capabilities for all household members).

There has also been some debate over the extent to which the capability approach is explanatory. Some argue that it is a normative approach that helps to describe different forms of social exclusion but that it is not an explanatory theory for any social phenomenon (Robeyns 2005, Deneulin and McGregor 2010). As such, it may not be helpful for uncovering causal mechanisms for the inequity presented in this study. However, Smith and Seward (2009) argue the capability approach can be interpreted from a critical realist perspective since *"Sen's notion of capabilities is an ontological conception of a relational society. In this perspective, an individual's capabilities emerge from the combination and interaction of individual-level capacities and the individual's relative position vis-à-vis social structures that provide reasons and resources for particular behaviors. Crucially, this conception of society is predicated upon a contextual notion of causality that is flexible enough to incorporate both individual and social causes into social analysis".*

We find the capability approach useful for interpreting the results of this study. The lack of health service provision in rural areas, with the resulting (often prohibitively) high indirect travel costs of accessing urban health facilities incurred by rural residents and the bureaucratic procedures (e.g. the need for ID cards and referral letters) that exacerbate the problem by requiring people to repeatedly travel to and from health facilities, can be categorised under environmental diversity. The policies needed to redress geographic barriers to

health care in LMIC are well understood and elaborated in the international literature, especially in terms of the expansion of primary health care (World Health Organization 2008). Addressing administrative and bureaucratic barriers is more challenging as they are often viewed as necessary – many social health protection schemes use membership cards and referral letters to prevent leakage of benefits to those who are ineligible and to promote efficient use of health care. Yet there is a need to design less arduous procedures which do not discriminate against people living in remote areas.

The study's results on the "long arm" and "buddy system" suggest that individuals without social networks or money for patronage lack the capacity to access PS. This could be categorized as differences in relational perspectives. This has been found in other literature on user fee exemptions (Walker and Gilson 2004, Ridde, Robert et al. 2012). Kabeer (2000) has described this gaps between rules and their implementation as "unruly practices". "Street-level bureaucrats" in public institutions unofficially perpetuate exclusion when public sector workers reflect the prejudices of their society through their position, in this way institutionalising discrimination.

Sen's approach is especially useful for interpreting the results on intra-household exclusion of elders. Several interviewees justified neglect of some old people by family members as retribution for elders' past misdemeanors. Others argued that exclusion of elders was unjustified, as it was caused by their loss of economic power. Regardless of the immediate cause of discrimination, the results highlight the inability to access free health care under PS by elders who lack the support of household members. Sen places such intra-household discrimination at the centre of its analysis, especially as regards women. Robeyns (2003) has described this an "ethically individualistic" approach which implies that the units of normative judgment are individuals, and not households or communities. She argues that despite his focus on the individual, Sen does not reduce human behaviour to methodological individualism: *"… the capability approach is not ontologically individualistic. It does not assume atomistic individuals, nor that our functionings and capabilities are independent of our concern for others or of the actions of others. The social and environmental conversion factors also allow us to take into account a number of societal features, such as social norms and discriminatory practices. In sum, the ethically individualistic and ontologically nonindividualistic nature of the capability approach is a desirable characteristic for well-being and inequality analysis"* (Robeyns 2003). She argues these properties of the capability approach make it "*attractive for feminist research, because ethical individualism 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*" (Robeyns 2003). The same could be argued as regards research on older people, as in this study. A capability approach to PS therefore takes the differential ability of some elders to access PS due to intra-household exclusion into account, implying the need for assistance and transportation for elders who cannot rely on family members to accompany them to the hospital.

Another complex issue raised in the results is differential subjective, internalized perceptions of health, wellbeing, and effective health services. Interviewees argued that some elders preferred traditional medicine to allopathic, while others argued that some elders did not believe they were sick because they did not expect to be able to access care. These subjective perceptions may have affected demands that were made of the state. It is striking that most of the people we interviewed did not actively demand their right to free health care, even if they were informed of it: only the members of the association of handicapped people made explicit demands and complaints about lack of rightful access, to no avail. Some interviewees were fatalistic about their lack of access to free health care, saying it was God's will and not the fault of the government. These could be argued to be examples of psychological adaption, or internalised discrimination. Sen incorporates internalised discrimination into the capability approach, arguing that *"our desires and pleasure-taking abilities adjust to circumstances, especially to make life bearable in adverse situations"* (Sen 1999).

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 a more objective set of measures such as whether people have access to health, education, can protest, vote, etc. A capability approach to PS would need to take internalized discrimination into account, not only by educating people on the benefits of allopathic health care and their right to free health care, but also by adapting provision, by asking traditional healers to refer patients to allopathic services for example. However, this aspect of the capability approach has been critiqued as a "false consciousness" argument that *"allows researchers and policy-makers to discount or devalue the meanings and understandings that form the basis for poor peoples' decisions and actions and in doing so opens the way for forms of paternalism where there is an assertion of 'superior' views, values and meanings which arise from higher authority, from theory or from a position of more enlightened understanding"* (Deneulin and McGregor 2010). As outline in the Introduction, this issue is a limitation of critical realism more broadly, and is taken up in the next section on social constructionism.

A further limitation of Sen's capability approach is that it does not specify which capabilities and freedoms public policy should promote. He argues that each society should determine this through public reasoning or public discussion, but this has been critiqued as overly 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 and McGregor 2010)*. In other words, in debates over equity, some issues and ideas are likely to be contested, with more powerful actors' interpretation of contested meaning being more likely to prevail than those of less powerful actors. This problem has two possible solutions. One is to adopt a more explicit explanatory framework which recognizes some universal principles; the other is to reject the idea of a universal explanatory framework and adopt a social constructionist approach (Deneulin and McGregor 2010). The latter is discussed in the next subsection. Here, we move to a more universalistic explanatory framework of social exclusion, proposed by Kabeer (2000).

Kabeer's social exclusion framework

Kabeer takes an anti-positivist stance in her work, arguing that "*Our knowledge of the world is constructed rather than discovered. It is therefore likely to be shaped and limited by the location of the knower in the world*" (Kabeer 1994). Yet she argues against the social constructionist paradigm, stating that the view that objectivity is impossible to achieve has *"disastrous implications for those who have to take policy decisions, since it denies the possibility of a theoretically informed practice"*. She ultimately adopts a critical realist approach in her work (Olsen 2004), arguing for a *"situated objectivity"* in research, entailing *"a commitment to look at contrary evidence; the aim of maximum replicability through accurate reporting of all processes employed…; a commitment to truth-finding or veracity; and clarification and classification of values underlying the endeavor"* (Kabeer 1994).

One of the main generative mechanisms of social exclusion proposed by Kabeer (2000) is Weber's concept of "social closure". This classic sociological concept 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). This involves the 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. While this concept is widely used in the analysis of the causes of poverty, it has been neglected in research on health inequalities; this has led to a call for a realist attention to social class as a causal mechanism in health inequalities studies (Muntaner, Ng et al. 2015).

In the results of this study, the "long arm" system is an outcome of social closure; health workers deliberately discriminated against people who were not part of the elite patronage system. The assertion that PS can be accessed through IPRES could possibly be seen as an outcome of social closure as it privileges access by formal sector over informal sector. But it is not clear if this was a deliberate and conscious strategy of policymakers designing PS. The monopolisation of PS by urbanites due to unequal distribution of hospitals could also be seen as another outcome of social closure – those living in rural areas without the financial resources to travel and stay in the city are excluded from free health care. However, again it is difficult to find evidence of whether this exclusion was conscious and deliberate on the part of policymakers; these questions of intent need further research in the context of PS.

Unintended or subconscious discrimination is termed "mobilisation of institutional bias" – it is another commonly occurring generative mechanism of social exclusion. Kabeer (2000) 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. Those who benefit are placed in a preferred position to defend and promote their vested interests"*. This mechanism operates without conscious decisions by those

who represent the status quo. Analysis of this dimension of power calls for the researcher to look beyond people's subjective explanations of conflict and to seek a more objective perspective to reveal processes of domination (Lukes argues that a full critique of power should include both subjective and objective interests).

The results suggest that the "buddy system" is an outcome of mobilisation of institutional bias. People who use the "buddy system" believe they are not discriminating against others outside of the system – many people denounce the "long arm" whilst supporting the "buddy system". But one could argue that in fact they are discriminating without realising it. Ostensibly, this interpretation of the results points to the need to alter power structures. Yet the results present a complex and contradictory picture as regards power relations.

Inclusion/exclusion was not fixed but was in flux, changing all the time. Many of the ostensibly "included" formal sector urban interviewees who had accessed to free health care under PS, described sometimes being excluded from PS due to a lack of bras longue or money, for example. Some described accessing PS but on adverse terms, as IPRES and PS often provided poor quality care (PS as a "curse"). This has been termed *adverse incorporation* (Hickey and du Toit 2013).

Historically rooted and contextual perspectives

Critical realism places cultural and historical specificity as well as social theory at the centre of the analysis. As such, it is important to ask why social closure and mobilisation of institutional bias occur specifically in the Senegalese health system. The design of this study did not allow us to answer this question, but the wider literature is helpful in this regard. Anthropologists such as Farmer (2004), Lock and Nguyen (2010) and Olivier de Sardan (2003) have sought to understand the causes of present day inequalities and ineffectiveness of SSA health systems by tracing them historically to the colonial and post-colonial eras, arguing for the need to look beyond the ethnographically visible and take into account history and wider politics. Farmer (2004) and Lock and Nguyen (2010) have highlighted that in SSA, early colonial health systems were primarily focused on the health of colonisers and the need for preservation of health of labourers. This led to coercive application of biomedicine on the workforce, while the health of the rest of the population was left largely to the care of missionaries. World War II ushered in new era of rights-based international rhetoric that put colonialism into question. Colonisers sought to justify their continued presence in colonies, in part by upgrading or introducing publicly funded colonial welfare policies. However, there was an unwillingness to invest necessary resources to cover the entire population. Late colonial health infrastructure was therefore hospital and urban focused and provided mainly curative services for the colonial and native elite. This inequitable structure continued in post-colonial era, in part because the personnel working in the health system pre and post independence were the same (due to the colonial policy of indirect rule) and in part because of the extreme shortages of health workers due to colonial education policies which had not trained sufficient native medical personnel. This history is almost never mentioned in research

and reports on UHC. This silence is troubling, as it goes some way to explaining why PS was implanted into a structurally inequitable health system. Yet it doesn't explain why until today, policies like PS continue to reinforce rather than overturn this inequity through social closure and mobilisation of institutional bias.

Jaffré and Olivier de Sardan (2003) seek to explain why in recent times existing personnel are unable or unwilling to expand access equitably. In an excellent and immensely detailed ethnography (published only in French), they analyse relationships between health workers and patients in five francophone West African cities, including Dakar in Senegal. They dedicate a chapter (Olivier de Sardan 2003) to tracing the origins of the difficulties they encountered, prime among which were the types of practices described in this study (the "long arm" and "buddy" systems), as well as unresponsive and poor quality care. They find that the three commonly invoked explanations - heartlessness or selfishness of health personnel; incompatibility of modern medicine with traditional African culture; and poverty or lack of income – are simply erroneous.

Rather, they attribute the difficulties to "practical norms"[4] that were present not only in medicine, but also in the wider bureaucratic culture, arguing that health personnel in all five of their case studies behaved towards patients in a similar way that bureaucrats behaved towards users in other public services. This wider bureaucratic culture is a subject on which Olivier de Sardan has published extensively (Blundo and Olivier de Sardan 2006) and is only briefly summarised here. He finds it is characterised by adaptations developed by colonisers in order to transcend the public / private boundaries of the classic Weberian bureaucracy imported to SSA from Europe. He argues that the need to transcend these boundaries is present in all bureaucracies, including in Europe, but the manner in which this is done varies. In colonial SSA these adaptations included: despotism within the bureaucracy; privileges accorded to bureaucrats regardless of competence or merit; and informal everyday corruption of "intermediaries" – i.e. "street level" bureaucrats, administrators, local leaders and others who interface between the bureaucracy and the wider population. As a result, the service users who colluded in this everyday corruption received an (overly) personalised service, while the "anonymous user" of services who was unable or unwilling to participate in corruption was treated with profound indifference. These bureaucratic adaptations worsened after independence, becoming more extreme in the post-colonial period, as has been widely documented by Olivier de Sardan and others (see (Bayart 2009) for example).

As with all bureaucrats, health workers continued to face a conflict of interest between their social and domestic obligations to maximize profit from their bureaucratic privileges on one hand and their work in an unstimulating,

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[4] Farmer (2004) similarly argues that health policymakers and health workers in SAA and other low income country contexts have been "socialized for scarcity" through a process *"informed by a complex web of events and processes stretching far back in time and across continents"* resulting in structural violence.

uncooperative, poorly managed and unproductive public sector, with the former priority dominating the latter. The indifference towards service users in the health sector took on a particularly troubling form, since health workers needed to numb themselves to the suffering they witnessed daily, and they lacked authority vis-à-vis patients due to their poor training and the presence of rival health knowledge, traditional medicine. The massive recruitment and training of health workers during the 1970s and 1980s was conducted within this institutional framework.

Jaffré and Olivier de Sardan show ethnographically how these practical norms of profound indifference to the anonymous patient and over-personalisation of services to the privileged patient continue to be passed from one generation of health workers to the next (with the exception of a few charismatic individuals who manage to overcome this transmission of norms), as newly qualified staff are berated by their seniors if they seek to deviate from the practical norms they themselves inherited. The introduction of user fees under structural adjustment, with the hope of improving service delivery through commercialization of the health system combined with community oversight and participation, did little, or nothing, to change this (worsening rather than improving access to care (McPake 1993)). In a more recent special issue Olivier de Sardan and colleagues present several other studies covering several West African countries (Olivier de Sardan and Ridde 2015, Ridde 2015) that echo the results on PS, demonstrating that user fee removal policies have also failed to address these underlying practical norms. This poses the question – what policies are needed, in conjunction with user fee removal, in order to overturn deep-rooted inequity in the health system?

At the end of their ethnography, Jaffré and Olivier de Sardan (2003) critique the standard global health interventions designed to improve equity and quality of care attempted in West Africa and elsewhere; these include training of health workers, increasing salaries, provision of public health information to the general population, vertical programmes targeting priority diseases such as HIV/AIDS, and patient-centred care. Many studies recommending these standard health sector interventions draw on a positivist tradition, focusing exclusively on of constructing 'objective' realities or prototypes based solely on observable phenomena. As a result these interventions are largely focused on addressing economic and psychological determinants of the problem.

A good example of this is the current major international policy focus on pay-for-performance (P4P), defined as "*the transfer of money or material goods conditional on taking a measurable action or achieving a predetermined performance target*" (Witter 2013). In LMIC, P4P is increasingly used to pay payment governments, local governments, NGOs, facilities and individual health workers), aiming to improve quality of care, increase the allocative efficiency of health services (by encouraging the provision of high priority and cost effective services); to increase technical efficiency (by making better use of existing resources such as health staff); and to improve equity of outcomes (for example, by encouraging expansion of services to hard-to-reach groups) (Witter 2013). Yet a recent literature review of P4P interventions to strengthen strengthening

delivery of sexual and reproductive health services (one of the most common groups of services targeted by this policy) found that despite its popularity with donors and rapid roll out across over twenty LMIC, there is a distinct lack of evidence on its impact, concluding that "*P4P may be beneficial in some settings*".

Jaffré and Olivier de Sardan argue these types of interventions fail to improve equity and quality of health services because they are developed in relation to an *"imagined world rather than the world as it is"* (Jaffré and Olivier de Sardan 2003). Jaffré and Olivier de Sardan contend that in the real world there medicine in West Africa suffers from an *"ethical deficit"* that needs to be addressed. They argue this needs to be done not in the typical format of workshops or training, but rather through formal negotiations with both health workers and patients on site. They propose that in these negotiations, issues such as *"funding, workforce, qualifications, but also the contempt in which patients are held, lack of professional conscience, lack of sanctions, not following procedure, lack of organization, absenteeism, corruption etc"* need to be openly discussed in the *"language of truth"*, without using the *"doublespeak that is so common in administrations and interactions with donors"* (Jaffré and Olivier de Sardan 2003).

In a recent editorial Olivier de Sardan and Ridde have argued that user fee exemptions are the latest in the long line of policies designed at the international level that fail to understand the real world of deep rooted causes ethical problems in health systems in West Africa (and perhaps elsewhere). Again, they call for more open and honest debate, pointing out that UHC policy documents remain silent on these issues despite the fact that these problems are informally recognized by policymakers (Olivier de Sardan and Ridde 2015, Ridde 2015).

However, Olivier de Sardan and his colleagues' insistence on combating "doublespeak" and corruption through negotiations that bring to light the "truth" is problematic. The critique of Sen discussed above (Deneulin and McGregor 2010), of the "*underestimation of the power that lies behind the meanings that can be brought to bear in such processes of public reasoning and deliberation*" could also be levelled against Olivier de Sardan and the critical realist approach more generally.

The social construction of corruption

Our results highlight areas of ambiguity where a social constructionist lens may aid interpretation; for example to explain how in same breathe a person can denounce "long arm system" as self-interested and corrupt and simultaneously argue the "buddy system" as solidaristic, when from an outsider's point of view, both practices could be defined as corrupt. Olivier de Sardan himself points out that there is a social and cultural logic of "normative pluralism" in everyday corruption between citizens and public officials in West Africa, characterized by a *"fluidity and variety of both formal and informal rules"* (Blundo and Olivier de Sardan 2006). Other anthropologists studying corruption in West Africa have also pointed to the plurality of interpretations at play. For example Smith (2007) finds that various types of apparent "corruption" in Nigeria were justified by people as a legitimate response to inequality, the only way to survive in a broken

system, or as morally upright, despite views of westerners to the contrary. In Senegal the "long arm system" and "buddy system" were similarly seen by many as the only way to survive in a broken health system – literally so, in the case of severe illness. Additionally, the "buddy system" was widely perceived as moral. Such research findings on the social construction of corruption are not purely an African phenomenon; in the literature on Europe, it has also been found that corruption cannot have a fixed definition because it is socially constructed (Tänzler, Maras et al. 2012). Granovetter (2007) has reviewed the sociological and anthropological literature on corruption from a variety of contexts and similarly concludes that corruption is it is not a "natural" fact but a social "factum".

Social constructionist philosophy thereby puts into question Olivier de Sardan's aim of combating corruption by establishing "truth" or "reality" through open negotiation; it questions whether it would be possible, or even desirable, for all stakeholders in the PS system to agree on whether to definitively denounce the "long arm system" and "buddy system" as corrupt. Social constructionists such as Gergen whose ideas are expounded by Burr (2015) assert that truth claims can shut debates down, since they establish limits on what people can say. Relatively powerful actors' versions of the truth are likely to prevail at the expense of others. The social constructionist lens therefore requires one to accept that in any negotiation, a plurality of realities will be in contest with each other. This suggests it is likely to be very difficult for all stakeholders in a health system or a health facility to agree on causal mechanisms of corruption and how these create social exclusion, and to change these practices. Yet from a social constructionist perspective, this is no reason not to engage in a debate; rather it is an excellent reason to have a debate. If one embraces this idea, it is still possible to promote the kind of open negotiation put forward Olivier de Sardan, or indeed the reasoning advocated by Sen, but without an expectation that an uncontested version of reality as regards the causes and consequences corruption in health care as regards user fee exemptions can be produced. This awareness may lead to the shifts in power relations and innovative culturally relevant and rooted changes to pave the way for UHC in Senegal and elsewhere.

5. Conclusions

This study identifies fifteen causes of inclusion in or exclusion from PS across the two qualitative datasets. These causes are grouped under four "parent" codes: PS as "a right", "a privilege", "a favour", or "a curse". The discussion seeks to reconcile these different causes and themes into a critical realist framework. The results are analysed through the lens of the capability approach to explain why possessing the right to access free health care (i.e. the PS policy) was of little use without having the means to access free health care (i.e. knowledge of this right, combined with the requisite level of state funding); and to explain why for many individuals, these means were also insufficient to actually achieve the end of accessing free health care due to differential capabilities.

The paper then draws on Kabeer's framework of social exclusion to identify two possible underlying hidden generative mechanisms: mobilisation of institutional bias and social closure. The results are then situated in the wider anthropological and historical literature to argue that these mechanisms were the result of complex historical processes in Senegal, including the development of medical infrastructure and practical norms within a highly corrupt colonial and post-colonial public bureaucracy. It is proposed that redressing social exclusion from PS would require an open debate about these multi-layered causes, since they are rarely acknowledged in Senegalese or international policy documents on expanding UHC and removing user charges.

A social constructionist perspective is then employed to point out that an open debate would, however, be unlikely to reach a common version of the "truth" about the morals and ethics at play in the health system that was acceptable to all, but that this lack of consensus could be important for preventing relatively powerful actors' versions of the truth from prevailing at the expense of others.

It is understandable that the conceptually complex interpretation of evidence provided in this study is not commonly used in policy reports on UHC. The task of raising sufficient funding to provide publicly funded health services in Senegal and in LMIC more widely seems economically and politically challenging enough without muddying the water with wider social questions about local power relations and corruption, combined with epistemological and ontological questions about reality and discourse. Yet lack of attention to these issues may be one of the reasons why in Senegal, as elsewhere in SSA, UHC policies are not experiencing widespread success. Indeed, an important agenda for future research is to ascertain whether these causes of exclusion occur in other countries. Some aspects likely to be context specific but others may be common to many post-colonial countries transitioning from high levels of out-of-pocket spending to publicly funded UHC and free care at point of use, in a context of high levels of public sector corruption.

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