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

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A B S T R A C T

Plan Sésame (PS) is a user fee exemption policy launched in 2006 to provide free access to health services to Senegalese citizens aged 60 and over. Analysis of a large household survey evaluating PS echoes findings of other studies showing that user fee removal can be highly inequitable. 34 semi-structured interviews and 19 focus group discussions with people aged 60 and over were conducted in four regions in Senegal (Dakar, Diourbel, Matam and Tambacounda) over a period of six months during 2012. They were analysed to identify underlying causes of exclusion from/inclusion in PS and triangulated with the household survey. The results point to three steps at which exclusion occurs: (i) not being informed about PS; (ii) not perceiving a need to use health services under PS; and (iii) inability to access health services under PS, despite having the information and perceived need. We identify lay explanations for exclusion at these different steps. Some lay explanations point to social exclusion, defined as unequal power relations. For example, poor access to PS was seen to be caused by corruption, patronage, poverty, lack of social support, internalised discrimination and adverse incorporation. Other lay explanations do not point to social exclusion, for example: poor implementation; inadequate funding; high population demand; incompetent bureaucracy; and PS as a favour or moral obligation to friends or family. Within a critical realist paradigm, we interpret these lay explanations as empirical evidence for the presence of the following hidden underlying causal mechanisms: lacking capabilities; mobilisation of institutional bias; and social closure. However, social constructionist perspectives lead us to critique this paradigm by drawing attention to contested health, wellbeing and corruption discourses. These differences in interpretation lead to subsequent differential policy recommendations. This demonstrates the need for the adoption of a "multi-epistemological" perspective in studies of health inequity and social exclusion.

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1. Introduction

1.1. The struggle for universal health coverage

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

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

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

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the poorest 20%, after the policy change. Furthermore, removing user fees was statistically significantly associated with greater increases in facility deliveries among women with a secondary education compared to women with no education (McKinnon et al., 2015). Surprisingly though, few studies have sought to understand the underlying *causes* of inequity in access to publicly funded user fee exemptions. Worryingly, UHC policy documents remain largely silent on this issue (Olivier de Sardan and Ridde, 2015; Ridde, 2015). This has prevented the development of effective policy responses. One objective of this study is to address this gap in the empirical literature by analysing causes of inequity in access to free health care following a policy of user fee removal in Senegal. In doing so, we also aim to achieve a second, linked, objective of exploring how choice of epistemology affects interpretation of results and subsequent policy development. This also addresses an important gap in the literature on UHC and public health more widely (Wainwright and Forbes, 2000). Our main argument is that the researcher's choice of epistemological paradigm for the interpretation of empirical evidence leads to subsequent differential policy recommendations for the reduction of inequity. This has important implications for the growing field of evidence-based health policy.

1.2. A user fee exemption policy: Plan Sésame in Senegal

Total expenditure on health in Senegal is low, at 6% of GDP in 2011 compared to the SSA average of 6.5%. Private expenditure on health as a percentage of total health expenditure is 41.7%. This is lower than the average for SSA (54.9%), but high compared to other world regions. 78.5% of private expenditure on health in Senegal is spent directly out-of-pocket as user fees (World Health Organization, 2013). As in many SSA countries, the reliance on user fees is the result of several decades of health system restructuring, incorporating austerity measures imposed under structural adjustment and decentralisation under the Bamako Initiative (Foley, 2010). As part of its strategy to reach UHC, Senegal has introduced a set of user fee exemptions targeting specific diseases and vulnerable population subgroups (MSAS, 2007). However, as elsewhere, these initiatives are poorly implemented (Soors et al., 2010) and health service providers often continue to charge fees.

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

Evaluations of PS suggest great inequity in access to these limited funds. In a survey of 2933 households in Senegal, Parmar et al (2014) find that only 48% of people aged 60 and over were "enrolled" in PS, i.e. both aware of PS and in possession of a national ID card that is needed to prove their age in order to access the Plan. Since 89% of older people had a valid ID card, it was lack of information about PS that accounted for the low enrolment rate. Having the following characteristics all statistically significantly ($p < 0.01$ or $p < 0.05$) increased a person's odds of enrolment: being male, being a household head, having formal education, living in an urban area, being relatively wealthy, belonging to the majority ethnicity, being a member of sociocultural associations, being married or not living alone, relatively high political and civic participation, perception of living in a safe neighbourhood, having access to information channels (TV or radio) and hospitalisation in the last year. Furthermore, only 10.5% of the target population was found to have ever used PS to access free health care (Ndiaye et al., 2014). Utilisation was also highly inequitable, with wealthier, formal sector people being significantly ($p < 0.01$) relatively more likely to use PS (Ba et al., 2015).

However, although this type of multivariate quantitative analysis is useful for understanding *patterns* of inequality, it does little to reveal underlying *causes* to explain *why* some social groups experienced inequity (Wainwright and Forbes, 2000). The hypothesis proposed, but ultimately untested, by Parmar et al. (2014) is that social exclusion causes inequitable access to PS. They adopt Popay's definition of social exclusion as a: *"dynamic, multidimensional processes driven by unequal power relationships interacting across four main dimensions – social, political, economic and cultural – and at different levels including individual, household, group, community, country and global levels"* (Popay et al., 2008, p. 2). Popay and colleagues understand these unequal power relationships to be embedded in social structures, but do not provide a theory of power. Rather, they call for more research into understanding the forces driving exclusionary processes in specific societies. Popay et al. (1998) argue this needs to be done by exploring explanations derived from lay knowledge and cultural practice in the context of a specific time and place. Our study responds to Popay's call and complements the quantitative study with qualitative data collected as part of the same research project, to uncover underlying causes of the patterns of inequity identified (Creswell, 2009).

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

1.3. Critical realist and social constructionist approaches to understanding causes of inequity

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

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