SOCIAL PROTECTION SYSTEMS

TYING THE KNOTS

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POWERPLAY BEHIND THE SCENE OF REDISTRIBUTIVE SOCIAL PROTECTION SYSTEMS?

Lessons from Senegal

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This research on redistributive social protection is still ongoing. Hence a summary of the state of play is provided as input for the presentation and discussion of preliminary research results at the international symposium on "Social protection systems – tying the knots" on September 5-6, 2016 in Bonn. Please do not quote or reproduce.

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1 | Introduction

This summary gives a state of play of the ongoing research by HIVA-KU Leuven on redistributive sociale protection. The research is conducted in the framework of the BeFinD consortium that provides policy support on 'Financing for Development' to the Belgian government. The study consists of two case studies, Senegal and Morocco, but since only the fieldwork in Senegal has been completed, the discussion of the preliminary results will remain limited to this case.

2 | Research topic & methodology

Over the past decade, social protection has come to feature more and more prominently on international and national development agendas. One key challenge that the quest for social protection currently faces, is the resource mobilization to finance social protection. Redistributive social protection has been put forward as a way to address this challenge. Its key trait is redistribution and solidarity between different population groups (e.g. different income, socio-economic background, geographical background, economic sector). When redressing exclusion and contributing to equity and social justice within society, social protection systems can be considered 'transformative'.

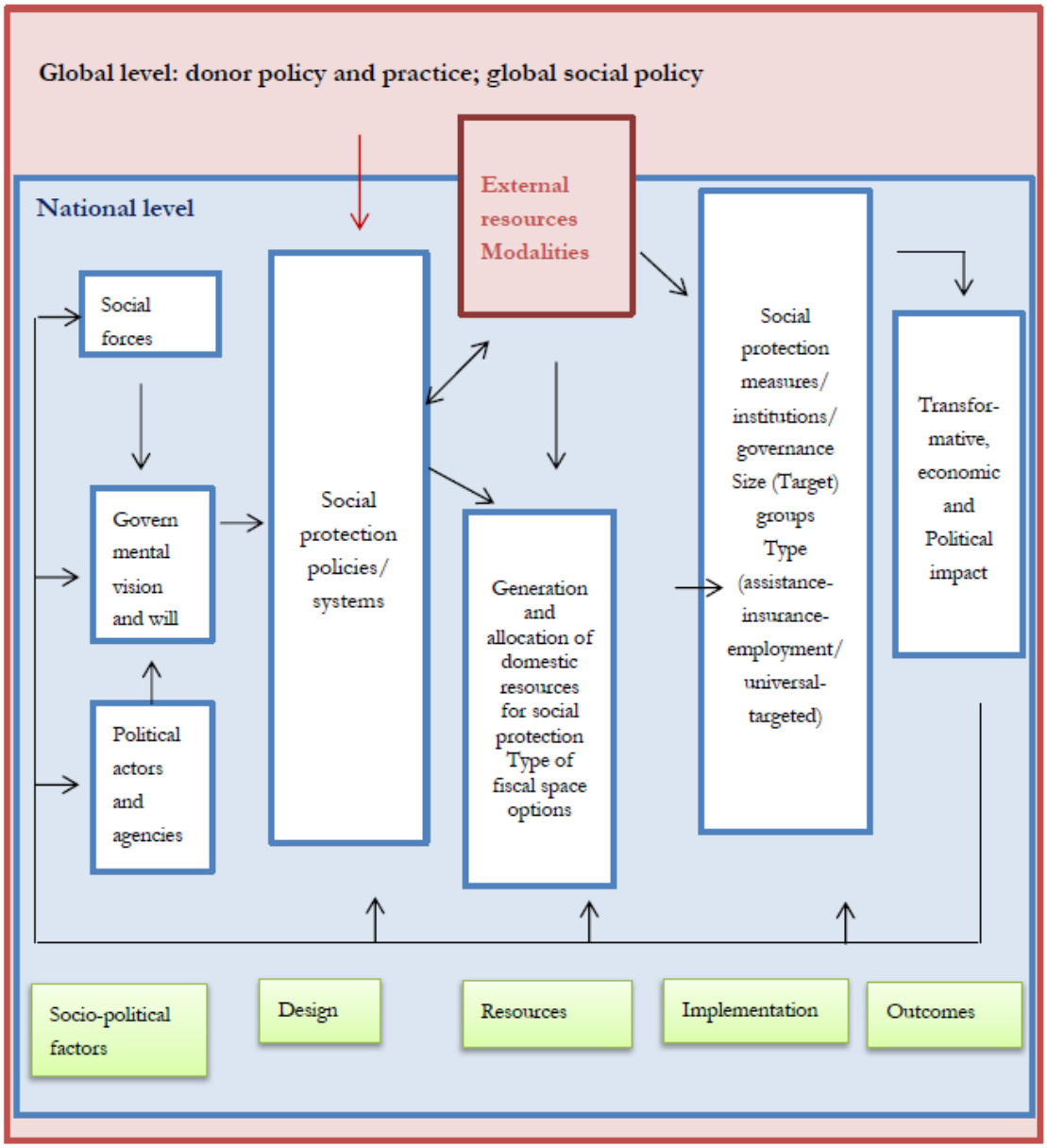
Previous research by HIVA argued that the redistributive, and hence transformative, potential of social protection systems is basically determined by a financial, technical and socio-political dimension (Fonteneau, 2012) (see figure 1). In particular the understanding of this socio-political dimension of redistributive social protection is lagging behind. Hence, this research aims to contribute to a better understanding of the political processes that determine the redistributive potential of social protection systems.

Reconciling the need for in-depth analysis with the limitations in time and resources, we have opted to focus the study on 1) recent or ongoing reforms in social protection 2) in the domain of health 3) in two cases: Senegal and Morocco and 4) more specifically regarding the policy of decentralized health insurance (CMU-DECAM) in Senegal and the establishment of a non-contributory scheme for poor and vulnerable families (RAMED) in Morocco. The study will explore and analyze how the political dynamics surrounding social protection reforms in health in Senegal and Morocco determine financial and technical features, as well the redistributive potential of the resulting social protection system. Data collection is based on literature study, document analysis, and field research with observation and semi-structured interviews. Field work in Senegal has been conducted in April – May 2015, and key preliminary findings are presented below. Fieldwork in Morocco will happen later in 2016.

3 | Theoretical framework

In an earlier research phase, a theoretical framework has been developed, inspired by Hikey's (2008) work on the politics of social protection in Africa and visualized below. It provides the basis for the case study research. Vice versa, the case study research is also used as a test for the theoretical framework.

Figure 1: Theoretical framework (Fonteneau, 2015, p.12)



The framework is presented as a tool to analyse how the socio-political, technical and financial aspects are shaping redistributive social protection. The socio-political dimension covers the interaction between actors involved in the national policy making as well as the influence of global social policy trends and donor policies and practices. The former contains: the government (including the Ministries), the political actors and institutions (political parties, Parliament, other national institutions), the organised civil society (NGOs, trade unions, social movements) and the other 'unorganised' social forces (including elites, spontaneous popular movements, influential leaders, etc.). From a theoretical perspective, those actors will interact in the discussions and decision making process related to the design of social protection policies and systems (see second box from the left in figure 1). These inter-actions will take place, both formally (consultations, elections, propositions, etc.) and informally (lobbying, influencing, etc.). The financial dimension refers to the resources that are available and/or to be generated in order to

fund the different measures that will be part of social protection systems (redistributive or not). In order to ensure nationally owned and sustainable social protection systems the mobilisation of these resources at the domestic level is crucial. External financial support provided by donors can be seen as less relevant from the perspective of redistributive social protection in case it supports the implementation of social protection programmes that are temporary and not nationally owned because designed and implemented by foreign actors. The technical dimension refers to the more operational side of implementing social protection systems, including the type of social protection measures (assistance/insurance/employment and universal/targeted), the governance structure, the organisation of service provision. These 'technical' decisions are often also partly political (Fonteneau, 2015, p.12-13).

4 | Preliminary findings

After his election in 2012, Senegalese president Macky Sall embarked on a quest to expand health coverage to 75% of the population by 2017. To achieve this, the Senegalese government has opted for decentralized voluntary health insurance through mutual health organizations subsidized by the state (CMU-DECAM). Additionally health assistance is being expanded, with special benefits for vulnerable groups ('gratuités' and 'bourse de sécurité familiale'). With the tight deadline, the pressure to move quickly was -and still- is high. Recent figures released by the government put current health coverage at 40% of the population, but this figure includes all mechanisms of health coverage (including the existing ones in the formal sector) and does not take into account possible overlap between them.

4.1 Technical dimension

Key traits of the CMU-DECAM policy are: 1) one mutual health organisation per community; 2) governed and managed by volunteers/members; 3) supported by a technical assistance unit of 3-4 experts at departmental level and a union of mutual health organisations at the regional level; 4) provides health insurance to its members and channels health assistance to vulnerable groups; 5) with membership being subsidized for 50% by the state and health assistance fully state-funded.

Officially CMU-DECAM has concluded the phase of demonstration and has entered in the phase of extension. However, key implementing institutions, such as the mutual health organisations at the community level, technical assistance units at the departmental level and the Agency for Universal Health Coverage at the national level are not yet fully operational. Implementation started in 2013 with only 100 active mutual health organisation. This number should climb to over 600 mutual health organisation but amounts mid-2016 to only 357, of which many have a track-record of less than two years. The average membership rate for mutual health Organisation is between 2 and 3 % of the target population, whereas 20% is considered as a minimum to become financially sustainable.

Being at such an early stage and with no reliable data on the services provided so far by the mutual health organisations, looking into the implementation or the impact of the technical modalities is too premature.

4.2 Socio-political dimension

Data collection did reveal interesting insights regarding the socio-political dimension. Reconstructing the formulation of the CMU-DECAM policy allows to map the role of different types of actors:

- A widely shared analysis among the consulted stakeholders, is that the rise of social protection on the international agenda and on the donor agenda has contributed to the problem formulation and agenda setting of social protection at national level. "Social protection is 'in' in Africa", one of the interviewees commented. The Ministry of Finance pointed out that because of structural adjustment plans investment in social protection became only possible after 2000. In 2006 social protection featured as a pillar in Senegal's poverty reduction strategy paper. This shows clear influence of international finance institutions. Different bilateral donors (USAID, ILO, The World Bank, the Belgian, French and Japanese cooperation) also have played and still play a significant role.

- An interesting dynamic is taking place between the Senegalese government, USAID and the Belgian development cooperation: Both USAID and BTC are piloting a health coverage scheme. USAID has played a role in the design of the DECAM policy, and is supporting the Senegalese government in the implementation, a.o. by establishing and training mutual health organisations. At the same time, the Senegalese government allowed the Belgian cooperation to pilot a different approach (UDAM) aiming for professional mutual health organisations at the departmental level. In this approach, a fusion between different existing mutual health organisations results within a department increases the overall scale of operations. Instead of volunteers, the departmental unit is managed by a professional team and governance is done by a board consisting of elected members of the different mutuelles and the mayors of the different villages. Stakeholders disagree on whether the two approaches are really so different, but the fact remains that the scale, degree of professionalization and the influence of the grassroots level do differ.

- The president is seen as the driving force behind this ambitious reform. Although health coverage was on the political agenda before the latest presidential elections, almost all interviewees agree that the current momentum and political will is his merit.

- At the moment, the president doesn't seem to be confronted with strong opposition when it comes to CMU. During elections, universal health coverage was on all parties' agenda's. Stakeholders agree that there is a political consensus on CMU, but disagree on whether there is a consensus on DECAM as the best way to translate it into practice. However, there seem to be very few politicians or representatives in parliament with strong expertise and a well-founded opinion in CMU. In fact, several observers expect that, when moving closer to the next elections, political parties will start recruiting in civil society circles, in order to build there profile on health coverage. Health coverage is expected to be on the agenda during elections, because of several hiccups in the implementation. Most importantly, the state struggles to keep up with payments to the health service providers, which are consequently faced with shortages in their operational budget. This in turn results a.o. in declining availability of drugs, no free health care, and worsening working conditions for health staff. The latter is, in turn, stirring up the unions.

- Trade unions have played a key role in the establishment of the currently existing social protection provisions for the formal sector in Senegal. They have been the driving force behind the establishment of health insurance institutions ('institutions de prévoyance maladie' or IPMs) in the formal sector and are strongly represented in their governance structures. They have, however, been far less involved in the policy process leading to CMU-DECAM. Different elements may explain this. Firstly, interviewees report that the unions did participate in the stakeholder consultations on the issue. However, since the expansion of the health coverage targeted mostly the informal sector, they were less informed, less organized and less invested. On the other side of the table, government actors wanted to move quickly and wanted to avoid lengthy negotiations with the unions. Several interviewees pointed out that an alternative approach integrating the expansion of the health coverage with the existing IPMs was not pursued for this reason.

- Still, several of the union representatives consulted said that they were currently considering how to engage more strategically with DECAM. Different options seem to be on the table. Firstly, unions consider mutual health organisation by profession/occupational sector to be an interesting tool for service provision, organisation and hence syndicalisation in the informal sector. Secondly, unions are realizing that if they organize their members of mutual health organisations, they could claim a presence in their governance structures. This would be a way of becoming part of the governance of DECAM. Thirdly, especially the unions in the health sector see that the working conditions of their members are being affected by DECAM. They point out that the state focuses too much on leading more and more people to health care (demand side), and should put more effort in improving the available health care (supply side).

- A very present civil society actor has been the mutual health organisations themselves. Although the Senegalese government did some efforts to develop the sector in the eighties, it lost interest afterwards, leaving the work to civil society organisations and financial and technical partners. Since 2000, the sector has become increasingly involved in policy influencing and advocacy at the national and regional level. It has played a significant role in the development of several national strategies on development of mutual health organisation and on social protection. Consequently, when the president called for national consultation to decide how to achieve universal health coverage, the mutual health organisations have the necessary expertise and track record to put a strong mark on the outcome. In hindsight, this was a good example of being ready with a particular solution at the time a window of opportunity opened up.

- The broader civil society seems to have had less influence in the policy formulation process. For example, the Umbrella of Civil Society Organisations (CONGAD) points out that the current approach ignored quite some existing initiatives. It also voiced its concern regarding the financial sustainability of the current approach, especially in combination with insufficiently refined targeting methods. Although also involved in consultation rounds, they are of the opinion that the debate has been too confined to the usual suspects. With support of the state, they have conducted a participatory process to collect more input at the grassroots level and have recently presented their outcome to the government.

4.3 Financial dimension

The information on the financial architecture behind CMU-DECAM is incomplete. Interviewees seem to agree that at the moment there is no clear plan on how CMU-DECAM will be financed in the long term. So far, the available budgets (currently located at the Ministry of Health) have been more than sufficient (in part due to lack of capacity to spend it) and the surpluses are transferred to the budget of the subsequent financial year. These budgets are currently fed by taxes (income taxes and indirect taxes) in the formal sector as well as by contributions by the technical and financial partners (Belgium, Japan, France, USA, World Bank, UNICEF).

In the light of the desired increasing in coverage, the expected population growth and the need to limit dependency of external/cooperation resources, a long term financial plan is necessary. According to stakeholders "the government is thinking about it" and is "in need of an action plan on how to think about financing". According to some, different studies are being conducted by different actors (the Ministry of Economy and Finance, with support of USAID and The World Bank, and the National Delegation on Social Protection (DGPSN). According to others, these studies and clear options are already available but 'stuck at the political level'.

The Ministry of Economy and Finance summarized that the budget of the Health Ministry cannot, in the long term, sustain the universal health coverage. However, the state budget can. They point out different options to create the necessary budgetary space: 1) improving the fiscal capacity of the state; 2) achieving more economic growth; 3) create new streams of revenue, such as specific taxes for health coverage or by increasing the overall tax base, for example through taxes on real estate, tobacco, telephone calls, remittances. Civil society representatives voice strong concern regarding the financial sustainability, but are at the same time ill-informed about ongoing studies and possible options. They do plan to increase the government's sense of urgency regarding this issue.

4.4 Reflections

Some questions and reflections emerging from the work in progress are:

- Interviewees all consider the current approach as a strong redistributive approach. On the one hand they feel the contribution of technical and financial partners is a form of international redistribution. On the other hand they point out that DECAM channels resources from the formal sector (income taxes) to the informal sector. However, there are some critiques as well. Firstly, the DECAM system provides access to public health care, whereas the formal sector systems provide access to private health care which is considered of better quality. Secondly, the risk exist that persons with health problems join the mutual health organisations while the healthy postpone. This would undermined the idea of solidarity on which health insurance is based and would make it unsustainable in the long run. Thirdly, a single system for all sectors is by many stakeholders considered as the 'fairest' option with most redistributive potential. However, different societal actors as well as government institutions defend their interests and turf, meaning the support for a fundamental reform is currently insufficient.

- USAID and some international civil society organisations are proponents of a grassroots based approach in which active citizenship and social control are key. At the same time, the Belgian cooperation is running a so far successful pilot based on professionalization

and scale (its department units have a membership rate of 10% compared to the average of 2-3%). To what extent is this dual approach contributing to more fragmentation? How deep are the waters between the proponents of DECAM and UDAM and will they be open to really embrace the lessons learned? How much direct and indirect influence do the external actors have (had) on the policy development process?

- Different civil society actors are not on the same page and actors active in the mutual health movement lack awareness about possible coalition partners outside their sector. The mutual health organisations are advocates of a system in which they are key actors, but risk losing the vote of confidence if they don't rise to the occasion. Trade unions are not convinced that geographically defined mutual health organisations are the way forward and may respond with the establishment of sector-based mutual health organisations. Other civil society organisations feel ignored, because their initiatives have not been taken into account in DECAM. At the same time, a coalition between unions and mutual health organisations could be a way to boost membership to mutual health organisations. It could also have important consequences for the governance structures, assuming that unions will claim a representation.

- There have been quite some instances of consultation and concertation. In that sense the policy process leading to DECAM seems to have been relatively open. However, the lack of capacity or expertise may have prevented some civil society actors from contributing maximally in the short notice.

- The president has made a bold promise and is pushing all actors to deliver. This translates in a rushed implementation. To what extent does the rush to boost coverage by 2017 risks putting in place a system that is - institutionally and financially – weak and possible unsustainable in the long term

- The private sector, or more specifically commercial insurance providers, seem very absent in the policy debate and the social protection landscape in Senegal.

- The policy formulation regarding the financing of universal health coverage is at least as important as the design of DECAM. However, this part of the debate seems to happen behind closed doors, and civil society actors are insufficiently aware, informed and ready to influence it. However, this will definitely affect the redistributive potential of the system.

5 | Way forward

The next research steps will be a fieldwork in Morocco, looking into the implementation of RAMED. Afterwards, both cases will be analyses further and insights will be presented in a research report. The report will offer an analysis of the interplay between national stakeholders (political leaders, administration, civil society, elites,) as well as between national and international stakeholders (international organisations, financial and technical partners). It will discuss how this political dimension sets the scene for the technical and financial design and implementation of social protection systems. It will conclude with a reflection on what lessons both cases offer for the promotion of redistributive protection. The study will be finalised mid-2017 with an international seminar for the presentation and discussion of its findings with scholars and civil society and government representatives.

References

Banque Africaine de Développement, & Fonds Africain de Développement. (2010). *République du Sénégal. Document de Stratégie par Pays 2010-2015* (Document de Stratégie par Pays) (p. 45). Département des Opérations Pays.

CLEISS. (2015b). Le régime sénégalaise de sécurité sociale. Retrieved from http://www.cleiss.fr/docs/regimes/regime_senegal.html

Devereux, S. (2015). *Social Protection and Safety Nets in the Middle East and North Africa* (Research report No. Vol 2015 No 80) (p. 128). Institute for Development Studies (IDS).

Fonteneau, B., & Van Ongevalle, J. (2015). *Redistributive Social Protection: Mapping Study* (BeFinD Working Paper No. Working Paper N°1 Social Protection) (p. 53). Leuven: HIVA - KU Leuven.

Hickey, S. (2008). Conceptualising the Politics of Social Protection in Africa. In A. Barrientos & D. Hulme (Eds.), *Social Protection for the Poor and the Poorest: concepts, policies, and politics* (pp. 247–264). New York: Palgrave Macmillan.

ILO, & République du Senegal. (2012). *Programme Pays de Promotion du Travail Décent au Sénégal* (p. 27). Retrieved from http://www.ilo.org/public/english/bureau/program/dwcp/download/senegal.pdf

Lavers, T., & Hickey, S. (2015). *Investigating the political economy of social protection expansion in Africa: At the intersection of transnational ideas and domestic politics* (ESID Working Paper No. No. 47) (p. 34). Machester: Effective States and Inclusive Development Research Centre (ESID).

Ministère de la Santé et de l'Action Sociale. (2013). *Plan strategique de développement de la Couverture Maladie Universelle au Sénégal 2013-2017* (p. 125). Dakar: Republique du Senegal.

Oxfam France. (2013). *La couverture maladie universelle au Sénégal. Du local au global* (p. 10). Oxfam.

Republique du Sénégal. (2013, February). *Stratégie de financement de la couverture maladie universelle au Sénégal*. Presented at the Atelier régional d'échanges Sud-Sud sur les stratégies de financement de la couverture sanitaire universelle, Ouagadougou.

Republique du Senegal. (2014). Plan Senegal Emergent. Republique du Senegal. Retrieved from http://www.gouv.sn/IMG/pdf/PSE.pdf

Sall, M. (2013, September). *Discours du président Macky Sall à la cérémonie officielle de lancement du programme de couverture maladie universelle*. Presented at the Ceremonie officielle de lancement du Programme National de Couverture Maladie Universelle (CMU) du Senegal, Dakar. Retrieved from http://www.dakaractu.com/Discours-du-president-Macky-Sall-a-la-ceremonie-officielle-de-lancement-du-programme-de-couverture-maladie-universelle_a52263.html

The World Bank. (2006). *Pension system and reforms. the case of Senegal*. Presented at the World bank Cors Course on Pensions. Retrieved from http://info.worldbank.org/etools/docs/library/238304/GroupSenegal.pdf

The World Bank. (2012a). *Ciblage et protection sociale. Note d'orientation stratégique* (No. AAA65-MA) (p. 161). Washington DC: The World Bank. Retrieved from http://www-wds.worldbank.org/external/default/WDSContentServer/WDSP/IB/2012/07/30/000020953_20120730111848/Rendered/PDF/AAA650ESW0P1120H0PRINTSHOP0VERSION.pdf

The World Bank. (2012b). *Pensions* (Africa Social Protection Policy Briefs) (p. 4). The World Bank. Retrieved from http://siteresources.worldbank.org/INTAFRICA/Resources/social-protection-policy-brief-pensions-EN-2012.pdf

Tine, J., Hatt, L., Faye, S., & Nakhimovsky, S. (2014). *Universal Health Coverage Measurement in a Lower-Middle-Income context: a Senegalese Case-Study* (p. 58). Bethesda: Health Finance & Governance Project , Abt Associates Inc. Retrieved from https://www.hfgproject.org/wp-content/uploads/2014/03/UHC-Measurement-in-Senegal-Case-Study.pdf

World Bank. (2013). *Republic of Senegal: Social Safety Net Assessment* (No. Report No: ACS7005) (p. 71). The World Bank. Retrieved from https://openknowledge.worldbank.org/bitstream/handle/10986/17575/ACS70050REVISE0ox0382140B00PUBLIC0.pdf?sequence=1