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TOWARD REDISTRIBUTIVE SOCIAL PROTECTION? INSIGHTS FROM SENEGAL AND MOROCCO

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Abstract

Social protection has come to feature more and more prominently on international and national development agendas. This quest for social protection in developing countries raises an important question: how can social protection act and be supported as an instrument for redistribution of wealth at the national level? Assessing and enhancing the redistributive potential of social protection mechanisms requires a multi-dimensional analysis and approach, encompassing political, technical, institutional and financial considerations. This study reports on a two-phased research combining conceptual work (Fonteneau & Van Ongevalle, 2015) with case studies in Senegal and Morocco in order to build and test a theoretical framework that can guide the assessment of the redistributive potential of social protection mechanisms in a developing context. The study offers in-depth insight into two ongoing social protection reforms: the adoption of Law 65.00 in 2002 on Basic Medical Coverage which initiated the introduction of a mandatory health insurance (AMO) for the formal sector and the establishment of a medical assistance scheme for the economically destitute (RAMED) in Morocco; and the 'Extension of the health coverage through mutual health organisations in the context of decentralisation' (DECAM) in Senegal. Based on insights from these two case studies, the study calls for development actors to support a maximalist interpretation of redistributive social protection, to make sure their support to social protection reforms is politically-smart, and to promote a more inclusive and meaningful stakeholder participation in policy making processes. The study demonstrates the need for a multi-dimensional analysis as well as the usefulness of the proposed theoretical framework to guide a comprehensive assessment of the redistributive potential of social protection mechanisms.

Preface

BeFinD is a consortium of four Belgian research centres at three different universities. It performs policy-oriented research related to the Financing for Development Agenda (2014-2017). The research is done on behalf of the Belgian Federal Public Service Foreign affairs, Foreign Trade and Development Cooperation, and hosted by the Flemish Inter-university Council (VLIR-UOS). The University of Namur (CRED), the University of Antwerp (IOB), and the University of Leuven (HIVA & GGS) are jointly coordinating research activities in 4 main areas: local resources for development, mobilising private resources for development, ODA and its relationship with other development-relevant funding flows, and global public goods. The research is oriented towards informing policies and practices of Belgian bilateral and multilateral development cooperation actors regarding the emerging landscape of development finance. HIVA-KU Leuven is contributing to the research activities on the redistributive potential of social protection, the role of the private sector in development, illegal financial flows, and global public goods. This report presents the results of our research on social protection.

Contents

List of abbreviations

CAFSP	Cellule d'Appui au Financement de la Santé et au Partenariat
DECAM	Décentralisation et Extension de la Couverture de l'Assurance Maladie
MSHPP	Ministère de la Santé de l'Hygiène Publique et de la Prévention
MSAS	Ministère de la Santé et de l'Action Sociale
CACMU	Cellule d'appui à la couverture maladie universelle
DGPSN	Délégation générale à la protection sociale et à la solidarité nationale
BSF	Bourse de Sécurité Familiale
PSD-CMU	Plan stratégique de développement de la couverture maladie universelle
UDAM	Unité départementale d'assurance maladie
ACMU	Agence de la Couverture Maladie Universelle
CONSAS	Concertations nationales sur la santé et l'action sociale
RAMED	Régime d'Assistance Médicale aux Economiquement Démunis
CNOPS	Caisse Nationale des Organismes de Prévoyance Sociale
CNSS	Caisse Nationale de Sécurité Sociale
PARCOUM	Programme d'appui à la réforme de la couverture médicale de base
AMO	Assurance Maladie Obligatoire
ADB	African Development Bank
CMB	Couverture Médicale de Base
WHO	World Health Organisation
AM(O)I	Assurance Maladie Obligatoire pour les Indépendents
AfD	l'Agence française de développement

Introduction

Social protection has come to feature more and more prominently on international and national development agendas. Over the past decade different UN agencies and bilateral donors developed or updated their approach on social protection: a Social Protection Inter-Agency Cooperation Board jointly chaired by ILO and the World Bank was established in 2012, the World Bank and ILO jointly launched the universal social protection initiative in 2015 and social protection has been integrated in the 2030 Agenda for Sustainable Development. The quest for social protection in developing countries opens an important debate on the role of domestic versus international resources in financing social protection (Barrientos, 2004; Cochon et al., 2004; Hujo & Mcclanahan, 2009). This research relates to this debate but approaches it from the angle of redistribution: What determines the redistributive potential of social protection measures? **How can social protection be strengthened as an instrument for redistribution of wealth** at the national level? Together the issues of financing and redistribution will determine to a great extent the sustainability, ownership and impact on inequality of social protection systems.

This research on redistribution in social protection is executed by HIVA-KU Leuven in the context of the BeFinD policy research centre. In the **first research phase** (2015), HIVA published a **mapping study** into the determinants of the redistributive potential of social protection mechanisms in developing countries. The paper draws attention to the importance of the financial, technical and socio-political dimension of social protection mechanisms and proposes a theoretical framework that visualizes how these dimensions interact and impact on redistribution through social protection mechanisms. The paper also noted that donor policies and practices are shifting away from isolated programs, towards supporting national social protection systems. To what extent the redistributive nature of social protection is an explicit concern in ongoing social protection reforms and in related donor interventions remained unclear (Fonteneau & Van Ongevalle, 2015).

This is where the **second research phase** picks up the thread. It aims to strengthen the toolbox to study the redistributive character of social protection reforms in developing countries, by applying the theoretical framework developed in the first phase on real cases. This allows us to both research the situation on the ground, and validate and fine-tune the framework at the same time. To do so, it marked out **case study research** into ongoing social protection reforms in two countries, **Senegal and Morocco**. The case studies were conducted between May and September 2016. In the first chapter of this report, the research rationale and questions are discussed. This is followed by a second chapter that summarizes key observations from the case studies and reflects on what they can mean for the understanding of and support to redistributive social protection in developing countries. The subsequent fourth and fifth chapter discuss the case studies in detail and offer deeper insights into ongoing reforms of social protection in health in Senegal and Morocco respectively.

1 | Research approach

1.1 Research focus

This research aims to strengthen the toolbox to study the redistributive character of social protection reforms in developing countries. Firstly, it investigates, in two cases, ongoing social protection reforms, reflects on their potential contribution to redistribution at the national level and discusses how the issue of redistribution has been an explicit concern in the technical and financial design, and the underlying socio-political process. For reasons explained below, the selected cases are Senegal and Morocco, two partner countries of the Belgian development cooperation. Secondly, the study provides this in-depth insight in ongoing social protection reforms in health in Senegal and Morocco by using the previously developed theoretical framework for analysing the redistributive character of social protection reforms. The confrontation of this tri-dimensional theoretical framework with the practice on the ground enables its further improvement and validation. This allows us to propose a 'tried and tested' theoretical framework for the analysis of the redistributive potential of social protection reforms. Ultimately, the research aims to contribute to a body of knowledge that can inform future strategy and policy development for development programmes that seek to support redistributive social protection systems.

This research focus has been unpacked in the following **four research questions**:

1. to what extent does the previously developed tri-dimensional theoretical approach indeed facilitate and foster an in-depth analysis and understanding of the redistributive nature of a social protection system? Do any lessons emerge from the case study that can improve the framework?
2. what technical and financial choices are shaping social protection systems in Senegal and Morocco and how do they affect the redistributive potential?
3. how did the policy making and implementation process underlying these choices unfold and what has been the role of different political and societal actors, including donors?
4. what can be learned for supporting the mobilization of domestic resources for financing social protection and the redistributive potential of social protection systems?

1.2 Key concepts

The focal point of this study is the redistributive potential of social protection. Hence, two key concepts are 'social protection' and 'redistribution'.

1.2.1 Social protection

There is no consensus on the definition or the scope of social protection. Different authors have provided overviews and discussions of the different definitions and components of social protection (Adesina, 2010; Devereux & Sabates-Wheeler, 2007, n.d.; Fonteneau, Vaes, & Huyse, 2014). This study joins the Institute of Development Studies (IDS) in the following description of social protection: 'Social protection can be defined as the set of all initiatives, both formal and informal, that provide social assistance to extremely poor individuals and households; social services to groups who need special care or would otherwise be denied access to basic services; social insurance to protect people against the risks and consequences of livelihood shocks; and social equity to protect

people against social risks such as discrimination or abuse (Devereux & Sabates-Wheeler, 2007; Devereux & Barrientos, 2008).

This definition points out the different components that make up social protection. There are two main components: social insurance and social assistance. Social insurance measures consist of programmes providing protection against risks arising from life-course contingencies such as maternity, old age, disability, work related injuries or sickness; social assistance measures provide support to those in poverty. They include various non-contributory cash or in-kind transfer programmes for individuals and households. Additionally, employment programmes (food-for-work, public works programmes) and labour market programmes (designed to protect workers, such as minimum wage legislation and minimising labour related risks) complement the basic components of social protection.

1.2.2 Redistribution

Redistribution is considered a key feature and one of the primary objective of social protection, next to the protection against risk (Cantillon, Van mechelen, Pintelon, & Van den Heede, 2013), and "social protection is undoubtedly the most important tool that welfare states have at their disposal for redistributing income" (Cantillon et al., 2013, p. 3). All welfare provision is, by definition, redistributive in some way (Cantillon et al., 2013; Spicker, 2011). But, what does redistribution actually mean? When can a social protection mechanism be considered more redistributive compared to another? In its simplest interpretation, a mechanism or measure is considered redistributive if the people who receive goods or services from a measure are not the same as the people who pay. A deeper analysis of the redistribution in social protection uncovers some important factors and dynamics that can be taken into account.

Firstly, redistribution can be classified as **vertical or horizontal**. Vertical redistribution may be progressive (from rich to poor) or regressive (from poor to rich). Horizontal redistribution goes from one kind of group to another (Spicker, 2011) or, as one could also say, reallocates income across the life course (Salverda, Nolvan, & Smeeding, 2009), for example from men to women, from households without children to households with children, from young to old. Much of the literature focuses on vertical redistribution, and assumes that social protection benefits are intended for the relief of poverty. However, in practice redistribution to people on lower incomes is not always the primary objective of specific measures (e.g. disability benefits). It is important to also take into account horizontal redistribution (Spicker, 2011).

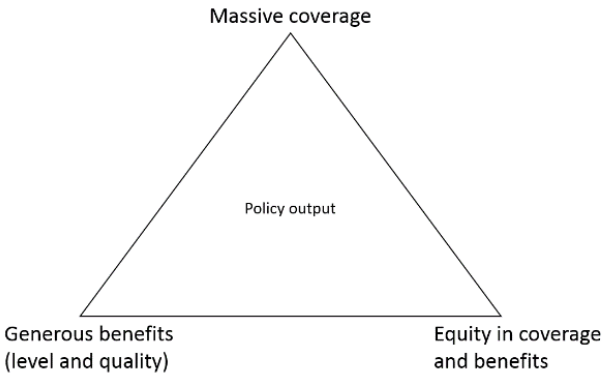
Secondly, it is most common to look for redistribution at the local or national level, but in fact redistribution can happen at **all levels: local, sectoral, national, regional and international or global.** When domestic resources are mobilized to finance social protection at national level, this would contribute towards a redistribution of wealth between different groups of a population within a given country. When instead external resources play an important role in funding social protection, this can be considered as redistribution at a global level. It may be considered problematic from a sustainability perspective if financing of social protection in a country is driven by external aid, but over the past decade various academics (Ooms, 2011) as well as policymakers (De Schutter & Sepú lveda, 2012) have argued in favour of alternative global redistribution mechanisms, such as the establishment of global social funds based on redistribution of wealth and cross-subsidisation between countries.

Thirdly, the degree of redistribution triggered by social protection mechanisms can be **interpreted in a minimalist or a maximalist way**. The discussion on 'universalism' by Martínez Franzoni &

Sánchez-Ancochea (2016) is insightful in this regard, as they use 'universalist' as an alternative term for 'redistributive'. They trace the different interpretations of universalism in social policy, which in their view could also be referred to as 'egalitarian social policy' or 'redistributive social policy'. Instead, they explicitely opt to refer to 'universalism', in order to demonstrate how this term with a powerful normative value can be given a pragmatic and feasible operationalization (Martínez Franzoni & Sánchez-Ancochea, 2016, p. 8).

They point out that originally universalism in social policy referred to tax-funded programs that provided benefits that everyone received as a matter of right. As many middle and low-income countries faced major obstacles – for example a large informal sector - to introduce such tax-funded citizen-based programs, a more minimalist interpretation of universalism gained ground. In the minimalist interpretation, universalism in social policy refers to the ambition to reach everyone even when the provided benefits differ. The focus then is on expanding coverage and not on the quality and level of the benefits (generosity) or on the even distribution of coverage and benefits across beneficiaries (equity). Martínez Franzoni & Sánchez-Ancochea (2016) make the case for a maximalist definition that instead includes all three dimensions and defines universalism as a **combination of coverage, generosity and equity** (see figure 1.1). They argue that an arrears in one of these dimensions can severely jeopardize the overall redistributive potential of a social protection program or system. For example, massive coverage and rights-based access but insignificant benefits, or expanding coverage but giving different beneficiary groups access to benefits of different generosity are situations where redistribution is crippled.

Figure Fout! Gebruik het tabblad Start om Heading 1 toe te passen op de tekst die u hier wilt weergeven..**1**
The triangle of coverage generosity and equity that determines universalism



Source Martínez Franzoni & Sánchez-Ancochea, 2016

The **paradox of redistribution** is a first important issue that supports their case. Intuitively one would assume that, in order to maximize redistribution, programs should not waste resources on people who can live without them. Instead the benefits should be targeted to those in need. However, social security research shows that targeting exerts downward pressure on the level of protection offered. Or, in other words, programs for the poor become poor programs: under-budgeted, institutionally weak and prone to political manipulation. Instead, when middle class is incorporated and stands to benefit, the public support for social spending is higher, and middle class will use its voice and political capital in favour of the programs. Although limited evidence is available on how this paradox behaves in the South, there is sufficient reason to assume that redistribution in the long

run goes hand in hands with both coverage and generosity (Martínez Franzoni & Sánchez-Ancochea, 2016). It should be noted that targeting is not the same as progressivity in contributions or benefits. In the case of targeting, benefits will only be accessible for a specific well-defined group of beneficiaries. Progressivity is about maintaining a relationship between income level and the size of benefits or contributions.

The influence of the **social stratification[1] of risks** is another important dynamic that needs to be taken into account when discussing redistribution. Social stratification of risks means that specific risks more commonly occur in specific socio-economic groups of the population or, put differently, that socio-economic profile of someone can to some extent predict what risks are more likely. For example, unemployment and illness are more frequent in weaker socio-economic groups, whereas work-related risks associated with the combination of work and life show a very different social stratification. A programme that addresses specific risks will have stronger redistributive and poverty reducing effects when those affected by the risk are concentrated in weaker socioeconomic groups. This implies that the overall redistributive potential of a programme or a social protection system as a whole is also determined by the types of risks it primarily aims it address. Taken into consideration the paradox of redistribution, Cantillon et al. (2013, p. 8) state that "it may be expected that downward pressures on benefit levels may have been stronger in relation to risks typically affecting vulnerable groups (such as long-term unemployment)".

1.3 Initial theoretical framework

Key entry point of this research is the role of social protection as a tool for redistribution at the national level. The section above summarizes some considerations that need to be taken into account when judging the redistributive character of social protection measures. The next question that arises is what determines this redistributive character. Previous research (Fonteneau & Van Ongevalle, 2015; Hickey, 2008; Lavers & Hickey, 2015) argued that the redistributive potential of a social protection system is determined by its financial, technical, and socio-political factors. In phase one of the research, the mechanisms at play were summarized in a theoretical **framework to analyse the redistributive potential of social protection mechanisms, visualized in figure 1.2.**

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 1.2). 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

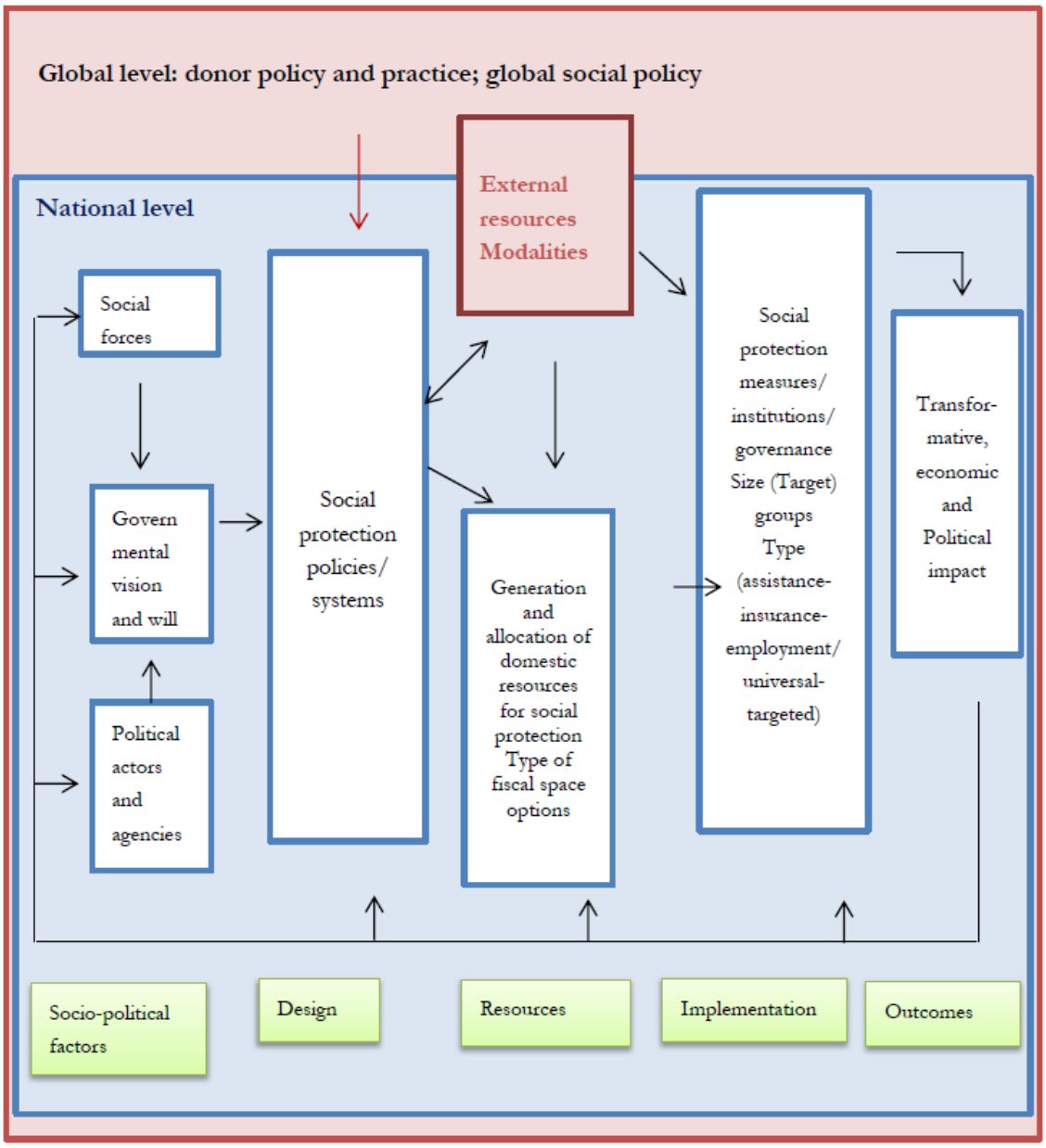
1 Social stratification can be understood as the process of ranking individuals and groups of society in different hierarchical socio-economic strata, based upon their occupation and income, wealth and social status.

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).

Additionally, the influence of **global** factors and international/development cooperation should also be taken into account. Global factors include, amongst others, trends in global economy or in international social policy that co-shape the context in which national policy processes unfold. International cooperation and development cooperation also impact on these policy processes, for example support by international organisations, bilateral donors or south-south exchange can play a role in how social protection policy is formulated, financed and implemented.

Figure Fout! Gebruik het tabblad Start om Heading 1 toe te passen op de tekst die u hier wilt weergeven..**2 Determinants for redistribution in social protection mechanisms**



Source Fonteneau & Van Ongevalle 2015, p. 12

The remainder of this research will apply this theoretical framework to explore specific social protection reforms in two cases.

1.4 Methodology

Policy analysis, an inductive approach and case study shape the methodological face of this study.

1.4.1 Case studies: Senegal & Morocco

The need for an in-depth analysis of a highly complex process in which the perspectives of multiple actors need to be taken into account, in combination with limited time and resources, supported the choice for a case study research design. The case studies should be seen as mostly illustrative, since

the first objective is to describe policy reforms, which are highly context specific, which makes generalisation of any insights difficult. However, the study does hope to inform more general insights in the analysis of the socio-political dimension and redistributive potential of social protection systems.

The case selection was based on four criteria. Firstly, to maximize the relevance of the study for Belgian development actors, only partner countries of the Belgian development cooperation were taken into consideration. Secondly, the countries had to be the scene of major, recent or ongoing reforms in social protection. Thirdly, in view of the focus on redistribution, in particular reforms towards more universal social protection were of interest. Finally, the availability of policy documents and the possibility of efficient data collection during field work also played a role. Initially Morocco, Senegal and Rwanda were shortlisted, but the latter risked to be hindered by data collection difficulties in the field due to a restrictive political climate. This led to the **selection of Senegal and Morocco as cases**. In both cases these criteria were also used to identify a specific social protection component for further investigation. In both cases, this prompted a focus **on social protection in health**.

1.4.2 Policy analysis

In line with the ambition of gaining better insight specifically in the socio-political dimension of redistributive social protection, this study approaches policy as the product of the balance of power between political and societal actors interacting on a specific policy topic, and recognizes that these actors, all with their own ambitions, agenda's and objectives, will continue to influence policy during the implementation (Crabbé, Gysen, & Leroy, 2006, p. 20-34).

An inductive approach is used to investigate the different stages of the policy cycle: detect, through observation, interesting patterns in how the socio-political dimension of social protection reforms determines financial and technical features, as well as the redistributive potential of the resulting social protection mechanism. The research focuses mostly on the first three phases of the policy cycle[2] as described by Crabbé et al. (2006) and De Peuter, De Smedt, & Bouckaert (2007): (1) agenda setting and goal setting; (2) policy development, including policy formulation and instrumentation and (3) policy implementation.

Data collection as well as in-case and cross-case analysis and reporting have been guided by a 6-step analytic approach (see box below 1.1; see annex 1) which was developed based on the first mapping study (Fonteneau & Van Ongevalle, 2015) and insightful research by Hikey (2008) and Hikey and Paver (2015). The study consisted of three rounds of data collection: a document analysis (reported on in an unpublished concept paper, March 2015), field research in May 2016 and September 2016, and literature study. These different rounds allowed for an iterative relationship between research design, data collection and data analysis.

Box 1.1 The six-step approach[3] for data collection and analysis in case studies

1. Political and economic country profile = a concise overview of the current political and economic landscape.
2. Snapshot of social protection landscape = mapping the different components of the existing social protection landscape, and identifying the components that are the subject of recent or ongoing policy reforms.
3. Reconstruction of the policy cycle = a more in-depth analysis of the recent policy developments in the selected domain of social protection.

2 See annex 1 for more information about the different stages of the policy cycle.

3 A more detailed elaboration of the analytical framework is provided in annex 1.

4. Analysis of the technical dimension = discussion of the technical features of the mechanism(s) through which social protection in the selected domain is/will be implemented.
5. Analysis of the financial dimension = discussion of the funding options being considered or implemented in the concerned mechanism(s).
6. In-depth actor map per domain = overview and discussion of all actors involved in the process of policy development and implementation.

1.4.3 Limitations

This assessment of the redistributive potential of the social protection reforms in the two case studies also has important limitations. Firstly, assessing the actual distributive impact of social benefits at a national level requires extensive calculations based on detailed data on income pre and post taxation. Due to the limited availability of quantitative date and the choice for a qualitative approach, this falls outside the scope of this study.

Secondly, the tax systems underlying the financial architecture of the social protection reforms in the case studies have not been investigated extensively. Yet, tax systems do not just affect levels of social spending; they also affect the degree of redistribution in tax and benefit systems. This is related to the manner in which social programmes are financed through income tax, social security contributions, payroll taxes, indirect taxation or other general tax revenue (OECD, 2012b). The overall level of the tax burden, the type of taxes, and the degree of progressivity in tax systems, all determine the redistributional potential of social protection mechanisms (Adema, Fron, & Ladaique, 2014). In the study general observations regarding financing sources for the social protection mechanisms under scrutiny are taken into account, but do not provide sufficient basis for a substantiated assessment of measurable redistributive effects or an in-depth analysis of the tax system's contribution to it.

Thirdly, the distinction between social protection programs or mechanisms and social protection systems is important. The focus in the case studies is on specific mechanisms in one domain of social protection: health. Integrating different mechanisms across the different domains of risks into one social protection system is an important challenge in most low- and middle income countries. The overall redistributive effect of a mechanism can depend on its interplay with other mechanisms in the same domain or in other domains. To assess the redistributive potential of the overall system, one will need to take into account all its components, how they are coordinated and how they interact. This is beyond the scope of this study, although the existence of a process or a plan to evolve towards a redistributive social protection system was taken into account.

Finally, the study is situated on the overlap between several well-developed research traditions. An exhaustive literature review of these different strands in literature was beyond the scope of this study. The literature review focused instead on those contributions addressing the development of social (protection) policy in developing countries, although several contributions from the literature on social policy development and effects in welfare states, or the literature on policy change in general were also taken into account. The data collection for the case studies happened between March 2016 and December 2016. As is to be expected with ongoing reforms, the situation on the ground has been evolving since.

2 | Assessing redistributive potential: key insights

The previous chapter presented three important ingredients in this study. Firstly, the discussion of the concept of redistribution in social protection (section 1.4) highlighted several considerations that need to be taken into account when assessing redistribution. These include the balance between coverage, generosity and equity; the risks associated with targeting including the paradox of redistribution; and the degree of vertical versus horizontal redistribution. Secondly, the previously developed theoretical framework argued that a good understanding of how a social protection mechanisms perform in these areas, demands insight in their technical, financial, and socio-political features (section 1.1). Finally, a step-wise approach for data collection and analysis was proposed, and has been applied in the collection and analysis of data on ongoing social protection reforms in the heath sector in the two case studies, Senegal and Morocco. This chapter brings together the key insights that emerged.

2.1 Case study summary

In the case of Morocco, the adoption of Law 65.00 in 2002 on Basic Medical Coverage initiated the introduction of a mandatory health insurance (AMO) for the formal sector and the establishment of a medical assistance scheme for the economically destitute (RAMED). In the case of Senegal, the Senegalese health ministry launched a strategy for the extension of social protection in health in 2013, with the 'Extension of the health coverage through mutual health organisations in the context of decentralisation' or DECAM as one of the key pillars. Using the theoretical framework, the technical, financial, institutional and political features of the mechanisms that these reforms introduced were investigated. A brief summary is provided below.

Senegal

The extension of the health coverage through mutual health organisations in the context of decentralisation or DECAM in Senegal since 2013 shows the following key features:

Technical dimension

- Voluntary health insurance
- Universal but designed for the informal sector
- Contributory but subsidized through tax ressources
- Free access for poor and vulnerable

Institutional

- Implemented through (newly established) community based mutual health organisations
- Managed by the new Agency for Universal Health Coverage
- Junctions between government actors, local authorities and MHOs crucial but still unclear

Financial

- Funded mainly through tax-incomes and donor support
- Mid-term and long-term sustainability problematic
- Considering different financial options, but no clear financial plan

Political

- International agenda and presidential push were crucial
- Important role of donors
- Conservative move of trade unions and limited input by CSOs
- Policy process partially informal and driven by key individuals

Morocco

The extension of a basic medical coverage through AMO and RAMED in Morocco since 2002 shows the following key features:

Technical dimension

- Separate mechanisms per target groups leading to fragmentation
- Mandatory health insurance (AMO) giving access to services in public and private sector
- Health assistance (RAMED) giving access to services only in specific region and in public sector
- Both contributory, but in RAMED the extreme poor are exempted from contributing

Institutional

- AMO managed by former mutual health organisations with strong union representation
- National Agency for Health Insurance (ANAM) as regulator but with limited enforcing power
- In practice no regulator or manager for RAMED, but topic of discussion

Financial

- AMO funded by employers and employees. Reimbursements go mainly to private health sector
- RAMED insufficiently financed by state, local communities and beneficiaries

Political

- Important role change agents in administration & King
- Role donors is not very visible, but provide important technical support
- Strong influence of trade unions and limited input by CSOs

2.2 Minimalist interpretation of redistribution

Observation
In both case studies, a balanced maximalist interpretation of redistribution does not feature prominently on the agenda of the national policy makers developing or reforming their social protection systems, nor on the agenda of financial and technical partners supporting these reforms. Efforts are ongoing in the areas of coverage, generosity of benefits and equity of access but there is a strong focus on expanding coverage. A better balance with generosity of benefits and equity of access is not explicitly and prominently pursued.

Recommendation for development actors
Initiate and/or support a transparent reflection on the redistributive potential of different social protection policy options and on the trade-offs being made between coverage, generosity and equity. This can promote a more holistic, balanced interpretation of redistribution in social protection and can avoid a too one-sided and technocratic focus on expanding coverage.

In both cases, the social protection reforms in health represent a rather minimalist interpretation of universalism and redistribution. The ongoing reforms in both Senegal and Morocco show **a strong emphasis on expanding coverage**. In the case of Morocco, the mandatory health insurance (AMO) for salary workers has been expanded to family members of beneficiaries, students, and pensioners. The introduction of health insurance for free professions and the self-employed is ongoing. In 2012 Morocco also opted for the generalization of its health assistance RAMED. In brief, key steps forward have been centred around coverage, although efforts are also being made in other areas, for example the improvement of benefits and services for some target groups, or the introduction of better data collection and management practices. In the case of Senegal, boosting coverage seems to be the leitmotif of its reform in social protection in health. President Macky Sall got elected on his promise to increase coverage from 20% of the population in 2012 to 75% in 2017. The voluntary universal health insurance, currently being introduced, has the ambition to address the coverage gap in the informal sector. Over the past years the government reported figures of coverage have gone up spectacularly, but they are not accompanied by a critical assessment (or even collection of data for such an assessment) of the actual benefits accessed and the equity in access.

Of course the expansion of coverage represents undeniable progress. However, in both cases, these swift evolutions in coverage are **not matched by the evolutions in the generosity of benefits or the equity of access**. For example, in the fragmented Moroccan system, beneficiaries of the health insurance (AMO) get freedom of choice with regard to the health care facilities they make use of, whereas beneficiaries of the health assistance (RAMED) are limited to the public health care infrastructure, where they may find that the health service they need is not available, forcing them to pay out-of-pocket in a private clinic anyway. This example also demonstrates the two aspects of generosity: on the one hand generosity refers to the scope of the benefits being offered, on the other hand it also covers their actual quality. In theory RAMED provides free access to a very broad package of health services in the public health sector, but health infrastructure is distributed geographically unevenly, and the public health care facilities are not being payed sufficiently to provide these services. Hence, the actual supply of qualitative health services is in practice limited. In the case of Morocco, the clear priority that has been given to improving social protection in health for the formal sector, while the expansion of RAMED was postponed for years, also demonstrates the unbalance with regard to equity. In the case of Senegal the challenge of matching coverage with the scope and quality of health services may be even more acute. Without expanding and improving the supply of health services across the country, efforts to implement universal health insurance will be void (and may, in the long run, damage the public support for and confidence in any type of health insurance).

Both cases also demonstrate some of the dilemma's related to **targeting**. In theory Senegal's DECAM implements a universal health insurance, but in practice it is designed specifically for the informal sector. Although one can argue that formal sector workers may benefit indirectly when their extended family members no longer rely on them for their health care, they draw no visible direct benefit. However, the system is for more than half tax-funded. There clearly is a transfer of resources, and hence redistribution, but the paradox of redistribution warns us that the longer-term implications may be limited public and political support. This is all too visible in the case of RAMED in Morocco. The RAMED health assistance is targeted only at the poor and vulnerable, has struggled for years to build sufficient political and public support and is still financially and institutionally weak. Additionally there are also many issues related to the operationalization of targeting. How to determine who gets access and who doesn't get access? In the case of RAMED for example, a minimal difference in monthly income can make the difference between free access through RAMED or no health coverage whatsoever, and this raises fairness issues.

By developing specific mechanisms for specific beneficiary groups the **potential for vertical redistribution becomes less developed** than the potential for horizontal redistribution. For example, in the case of Senegal, DECAM is designed for the informal sector and hence the heterogeneity of the insured beneficiaries will be low. The mechanism will mostly cover rural, informal workers confronted with similar precarious working conditions and livelihood risks. Although the attempt of providing social protection for health in the informal sector is very laudable, one should also point out that this goal could have also been achieved by including these beneficiaries in the health insurance mechanisms of the formal sector, which could have had a far bigger redistributive effect.

Looking at the discourse present in these policy processes on social protection in health or the development cooperation supporting these process, the research did not come across clear references to redistribution in either of the cases. Although some references to equality and social justice in general terms can be found, national governments and financial and technical partners don't clarify their understanding of and position to redistribution in a concrete manner. Hence, it remains unclear to what extent they actually aim to promote redistribution through social protection, and if so, how they interpret and operationalize this objective. Initiating or supporting a more transparent reflection, including on the trade-offs being made between coverage, generosity and equity, could promote a more holistic interpretation and implementation of redistribution in social protection.

2.3 Indispensable political dimension

Observation
Politics are indispensable for understanding social protection policy in low- and middle income countries, and for assessing how the development of redistributive social protection can be supported. Investigating this political dimension requires awareness of the driving role of political settlements, the role of both formal and informal power dynamics and institutions, the role of international and transnational actors, and the role of ideas. There is very little publicly available evidence to show that technical and financial partners supporting social protection reforms are aware and currently engage with these dynamics.

Recommendation
Institutions matter for development and behind institutions lie politics. Efforts to support redistributive social protection need to be politically-smart. This requires a strong analysis of the political environment in which a social protection mechanism is put on the agenda, operationalised and implemented, as well as the development of clear strategies on how to engage with these political dynamics and how to enable the own organization to do so.

Different scholars point out that the research on social protection policy in low and middle income countries focuses on definitional debates, policy design and effectiveness, and pays relatively limited attention to the politics that shape these policies (Barrientos, 2013; Bender, 2013; Haggard & Kaufman, 2008; Lavers & Hickey, 2015, 2016). However, the awareness of the **importance of politics** in understanding social protection policy in low and middle income countries is growing (Barrientos & Hulme, 2010; Béland, 2011; Bender, 2013, 2017; Devereux & Sabates-Wheeler, 2008; Hickey, 2008; John & Putzel, 2009; Khan, 2010; Lavers & Hickey, 2015). Lavers and Hickey (2016 p. 389) argue "that politics need to be at the centre of efforts to understand social protection in low income countries and the evident variation in country experience."

Lavers and Hickey point out that the literature on politics in development agrees that "political bargaining among elites, and between elites and non-elite factions, leads to the establishment of a 'political settlement', which then closely shapes processes of institutional design and the redistribution of resources within society" (Lavers & Hickey, 2016, p. 389). This **'political settlement'** approach interprets social protection as one of the means that different powerful and organized groups use to ensure political and social stability in a way that serves their interests. In that respect, social protection can be seen as the glue as well as the result of a deal or 'settlement' between these groups. The 'political settlements' approach also presumes that in less industrialized contexts groups tend to be shapes by a variety of identities, including ethnicities, region and religion, and hence political elites can relate to these factions on a patron-client basis. This underscores the importance of power dynamics and informal politics and institutions in such contexts. Applying this to the understanding of social protection reforms, the authors argue that such processes of negotiation lead to the formation of policy coalitions, or coalitions of actors, ideas and interests, that support specific problem formulations and policy solutions (for a figure of the framework, see annex 2). This has interesting implications. Firstly, it means different social protection policy proposals will be supported by different coalitions, and hence strengthening the position of specific actors or interest groups will also affect what coalition dominates and which policy option prevails. Secondly, it means that moments of instability create space for policy change, during which social protection could be a means to improve stability. Thirdly, it also implies that different types of political settlements will, depending on how the gained their mandate, be susceptible to different types of drivers (e.g. votes, public support, patronage, military power, international legitimacy, …). But, in the end, political survival will most often trump long-term interests of the wider population (Byiers, Berliner, Guadagno, & Takeuchi, 2015).

This approach has been useful for exploring, for example, why the reforms in Senegal and Morocco unfolded when they did: after a new government coalition came to power in Morocco and after a new president was elected in Senegal. Such instances can be seen as the window of opportunity for different groups to engage in the negotiation of a settlement about the redistribution of resources, a negotiation that will be determined and will determine the institutional landscape. It also increases insight in why specific options were selected. For example strong existing institutions and strong interest groups, such as the mutual health organizations for the public and private sector in Morocco, or the trade unions represented in the bipartite social security institutions for the formal sector in Senegal, determined the scope of the reform by vetoing fundamental changes that would affect their own position. Such resistance of powerful actors can limit the policy space for change to areas or options where the established interests are less strong. In both cases, but especially in the case of Morocco, this leads to an increase of fragmentation in the short term. On the other hand, one can also argue that such 'conservative' position of interest groups safeguards existing social protection mechanisms from becoming overstretched or eroded, especially in situations where the commitment for developing robust financing social protection remains weak.

An element that needs to be taken into account is the role of international and transnational actors. Bender et al. (2014, p. 4) see extensive social protection reforms as a global phenomenon, as over the past two decades many low and middle income countries, in Africa, Asia, Latin America, have been the scene of reforms introducing, extending or improving social protection. The authors also stress that this global phenomenon is not uniform across countries, and that domestic factors are insufficient to explain this diversity. They argue that apart from domestic factors, these policy changes are also attributed to **international influences and interdependencies**. Policy transfer and policy diffusion[4] are important dynamics in this regard (Bender, Keller, & Willing, 2014). In the case of Senegal, this can be illustrated by the introduction of the Bolsa Familia-inspired Family Security Grants after a study visit of Senegalese officials to Brazil, or by interviewees' frequent references to social policy reforms in Rwanda and Ghana when reflecting on the strengths, weaknesses and possible ways forward for the Senegalese approach. Lavers and Hickey further also stress the importance of **transnational actors** in this regard. The case studies support this argument. In line with what Lavers and Hickey (2016) point out, global policy networks and epistemic communities[5] in support of social protection built by transnational actors have co-shaped the national social protection policies. In the case of Senegal, this can be illustrated by the strong influence of the 'universal health coverage' agenda spearheaded by the World Health Organisation, as well as the rise of social protection on the international agenda. Interviewees indicate that these transnational processes have played a key role in the agenda setting of health coverage, leading to the ongoing reform in Senegal. It is also demonstrated by the consensus that was built around the role of mutual health organization in delivering the envisioned universal health insurance in Senegal. In this process, the role of key individuals that have, for decades, been part of transnational networks devoted to mutualisms, and the influence of the policy input developed by these networks at regional and international level were instrumental in the selection of DECAM as the most desired policy option.

Another element that, according to Lavers and Hickey (2016), remains underexposed in existing literature on social protection policy in developing context is **the role of ideas.** Others point out the importance of mental models, culture, values and norms (Bender, 2017). In brief, attitudes toward social policy and redistribution are influenced by beliefs about the respective responsibility of individual, society and state, as well as by the attitudes towards the poor, the existence or absence of an insurance culture, or religious aspects. Although it was beyond the scope of the case studies to look extensively for more evidence of the link between ideas and the social protection policy, some examples emerged. In Morocco for example high level officials stated they considered it normal for those who are productive and contribute to the economy to have more freedom of choice in the health services they use, whereas those depending on the state can make no claim to the same services and should accept what they are given. In Senegal, different interviewees indicated that the success of the voluntary health insurance may be hindered by the belief that taking insurance can call down misfortune upon oneself, while different experts also stated that the support for a mandatory

4 Policy transfer can be defined as "the process, by which knowledge about policies, administrative arrangements, institutions and ideas in one political system (past or present) is used in the development of policies, administrative arrangements, institutions and ideas in another political system" (Dolowitz & March, 2000, cited in Bender et.al. (2014, p.11). Policy diffusions can be understood as "the process whereby policy choices in one unit are influenced by policy choices in other units" (Maggetti & Gilardi, 2013 cited in Bender et.al. 2014, p.13). Policy diffusion is about communication and the spread of policy (innovation) between different interdependent policy units, which can be situated at any level from the local to the transnational.

5 Epistemic communities are groups of professionals, often from a variety of different disciplines, which produce policy-relevant knowledge about complex technical issues. Such communities embody a belief system around an issue which contains four knowledge elements: [1] a shared set of normative and principled beliefs, which provide a value-based rationale for the social action of community members; [2] shared causal beliefs, which are derived from their analysis of practices leading or contributing to a central set of problems in their domain and which then serve as the basis for elucidating the multiple linkages between possible policy actions and desired outcomes; [3] shared notions of validity – that is, intersubjective, internally defined criteria for weighing and validating knowledge in the domain of their expertise; and [4] a common policy enterprise – that is, a set of common practices associated with a set of problems to which their professional competence is directed, presumably out of the conviction that human welfare will be enhanced as a consequence (Haas, 1992).

insurance was limited because this constitutes a too intrusive state interference in the individual sphere.

In both cases, a closer look at the role of (bilateral and international) technical and financial partners yields very little trace of explicit **political analysis**. Although it can be assumed that governmental and non-governmental development actors include domestic politics in their context analyses and programme design processes, it remains unclear how comprehensive and solid these considerations of the political dimension are, and to what extent actual strategies for engaging with these dynamics are developed and implemented.

In fact, this is an issue in development cooperation in general. As is stated in the Doing Development Differently Manifesto (2016): "(…) genuine development progress is complex: solutions are not simple or obvious, those who would benefit most lack power, those who can make a difference are disengaged and political barriers are too often overlooked. Many development initiatives fail to address this complexity (…)". At the same time many contributions by academics and development practitioners alike support the analysis that without taking into account complexity and politics, development cooperation will always underperform (Hall, Cleaver, Franks, & Maganga, 2013; Hudson, Marquette, & Waldock, 2016; Menocal, 2014; ODI, 2016; Ramalingam & Bound, 2016). The challenge this presents is nicely summarized by Menocal (2014) "one of the most important lessons to emerge in international development over the past two decades is that institutions matter, and that behind institutions lie politics. (…) What is needed is a shift not only to think politically but also to work differently. This means asking hard-hitting questions about how change happens; the role external actors play in supporting that change; and what sorts of programme approaches, funding and staffing are needed as a result."

These insights present significant challenges for the general practice of development actors. Specifically for aiding social protection reforms, they support the need for a strong analysis of the broader political (policy coalitions, stakeholders, power balances and dynamics, transnational actors, ideas and mental models), technical (effects of implementation and operationalization choices on coverage, generosity, equity), institutional (power, capacity issues, coordination issues) and financial (fiscal architecture, financial feasibility) environment in which social protection policy are being introduced. This analysis should then trigger a strategizing exercise on how to engage with these dynamics and what is needed to enable the development actors to put these strategies in practice.

2.4 Patchy stakeholder participation

Observation
Although some possibilities for participation in the development of social policy may exist, the actual involvement of stakeholders is limited: not all stakeholders are included and/or their possibilities for actually influencing policy are restricted. This has to do with a reductive interpretation of what stakeholders are relevant and a lack of proactive stakeholder engagement on the one hand. On the other hand, stakeholders, and specifically civil society organisations, don't have social protection prominently on their radar or lack capacity and expertise to engage in the policy process in a meaningful way.

Recommendation
Supporting the involvement of all stakeholders in social protection policy processes contributes to a comprehensive and shared assessment of the social protection situation on the ground and promotes a wider debate on the policy options to move forward. This is important for the development and implementation of suitable and feasible policy options that enjoy public support. Providing tools to guide such stakeholder participation (e.g. the assessment-based national dialogue) or strengthening capacity of stakeholders to participate can contribute to this.

Civil society organizations can play an important and multifaceted role in improving social protection, and often do so. Their contribution can pertain to the introduction, experimentation and implementation of social protection mechanisms, but also in building coherent social protection systems at national level (Fonteneau et al., 2014, 2014; Friedrich-Ebert-Stiftung, 2015; Hudson et al., 2016; Taylor-Gooby, 2016; Vaes, Fonteneau, & Van Ongevalle, 2016). However, in both cases only a fragment of the civil society did actively take part in the policy formulation process on the expansion of social protection in health.

In the case of Senegal, the mutual health organisations supported by influential resources figures (in several cases with a fine record in development agencies or international organisations) played a significant role. The trade unions concentrated on the reforms targeting the formal sector and did played a far less active role in the development and operationalization of DECAM, as it was to focus on the informal sector and hence outside their core business. Other civil society organisations felt side-lined in the policy process, or lacked expertise to strongly position themselves. They did take note of this important development and the need to engage on the topic. Attempts are being made to build policy influence on the topic, for example by collecting grassroots feedback to guide the next policy cycle.

In the case of Morocco, events unfolded similarly. The trade unions initially played an important role in creating policy space for RAMED but then focused their efforts on influencing AMO, the formal sector component. They have been a stalwart in the further development and operationalisation of AMO. Other civil society organisations indicate they have difficulty gaining access to the policy process. One explanation is that available government funding for CSOs is not directed towards the domain of social protection policy and hence few CSOs have built expertise and experience. International organisations and bilateral donors also focus on trade unions whenever involving civil society, and implicate other CSOs far less. An exception to this rule have been the professional associations (e.g. of doctors, pharmacists) who have participated actively in policy formulation and negotiation.

In both cases, the policy processes preceding the ongoing reforms did not proactively seek to mobilize different stakeholders and include them in the debates and policy decision on social protection reforms. Instead, participation was reduced to the usual suspects. This was also possible because other actors, although representing important constituencies, did not have the expertise and capacity to spot this important policy reform in time, to gain access to the process and provide meaningful input. The **assessment-based national dialogue approach** promoted by the ILO provides a tool to address these constraints (ILO, 2016). It is a way to take stock of existing social protection realities in order to understand what elements of a basic national social protection floor are in place, where "holes" in floors exist. It takes an explicitly participatory approach to the identification of priority policy options for the successful and coordinated development of nationally defined social protection floors. This means all relevant stakeholders, including line ministries, local government bodies, workers' and employers' organizations, civil society organizations, academics, and development partners, should be involved from the outset. Working with stakeholders who have sufficient political power and technical expertise is critical to avoid future blockages in the process (ILO, 2016, p. 44).

2.5 Useful theoretical framework

Observation
The proposed theoretical framework facilitates the analysis of redistribution in social protection mechanisms and reforms but it needed an institutional dimension and a better reflection of the importance of the political dimension. The framework has been revised accordingly.

Recommendation
Using the proposed theoretical framework in combination with the insights presented above can assist in a more comprehensive and realistic assessment of the redistributive potential of a specific social protection mechanisms. It will also allow to determine important obstacles or levers for promoting more redistribution.

The case studies confirm the value of the conceptual framework put forward at the beginning of this study but have also shown that it may lack an institutional dimension and does not fully reflect the importance of the political dimension. Four adjustments bring us to propose the following, adapted, visual of the conceptual framework (see figure 2.1).

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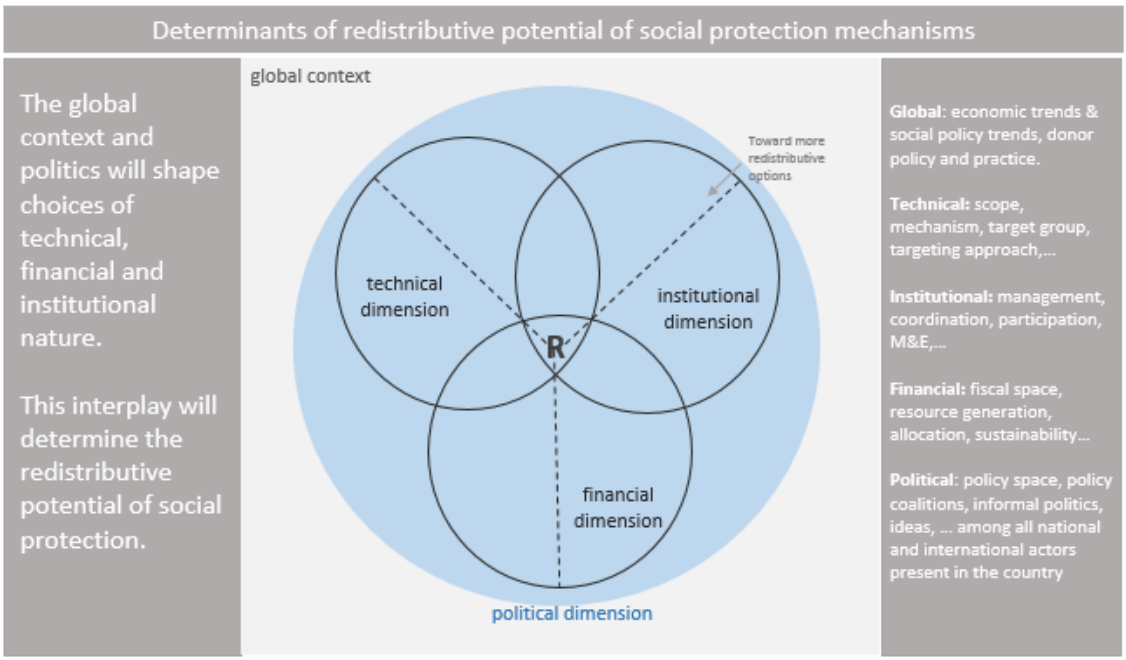
Conceptual framework: determinants of redistribution in social protection



Source Adapted from Fonteneau & Van Ongevalle (2016)

Firstly, in both case studies, politics have been key to understand the policy space, the selection of specific policy options, the ups and downs in the implementation. In that sense, the political dimension is dominant, and present in all other dimensions as well.

Secondly, apart from the technical choices with regard to mechanisms, target groups, targeting approaches, service packages, data collection, etc., the institutional set-up responsible for the implementation, management, regulation and monitoring and evaluation of social protection mechanisms is of importance. The initial conceptual framework included this in the technical dimension, but we now propose to present it as a separate dimension. As the observations from the case studies have shown, the institutional dimension, and in particular the relative power and mandates of the different institutions involved, the coordination between them, and the representation of different actors within them, can affect the implementation of social protection

policy and its contribution to redistribution. Including this as a separate dimension also brings in an actor-focus, which supports the analysis of the political dimension.

Thirdly, the original conceptual framework emanated a certain logical chronology, from politics setting the scene for technical choices and financial considerations to come to the technical nitty gritty of implementation. The cases show that this chronology does not always reflect reality. The case of Senegal showed that technical choices are not always preceded or flanked by clear financial decisions, and that specific technical mechanisms can be adopted without much policy discussion or institutional embedding (e.g. the Family Security Grants inspired by Bolsa Familia). The case of Morocco showed how the existing institutional dimension can affect politics and determines the feasibility of specific technical options. In brief, the interplay between these different dimensions should not be seen as linear but as a continuous dynamic in which beginning and end are difficult to differ.

A fourth aspect to be included in the conceptual framework is the importance of the interplay between the different dimensions. Choosing for a technically redistributive mechanism is an important step, but it will be equally important that the financial architecture and institutional set-up support this. When decisions in all dimensions work together, the potential for redistribution can be maximized. The framework can help this pursuit for balance by uncovering gaps and obstacles for redistribution, and by highlighting possible forces and levers for advancing redistribution.

3 | Case study 1: Senegal

Population: 13, 97 million (2015)
Area: 196,722 sq. km
Languages: French, Wolof, Pulaar, Jola, Mandinka
Religion: Muslim (95, 4%), Christian (4, 2%), animist (0, 4%)
Life expectance: 61,3 (2015)
Dependency ratio[6]: 87, 6% (2015)
Informal sector: 40 - 60% of GDP (2015)
Corruption Perception Index Ranking: 64/176 (2016)
(Transparency International 2016; CIA World fact book 2015)

3.1 Political and economic country profile

Recent developments in the field of social protection did not happen in a political or economic vacuum. Different political and economic factors set the scene.

Politically, Senegal can be viewed as one of the most stable countries in Africa, where pluralism and democratic institutions have been progressively strengthened since its independence in 1960. Since then the country has gone through three peaceful political transitions with four presidents: Leopold Sedar Senghor (1960-1980), Abdou Diouf (1981-2000), Abdoulaye Wade (2000-2012), and since March 2012, Macky Sall. The next presidential election is expected in 2019 and legislative elections are planned for 2017.

Macky Sall came into power after winning the second voting round with around 65% of the votes from Abdoulaye Wade. Long-time members of the Senegalese Democratic Party (PDS), both politicians were for a long time on the same political line and Sall served as Prime Minister under Wade from 2004 to 2007. After a conflict with Wade, Sall founded his own party and joined the opposition. When Sall's successful bid for presidency ended the 12 year rule of Wade, he opted to make social protection one of his spear points and linked it to a promise with a firm deadline: "(…) d'atteindre au moins 75% de couverture maladie de base de la population sénégalaise à l'horizon 2017" (Sall, 2013). This was a break with Wade's political agenda: overall Wade had had less attention for social protection, with social protection rising on the political agenda mostly at the end of his presidency.

Several **economic factors** need to be taken into account to understand recent social protection developments. Senegal has the fourth largest economy in the West African sub-region and aspires to become an emerging country by 2035. In 2015, the World Bank reported it remained stuck in a low-growth equilibrium since 2006, with an average far behind on the average growth at Sub-Saharan level. 2014 may have been a tipping point: the economic growth began to trend upward. Over the course of 2015, Senegal's macroeconomic performance has been strong with a growth rate of 6.5%,

6 The number of individuals that are likely to be economically "dependent" on the support of others.

a rate that hasn't been achieved since 2003, making Senegal now the second fastest growing economy in West Africa, behind Côte d'Ivoire.

The industrial sector and the service sector contribute most to the GDP and have good growth rates, especially the construction, telecom and banking sectors are currently drivers of economic growth. However, the industrial and the service sector employ less than a fifth of the population. Although the smallest contributor to the GDP, the agricultural sector employs the majority of the population and is the primary source of employment in rural areas.[7] The sector has witnessed several setbacks due to low rainfall and over-exploitation of fish stocks. Better weather conditions and the growing production in horticulture are expected to give the sector a boost in the medium term. In search for inclusive growth, Senegal attempts to support productivity and growth in the agriculture sector. This rationale supports the provision of subsidies to farmers, but also the extensions of health coverage in rural areas. With healthier workers and less lost days due to i.e. malaria, the agricultural sector could become more productive.

A very substantive informal economy cuts across the different economic sectors. According to a 2011 census, 48,8% of the active labour force is employed in the non-agricultural informal sector (ANSD, 2013, p. 9). In the agricultural sector, the main employer in de country, that rate amounts to almost 100%. The share of the informal sector in value addition in agriculture and forestry is close to 100% (ECA, 2015) and the informal sector's contribution to GDP is estimated between 40% and 60% (CIA 2016). Despites its important contribution to the gross domestic product, the social protection coverage in the informal sector is minimal. On the other hand, informal sector workers currently do not systematically contribute to government resources through taxation. This study did not come across a clear strategy on how to address this issue or a strategy including social protection as a tool for formalization of the informal sector[8].

According to a 2011 poverty household survey, poverty remains high at 46.7% of the population and the drop in number of poor has stagnated, or may even have risen during the 2006-2011 period (World Bank, 2015; IMF, 2013). Its most recent GINI coefficient (2011), measuring the degree of inequality in the distribution of family income in a country, designated Senegal as the 60th most unequal country out of 144 with a GINI of 40.3 (CIA World Fact book 2016). Poverty, inequality and the lack of social protection in the informal sector explain why Senegal wrestles with a high transfer of revenue from middle class individuals with a stable income to their (extended) family members. This type of informal solidarity with the extended family prevents middle class from saving. Without the savings of its citizens, the Senegalese government has to resort to loans from external/foreign lenders, which is far more expensive. At the Ministry for Economy and Finance, the logic goes that if basic social protection coverage would improve, the need for informal solidarity would decrease, savings and hence internal loan capacity would go up, giving the government better access to resources.

Several important recent **policy initiatives** set the scene for the recent developments in social protection. Macro-economic policy is currently guided by the 'emerging Senegal plan' (Plan Sénégal émergent or PSE) that aims to turn Senegal into an emerging economy by 2035. The first implementation period runs from 2014 till 2018, and the first set of 14 of the 27 flagship projects and 5 of the 17 major reforms of the PSE were launched in 2014. For its first implementation period, the

7 Agriculture's contribution to GDP was estimated approx. 17% (2015 estimates) whereas industry and services stood at approx. 24 and 58% respectively. According to 2007 estimates the former covers about 77% of the active labor force and the latter about 22% (CIA World Fact book 2016).

8 This is on the agenda of the ILO but only since recently and so far it is not accompanied by clear operational approach. Also, the Ministry of Labour, ILO's the main interlocutor, is not in charge of social protection in health.

PSE is organised around three topics: structural transformation of the economy and growth; human capital, social protection and sustainable development; and governance, institutions, peace and security (Republique du Senegal, 2014). Additionally, Senegal also has a Decent Work Country Programme covering the period of 2012 to 2015 that recognized i.e. the limited coverage for the formal sector, no coverage for the informal sector, and unequal access to social protection for men and women as important challenges. Consequently, the reinforcement and extension of social protection was identified as one of two priority areas for intervention (ILO & République du Senegal, 2012). Also shaping the broader policy context for social protection policy, is the development of a long-term strategy for territorial development, the 'Plan national d'aménagement et de développement territorial' (PNADT 2015-35) and the adoption in 2013 of the Decentralisation Act III. The decentralization of the public sector has been ongoing since 1970 and has also impacted on the governance in the health sector (Tine, Hatt, Faye, & Nakhimovsky, 2014).

3.2 Snapshot of social protection landscape

The 2014-2015 World Social Protection Report (ILO, 2014) summarized the state of social security around the world. For Senegal it showed a significant increase in social protection expenditure over the past 15 years. However, the overall social protection system is considered underdeveloped and presenting significant gaps. Assessing existing legislation in Senegal on its attention for social protection in the different domains of sickness, maternity, old age, employment injury, invalidity, survivors, family allowances, and unemployment, ILO only traced 'limited' legal coverage. In particular with regard to unemployment and invalidity it did not detect any relevant legislation.

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Overview of social protection coverage in Senegal

Target group Area of risk	Formal sector: civil servants	Formal sector: salary workers	Formal sector: self-employed	Informal sector	Vulnerable groups: +60, -5, pregnant women & students
Birth	Mandatory insurance >> cash maternity benefits (CCS)	Mandatory insurance >> cash maternity benefits (CSS)	No	No	Medical assistance: free prenatal consultations, vaccination new born, post-natal follow-up and caesareans
Family allowances	Yes	Yes	No	No	Program for Family Security Grants (BSF) with conditional cash transfers
Work (injuries, illness, disability, & death)	Mandatory insurance	Mandatory insurance	Voluntary insurance (CSS)	No	No
Work (unemployment)	No	No	No	No	No
Health	Mandatory insurance (fixed budget item)	Mandatory insurance (ICAMO & IPM)	Voluntary health insurance (MHO)	Voluntary health insurance (MHO & ACMU, DGPSN)	Free health care
Old age	Mandatory insurance (FNR)	Mandatory insurance (IPRES)	No	No	No
Natural Disasters	Emergency relief (FSN)				

* Managing institutions: Caisse de Sécurité Sociale (CSS), Centres de Protection Maternelle et Infantile (PMI), Centres de Santé à Soins Obstétricaux d'Urgence (SSOU), Institution de Coordination de l'Assurance Maladie Obligatoire (ICAMO), Institutions de Prévoyance Maladie (IPM), Institutions de Prévoyance Retraite (IPRES), Caisse autonome de Prévoyance Social Universelle (CAPSU), National Retirement Fund (FNR), Private Sector pension Scheme (IPRES), Mutual Health Organisations (MHO) and Agence de la Couverture de Maladia Universelle (ACMU), Fonds de Solidarité Nationale (FSN), Délégation générale à la protection sociale et à la solidarité nationale (DGPSN).

* Provisions highlighted in orange are contributory. Other provisions are either fully employer-funded or tax-funded.

* Other domains covered by the ILO definition of social protection include death and disability. With regard to the former, no clear mechanisms were mapped. The latter is subject of ongoing reforms, but a detailed description is beyond the scope of this study.

Source CLEISS, 2015b; Ministère de la Santé et de l'Action Sociale, 2013

In the existing social protection system salary workers in the formal sector are best off, with access to **social insurance** that covers risks related to birth, health, work accidents or sickness, invalidity and old age. There are two **pension** systems: public sector employees are covered by the National

Retirement Fund (FNR), private sector workers are covered by the Private Sector Pension Scheme (IPRES). For **health** coverage too different mandatory employer-based systems for public sector and private sector employees are in place. The former are covered by health insurance funded from the general government budget and overseen by the Ministry of Finance. In order to reduce out-of-pocket payment for workers, a number of public sector agencies have also implemented their own complementary health insurance scheme to cover additional health care costs. The private sector employees are covered by health insurance provided through Social Health Insurance Institutions (IPM) acting under oversight of the Ministry of Labour. Private sector retirees and some categories of public sector retirees have access to health care through the Old-age Pension Fund (IPRES). The self-employed in the formal sector can, voluntarily, access private social insurance related to health and work accidents. Workers in the informal or rural sector that are not eligible for any of the mandatory systems can voluntarily join a mutual health organization. As pointed out by the ILO assessment (ibid), there is no coverage for unemployment.

There are several **social assistance** provisions, accessible to different vulnerable groups, mostly aimed at providing access to basic health care and offering in some instances family allowances. Four major instruments are (1) the Plan Sésame for seniors, running since 2006 and providing national free health care for people aged 60 years or more; (2) free health care initiatives for children under five; (3) free basic health care for students funded on the general budget and under oversight of the Ministry of Education. (4) the subsidies for caesarean sections, providing free caesareans since 2011 in the entire country; and (5) subsidies targeting priority diseases, leading to i.e. free ARVs for HIV and anti-TB treatment in all public health facilities since 2004 (Tine et al., 2014).

There has been quite some **evolution in the Senegalese social protection context**. In 2002 Senegal adopted a Strategic Document on Poverty Reduction 2003-2005 that did not at all take into account social protection. Three years later (2005), a first National Strategy on Social Protection 2005-2015 was on the table, and twelve years later (2014), Senegal embedded social protection as spear point in its key policy document the 'Emerging Senegal Plan'. A closer look at recent policy developments reveals that over the past decade several domains of social protection have been or are in flux. The pension system is one. Confronted with several problems, including a financial deficit for the National Pension Fund (FNR), low pensions in the IPRES scheme, failing governance and lacking supervision, the pension system has undergone some reforms in the beginning of the century (The World Bank, 2006). A more fundamental revision has been the topic of discussion at a national social conference on "The reform of the Senegal pensions, toward a viable and inclusive" [own translation] in June 2016. Another significant development has been the 2013 launch of a programme for family allowances or the 'programme de Bourse de Securité Famiale', inspired by the Bolsa Familia model. A pilot targeting 50.000 vulnerable families was launched in 2013 and an upscale to 200.000 families nation-wide has been the ambition. However, all consulted stakeholders confirm that health coverage is currently *the* issue at the top of the social protection agenda in Senegal, and more specifically the process toward the universal health coverage (CMU) that will include the informal sector.

This process is guided by the Strategic Plan for the Development of Universal Health Coverage in Senegal, developed by the Ministry of Health and Social Action in 2013. The plan aims for a major reform in the health pillar of social protection with the introduction of universal health coverage. It is built around three axis: (1) improving access to free services (gratuités), (2) strengthening the mandatory health insurance for the private sector (via IPMs) and (3) building decentralized health insurance delivered through mutual health organization. The latter is referred to as the project for

'Extension of the health coverage through mutual health organisations in the context of decentralisation'[9] or DECAM, equally the main focus of this case study.

3.3 Mapping the move toward universal health coverage

This section investigates the ongoing introduction of health coverage through mutual health organisations and brings together the available information on the technical and financial choices that are shaping DECAM, and on the underlying policy making and implementation process, including the role of different national and international actors.

3.3.1 Technical dimension

With the recent reforms, Senegal is combining two **regimes**. On the one hand it is expanding its medical assistance by providing free health care to specific target groups. On the other hand it is reinforcing its health insurance, through the reform of the existing health insurance in the formal sector and the introduction of DECAM to build health insurance in the informal sector. Looking at DECAM, Senegal has opted for a voluntary, contributory but subsidized health insurance mechanism managed by community based mutual health organisations.

Figure 3.1 shows the basic idea of the DECAM approach in relation to the other social protection mechanisms in health. On the left side, the different access point to health insurance in the formal sector are visualized: mandatory contributory mechanism managed by the IPM for the private sector, by the state for the public sector, and as part of the pension system accessed by retirees through IPRES. These mechanisms provide coverage for those households of which the head is or was employed in the formal sector. On the right side the figure shows the much larger portion of the population that is active in the informal sector and that - some private insurers and some professional and community-based mutual health organisations aside - remains uncover for health risks. Across formal and informal sector recently expanded health assistance provides free basic health coverage for specific target groups: students, older than 60, younger than 5 and some health conditions. DECAM has the ambition to provide a health insurance for the remaining population. It should thus be seen as a complement to the health insurance in the formal sector and to the provision of targeted free basic health care as a social service. The financial flows have also been visualized, with orange arrows representing the flow of public resources, green arrows representing the flow of employees' contributions and yellow arrows representing the flow of employers' contributions.

DECAM builds a **universal** mechanism, in the sense that it aims to cover all residents of local communities that do not benefit from any mandatory health coverage. Although it is clearly designed for the informal sector, it does not explicitly exclude anyone. Members contribute half of the membership fee themselves, the other half is covered the government. Specific provisions exist for people belonging to vulnerable groups: their full fee is payed for by the government.

9 [Extension de la couverture du risque maladie à travers les mutuelles de santé dans le contexte de la Décentralisation].

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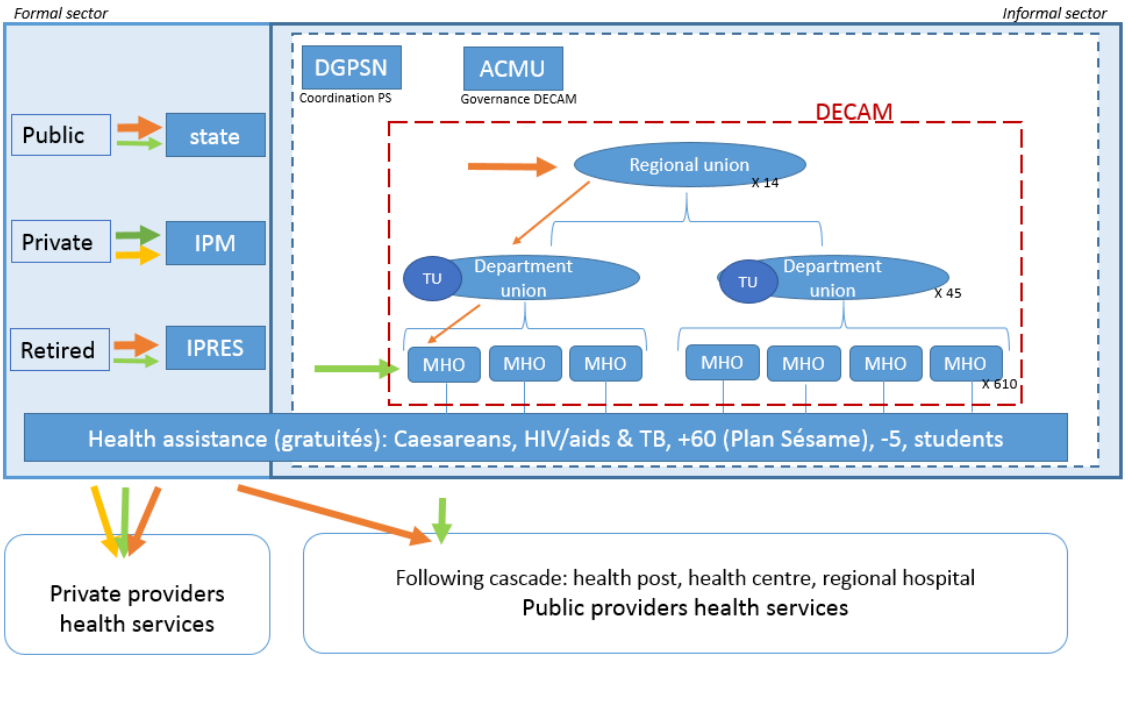
DECAM in Universal Health Coverage of Senegal



* Caisse de Sécurité Sociale (CSS), Institutions de Prévoyance Maladie (IPM), Institutions de Prévoyance Retraite (IPRES), Agence de la Couverture de Maladia Universelle (ACMU), Délégation générale à la protection sociale et à la solidarité nationale (DGPSN), Technical unit (TU).

Pivotal figure in the **implementation** of DECAM are the **community-based mutual health organisations (MHO)**. There should be at least 610 or one for each local community. These MHOs will be responsible, i.a. for sensibilisation, member recruitment, collection of membership contributions, closing contracts with health care providers, reimbursement of beneficiaries' health expenses at the level of health posts and health centres, and identification of vulnerable groups. The harmonization of the type of services provided by the different mutual health organisations happens through a Minimal Benefit Package (Paquet Minimum de Bénéfices, PMB) determined by the Ministry of Health. Clearly, a crucial challenge is the institutional architecture: how to organize the mutual health organisations and reinforce the interface between community-based mutual health organisations and the different public institutions? Another crucial challenges will be the establishment of the healthy MHOs. Experience and research have shown that building strong, community-based organisations takes time and is most often a difficult and gradual process with ownership often remaining an issue. In the current timeline of DECAM there is no room for slow and gradual. Abt Associates, an American-Senegalese consultancy with strong ties to USAID, is currently establishing MHOs one by one. The question is to what extent these MHO are actually viable and will be able to carry the significant responsibilities of channelling public resources. A union of MHOs at the department level is next in the DECAM structure. The 45 departmental unions will have as main roles the sensibilisation towards the local authorities, mediation between different MHOs, and reimbursement of beneficiaries' health expenses at the region hospitals, contracts with hospitals and the provision of technical support to the MHO. In fact, although the department union will play a supportive role, this final task will be mostly executed by a separate Technical Unit (TU) of approximately four professionals who will assist MHOs in their administration and conduct monitoring and evaluation. Next up is the union of MHOs at the regional level. One key role for the 14 regional unions is mediation between the different organisations at the regional level and

representation of the MHOs on the political scene. It also has to negotiate enabling conventions and provides technical assistance, through training, a data management system, experience sharing, etc. Finally, a national federation will unite all MHO structures.

Two important points need to be taken into account to understand this set-up. Firstly, all these structures, except for the technical unit, will be staffed by volunteers, unless individual mutual health organisations decide to use part of their income to hire permanent staff. Secondly as has been pointed out in the strategic document, the DECAM policy is more than the installation of this structures. It should also forge a strong partnership between the government, the local authorities at municipal level and the mutual health organisations. In that sense it is the translation of the decentralization policy that Senegal opted for almost a decade ago. A more elaborate visualization of what the entire structure should look like, is offered in annex 2.

On the **governance side**, two key organisations are in play. The General Delegation for Social Protection and National Solidarity (DGPSN) and the Agency for Universal Health Coverage (ACMU). Both structures are rather new and the delineation of their respective mandates did not go without tension. The DGPSN, established in 2013 as an autonomous structure linked to the president, is responsible for assisting in policy development on social protection and for the coordination between the different social protection mechanisms[10]. The DGPSN is governed through an orientation council and headed by a general delegate. Its orientation council is composed mostly of public servants, with only 2 out of 13 members 'representatives of the Platform of Non-state Actors'. It is unclear, including to civil society organisations interviewed, who these two representatives are. Originally, the DGPSN was meant to become the pivotal structure for coordination and management of social protection in Senegal, but quickly part of its competences were transferred to a new structure, the Agency for Universal Health Coverage. ACMU[11] was established in 2015. It is an autonomous institution, with the Ministry of Health and Social Action as its technical line ministry and the ministry of finance is the financial line ministry. It took over the health component of social protection from the DGPSN. It has to manage the different social protection mechanisms in health, except for the mandatory health insurance in formal sector. Its main responsibilities are the promotion of mutual health organisations; the development and implementation of policies for the extension of health coverage to vulnerable groups; ensuring the financing of the universal health coverage; and developing a data collection and management system. ACMU is directed by a General Director, and a Supervising Committee. Of its nine members one is a representative of the mutual health organization, and no other clear representation of civil society is envisioned. The articulation between DGPSN and ACMU remains unclear.

Members of the voluntary health insurance get access to **health services** in the public sector, although the mutual health organisations can close additional conventions with private cabinets and pharmacies to include them in their insurance. With their membership card, beneficiaries can access care (consultation as well as some medicines) by paying only the moderator ticket. They do have to respect the health care pyramid, addressing the health post or the health centre first before being referred to a regional or national hospital. The mutual health organization or its union will reimburse the health care provider. This presumes health service providers keep track of the services to insured

10 The DGPSN has to coordinate and drive the different social protection instruments. This includes the universal health coverage, the programme for Family Security Grants, the Sesame Plan for elderly, the social protection measures for disabled and for vulnerable groups and the establishment of a national unique registry, as an instrument for coordinating and harmonising the targeting of the different mechanisms.

11 ACMU was predeceased by CACMU, the Support Unit for Universal Health Coverage that developed and operationalized the DECAM policy. Its duties were the promotion of universal health insurance; the strengthening of intra- and inter-sectoral collaboration; the establishment of solidarity mechanisms for financing; the regulation of prices for the providers of sanitary services in both the public and the private sector; and the monitoring and evaluation of different health insurance systems. However, CACMU was understaffed, lacked resources and technical capacity. It was also embedded in the Ministry of Health, were it suffered.

patients, keeping patient data that will enable the mutual health organisations to reimburse correctly. This system also assumes that mutual health organisations keep track of the number of members and their status (belonging to a vulnerable group or not) and communicate this to the government, enabling the government to pay the membership fees. At the moment this practice of data collection and management is still an issue at all levels However, it is even more problematic in the case of the free medical care provided to vulnerable groups (les 'gratuités'). Health service providers fail to register all freely provided services correctly and the government fails to reimburse fully and timely, putting especially the hospital in a very difficult position. They are prefinancing the free care promised by the government and running out of funds. This in turn affects the working conditions for the health staff, forces the providers to charge beneficiaries of free care, and means beneficiaries of the voluntary health insurance get access to a health system that is depleted, unequipped, understaffed and forced to charge anyway. In that sense, the decision to launch free care for specific groups while at the same time attempting to convince the population to join health insurance seems to have led the negative synergy.

Departmental Health Insurance Unit: experimenting with a different approach

Interestingly an alternative approach is being piloted simultaneously with the first phases of the implementation of DECAM, as part of the bilateral cooperation between Senegal and Belgium. This approach focuses on a mutual health structure on the department level instead of the community level and puts a Departmental Health Insurance Unit12 or UDAM central. The executive management of the UDAM is in the hands of a professional team, while the members still remain in charge of the overall direction through the executive board and the general assembly. Like in DECAM members pay a moderator ticket and the service providers are reimbursed by the UDAM. At the start, the package covered by the UDAM did not include services at the level of regional hospitals, the rationale being that health posts and health centres should become better equipped and able to offer basic surgical procedures as well. Since the supply side of health services is not yet sufficiently developed to provide this, the process of including such services in the package is ongoing. The UDAMs also work with a forfeit instead of a flexible reimbursement of health services. On the one hand this discourages health services providers to offer unnecessary services and improves the predictability of the overall costs. It is also a way to embed solidarity in the system with reimbursements for 'cheap' patients compensating for the 'expensive' patients. Another instrument used to improve solidarity is the promotion of group membership. In the UDAM members are obligated to join with at least 5 family members, and villages are encouraged to join together. This formula is having increasing success with several villages adhering.

Key arguments put forward by the Belgian Development Cooperation in favour of this approach are its feasibility, long term institutional and financial viability and better management. Establishing UDAMs in 45 departments would be far more feasible than establishing at least 610 mutual health organisations at community level. Taking into account the challenging institutional sustainability of MHO run by volunteers, it is consider a more viable option in the long term. This also goes for the financial sustainability. Being at the department level, the UDAMs can cover a bigger constituencies and this means they could benefit from economies of scale. So far, average adherence rates for MHOs at community level are suck around 2% to 3% of the target population. The pilot UDAMs have succeeded in reaching 10%. A study financed by the Belgian Development Cooperation indicated an adherence rate of 20-25% would allow the structure to become fully self-sufficient. A professional team in charge is considered to provide more guarantees for competent management and continuity than volunteers, especially in view of the responsibility of the MHOs to also participate in the implementation of free health care for vulnerable groups and the program for Family Security Grants.

Opponents argue that the UDAM structure has not proven its financial viability, since the professional staff is currently still funded by the Belgians. They also oppose the smaller role for the members in the management of the MHO, which they considered an infringement on citizenship and a loss of social control. Taking a step back, it is an interesting observation that both Belgium and the United States (BTC/CTB and USAID) are currently involved in projects that support the implementation of decentralized health insurance for the informal sector, but with different approaches. It raises two instant question. To what extent will the lessons learned in both experiment be taken into account? In this regard, the DECAM policy also shows some

12 [Unité Départemental de Assurance Maladie].

interesting adjustments that might be inspired by the UDAM approach. For example, the introduction of technical units at department level payed for by the ACMU to support professionalization of the management in MHOs, and the possible introduction of forfeit instead of flexible reimbursement. Secondly, how do both approaches score on ownership? Contrary to UDAM, DECAM is being perceived as a national policy initiatives, whereas UDAM so far still has a stronger development project image.

3.3.2 Financial dimension

The mechanism of decentralized health insurance provides coverage through a subsidized contributory mechanism with the members paying 50% of their membership fee and the government contributing the remaining 50%. For vulnerable groups, the government will pay the full membership cost. Or, put differently, DECAM is financed through the contributions of the subscribers and tax incomes.

The financial architecture **directing public resources** into the decentralized health coverage system is still in full development.[13] It was reported that currently 50% of the reimbursements go to the regional unions and for 50% to the mutual health organisations. The adequacy of division is contested, with different observers fearing that the mutual health organisations will remain underfinanced. On the other hand, actual data on the actual services delivered at the different levels, and at what cost, do not yet exist. This lack of data collection and data management is hindering a facts-based reimbursement.

Looking at the bigger picture, interviewees seem to agree that at the moment there is no clear plan on how 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 increase 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"[14] and is "in need of an action plan on how to think about financing"[15]. 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"[16].

The Ministry of Economy and Finance summarized that the budget of the Health Ministry cannot, in the long term, sustain the universal health coverage. 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

13 The establishment of a National Solidarity Fund (Fond National de Solidarité Santé or FNSS) as well solidarity funds at departemental level (Fonds Départemental de Solidarité Santé or FDSS) were planned. The former will feed the latter and will provide the state subsidies to 1) increase the benefit package of all beneficiaries; 2) cover the adherence of targeted vulnerable groups and 3) provide state garantuees to enhance partnerships between mutual health organisations and financial institutions. The state of play of these funds is unclear.

14 Interview government official 4 in May 2016, Dakar, Senegal.

15 Interview government official 3 in May 2016, Dakar, Senegal.

16 Interview government official 2 in May 2016, Dakar, Senegal.

same time ill-informed about ongoing studies and possible options. They do plan to increase the government's sense of urgency regarding this issue.

3.3.3 Socio-political factors

The DECAM policy did not appear out of the blue. Table 3.2 offers a chronological overview of the different steps that proceeded the development of this policy. It shows two things in particular. First, the rise of social protection as a concept in the international and - with some delay - in the Senegalese development policy. Secondly, the interaction between the ongoing (and, according to some, stagnated) policy development process on the mutual health organisations and the development of a policy on universal health coverage in Senegal.

Since the '60s-'70s mandatory insurance mechanisms for health and old age exist in the formal sector. Additionally, professional as well as community based mutual health organisations have developed since the late '80s. They have been supported by donors (i.e. USAID, ILO, WHO, Belgian Mutual Health Organisations) and at times by the Senegalese government, but they never realized extensive coverage. Access to health services remained problematic for the majority of the population, despite different attempts by donors, civil society and at times the Ministry of Health to boost the development of mutual health organisations (e.g. biannual regional concertations as of 1999, development of a strategic plan in 2004).

Meanwhile, over the past decade, social protection rose on the international development agenda and made its entry in the Senegalese development policy as well. In 2005 it drafted its Poverty Reduction Strategy 2006-2013 (DSRP II) explicitly mentioning the need to extend social protection and putting a strong emphasis on health. It also stresses the importance of developing mutual health organisation as part of health coverage, thus integrating the key message brought forward by the 2004 Strategic Plan on the Development of Mutual Health Organisations sponsored by the Ministry of Health and donors. Also in 2005 a National Strategy on Social Protection was developed, aimed at reinforcing existing instruments of social protection, including disaster prevention and social protection for vulnerable groups (Banque Africaine de Développement & Fonds Africain de Développement, 2010, p. 15). Again the development of mutual health organisations was included.

In 2006, former president Wade introduced Plan Sésame, providing free health care for the aged above 60. Its reason for existence was never questioned, but the programme suffered financial difficulties and did not take off. Overall health coverage remained problematic. By 2012 mandatory health insurance systems only reached a coverage of 11% of the population, according to the Senegalese government (Mbengue, 2016). Voluntary systems, through community-based mutual health organisations or private insurers did not succeed in boosting coverage significantly. Even all mechanisms combined covered less than 20% of the population. A 2013 assessment estimated that of the 20% covered, the mechanism targeting public servants represented 40%, the mechanism for the private sector (IPM) 24%, the voluntary system based on mutual health organisations 27% and private insurers 8%. Especially population in the rural and informal sector were left without coverage (Republique du Senegal, 2014).

During his election campaign, president Sall made health coverage a spear point with his promise the extend coverage from 20% in 2012 to 75% in 2017. After his election in 2012 health coverage shot to the top of the political agenda. With such an ambitious presidential deadline swift policy making was demanded. National concertation were held in 2013, including social partners, the mutual health organisations and the financial and technical partners, to discuss the different options for improving coverage. In 2013, the Senegalese government concluded that "the system for health coverage is no

longer in line with the aspirations and demographic demands and the eradication of poverty in contemporary Senegal" (Ministère de la Santé et de l'Action Sociale, 2013) [own translation]. It launched a strategic plan for the development of universal health coverage in Senegal. It used the previously defined National Strategy in Economic and Social Development as a starting point, in which social protection is pursued through "the extentions of social protection in the informal sector and to vulnerable groups by the implementation of a basic universal health coverage through mutual health organisations" (Ministère de la Santé et de l'Action Sociale, 2013, p. 19) [own translation]. It added that the key challenge would be to create a synergy between the efforts by the government, the municipalities and the community-based dynamics. To this effect « the hard core of the DECAM strategy is to implement an effective partnership between the mutual health organisations, the municipalities and the state" (Ministère de la Santé et de l'Action Sociale, 2013, p. 19) [own translation].

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Chronological overview of policy developments leading to DECAM

Policy developments on		
universal health coverage		mutual health organisations
1975	Mandatory social and health insurance extended to all formal sector workers	
	Emergence of mutual health organisations as an associative movement in Senegal.	End '80s
	Start of active promotion of a decentralized health mutualism by the Senegalese government. After two waves of support for the development of MHO, the issue will fall off the political agenda, although different international partners will continue support.	1994
	Law on the decentralisation of the administrative and health system adopted. Decentralization becomes a key element in the reform of public political structures.	1996
2001	Social protection became a preferred instrument of the Millennium Development Goals and the World Bank promoted social protection as a key component of international poverty reduction strategies. In 2001, the International Labour Organisation launched major campaign to promote the extension of social security coverage.	
2002	The 2002 International Labour Conference (ILC) Resolution on Decent Work and the Informal Economy marked a tripartite consensus on informality and included social protection as one of four pillars for decent work in the informal sector.	
	The Strategic Plan for the Development of Mutual Health Organisations in Senegal[17] was developed. The process was driven by the Ministry of Health but with strong involvement of MHOs, the ILO, USAID, consultancies GRAIM, EPOS and Abt Associates, and the Belgian Christian Mutual Health organization	2004
2005	The World Health Assembly Resolution 58.33 on Sustainable health financing, universal coverage and social health insurance was adopted.	
2005	First National Strategy on Social Protection[18] adopted, covering the period 2005-2015.	
2006	Strategic Document for Poverty Reduction 2006-2010[19] (DSRP II) was developed, revising and updating the first DSRP. DSRP II was based on 4 spear points of which the third was dedicated to social protection, the prevention and management of risks and disasters.	
2008	National strategy for the extension of coverage for health risks of the Senegalese population[20] was developed by the Support Unit for the Financing of Health and Partnerships (CAFSP) and sponsored by the American (USAID) and French development cooperation (AfD). It proposed the establishment of a National Fund for Health Solidarity[21] and a pilot for	2008

17 [Plan Stratégique de Développement des Mutuelles de Santé au Sénégal].
18 [Stratégie nationale de protection sociale].
19 [Document de Stratégie de Réduction de la Pauvreté pour la période 2006-2010].
20 [Stratégie nationale d'extension de la couverture du risque maladie des Sénégalais].
21 [Fonds National de Solidarité Santé].

	decentralisation and extention of health coverage[22] (DECAM) in Diourbel, Kaolack, Kolda, Louga et Saint-Louis.	
2009	A National Plan for Health Development[23] (PNDS 2009-2018) was developed that, amongst other issues addressed the health coverage for vulnerable groups and that referred to the National Strategy for the extension of coverage (above) to address this.	
	A national workshop on the sustainability of mutual health organisations in Senegal[24] was organised by the Ministry of Health and USAID.	2011
2012	A new government headed by president Macky Sall came to power in Senegal. His main campaign promise was to extend health coverage from 20% of the population in 2013 to 75% in 2017.	
	The ILO adoped its Social Protection Floors Recommendation (No. 202)	
	The Senegalese Ministry of Health, Public Hygiene and Prevention (MSHPP) was reformed into the Ministry of Health and Social Action (MSAS). Mack Sall also appoints a new Minister at the head of MSAS, Mrs. Awa Marie Colle SECK.	
	The Support Unit for Universal Health Coverage (CACMU) is established to replace the CAFSP. Connected to MSAS cabinet, the cel is charged with the development of a system that offers financial access to health care for all.	
2013	The MSAS developed a Strategic Plan for the Development of the Universal Health Coverage in Senegal, covering the period 2013-2017. Central to its approach is the creation of one mutual health organisation in each local community.	2013
2013	The General Delegation on Social Protection and National Solidarity[25] (DGPSN) is established, connected to the cabinet of the president. The DGPSN is charged with the management of national solidarity for the poor and the Family Security Grants[26] (BSF).	
2015	The Agency for Universal Health Coverage (ACMU) is established	

The Ministry of Health and Social Action reported that policy discussion on the extension of health insurance started in 2007 and engaged different parties involved in the organisation, implementation and financing of health and social protection, including administrations, social partners, civil society, donors and mutual health organisations. The results of these debates have been integrated in the National Plan for Health Development (PNDS 2009-2018) and again in the Stratégie Nationale de Développement Economique et Social (SNDES 2013-2017) (Ministère de la Santé et de l'Action Sociale, 2013, p. 7). However, this does not entirely do justice to the **reflections regarding decentralization and the development of mutual health organisations** that had been ongoing since the mid-'90s. A mapping of the different policy documents throughout the process as well interviews with stakeholders indicate that the proponents of the community based mutual health system succeeded in gradually embedding mutualism in Senegal's social protection policy. In fact, because of the policy formulation efforts they had been doing over the course of the past decade, they had concrete propositions ready when a political window of opportunity opened up and were thus able to make mutual health organisations the pivot of the DECAM policy.

Also important has been the **role of various international donors**. It is beyond the scope of this study to reconstruct all development cooperation relevant to social protection and offer an exhaustive discussion, but some features stand out. Firstly, there has been the role of international organisations in pushing social protection on the agenda. The World Bank, the ILO, the WHO, the UN and the AU have clearly contributed to the agenda setting of social protection, and specifically health

22 (Décentralisation et Extension de la Couverture de l'Assurance Maladie - DECAM).
23 Plan National de Développement Sanitaire.
24 [Atelier de contribution à la pérennisation des mutuelles de santé au Sénégal].
25 [Délégation générale à la protection sociale et à la solidarité nationale].
26 Bourse de Sécurité Familiale (BSF).

coverage. Their influence is visible through the many references in the various policy documents, for example with regard to the WHO resolution approved at its assembly in 2005 on fair access to health services, the UN resolution on universal coverage adopted in 2012, the efforts of the Economic and Monetary Union of West Africa to support the development of mutual health organisations. As one stakeholder pointed out: "By 2012-2013 universal health coverage was really 'hot' in Africa. It was in all the big debates at the United Nations, the African Union, and so on. There was a clear paradigm shift"[27] [own translation].

Secondly, there is the interesting role of international and bilateral donors in gradually embedding mutualism in the current health coverage approach. In particular USAID seems to have played a significant role, as it has been supporting the development of mutual health organisations and of policy on the issue since the '90s. For example, the current DECAM policy refers to the National Plan for Health Development (PNDS) that in its turn is based on the National Strategy for the Extension of Coverage for Health Risks developed with assistance of USAID and AfD.

Finally, the role of specific individuals should be taken into account in this interaction between development cooperation and national policy. For example, François Diopp, a renowned specialist in and strong proponent of mutual health organisations, has been participating in the policy discussion and formulation since it started in the '90s. He previously worked for USAID and his consultancy Abt Associates is currently a key implementing partner of DECAM. Abt Associates co-authored with USAID and AfD the previously discussed National Strategy for the Extension of Coverage for Health Risks. The current general director of the Agency for Universal Health Coverage, Mr Cheikh Seydi Aboubeker Mbengue, previously worked for USAID. Although it is difficult to assess to what extent the national DECAM policy is in fact USAID inspired, it is quite clear that key resources persons and officials involved in DECAM have (or had) a strong relationship with USAID. Interestingly an alternative approach to DECAM is being piloted simultaneously, as part of the bilateral cooperation between Senegal and Belgium. This approach focuses on the department level instead of the community level and puts the Departmental Health Insurance Unit[28] or UDAM central. This means both Belgium and the United States (BTC/CTB and USAID) are currently involved in pilot projects experimenting with different approaches for the coordination and capacity reinforcement of the mutual health organisations that will play a lead role in the new universal health system. Interviewees clearly indicate that the concertation and exchange between them not going smoothly.

Even more difficult is reconstructing the role that different **national actors** have played. Interviewees could not identify any experts on the matter of CMU in the parliament or the respective political parties. The civil society seems divided. On the one hand mutual health organisations clearly participated and shaped the policy discussion. On the other hand other trade unions seems to have invested little effort, and other civil society organisations indicate they were not ready to provide input or they were ignored. These are important dynamics to understand the final policy choice. For example, the option of reforming the entire health coverage system, formal sector mechanisms included, would have meant negotiations with well-established structures in which employers and trade unions are strongly represented. Stakeholders indicate that these parties did not favour a revision of the existing structures, and the outlook of protracted negotiations was not considered favourable in the light of the presidential countdown to 2017. For easier than reviewing existing structures, was to limit the exercise to the sector were hardly anything existed: the informal sector. A similar dynamic may have happened in the rural sector where CNCR[29], the umbrella organization

27 Interview government official 2 in May 2016, Dakar, Senegal.

28 [Unité Départemental de Assurance Maladie].

29 Conseil National de Concertation t de Coopération des Ruraux (CNCR).

representing almost thirty agricultural federations and unions, reportedly was piloting a health insurance for farmers in cooperation with the government. However, this initiative was not taken into account and even undermined by the new DECAM policy. Recently, CONGAD[30], the national platform representing 178 CSOs, embarked on a decentralized consultation of its constituency on the issue of health coverage and handed over its input for improving the current reform toward universal health coverage to the Health Ministry in June 2016[31].

3.4 Analysis of redistributive potential

As was pointed out by Fonteneau and Van Ongevalle (2014), the potential for redistribution of wealth of a mechanism will be determined by the different technical, financial and socio-political factors. Applying this to the DECAM approach as described above (see recap), leads to the following remarks regarding the potential for redistribution.

The choice for a universal health insurance system is a good foundation for redistribution. However, in this case the mechanism is specifically designed for the informal sector, meaning the heterogeneity of the insured beneficiaries will be low. The mechanism will mostly cover rural, informal workers confronted with the same precarious working conditions and livelihood risks. Poor and vulnerable groups can adhere to the same mechanism, but at the expense of the state. This is a more redistributive choice compared to developing a safety net only providing services to the poor. However, it also means the government has opted to include the poor and vulnerable in the same mechanism, thus further increasing the risks the mechanism is exposed to. Option that would have increased the potential for redistribution between different socio-economic population groups, would have been to fuse mechanisms covering the formal and informal workers, or to include the poor and vulnerable groups in the health insurance covering the formal sector workers, at the expense of the state. A mandatory insurance would have increase redistribution potential as well. Instead group-based membership to the voluntary mechanism has been envisioned but this is not enforced in practice. This means selective membership (only adhering those that face most health risks) remains a challenge, further increasing the homogeneity of the membership base and thus limiting the potential for redistribution.

DECAM will be financed through a combination of budget reallocation, increased (indirect) tax revenue and improving tax collection capacity, extending membership contributions and use of aid and transfer. The available information did not allow to determine the relative importance of each of these financing sources. However, in general terms it can be said that the use of tax income to subsidize the health insurance of the informal sector definitely is a strong redistributive element. The significant involvement of different international development partners, although problematic from a sustainability perspective, is also a sign of international redistribution.

Investigating the socio-political dimension, two different aspects come up. On the one hand the interplay within and between the different institutional actors charged with the implementation, management and governance of a social protection mechanism. In the case of DECAM, its success will depend on establishing the partnership between the central government agency, the local authorities and the mutual health organisations. Additionally, the interplay between DECAM and other social protection mechanisms (BSF, gratuités) may also affect the potential for redistribution of all the mechanisms.

30 CONSEIL DES ORGANISATIONS NON GOUVERNEMENTALES D'APPUI AU DEVELOPPEMENT.

31 Interview civil society representative, May 2016, Dakar.

On the other hand there are the politics that have shaped and continue to shape the policy formulation and implementation of DECAM. From the case study it is clear that these political dynamics are crucial to understand the different choices made. Political factors that have clearly played a role include: (1) the rise of social protection on the international development agenda and the emphasis on universal health coverage in key institutions such as the WHO; (2) the long track record of donor involvement in the development of mutual health organisations, which contributed to the development of a network (an epistemic community) of professional and community-based mutual health organisations, expert resource persons, favourably-disposed policy makers and financial and technical partners in support of the idea of mutualism; (3) the presidential promise to boost coverage, creating momentum as well as high time pressure to move ahead; (4) the fact that previously formulated policy documents featuring the development of mutual health organisations were available at the time policy formulation accelerated; (5) the trade unions that did not lobby for the inclusion of the informal sector but instead opted to protect the health insurance in the formal sector from absorbing additional risks and from changes in governance possible weakening union position; (6) the civil society that did not have a strong track record on social protection and possibly lacked capacity and legitimacy to really influence the policy formulation; (7) the importance of the principle of decentralization embedded in Senegalese public policy; (8) the absence of redistribution as a guiding idea in the entire policy process.

4 | Case study 2: Morocco

Population: 33.3 Million (2015)
Area: 446,550 sq km (excluding Western Sahara)
Languages: Arab, Berber, French
Religion: Muslim (99%), other (1%)
Life expectance: 76.7 (2015)
Dependency ratio[32]: 50.1% (2015)
Unemployed: 9.2% of labour force (2013)
Corruption Perception Index Ranking: 90/176 (2016)
(Transparency International 2016; (CIA, 2015; The World Bank, 2015)

4.1 Political and economic country profile

The scene for recent development in the field of social protection is partially set by **political factors.** Morocco is an ex-protectorate of France. After independence in 1956, Sultan Mohammed became king. He was succeeded in 1961 by his son, Hassan II, who ruled for 38 years. King Hassan II played an important role in the search for peace in the Middle East but also brutally oppressed domestic opposition. Mohammed VI, his son and successor as of 1999, introduced some economic and social liberalisation.

In response to the pro-democracy 'Arab Spring' protests in 2011, King Mohammed VI launched a reform program that included a new constitution, passed by popular referendum in July 2011. The new constitution grants more powers to the prime minister and parliament, but the king still retains veto power over most government decisions and he and his court (the Makhzen) maintains a firm grip on executive power. Since the reform, the Moroccan constitution also explicitly refers (in article 31) to the right to social protection, health coverage and mutual solidarity, and it stipulates the ambition of the government and the public institutions to mobilise all available means to facilitate an equal access to this rights.

The moderate Islamist Justice and Development Party (PJD) became the biggest party in the parliamentary elections of November 2011. In line with the new constitution, the king appointed PJD leader Abdelilah Benkirane's as prime minister. The PJD has filled most key government posts but rules by coalition government. Its original main coalition partner, the Istiqlal party, withdrew in 2013 after a dispute over cuts and other issues. A new coalition was formed with centre-right National Rally of Independents (RNI), which is close to the King, and led to the replacement of 19 ministers on key posts. The new coalition weakened the ruling Islamists who are trying to introduce unpopular reforms to subsidies on fuel and food and the pensions system.

General elections in October 2016 resulted in a resounding victory for the PJD gaining a total of 125 seats in parliament. However, its main opponent, the royalist Authenticity and Modernity Party (PAM) also doubled its number of seats from 55 to 102. With whom PJD will form a government

32 The number of individuals that are likely to be economically "dependent" on the support of others.

remained to be seen at the moment of writing, as both PJD and PAM had ruled out a cooperation. Issues that featured in the electoral programmes of most political parties were the bad state of the educational system, the high youth unemployment, the pension reform, and improvement of health services and coverage. However, the public debate in the run-up to the elections seemed mostly dominated by PJD-PAM rivalry: "The rivalry (…) overshadows important yet unaddressed structural social and economic issues that have long plagued the country" (Fabiano, 2016).

Morocco does have a rather stable **economy**. Key economic sectors include agriculture, tourism, aerospace, phosphates, textiles, and apparel (CIA, 2015). The past decades were marked by steady growth. Although poor harvests and the economic crisis of 2008 did cause an economic slowdown, growth has been averaging 4.3% per year between 2010 and 2013 (The World Bank, 2015, p. 2). 2015 was a strong year but latest estimates indicate a deceleration of the growth in 2016, mostly due to a contraction in agricultural production. It is expected that 2017 will partly redress this trend. The emergence of new growth drivers in higher value-added industries such as manufacturing and aeronautics is a promising trend (The World Bank, 2016).

Key challenges today remain the high unemployment, rising prices of basic commodities, poverty, inequality, and illiteracy, particularly in rural areas. Extreme poverty has nearly been eradicated and relative poverty and vulnerability declined significantly. Still, 20% of the population lives in poverty or under threat of falling into poverty. Morocco's Gini coefficient, a key indicator for inequality, stands at 0.41, one of the highest in the MENA region, and the country also lags behind when it comes to health and education, especially in the rural areas. Unemployment remained at 9-10% since 2009 and participation rates, especially among youth and women, are declining[33] (The World Bank, 2015).

From an overall development and social protection perspective, some interesting **policy developments** are taking place. The government is implementing several investment programs aimed at improving the business environment, such as the National Emerging Industries Agreement (PNEI), Plan Maroc Vert for the agriculture sector and the Halieutis Strategy for the fishing sector. In 2015 it adopted the 'Vision 2015-2030', a new strategy to guide major reforms in the education system. The same year, a new national Employment Strategy was developed. Since 2014 an Integrated National Youth Strategy (with measures for economic, social and political inclusion) has been on the table (The World Bank, 2015), since 2013 a National Strategy for the promotion of Micro-enterprises (providing incentives for formalisation) is being implemented.

4.2 Snapshot of social protection landscape

The 2014-2015 World Social Protection Report (ILO, 2014) summarized the state of social security around the world. The ILO assessed Moroccan legislation on social protection as 'semi-comprehensive'. Amongst the different social protection domains - sickness, maternity, old age, employment injury, invalidity, survivors, family allowances, and unemployment - all areas were covered by at least one programme anchored in national legislation, except for the risk of unemployment. Assessing legal frameworks as well as coverage, governance, benefits and targeting, the ILO and the World Bank seem to agree on the state of the Moroccan social protection system: it is fragmented, favours the wealthiest households, is limited in scope, and coverage and is poorly targeted (ILO, 2008; The World Bank, 2015).

33 So, while unemployment rates may be declining.

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Overview of social protection coverage in Morocco

Target group / Area of risk	Formal sector: civil servants	Formal sector: salary workers	Formal sector: self-employed	Informal sector	Vulnerable groups
Birth	Mandatory insurance (CNOPS)	Mandatory insurance (CNSS)	No	No	Medical assistance through RAMED (CNSS)
Family allowances	Yes	Yes	No	No	Conditional cash transfers trough Tayssir (Ministry of Education). Possibly some other non-contributory safety net programs
Work (injuries, illness, disability, & death)	Mandatory employer-liability (private insurer)	Mandatory employer-liability (private insurer)	No	No	No
Work (unemployment)		Mandatory insurance (IPE)	No	No	No
Health	Mandatory insurance (CNOPS)	Mandatory insurance (CNSS)	Voluntary insurance (Inaya): never implemented	Voluntary insurance (MHO): marginal	Medical assistance through RAMED (CNSS)
Old age	Mandatory insurance (RCAR & CMR)	Mandatory insurance (CNSS); voluntary additional insurance (CIRM)	No	?	?
Natural Disasters	?				

* Caisse nationale de Sécurité sociale (CNSS); Caisse nationale des Organismes de Prévoyance sociale (CNOPS); L'Agence Nationale de l'Assurance Maladie (ANAM); Régime Collectif d'Allocation de Retraite (RCAR); Caisse Interprofessionnel de Retraite Marocaine (CIRM).

Source CLEISS, 2015a; ISSA, 2010; The World Bank, 2015

In broad strokes[34], the Moroccan social protection system features four major **social insurance** mechanisms implemented at a national level and mostly targeting the private and public sector workers: the Caisse Nationale de Sécurité Sociale (CNSS) providing mandatory social insurance to employees in the private sector; the Caisse Nationale des Organismes de Prévoyance Sociale

34 For a full overview of the different social protection provisions in place in Morocco, a combination of different sources can be consulted, including the ILO Social Security Inquiry (with data dating from 2013), the ILO's World Social Protection report from 2014/2015 and two strategic notes by the World Bank on social protection (2002) and on targeting and social protection (2011).

(CNOPS) managing the mandatory medical insurance (AMO) for the employees in the public sector; the Régime Collectif d'Allocation de Retraite (RCAR) administering the pensions of local state employees and temporary workers in the public sector; and the Caisse Marocaine de Retraite (CMR) which administers a number of non-contributory pension schemes for, among others, old resistance fighters, civil and military invalidity pensions. This is complemented the Caisse Interprofessionnel de Retraite Marocaine (CIRM), an initiative of employers, that provides complementary pensions for private sector employees. Additionally, there are several mutual societies and private schemes, but their coverage is marginal (The World Bank, 2015, p. 16).

Additional instruments offering **social assistance** to the poor and vulnerable groups also exist. The government invested in education support (program TAYSSIR with conditional cash transfers), health assistance (through RAMED), social assistance to specific groups (e.g. programs for disabled individuals, and social protection centres) and social funds to stimulate local infrastructure investment and income generating activities. The government also launched a National Initiative for Human Development (INHD) that is comprised of several programs providing safety nets, such as Program to Fight Poverty in Rural Areas, Program to Fight Social Exclusion in Urban Areas. It was beyond the scope of this study to trace, across these different programs and measures, what is being covered by which program for who. A more detailed description of the social assistance programs can be found in annex 3.

Despite the variety of safety-nets, the last available data of 2009 showed that public expenditure was dominated by butane and food subsidies expenditure: on total public spending, the subsidies took 68.2% of the budget, while non-subsidy safety nets represented 3.1% (The World Bank, 2015, p. 24). As in many countries in the Middle East and North Africa (MENA), Morocco favoured consumer price subsidies on food and fuel for a long time. These subsidies (for example on liquid fuel, butane, bread, sugar) were designed to safeguard poor households from price fluctuations, but turn out be very expensive while favouring in fact the wealthiest households (that consume the most) (Devereux, 2015; The World Bank, 2012, 2015). Morocco is now in the process of reforming its subsidy system. In 2014 it announced the end of subsidies of gasoline and fuel oil and had started to cut significantly diesel subsidies as part of its drive to repair public finances. But the government, keen to avoid the kind of social unrest, said it would continue to subsidise wheat, sugar and cooking gas used by poorer Moroccans.

Recent and ongoing reforms are - slowly - changing the face of social protection in Morocco, especially with regard to unemployment, pensions and health. In view of the high mobility on Moroccan labour market, steps are being made to cover the major risk of unemployment. In 2000, social dialogue led to an agreement on the establishment of an unemployment insurance scheme (Indemnité pour perte de l'emploi, IPE) for private sector workers affiliated with CNSS. After years of studies and debate (between workers' representatives, employers' representatives and the government) the IPE was finally launched in 2014.

With regard to pensions, technical reforms scattered across the different providers have been taking place between 2002 and 2006: the main providers CMR, CIMR, RCAR implemented changes, such as an increase of the contributions, an indexation of the pensions and an adjustment pension age. However, these changes were of a technical nature, adjusting specific modalities within existing regimes and by no means a fundamental adjustment of the pension system. Given the fragmented nature of the pension system that is suffering from structural problems, a social dialogue on the need for a reform has been ongoing since 2007, a systemic review of the pension system was announced in 2010. One of the issues raised, is the bad financial health of the current systems and the

questionable long term viability[35]. The by the government announced changes triggered mass demonstration in Casablanca on 29 November 2016 and a national strike on 10 December 2016 was organised by a coalition of the four major union confederations. They jointly denounce "the absence of a fair social policy and social dialogue on the part of the government which takes unilateral decisions that threaten the social stability of the country and who called on the government to establish a participatory approach in reforming the pension system (Arbaoui, 2015). In the meantime, the Moroccan government has requested capacity support at the ILO (ILO, 2012).

Last but not least, important efforts to increase the coverage of social protection related to health for salary workers, independent workers and the poor are ongoing. This has been launched by the adoption of **Law 65.00 in 2002 on Basic Medical Coverage**. The law has resulted in the introduction of a mandatory health insurance[36] (AMO) for the formal sector and the establishment of a medical assistance scheme for the economically destitute[37] (RAMED[38]). The expansion of the latter to the national level and the expansion of former to other target groups (e.g. independent workers and students) are still work in progress. According to interviewees, this is the most significant reform in social protection at the moment. The move towards basic medical coverage for all, and specifically the introduction of RAMED, has been selected as the focus of this case study.

4.3 Expanding health coverage though different routes

This section investigates the ongoing introduction of health coverage through mutual health organisations and brings together the available information on the technical and financial choices that are shaping DECAM, and on the underlying policy making and implementation process, including the role of different national and international actors.

4.3.1 Technical dimension

In essence, the 2002 Law on Basic Medical Coverage embodies a choice for two different **regimes**. On the one hand a contributory mandatory health insurance is envisioned to cover (1) all active workers and retirees in the formal public and private sector as well as their families, (2) all self-employed or independent workers, (3) veterans and (4) students. On the other hand a contributory medical assistance scheme is to provide access to health services for all indigents that are not covered by the health insurance. This medical assistance is contributory and state-subsidized. Figure 4.1 gives on overview of the different regimes, target groups, mechanisms and resource flows.

Within these two regimes, a further breakdown into specific **target groups**, each served by a separate mechanism, is being implemented. In fact, the overall population can be divided in three major groups, representing roughly a third of the population each: 'salary workers', 'self-employed or independent workers' and 'the poor'. Each of these groups is subdivided: (1) salary workers either belong to the public sector or the private sector; (2) independent workers can be divided according to socio-professional category, which roughly means between organised professions (formal sector) and the informal sector; (3) the poor are divided into two groups, either poor/vulnerable or extreme poor/indigent, depending on their level of income. An additional group cutting across is that of the

35 Although the Moroccan population is currently young, the demographic deterioration is expected to be rapid. Even more problematic is that the system demographics, especially of the public pension systems even worse off are: the aging process if the pension schemes is faster than the ageing process of the total population, and both threaten the long term viability of the systems (The World Bank, 2015, p. 17).

36 Assurance Maladie Obligatoire.

37 Régime d'assistance médicale.

38 Régime d'Assistance Médicale aux Economiquement Démunis.

students. For each of these different groups different mechanisms for health coverage have been or are being implemented.

The mandatory health insurance (AMO) for salary workers in public and private sector is managed by two different institutions, respectively the CNOPS and the CNSS. CNOPS and CNSS were established as mutual health organisations decades ago but are now transitioning to public institutions managing the mandatory health insurance. For the workers in the public sector, the current reforms do not change much. For CNOPS itself however they do pose a sustainability challenge. CNOPS is currently absorbing a lot of retirees in its population, as well as students (between 40.000 and 50.000) and this is putting pressure on the financial viability. Workers in the public sector often also have complementary health insurance through mutual health organisations or private insurance companies. Clear progress has been made for salary workers in the private sector falling under the AMO managed by CNSS: although employers still register their employees and their performed hours incompletely, coverage in the private sector has expanded. When all coverage issues are resolved, AMO should cover about 3 million public and private workers directly, and about 7 million people when including dependents.

Besides the health insurance for the salary workers in the private sector, CNSS has recently been mandated to manage the health insurance for the independent workers (AMI) still in the making. This will happen through the establishment of a separate fund, but details on how to fee collection, rates, service package and the government's role are not available yet. A law on the issue has been adopted in August 2016 (Law 98-15). Reportedly, the insurance envisioned by this law would be mandatory and would cover over 11 million people or 30% percent of Morocco's population. Interviewees nuance that the actual implementation will be gradual, starting with the organized professions (Anon, 2016). This operationalization of AMI for different sub-sectors will require further implementing, and it remains unclear how the financial sustainability can be ensured and if, when and how the unorganized informal sector will be included (Interviews public servant, 2016).

Moroccan residents that cannot access AMO and whose annual income is equal to or lower than 5.650 dirhams (approx. 525 euro) per family member, have access to the medical assistance scheme RAMED. RAMED is seen as a way to ensure everyone's constitutional right to access to health. RAMED further distinguishes between poor, who do have to contribute, and the extreme poor, who are currently exempted. RAMED uses a rather sophisticated methodology for targeting that combines proxy means testing and community targeting methods[39]. However, a 2012 evaluation indicated the use of outdated data and very high errors of exclusion, with 72% of the actual target population excluded from the program. Another point of critique was that applicants need to register in person at designated facilities which may exclude families in remote areas, and that few efforts are being done to guard the quality of the data collection and data management (e.g. no digital data input at the local level, processing of paper applications takes long, local officials not trained to accompany applicants to provide correct data). There are some communal mutual health organisations active in the informal sector but their coverage is almost negligible. In 2008 it was estimated that nine million people, nearly a third of the population, would be covered by the RAMED system (ILO, 2008, p. 34-35). However, at the time of writing there was no systematic outreach and the system relied on self-registration, which may limit the accessibility for underprivileged households with limited access to information. Since RAMED's start over 10 million people have had access at some point in time, and end 2016 the number of active cards stood at 6.345.525 (ANAM, 2016, p. 48).

39 Based on the data collected through the application form, a household receive a particular score that needs to be bellow certain predetermined thresholds to qualify. Additionally inter-ministerial local committees decide on eligibility, as a mechanisms to reduce exclusion errors (The World Bank, 2015, p. 30).

Overall, the social protection in health leaves two coverage gaps. Firstly, those belonging to the unorganized informal sector and not fitting the RAMED criteria are not covered by any system and no clear initiatives are ready to address this. Secondly, incomplete registration by private sector employers of their employees has led to a coverage gap in the formal private sector. According to the Moroccan administration, the currently active systems combined achieve a coverage of approximately 60% of the total Moroccan population, whereas in 2005 this was still only 25% (ANAM, 2016, p. 46).

Belonging to one or the other regime has far reaching consequences for the **services one can access**. Those covered by AMO can have access to the health care services in the public or private sector, at any level in the health care cascade and anywhere in the country. They will be reimbursed by their insurance. However, there is a difference between the packages offered by CNOPS and CNSS. CNOPS has a far more complete package. CNSS has been gradually expanding its package since 2010 but the convergence of both systems remains a challenge today. Those who are not covered by AMO can only access medical assistance if they have a valid RAMED card. With a card, they can only access health services in the public sector, only in the region where the card has been issues and only at the lowest level of the health care cascade unless they have a referral. RAMED does not provide reimbursements but offers free health care. In theory, those covered by RAMED have access to a very complete health care package but under the condition that the listed services are available. In practice many services are not available in the public health system, due to the basic health infrastructure and lack of human resources, in which case a Ramedist has no other option but to turn to the private sector and pay out of pocket. Several civil society representatives and public servants alike confirmed that the gap between demand and supply in the Moroccan health sector, and the uneven geographical distribution of health providers means the equal access to the right to medical care often remain empty words.

Current reforms will also affect the possibility of CNOPS and CNSS to establish and manage health care facilities themselves. Both organisations have done so in the past (for example a pharmacy in the case of CNOPS and policlinics in the case of CNSS) but a new law being drafted could make this impossible. This would address the possible conflict of interest that can arise when managing the insurance while also managing service provision but would also curtail one of the ways to address the gaps in the health care supply.

Looking at the **governance** side, the picture becomes even more complex. Lead players are the Ministry of Health, the Ministry of Finance, ANAM and the King. ANAM, a government agency with financial autonomy, is the regulating body of AMO. Legally, it is also charged with the financial management of RAMED. However, in contradiction to the law, the implementing order does not recognized the financial management role of ANAM. At least until September 2016 the Ministry of Health was keeping the management in own hands, and had not forwarded any budgets to ANAM. The financial management aside, the law did not arrange for a regulatory body for RAMED. Meaning that there is no official regulator for RAMED, and the establishment of such structure is currently on the political agenda.

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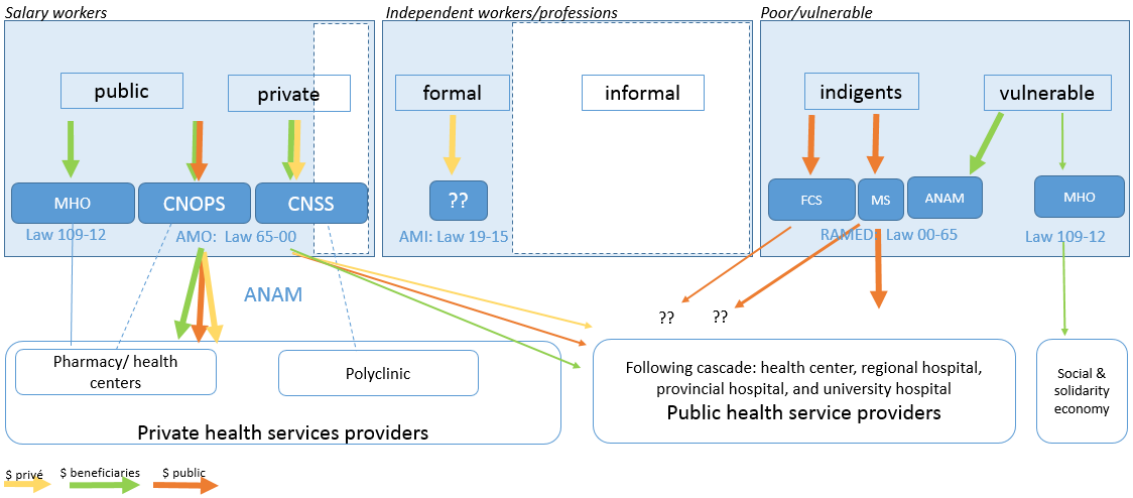
Mechanisms providing basic medical coverage in Morocco



* Mutual Health Organisation (MHO); l'Agence Nationale de l'Assurance Maladie (ANAM), Assurance de Maladie pour les Indépendents (AMI); Fond de Cohesion Sociale (FCS), Ministère de la Santé (MS); Régime d'Assistance Médicale aux Economiquement Démunis (RAMED); Caisse Nationale des Organismes de Prévoyance Sociale (CNOPS); Caisse Nationale de Sécurité Sociale (CNSS).

Important decisions on the guiding principles, the main mechanisms, the governance structure have been made. The discussion is no longer about what general approach would be most suited and viable. Instead, there are some acute challenges on a rather technical level. For example, the transition period for CNOPS and CNSS has come to an end, and different changes should come into effect. As mutual health organisations, both organisations invested in their own health service providers, such as a pharmacy or a polyclinic. Transitioning into public institutions, they will no longer be allowed to combine the roles of provider and manager, and will have to sell off their own health care structures. Other challenges are the development of treatment protocols with the health sector, and the enforcement of previously made price agreements by ANAM. The development of a data collection and management system is also high on the agenda.

But the biggest challenge of all is the gradual expansion and harmonisation and convergence of the different systems, the ultimate goal of the Moroccan approach. The reform is cumulative, as it builds on what existed and progressively expands scope. Many interviewees agree that in a first phase it does cause fragmentation. However, interviewees and policy documents all explicitly point out that the progressive harmonisation of the different systems will enable a convergence into a unified system. An exact timeline does not exist, but different interviewees speculate it will take at least two terms to arrive at this stage.

4.3.2 Financial dimension

The financing of the **AMO**, the mandatory health insurance is partially based on a solidarity contribution by employers of 1.5% of the total of salaries payed. Additionally employer and employee each contribute 2% of the salary. Pensioners contribute 4% of their pension. Students in public education are exempted from contributing and have free access. Students in private education pay a forfeit. CNOPS and CNSS use the same employer-employee contributions, but in the public sector contributions are held at the source (ANAM, 2014). These arrangements are currently sufficient to "keep things going", as one interviewee put it. In fact, in 2013, both CNOPS's and CNSS's income exceeded its costs. However, the long term viability of both funds, and especially of CNOPS, is facing challenges. One of them is the financing of costs related to chronic diseases, and of the expansion of

the coverage. The financial health of the AMO over the next 10 years has been the subject of an actuary study in 2016 (ANAM, 2016).

An interesting aspect in the financial architecture, is the distribution of reimbursements to the private and public health care providers. Only between 6% and 10% of the reimbursements by CNOPS and CNSS go to the health care facilities in the public sector. This while 71% of the CNOPS' incomes are coming from the government in its role as employer.[40] This means there is a transfer of public resources to the private health care providers. ANAM has launched a campaign to boost the image of the public health care sector, but so far this has not been successful.

The government, the local communities and the beneficiaries themselves combine efforts to finance **RAMED**. Financing studies anticipated that the state would contribute 75%, local communities 6% and the beneficiaries 19%. However, these estimates were based on the assumption that the population covered by RAMED would be 55% extreme poor and 54% poor, whereas in reality the ratio currently is 87% versus 13%. Hence, far less 'Ramedistes' can currently contribute to the system, meaning less income is generated. At the same time the cost is also higher than expected, because of the increase in demand of medical care with 200% since the introduction of RAMED (Semlali, 2016).

Complications related to governance also hinder the financing. Legally ANAM is in charge of the financial management of RAMED, but the Ministry of Health has currently assumed this role. However, at the moment of writing there is no separate budget line for RAMED. Instead health service providers get financing either directly from the health budget or through the Fund for Social Cohesion[41]. This is however overall funding and not a direct response to costs being made for the care provided to 'Ramedistes'. In fact, at the time of data collection, interviewees confirmed that it is not known how much RAMED is actually costing, and they strongly doubted whether the financing by the state is, in each of the health care facilities, in proportion to the costs made in response to RAMED.

In the meantime ANAM, without a budget to manage, remains side-lined when comes to RAMED. In response to this anomaly many local communities are refusing to contribute. The contributions of the beneficiaries are being collected in a fund, but this money too is stuck due to the stand-off between ANAM and the Ministry of Health. The Ministry of Economy and Finance also plays a role in the problematic financial situation of RAMED, because in absence of predictability of costs and a clear source of incomes for RAMED it has prevented a budget line from being opened.

Looking at the **overall** picture, interviewees assert that the current costs of the health system are not in proportion to the health budget. The current budget cannot suffice to finance the generalization of RAMED and decrease the out-of-pocket share of the households in health cost. Interviewees with a long track record in public service also seem to agree that the financial sustainability of the current approach is relative. Since there is political and social support, the systems will continue to exist. It is considered near to impossible for the state to come back on its decision to provide medical assistance. This means that to guarantee the continuation, a balance is pursued between the coverage and quality of the services and the overall cost.

40 Interview with CNOPS official, Rabat, September 2016.
41 Fond de Cohésion Sociale.

4.3.3 Socio-political factors

Interviewees agree that the policy process on CMB **started** at the end of the '80s. Table 4.1 provides a timeline of key events. Following the structural adjustment plan, the situation in the health sector around 1989 was dire. Some social protection mechanisms in health (mostly mutual health organisations) existed since independence, but they were limited to the formal sector, facultative, and dependent on the goodwill of employers and employees. Overall coverage was very low and the services covered were minimal. Those left uncovered were mostly people in precarious situations. Although in theory they had access to free medical care, public hospitals did not receive sufficient government funding to provide this care, and no legislation existed to force them. The havoc in the infrastructure, education, and health sector triggered waves of social unrest and bread riots in the '80s and early '90s.

In 1990 the Moroccan government responded with a first major reform in the health sector: medical assistance for the poor and medical insurance for the formal sector workers were introduced. These provisions have been gradually expanded and build on by subsequent governments, but the coverage of the facultative insurance mechanisms only reached 17% and the medical assistance based on a 'poverty card' was notorious for its malfunctioning.

In 1998 the first opposition government, headed by the socialist Abderrahmane Youssoufi, was elected in 30 years. During its period in office, the Youssoufi government (1997-2002) managed to build a consensus on phasing in universal health coverage for the Moroccan population. This led to the adoption of the **Law 65.00 on basic medical coverage in 2002**, which triggered the current reform process. The law contained the introduction of both AMO and RAMED.

Only after the law entered into force in 2005 the first real steps for its implementation were made. As of 2005 the different actors started to put things into motion, but "everybody was playing in his own corner". In 2008, a 6-month pilot for RAMED was introduced in three provinces. It would take until 2012 before the generalisation of RAMED is announced.

Stakeholders all agree that the process has recently undergone a clear acceleration. According to some, this has been triggered by the Arab Spring of 2011, putting pressure on the government and resulting in a revised constitution that recognizes social protection as a right to all. Other stakeholders point to the establishment of an interministerial committee[42] on the reform of basic medical coverage in 2013. It held its first meeting in December 2014 and has reportedly been key in clarifying key political choices, formulating a shared strategy and increasing the visibility of this reform. The committee is composed of public servants and no civil society representatives take part, but whenever necessary experts are invited to provide input.

For both AMO and RAMED it can be said that the policy process went through a first cycle of agenda setting, goal setting, policy formulation and implementation, with the first policy effects now becoming visible and feeding a new policy cycle. Having gone through different stages of expansion and generalisation, both RAMED and AMO face important challenges to maintain their sustainability. For example, even combined, RAMED and AMO cover only 60% of the population today. How to reach the remaining 40% is an important question. Also, after three years generalized RAMED, Minister of Health, El Houssaine Louardi, recognized the need to evaluate: "we have been asked to rethink our vision and methodology in order to confront the current realities of targeting, care, financing and governance of the regime" (quoted in L'Economist, 16/03/2015) [own translation].

42 Comité Interministériel de pilotage de la réforme du régime de la couverture médicale de base.

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Timeline reforms in health sector

Policy developments		
National	International	
	Financial institutions IMF and World Bank push for structural adjustment plans including in Morocco	'70s '80s
1989-1990	Start of reflections on health coverage after structural adjustment plans had caused social havoc. In response, facultative health insurance for the formal sector and medical assistance for the poor are introduced.	
1998-2002	First socialist government, under prime minister Youssoufi, builds a consensus on phasing in universal medical coverage for the Moroccan population.	
	UN, the World Bank, and the ILO all include social protection in their development policy.	2000-2002
2002	Law on Basic Medical Coverage 65.00 was adopted, introducing 1) mandatory health insurance for the formal sector (AMO) and 2) a non-contributory health assistance scheme for poor and vulnerable families (RAMED)	
	The World Health Assembly Resolution 58.33 on sustainable health financing, universal coverage and social health insurance was adopted	2005
2005	Social partners signed a charter in support of Basic Medical Coverage	
	Law 65.00 enters into force. Establishment of the National Agency on Health Insurance (ANAM)	
	Official introduction of AMO, leading to an expansion of health coverage from 17% in 2005 to 34% in 2007	
	First phase of the Parcoum[43] programme on medical coverage reform financed i.e. by EU and AfDB.	2006-2008
2008	RAMED pilot is launched in two regions. It is planned to run for 6 months but stagnates.	
2011	Arab Spring	2011
2011	Revision of the constitution with inclusion of social protection as a right	
2012	Following the evaluation of the RAMED pilot, its generalization was announced by the King.	
2013	Establishment of an inter-ministerial committee uniting all government departments and structures involved in basic medical coverage. With support of the EU.	
	New director at ANAM develops strategy and improves coordination	
2014	A road map 2014-2018 is developed, setting-out the gradual development of the universal health coverage. It is also the start of the publication of annual reports by ANAM	
2016	Students included in AMO.	
	Law on Mandatory Health Insurance for Independent workers (AMI) adopted.	
	Policy discussion and study on a possible regulating body for RAMED ongoing.	

From this reconstruction of the socio-political process that led to the adoption of Law 65.00 on universal basic health coverage, the following reading of how **national actors** joined forces emerged: The public pressure during the '90s and the arrival of a socialist government in 1998 created a window of opportunity for universal health coverage to rise on the political agenda. Over the next years, a group of national experts, worked on drafting a consensus proposal. Within it, a group of public servants, many from the Health Ministry, lobbied for the inclusion of both AMO and RAMED. They

43 The EU-financed Medical Coverage Reform Support Programme, currently in its third phase, see below.

believed that if RAMED did not make this bill, it would be near to impossible to get it back on the agenda afterwards.

They had to work with the limited data available and did many concessions (e.g. not establishing an new expensive regulating body), but succeeded in including RAMED, in part thanks to the support of King Mohammed VI and the trade unions. The unions insisted on a reflection about the system in its totality ("une reflection globale"). Although their interests and say weighed far more heavily in the discussion on mechanisms targeting the formal sector, their principal support for a discussion about covering both the formal and informal sector kept RAMED on the agenda. King Mohammed VI, in line with his reputation as 'King of the Poor', strongly supported RAMED. Different stakeholders assert that his support unblocked discussions and forced the government to create some financial space for RAMED. The fact that he, in person, launched the generalisation of RAMED is also seen as an explanation for the momentum that has been created since.

Against this coalition of forces in favour of a broad social protection in health, other actors played a more restraining role. The Ministry of Economy and Finance in particular complicated policy formulation and implementation on RAMED due to legitimate concerns about the financial predictability. To date, it remains unclear how much RAMED costs, due to gaps in data collection and data management. Also, the service package covered by RAMED has been defined in a way[44] that complicates long term cost-assessment. The packages covers a very broad range of health services, including for example all preventive care, dental care, and orthodontics for children, and excluding only plastic surgery explicitly. The condition is that the services are provided at public health care facilities (Law 65.00, Titre II, Art. 121). Consequently, the more investments are made in the public health sector and the more services become available, the more RAMED will cost. The historic health care demand proved to be a bad indicator, as has been shown by a rise in demand with 200% since 2012.

That this is not a simple story of good guys versus bad guys, becomes even clearer when also looking at AMO. Targeting the formal sector, the trade unions played a key role in the policy formulation on AMO. They were instrumental in creating the policy space for the reform but also insisted on the preservation and reinforcement of the existing structures under their control: CNOPS and CNSS. Hence, several interviewees link the cumulative nature of this reform and the following fragmentation at least in part to the lobby of the unions. The reforms in the health sector are at the top of the political agenda, especially during the run up to the elections of October 2016. Although it is not a topic of a broad public debate, political parties and trade unions are very active and vocal on the issue. For the unions, public service provision in education and health are currently top priority, and they will not support parties that think otherwise.

Except for the unions and some profession-based organisations (e.g. representing the pharmacists, the doctors), no indications of significant participation of other civil society organisations was found. CSOs indicate this may be due to the fact that few CSOs have specialised on the topic of social protection in health, because very little funding is available to do so. They also link social protection to (decent) work and hence to a domain that has been claimed by the unions. In fact, almost all reports of concertation with non-state actors in this policy process refer to the unions. In view of the low degree of union membership, CSOs do not feel this is the right course of action.

44 WHO considers this to be a 'negative' definition of the service package: it states people have a right to all services and notes some exceptions. WHO prefers a 'positive' definition that describes in detailed what can be offered and that can be expanded when financial possibilities expand.

This interplay between different national actors led to a cumulative reform that aimed to gradually expand coverage through the establishment of different parallel mechanisms, thus also contributing to fragmentation. One assessment, dating 2008, came to a harsh verdict on the merits of this process: "When the reform of health funding in Morocco was implemented through the AMO and the RAMED, the power struggle between these different vectors of influence impeded the delivery of the expected product. The initial project, prepared by a group of national experts, ultimately emerged so diluted as to be ineffectual. Health insurance coverage rose from 17% in 2004 to nearly 35% in 2007, but there were many observable flaws in its functioning." (Zine-Eddine El-Idrissi et al. 2008). Although clear flaws in the functioning clearly still exist, recent events make it difficult to maintain this judgement: meanwhile the generalisation of RAMED did go through, manifest difficulties in coordination have been addressed to some extend since the arrival of a new ANAM-director and the establishment of an inter-ministerial committee, and the goal of gradual expansion is still being pursued in practice with some recent advances (students, law on AMI). Despite these recent developments it is still true - and confirmed by several interviewees - that the basic idea of the basic medical coverage was

The role of **international actors** should also be taken into account. Key international actors in the domain of health are the EU, the World Bank, the ADB, the European Investment Bank, the Global Fund and the French Development Agency. In particular the World Bank, the ADB, and the European Union have supported the move to universal health coverage through their participation in the Support Programme for the Reform of Basic Health Coverage (PARCOUM), ongoing (in different phases) since 2002. WHO is providing technical support. However, all interviewees agree that the direct influence of international on actual policy choices was very limited. This aligns with the observation that external funding in fact represents only a very small portion of the health budget in Morocco (around 1.1%) (WHO 2016).

4.4 Analysis of redistributive potential

As was pointed out by Fonteneau and Van Ongevalle (2014), the potential for redistribution of wealth of a mechanism will be determined by the different technical, financial and socio-political factors. Applying this to the move toward Basic Health Coverage (CMB) in Morocco as described above (see recap), leads to the following remarks regarding the potential for redistribution.

A first striking observation is the fragmentation in the Moroccan system. Different mechanisms serve different target groups. The long term goal may be gradual harmonisation and convergence, leading to a unified system, but very few attempts to transcend the different silos and to establish redistribution between the different socio-economic population groups have been observed in this study. The health assistance (RAMED) is partially financed by the state budget and can hence be considered tax-funded to some extent. But in the light of the clearly insufficient funding (leading to strong pressure on the public health care providers) and the ongoing discussions on the introduction of a moderating ticket in RAMED, this seems a very half-hearted attempt at redistribution. This resonated with how key officials formulate the government's priorities: "Let's begin with solidarity between the sick and the healthy. Maybe afterward we can work on solidarity between the rich and the poor".

That solidarity between the sick and the healthy is indeed being increased to some extent through the current reforms, because the heterogeneity of the different target groups is increasing. This is a logic result of making the insurance mandatory. For the health insurance in the public sector it is also the consequence of including the retirees and the students in its population.

Looking at redistribution that promotes equal rights, another observation comes up. The medical assistance scheme for the economically destitute (RAMED) was established to counteract the unequal access to health care: in 2008 more than half of the Moroccan hospital budget benefitted the 30% richest whereas less than 8% was spent on the 30% poorest (ILO, 2008, p. 34). RAMED has indeed increased access to health services for the poor, as the spectacular rise in demand can show. However, the choices made by the Moroccan government have also consolidated a dichotomy between different population groups, giving some groups more rights and choices, while limiting the rights and choices of others. Beneficiaries of the mandatory health insurance can access private and public sector, whereas the 'Ramedistes' can only access the public sector. This is especially problematic because the supply of health services is geographically badly distributed, leaving some areas with hardly any services and concentrating the services in major cities. Additionally, because of the bad image of the public sector the flow of resources in the health insurance is in fact reinforcing the gap between private and public health care providers. This difference in services one can access reflects a certain idea on the respective roles of the state and the individual. As one high ranking official chose to phrase it: "We believe it is normal that whoever is credit worthy gets access to the best system and the most options. Whoever is payed for by the state, will have to settle with what is offered".

Different institutional hitches have also affected redistributive potential. Firstly, the fragmentation and the lack of coordination have impeded a smooth implementation of the reform especially during its first decade. The law was adopted in 2002 and come into force in 2005 but until the establishment of an interministerial committee in 2013, the different components active in the reform worked parallel. Secondly, the reconstruction shows that RAMED is, institutionally, not well-imbedded. It does not have a predictable and reliable funding source, it does not have a regulator, the managing role of ANAM is being undermined and the implementation of RAMED on the ground has mostly just been added to the work load of local public servants.

A part from these technical and financial factors, politics clearly have shaped and continue to shape the policy formulation and implementation of CMB reform. Political factors that have clearly played a role include: (1) social unrest and public pressure preceded different accelerations in the reform process (during the '90s; and in 2011 with the Arab Spring); (2) change makers within the administration played in important role in building political consensus on a system for basic medical coverage, and in keeping RAMED on the political agenda; (3) the support of the King and the trade unions was key to expand the scope of the policy discussion and also include coverage of the poor and the informal sector; (4) the existence of strong institutions (mutual health organisations) backed by the trade unions was an important argument in favour of a cumulative reform that would gradually expand coverage and evolve toward a unified system in the long term; (5) aside from trade unions, civil society organisations have played a very limited role. This can be explained because they lacked (and still lack) expertise on the topic, but also because they were not actively consulted or included in the policy formulation process.

- APPENDICES -

appendix 1 Analytical framework

Building on the tri-dimensional analysis of redistributive protection put forward in the first research paper (Fonteneau & Van Ongevalle, 2015) and using insightful research by Hikey (2008), Hikey and Paver (2015), we developed an analytic framework that unpacks how the tri-dimensional analysis can be applied to a specific social protection system in a country. This analytic framework offered guidance for the data collection as well as for the in-case and cross-case analysis and reporting.

The framework is built around 6 key components:

1. **Political and economic country profile =** a concise but up to date overview of the current political and economic landscape.

   This section includes information on: (1) the current political settlement; (2) recent shifts in power and the window of opportunity this may have created for agenda setting on new policies; (3) the place of the different actors involved in social protection within the larger political and economic system; (4) the economic context in which different options for financing social protection need to be considered; (5) major policies that determine the broader context.

2. **Snapshot of social protection landscape =** mapping the different components of the existing social protection landscape, and identifying the components that are the subject of recent or ongoing policy reforms.

   Social protection can address risks in a variety of domains. Following the Social Security (Minimum Standards) ILO Convention, 1952 (No. 102)[45], this framework considers birth, death, work (unemployment and work-related injuries and illness), health, old age and natural disasters as key domains of risk. The snapshot maps the existing mechanisms that aim to address risks in these domains, and discusses who has access to these different branches of social protection. In ongoing national policy processes not all of these domains are necessarily addressed and some may receive far more attention than others. Because our interest is in the redistributive power of social protection, the focus be on a domain characterize by important reforms towards universal protection. Based on the snapshot, one domain will be selected for further investigation in the case study.

3. **Reconstruction of the policy cycle =** a more in-depth analysis of the recent policy developments in the selected domain of social protection.

   This will entail (1) a reconstruction of the timeline of recent policy events; (2) a discussion of the different stages of the policy cycle: problem formulation, agenda and goal setting, instrumentation, implementation (see above); (3) a discourse analysis that summarizes the explicit policy goals and hints about the underlying policy theory and paradigm; (4) a discussion of

45 This convention lays down the minimum standard for the level of social security benefits and the conditions under which they are granted.

elements that can explain the course of the policy process (such as patch dependency, the involvement of different actors including donors or international organisations).

It is likely that several measures or mechanisms exist or are being implemented in a specific domain of social protection. The study will focus on the mechanism that aspires the most universal coverage.

4. **Analysis of the technical dimension =** discussion of the technical features of the mechanism(s) through which social protection in the selected domain is/will be implemented.

   Social protection can be delivered through four main mechanisms. The first is social insurance (contributory schemes), the second is social assistance (tax based), the third covers employment protection and promotion (both in a passive and an active way) and the fourth covers social services (also see above). This section will investigate: (1) the mechanism(s) deployed; (2) the intended target group; (3) the key implementing actors; (4) management and coordination.

   Institutions that deliver social protection can be divided between the state (government agencies) and non-state actors, where non-state actors include the market (e.g. private insurance), the family (e.g. remittances), religious institutions (e.g. mosques and churches), as well as international agencies (e.g. the WFP), international NGOs (e.g. Save the Children) and local NGOs (Devereux, 2015, p. 37).

5. **Analysis of the financial dimension** = discussion of the funding options being considered or implemented in the concerned mechanism(s).

   Several studies have demonstrated the affordability of basic social protection packages in a range of low- and middle-income countries (ILO, 2008, Fonteneau, 2014). The 2014 World Social Protection Report (ILO, 2014) identified eight different options to create the necessary fiscal space for financing social protection. These are (1) reallocation of current public revenues; (2) increasing tax revenues; (3) extending social security contributions; (4) borrowing or restructuring existing debt; (5) Curtailing illicit financial flows; (6) drawing on increasing aid and transfers; (7) using fiscal and central bank foreign exchange reserves; (8) adopting a more accommodating macroeconomic framework.

   This component will investigate (1) which financial options have been considered and/or selected in the mechanism(s) and the reforms discussed, (2) how participatory and in-depth this debate has been, (3) what the prospects are for sustainable financing and (4) the potential for redistribution at the national level.

6. **In-depth actor map per domain** = overview and discussion of all actors involved in the process of policy development and implementation.

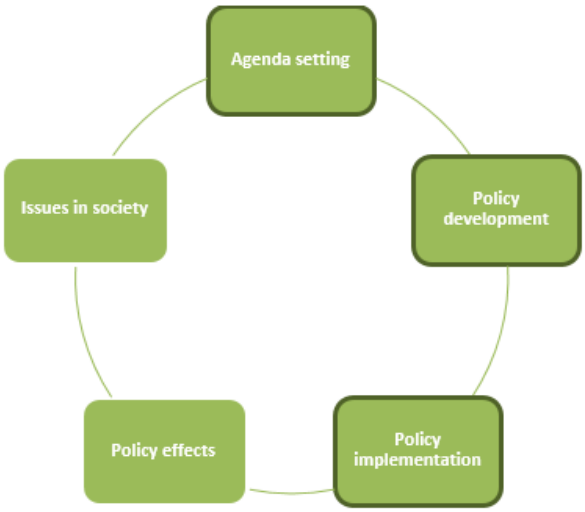
   This should provide insight in the role of IOs, donors, international NGOs, national CSOs, ministries, other official institutions, political parties, parliament, elites, etc. Aspects to consider include: the history of the actor, its key interest and agenda, its relative power, its key ideas on social protection, the influence of external actors on its views regarding social protection, its role in the policy process. The actor map will be informed and will inform the reconstruction of the policy cycle (component 3).

The framework has been used in the first round of data collection, as guide for identifying and structuring relevant data available in policy documents and literature. The result of this first round, was represented in a first concept note. This exercise allowed to pinpoint questions, patterns, and knowledge gaps that need to be addressed based on the field research. After insights from the field had been added to complete this picture, a final screening of literature was done to cross-check any findings with previous research. To round up, key findings and more general insights for supporting the redistributive potential of social protection have been put forward.

A key resource in determining our research approach, has been de policy cycle, schematically summarized in figure a1.1 below. This representation of the policy cycle distinguishes between four key phases in a policy process (Crabbé et al., 2006; De Peuter et al., 2007):

- agenda setting and goal setting: certain issues make it onto the political agenda, a problem formulation describes the undesired situation and implicitly set goals for the desired situation;
- policy development, including policy formulation and instrumentation: different solutions are being identified, considered and selected, a process that can vary in openness with different degrees of participation for societal actors like media, interest groups, citizens and civil servants. The policy choices are political and determined by the power balance between the actors involved;
- policy implementation: operationalisation in policy measures, instruments, division of tasks, allocation of resources and mandates, the formulation of rules and procedures, and the establishment of mechanisms for management and coordination. Implementing actors can exert a strong influence on how the policy is executed;
- policy effects: implementation of policy will result in policy output (acts performed by executive actors, such as for example the number of pensions distributed), in policy outcomes for the target group (such as a decrease in salary workers above 60 years old living in poverty) and in policy impact at the broader level (such as a formalization of economy). These policy effects and side effects together with external events determine needs and problems in society and are the beginning of a new policy cycle.

Figure a Fout! Gebruik het tabblad Start om Heading 6 toe te passen op de tekst die u hier wilt weergeven..**1 Schematic representation of a policy cycle**

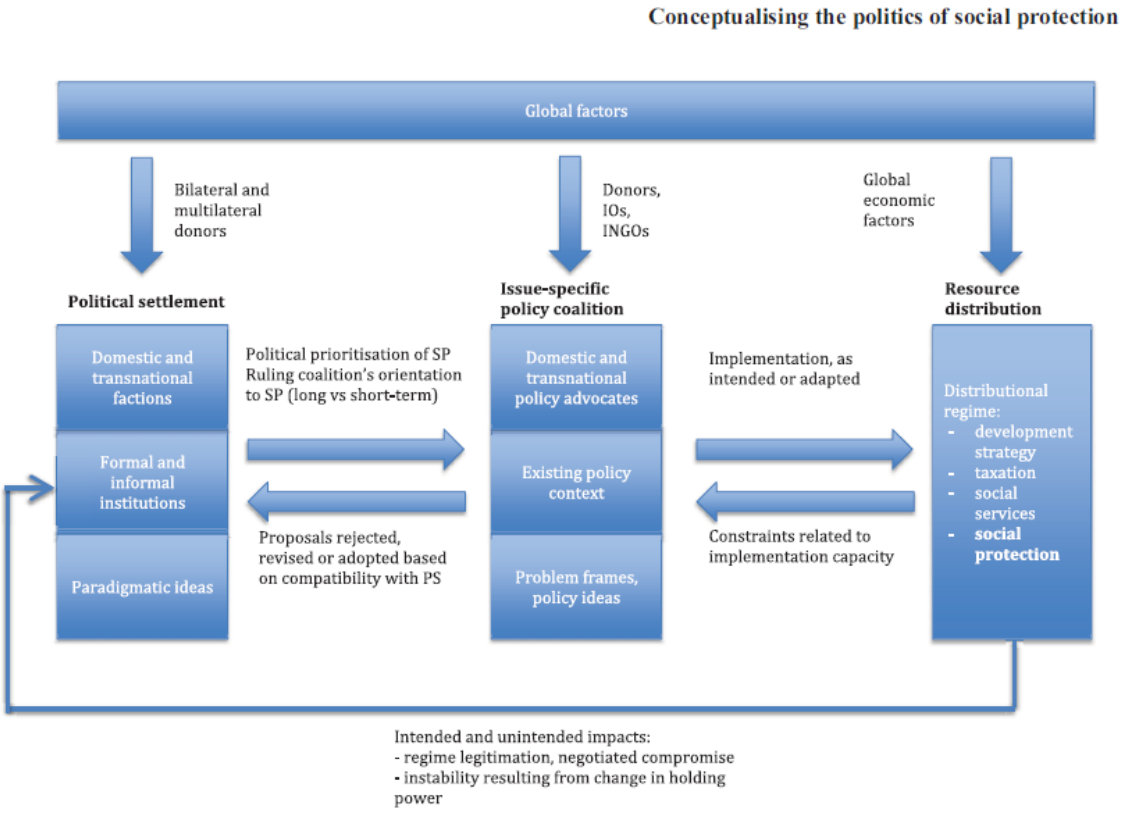


* The highlighted policy phases include problem formulation and agenda setting, goal setting and policy formulation, and the implementation.

Source Crabbé et al., 2006

appendix 2 Politics in social protection

Figure a Fout! Gebruik het tabblad Start om Heading 6 toe te passen op de tekst die u hier wilt weergeven..**1**
Conceptual framework: politics in social protection



Source Lavers & Hickey, 2016 p. 395

appendix 3 Social protection in Senegal

Quite some other programs providing social safety nets have been identified in a 2013 World Bank assessment.

- Food Security Commissariat (Commissariat à la Securité Alimentaire - CSA) provides food aid assistance to vulnerable populations either in response to catastrophes or through rice distribution at public rallies and religious festivals;
- National Solidarity Fund (Fonds de Solidarité Nationale – FSN) is responsible for providing immediate responses to crisis and emergency situations, including financial, medical and material support;
- Community-Based Re-adaptation Program (Programme de réadaptation à base communautaire PRBC) provides social, economic and cultural integration for disabled persons via material support and funding of income generation activities; vulnerable elderly (over 60 years) via capacity strengthening, grants and subsidized loans for income generating activities to groups of elderly;
- National School Lunch Program (Programme d'alimentation scolaire - DCaS) provides school lunches funded through the national budget;
- WFP School Lunch Program (PAM Cantines Scolaires) supports the national school lunch program by providing hot meals in pre-schools and primary schools located in rural and peri-urban vulnerable areas;
- Educational Support for Vulnerable Children (Bourses d'étude pour les orphelins et autres enfants vulnérables – OEV) a program through the National HIV-AIDS Council to provide for schooling or professional training to children orphaned or affected by HIV-AIDS and other vulnerable children;
- Poverty Reduction Program (Programme d'appui à la mise en oeuvre de la Stratégie de Réduction de la Pauvreté – PRP) supports grants for income generating activities for vulnerable groups, primarily women, the disabled and HIV-AIDS affected populations;
- a pilot Cash Transfers for Child Nutrition Program (Nutrition ciblée sur l'enfant et transferts sociaux-NETS) entailing cash grants to mothers of vulnerable children under 5 years old to mitigate the negative impacts of food price increases;
- WFP Vouchers for Food Pilot Program (Bons d'Achat – PAM CV) to address food insecurity among vulnerable households due to rising food prices;
- The Social Protection Initiative for Vulnerable Children (Initiative de protection sociale des enfants vulnérables – IPSEV) Cash grants to households to help them maintain vulnerable children and ensure access to health and education services (World Bank, 2013).

Table a3.1 below summarizes the main social protection provisions in place.

Table a Fout! Gebruik het tabblad Start om Heading 6 toe te passen op de tekst die u hier wilt weergeven..**1 Overview of existing provisions (anno 2015) for different social protection components in Senegal**

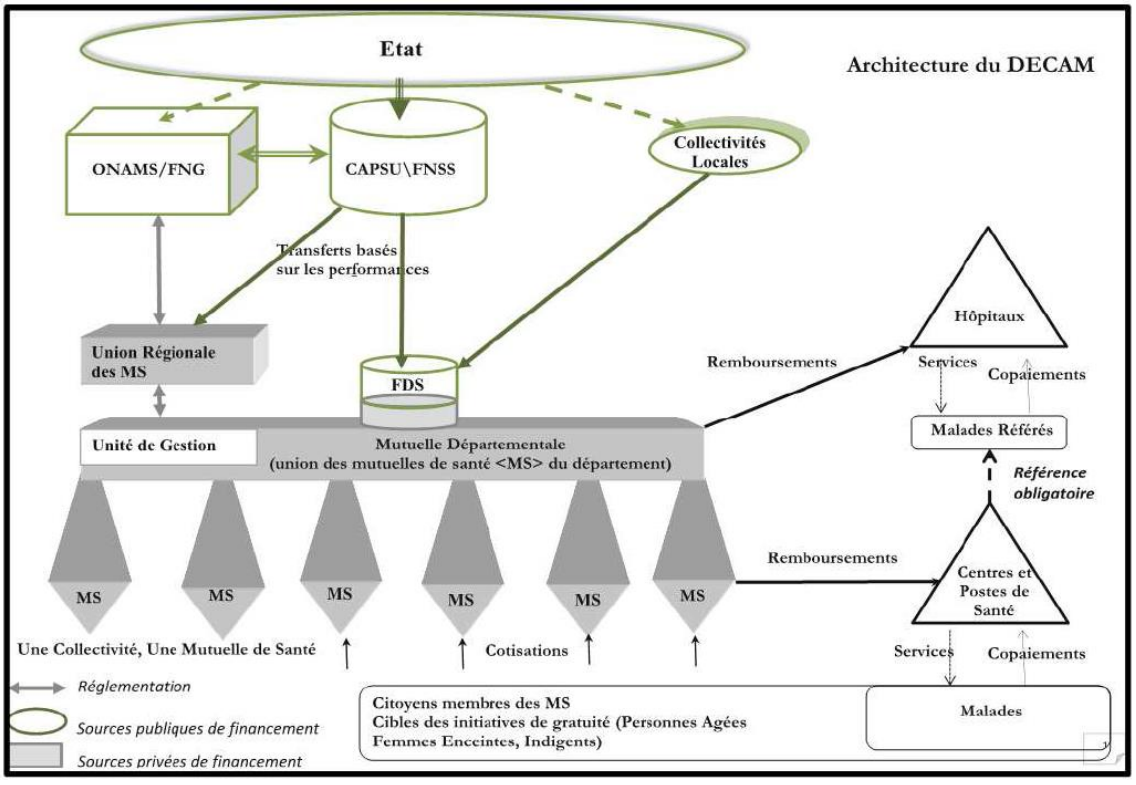
Risk area	Target groups	Covered by	Managing institution	Services include	Coverage
Birth	Formal sector	Mandatory insurance based on contributions by employer	Caisse de Sécurité Sociale (CSS)	Prenatal allowance, maternity allowance, family allowance, compensation	
	Everyone	Medical assistance	Centres de Protection Maternelle et Infantile (PMI)	Prenatal consultations, vaccination new borns, post-natal follow-up	
	Everyone	Medical assistance	Centres de Santé à Soins Obstétricaux d'Urgence and hospitals	Free caesareans	
Health	Salary workers in the private sector + family	Mandatory insurance based on employees' and employers' contributions	Institution de Coordination de l'Assurance Maladie Obligatoire (ICAMO) Institutions de Prévoyance Maladie (IPM)	Refund of 40% to 80% of for health care	700.000
	Civil servants + family	Mandatory regime financed through fixed budget item	Ministry of Finance		300.000
	Self-employed in the formal sector	Voluntary health insurance based on contributions	Private mutual health organisations		
	Retirees (from formal sector) + family	Pension based on contributions	Institutions de Prévoyance Retraite (IPRES)	Free health care in IPRES structure	
	Vulnerable groups (+60, -5, pregnant women, poor)	Medical assistance	Plan Sésame & other programs	Free health care	
	Workers in informal sector	health insurance based on partial or complete subsidized contributions	Caisse autonome de Prévoyance Social Universelle (DGPSN, CAPSU)	Minimum package health care	still under development

Work Accidents & sickness	Salary workers in the formal sector	Obligatory insurance based on contributions by employer			
	Self-employed in the formal sector	Voluntary insurance	Caisse de Sécurité Sociale (CSS)		
Old age	Civil servants	Obligatory insurance based on employees' and employers' contributions	National Retirement Fund (FNR)		35.000
	Salary workers in the private sector (and specific types of civil servants)		Private Sector pension Scheme (IPRES)		200.000

* Highlighted provisions have been introduced after 2010.

Source CLEISS, 2015b; Ministère de la Santé et de l'Action Sociale, 2013

Figure a Fout! Gebruik het tabblad Start om Heading 6 toe te passen op de tekst die u hier wilt weergeven..**1 Overview of the DECAM structure**



Source Ministère de la Santé et de l'Action Sociale, 2013, p. 22

appendix 4 Social protection in Morocco

Table a Fout! Gebruik het tabblad Start om Heading 6 toe te passen op de tekst die u hier wilt weergeven..**1 Overview of existing provisions (anno 2015) for different social protection components in Morocco**

Old age	Salary workers in public service	Obligatory insurance based on contributions by employer	Régime Collectif d'Allocation de Retraite (RCAR)	Basic pensions	200.000
	Civil servants, old resistance fighters, old civil and military personnel	Non-contributory, social assistance	Caisse Marocaine de Retraite (CMR)	Basic pensions and invalidity pensions	700.000
	Salary workers in private sector	Obligatory insurance based on contributions by employer	Caisse nationale de Sécurité sociale (CNSS)	Basic pensions	2.000.000
	Salary workers in private sector	Voluntary social insurance organized by employer	Caisse Interprofessionnel de Retraite Marocaine (CIRM)	Pensions, invalidity pensions, survivors benefits	
			Private insurance companies		
Family	Parents with children between 8 and 15, in rural areas with poverty rate + 30% and school desertion rate + 5%	TAYSSIR	Social Affairs Directorate at Ministry of Education	Conditional cash transfers to improve participation in primary school	812.000
Additional safety net programs	Individuals with disabilities	Program for Disabled Individuals	Social Development Agency and Entraide of Ministry of Social Development	Support to initiatives that support the target group + management of polyvalent centres.	10.989
	Individuals in vulnerable situations	Social Protection Centres	Social Development Agency (ADS) and Entraide of Ministry of Social Development	?	160.000
	Girls and women in difficult socio-economic conditions	Centres for Training & Education	Ministry of Social Development	Cover costs of education, training, and medical support	200.000

	School drop-outs	Centres for Vocational Training for Disadvantage populations	Ministry of Social Development		14.207 /year
	Children between 4 and 6 of poor families	Jardin d'Enfants	Ministry of Social Development	Access to pre-school and primary education	69.000
	Poor and vulnerable population in urban areas	Housing programs		Social housing	
	Rural populations	Program to Fight Poverty in Rural Areas	National Initiative for Human Development (INDH)	Supports subprojects e.g. aimed at increasing access to equipment and social services such as health and education	457.571 /year
	532 selected urban neighbourhoods	Program to Fight Social Exclusion in Urban Areas	National Initiative for Human Development (INDH)	?	
	10 categories of vulnerable persons (widows, disabled, orphans, drug users, HIV affected, etc.)	Program to Fight Social and Economic Vulnerability	National Initiative for Human Development (INDH)	Supports subprojects	

Source CLEISS, 2015a; ISSA, 2010; The World Bank, 2015

appendix 5 List of persons consulted

Interviews between 14 and 29 September 2016 in Rabat
Mrs. Khadija Meshek, Juriste Experte en Législation Sanitaire
Dr. Hafid Hanchi, National Professional Officer, World Health Organisation
Mr. Abdelaziz Adnane, Directeur de la CNOPS
Mr. Aziz Khorsi, Chef de Division de la Communication, CNOPS
Mr. Abdellatif Moustratraf, Chef du Département des Opérations et de Gestion du RAMED, Agence National de l'Assurance Maladie
Mr. Abdil Nrigui, Chargé des Relations Publiques, Agence National de l'Assurance Maladie
Dr. Laïla Ibn Makhlouf, Chef de la Division des Normes Médica-techniques, Agence National de l'Assurance Maladie
Dr. Abdelmajid Sahnoun, Conseiller, Agence National de l'Assurance Maladie
Mr. Franck Iyanga, Secrétaire Général de l'Odt travailleurs immigrés au Maroc, Organisation Démocratique du TravailMr. Habib Karoum, Chef de Service Hôpital et président de l'Association Marocaine des sciences infirmières et techniques sanitaires (AMSITS)
Mrs. Rachida Fadil, Présidente de l'Association des sage femmes au Maroc (ANSFM)
Mr. Mourad Gourouhi, Directeur exécutif, Association Tanmia.ma
Mr. Mohamed Benyamna, Trésorier Aribat Moubadara
Mr. Ali Lofti, Président du Réseau Marocain pour la Défense du Droit à la Santé, et Secrétaire Général de Organisation Démocratique du Travail (ODT)
Prof. Dr. Abdeljalil Cherkaoui, ex-directeur de l'Entraide Nationale du Maroc
Mrs. Asma El Alami El Fellousse L., Economiste, Ecole Nationale de Santé Publique et Secrétaire générale de Réseau d'Economie et Systèmes de Santé au Maghreb. ex MinexMS Chef de Service de l'Economie Sanitaire
Mrs. Amal El Amri, secrétaire national chargée du département international de Union des Travailleurs Marocaine
Dr. Hassan Smilali, Ministère de la Santé, division RAMED
Mrs. Khadija Meshek, Juriste Experte en Législation Sanitaire
Mr. Malik Souali, CTB-BTC Maroc

Interviews between 10 and 22 May 2016 in Senegal (Kaolack, Koungheul, Thiès, Dakar)
Mr. Vincent Vercruyssen, représentant résident, BTC-CTB Senegal
Mrs. Fabienne Ladrière, responsable projet PAODES à Kaolack, BTC-CTB Senegal
Mr. Stefaan Van Bastelaere, senior health expert, BTC-CTB Brussel
Mr. Paul Bossyns, coordinator of the Cel Health, BTC-CTB Brussel
Mr. Malick Ndiaye, expert Paodes Kaolack, BTC-CTB Senegal
Mr. Seyni Thiam, chargé de programme, BTC-CTB Senegal
Mr. Dirk De Clercq, Ambassadesecretaris voor Ontwikkelingssamenwerking
Mr. Ibrahima Senghor, directeur general de l'Unité Départementale d'Assurance Maladie (UDAM) de Koungheul
Mr. André Demba Wade, coordonnateur, Groupe Recherche Appui initiatives Mutualistes (GRAIM)
Mr. François Paté Diopp, chef d'équipe, Abt Associates
Mr. Mbaye Sene, Conseiller en Financement Social, Abt Associates

Mr. Cheikh Seydi Aboubeker Mbengue, directeur général, l'Agence de la Couverture maladie universelle (CMU), Ministère de la Santé et de l'Action Sociale
Mr. Serigne Diouf, représentant du directeur général, l'Agence de la Couverture maladie universelle (CMU), Ministère de la Santé et de l'Action Sociale
Mr. Ousseynou Diop, directeur du Registre National Unique (RNU), délégation générale à la protection sociale et à la solidarité nationale (DGPSN)
Mr. Sérigne Diouf, chef du Service Régional de Dakar, l'Agence de la Couverture maladie universelle, Ministère de la Santé et de l'Action Sociale
Mr. Babacar Lo, conseiller en renforcement du système de santé, USAID Senegal
Mr. Karim Cisse, directeur général du Travail et de la Sécurité sociale, Ministère du Travail
Mr. Pape Birama Diallo, vice-président du haut conseil du dialogue social et chef du Département Dialogue Social et Négociation Collective, Union Nationale des Syndicats Autonomes du Sénégal (UNSAS)
Mrs. Marième Ba Konate, secretaire géneral, l'Union Démocratique des Travailleurs du Sénégal (UDTS)
Mr. X, Confédération Nationale des Travailleurs du Sénégal (CNTS)
Mrs. Francoise Medor, l'Union Démocratique des Travailleurs du Sénégal (UDTS)
Mr. Baba Ngom, secretaire général en retraite, Conseil National de Concertation et de Coopération des Ruraux (CNCR)
Mr. Mamadou Cisse, point focal santé, Conseil des Organisations Non Gouvernementales d'Appui au Développement (CONGAD)
Mr. Mbaye Dia, président, Conseil des Organisations Non Gouvernementales d'Appui au Développement (CONGAD)
Mr. Sanor Dieye, economiste chargé suivi protection sociale, Unité Coordination et Suivi de la Politique Economique (UCSPE), de la Direction Général de la Planification et des Politiques Economiques (DGPPE) du Minsitère de l'Economie, des Finances et du Plan
Mr. Mamadou Dia, Unité Coordination et Suivi de la Politique Economique (UCSPE), de la Direction Général de la Planification et des Politiques Economiques (DGPPE) du Minsitère de l'Economie, des Finances et du Plan

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