2019

Corporate Social Responsibility, Path Dependency and Cultural Influence: An Analysis of Equitable Health Insurance Schemes for Niger

Mounkaila Noma, Reynatou

UNIVERSITY OF
PLYMOUTH

Plymouth Business School

Corporate Social Responsibility, Path Dependency and Cultural Influence: An Analysis of Equitable Health Insurance Schemes for Niger

By

Reynatou Mounkaila Noma

A thesis submitted to the University of Plymouth in partial fulfillment for the degree of

Doctorate of Business Administration

February 2019

Copyright statement

Dedication

This thesis is dedicated to my parents, to my mother Fatchoumatou Noma and my father Mounkaila Noma. I am grateful for their support and encouragement. And to my brothers and sister: Djibrilla, Abdoul-Magid, and Saadia.

Acknowledgement

All the glory to the Almighty, God. I wish to extend my sincere thanks to my supervisors Prof Kerry E Howell, Craig Wight and Jonathan Moizer. Special thanks to my director of studies Prof Kerry E Howell for his time, support, encouragement, guidance and critical advice. With a tremendous experience as a supervisor, Prof Howell always had the time to give feedback on my work. He has been very helpful throughout the entire years involving the research process. I would like to thank my examiners Dr Mojisola Olugbode and Dr Jonathan Smith for their time and feedback.

I equally thank the management of the commercial insurance of Caren and Sunu assurance who allowed their staff to participate in the data collection of this research. I would like to express my gratitude to all the staff that kindly accepted to be involved in the study. A special thanks to all the staff at the ministry of health, in Niamey who thoughtfully accepted to participate in the interviews and focus groups. I appreciate the support from all those who directly or indirectly had a positive impact on this thesis.

Author's Declaration

At no time during the registration for the degree of Doctor of Philosophy has the author been registered for any other University award without prior agreement of the Doctoral College Quality Sub-Committee.
Work submitted for this research degree at the University of Plymouth has not formed part of any other degree either at the University of Plymouth or at another establishment.

Word count of main body of the thesis: **61,000**

Signed: 

Date: 30 November 2017

Abstract

Health care is essential for the wellbeing of people and the development of a country. Populations in developing countries tend to encounter challenges in accessing good healthcare which could however be improved with health insurance. This thesis investigates the reasons for the low health coverage in Niger, in the perspective of proposing equitable schemes for attaining universal coverage. The study sheds light on the low rate of health insurance coverage in the country, as at least 70 % of the population, essentially from the informal sector does not have sustainable health insurance plan. For this study, the theoretical framework of CSR, culture and path dependency of healthcare policies informed about the role of these three concepts in the development of health insurance in Niger.

Critical ethnography used as the theoretical methodology enabled a close look at the explaining factors for the low coverage. Moreover, the triangulation of data collection including interviews, focus groups and questionnaires generated in depth results useful to address the research question.

The analysis of the data involved a triangulation with thematic, discourse and comparison analysis for the qualitative data; while some of the quantitative data involved statistical analysis.

Three prominent themes emerged from the analysis of focus groups and interviews. The theme structure of health insurance concerned the different institutions providing health insurance and their level of financial contributions to health expenditure. The theme consumption of health insurance referred to the different groups of the population and their consumption of health insurance. Results confirmed the literature as the informal sector is the largest uninsured segment in Niger. The study made a distinctive contribution by showing the impact of CSR, culture and path dependency of policies in the development of health insurance.

Through praxis by combining literature and the research findings, recommendations have been made for an equitable health coverage. A mix of mechanisms for financing health insurance seems necessary to address the lack of financial resources. Then, it is important to develop health coverage for the informal sector by addressing the barriers of culture and education. Private insurance, which only covers 3% of the population, would need to extend its market through corporate social responsibility. The extension of public insurance would require a reform of policies, which would favour the development of health insurance for the informal sector. The proposed mechanisms of basket fund raising and exchange of services in particular are likely to increase the number of uninsured people from the poor segments.

Tables of content

Copyright statement ii

Dedication iii

Acknowledgement iv

Author's Declaration v

Abstract vi

Tables of content vii

List of tables x

List of figures xi

List of abbreviations xii

Chapter 1: Introduction 1
- **1.1 Background of the study** 1
- **1.2 Problem statement and research justification** 2
- **1.3 Objectives of the research** 8
  - 1.3.1 General objective 8
  - 1.3.2 Specific objectives 8
- **1.4 Research questions** 9
  - 1.4.1 Research question 9
  - 1.4.2 Specific research questions 9
- **1.5 Overview of the thesis** 9

Part 1: literature review 12

Chapter 2 Philosophical and theoretical literature review 13
- **2. 1 Introduction** 13
- **2. 2 Philosophical review** 14
  - 2.2.1 Adam Smith and the theory of free trade 14
  - **Liberalism** 16
  - 2.2.2 Karl Marx, communism and socialism 20
  - 2.2.3 Capitalism versus socialism 26
- **2.3 Theoretical framework of this research** 30
  - 2.3.1 The relevance of the CSR pyramid model 30
  - 2.3.2 The role of culture in access to health insurance 36
  - 2.3.3 The theory of path dependency 38
- **2.4 The theory of social contract and social justice** 40
  - 2.4.1 The theory of social contract and public insurance 40
  - 2.4.2 Social justice 43
- **2.5 Conclusion** 46

Chapter 3: Health insurance and its developments in Niger 48
- **3.1 Introduction** 48
- **3.2 Health insurance in Niger** 49

3.2.1 Health insurance and social justice 49
3.2.2 Out of pocket payments 51
3.2.3 Informal sector and health insurance 53
3.2.4 Healthcare financing in Niger 55
3.3 Studies on health insurance systems 59
3.4 Studies on pro poor health insurance mechanisms 61
3.5 The relevance of culture, CSR and path dependency for health insurance in Niger 63
3.5.1 Culture 63
3.5.2 Private insurance and corporate social responsibility 66
3.5.3 Health insurance policies and path dependency 68
Healthcare policies and the financing of health insurance 68
Health insurance policies and the informal sector 69
3.6 Summary 71

Part 2: Methodology 73

Chapter 4: Research Methodology 74
4.1 Introduction 74
4.2 Qualitative research, philosophical perspectives and the implications of critical theory in this research 74
4.2.1 Paradigms of inquiry, ontology, and epistemology 75
4.2.2 Empiricism and rationalism 76
4.2.3 Critical realism 77
4.2.4 Epistemology and paradigms of inquiry 77
4.2.5 Phenomenologist paradigms 78
4.2.6 The implications of critical theory for this research 80
4.3 Philosophical methodologies in qualitative research 83
4.3.1 Grounded theory 83
4.3.2 Hermeneutics 84
4.3.3 Action research 84
4.3.4 Ethnography and the research study 85
4.4 Research methodology 87
4.4.1 Conceptual framework 87
4.4.2 Data collection 88
4.4.3 Methods of data collection 91
4.5 Data analysis 95
4.5.1 Data analysis and triangulation 95
4.5.2 Analysis of quantitative data 96
4.5.3 Analysis of qualitative data 97
4.6 Research limitations and rigour 105
4.6.1 Research limitations 105
4.6.2 Research rigour 107
4.7 Conclusion 109

Part 3: Data Analysis and Recommendations 111

Chapter 5: Data Analysis 112
5.1 Introduction 112
5.2 Thematic Analysis of interviews 112
5.2.1 Thematic analysis of interviews from the ministry of health 112
5.2.2 Thematic analysis of interviews from commercial insurance 118
5.3 Analysis: focus Group ministry of health 123

5.3.1 Discourse analysis 123
5.3.2 Thematic Analysis 130
5.4 Analysis: focus Group for commercial insurance 132
5.4.1 Discourse analysis 132
5.4.2 Thematic analysis 139
5.5 Cross data analysis of focus groups 142
5.6 Analysis of surveys 145
5.6.1 Analysis of the survey for the informal sector 146
5.6.2 Analysis of survey with health practitioners 154
5.7 Summary of findings 163
5.7.1 Key findings and research questions 163
5.7.2 Research findings and literature 167
5.8 Conclusion 169

Chapter 6: Discussion and recommendations 170
6.1 Introduction 170
6.2 Research question revisited 170
6.3 The development of health coverage for the informal sector 173
Culture and awareness 173
The development of community based insurance 174
6.4 Extension of private insurance and corporate social responsibility 175
..... 176
6.5 Extension of government health insurance and reform of health policies 176
..... 176
6.6 Conclusion 178

Chapter 7: Conclusions 179
7.1 Introduction 179

7.2 Summary of the research 179
7.3 Contributions to knowledge 181
7.4 Methodological contribution 182
7.5 Practical contribution 183
7.6 Limitations of the study 184
7.7 Implications for future research 185

References 186

APPENDICES 240
Appendix A. Letter ministry of health 240
Appendix B. University letter 241
Appendix C. Questions of Online questionnaire 242
Appendix D. Questions interviews series 1 (ministry of health) 244
Appendix E. Questions interviews series 2 (commercial insurance) 245
Appendix F. Questions Focus group (ministry of health) 246
Appendix G. Questions Focus group (commercial insurance) 247
Appendix H. Consent form for interviews 248
Appendix I. Consent form for focus groups 250
Appendix J. Example analysis for interviews at the ministry of health: 251
Appendix K. Summary of qualitative data (3 Main themes) 253
Appendix L. Questions of questionnaire for the informal sector 254

List of tables

Table 4. 1 Main differences between positivism and interpretivism 78
Table 4. 2 Example of how codes were generated from raw data for interviews series 1 100
Table 4. 3 Example of how codes were generated from raw data for interviews series 2 102
Table 4. 4 Techniques used for establishing trustworthiness..... 108

Table 5. 1 Table summarizing findings from the two focus groups 142
Table 5. 2 Willing to pay for health insurance by gender and age of the participants 148
Table 5. 3 Awareness of a health insurance company by holding health insurance, gender, age group and rating the importance of health insurance ……150

List of figures

Figure 1. 1 Different systems of health insurance 3

Figure 3. 1 Total health expenditure in Niger in 2012 51
Figure 3. 2 Plan for communal health insurance system 54
Figure 3. 3 Evolution of government's budget of health 56
Figure 3. 4 Healthcare financing in 2012 58

Figure 4. 1 Critical theory and philosophical perspectives 82
Figure 4. 2 Conceptual framework of influencing factors for universal health coverage 88
Figure 4.3 Thematic map showing three mains themes 101
Figure 4. 4 Thematic map showing three mains themes 104
Figure 4. 5 Analysis process for focus groups 105

Figure 5. 1 Shared main themes from the two focus groups 145
Figure 5. 2 Age distribution of the participants 147
Figure 5. 3 Importance of Health Insurance as reported by the study participants 147
Figure 5 . 5 Distribution the study participants towards their awareness of a health insurance company 150
Figure 5. 6 Ways for improvement of health care for the informal sector as reported by the study participants 152
Figure 5. 7 Characteristics of the eight participants who reported that health care improvement required contribution of the informal sector 153
Figure 5. 8 Do you have health insurance ..... **Error! Bookmark not defined.**
Figure 5. 9 how would you rate the importance of health insurance? 155
Figure 5. 10 which institution (s) do you think provide health insurance? 156
Figure 5. 11 how would you rate the commitment of the government to develop health insurance for all? 157
Figure 5. 12 who are covered by government insurance? 157
Figure 5. 13 should the government be more involved in the development of health insurance? 159
Figure 5. 14 Does the informal sector have access to government insurance? 160
Figure 5. 15 Are populations from rural areas covered by health insurance? 161
Figure 5. 16 How to improve the health insurance system? 162
Figure 5. 17 Prominent themes generated from interviews and focus groups 164

Figure 6. 1 Proposed model for funding 171
Figure 6. 2 Proposed payments options for the informal sector 177

List of abbreviations

Acronym	Full term
CADEMS	Cellule d'Appui au Développement des Mutuelles de Santé
CBHI	Community-Based Health Insurance
CSR	Corporate Social Responsibility
ECOWAS	Economic Community of West African Countries
GDP	Gross Domestic Product
HMI	Health Mutual Insurance
ILO	International Labour Organisation
NIGELEC	Société Nigérienne D'électricité
NGO	Non-gouvernemental Organisation
OECD	Organisation for Economic Cooperation and Development
UHC	Universal Health Coverage
UNDP	United Nations Development Programme
UNICEF	United Nations Children Fund
USAID	United Stated Agency for International Development
WHO	World Health Organisation

Chapter 1: Introduction

1.1 Background of the study

Niger is classified as one of the least developed countries with a population of 20 million and a birth rate of 7% (one of the highest in the world), (World Bank, 2016). With 63% of the population living on less than a dollar a day, the country faces recurrent episodes of famine and 43% of the population is facing chronic food insecurity (UNICEF, 2013).

In relation to the rest of the world, West Africa is a region with one of the highest rates of malaria and HIV (World Malaria Report, 2011). In a country such as Niger, for instance, a child is 40 times more likely to die before the age of five compared to a developed country such as the United Kingdom (WHO, 2005).

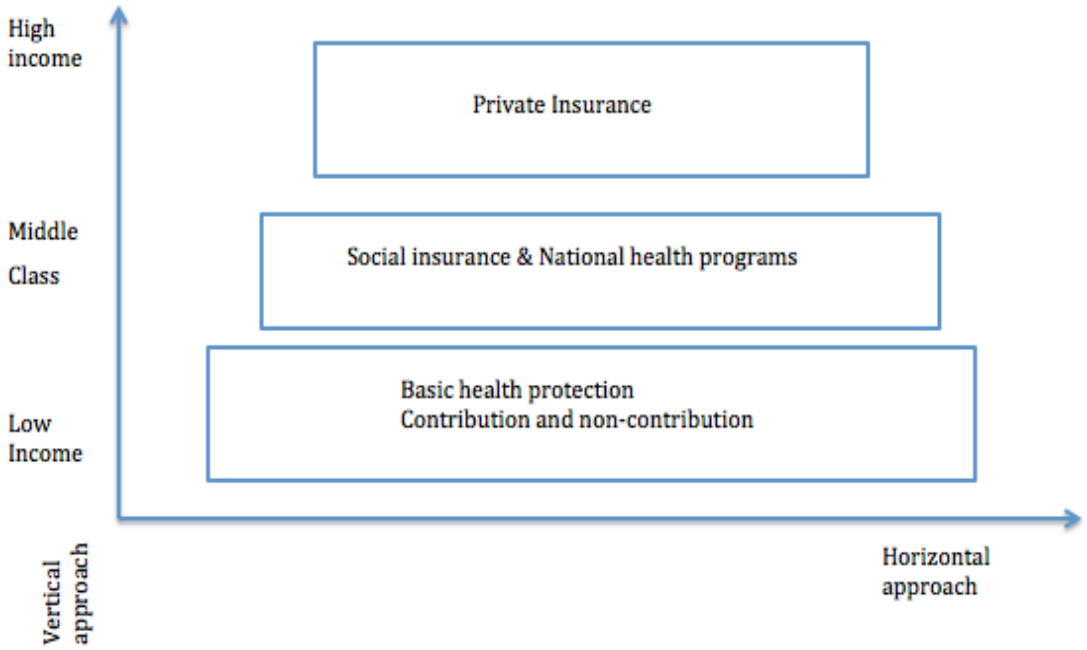
At the Abuja declaration in 2001, member countries of the Economic Community of West African States (ECOWAS) decided to allocate 15% of their national budget to health; however, the practical implementation was unattainable in Niger due to limited financial resources (Smith and Creese, 1994; Kaseje, 2006). There is a correlation between a country's economic development and its ability to deliver good health services. McPake (2009), Baronov, (2010) and Abdullahi (2011) suggested that the cycle of debt since the postcolonial period weakened the economic structures and resulted in the cut of the health budget. Moreover, endemic corruption in some countries limits development; in this sense, Moyo (2009) claimed that existing corruption is worsened by foreign aid since African countries rely on donations. On the other hand, Liu (2003) explained that the involvement of government in healthcare is beyond simply financing the sector; rather, governments should be involved in the monitoring and implementation of the right policies. However, Kaseje, (2006) believed in a multi-stakeholder system, where public and private entities will bring different capacities and inputs. According to the World Health Organization, African Health Report (2010), healthcare system in most countries is a mix of public and private providers. It is therefore essential to explore the involvement of these sectors in the sustainable improvement of health insurance (Smith and Zwi, 2001). Moreover, the involvement of those two sectors is crucial in attaining universal health coverage, which reduces out of pocket payments and financial barriers (Oxfam, 2013).

1.2 Problem statement and research justification

Health insurance is a contract that requires the health insurer to pay some or all the health care costs in exchange for premiums paid by its members (Chandra et al, 2006). Systems of health insurance could be optional or compulsory. Voluntary health insurance reflects the choice of the insured individual to be covered (Maarse, Paulus et al, 2005). Obligatory insurance on the other hand monitored by the government decreases adverse selection excluding some segments of the population (Campbell & Campbell, 1953; Walker, 1969). Literature suggested that health insurance is mainly funded through social insurance or tax-based systems (Hofman, 2003; Falk, 1952; Campbell & Campbell, 1953; Murray, 2007; Zimmerman 2011). Taxed based systems are funded through regular income from the formal sector while social insurance is usually a mix of mechanisms involving funding from government, households and the private sector, in the sole objective of covering the entire population in an equitable way (Carrin, 2002). On this, Jeffreys-Jones (2015) argued that social insurance has a socialist origin and has been reinforced by labor movements and social security. Normand and Busse (2002) outlined the two characteristics of social insurance including a) insured people paying regularly through wages and b) the quasi-public bodies that monitor and fund partially the system. They also considered that social insurance is mandatory for all and is a key element in the transition towards universal health coverage (UHC). Kieny and Evans (2013) agreed that universal coverage does not only aim at enrolling the entire population but also prevent financial impoverishment created from out of pocket payments. The choice of social health insurance or tax-based system determines the attainment of the government goals in terms of health insurance. For this reason, it is crucial to choose the appropriate system based on socioeconomic factors (Wagstaff, 2009). In this sense, the ultimate goal of health insurance is to offer universal coverage for all, which ensures an equitable access to healthcare even those who cannot contribute.

The following figure illustrates the different health protection schemes available for different layers of the population in relation to the level of contribution.

Figure 1. 1 Different systems of health insurance



Source: adapted from ILO, 2014 and Pauly (1976)

Based on this model, the vertical approach involves the contributive scheme when individuals pay health insurance based on their revenue. The high-income group, for instance, can afford to pay private insurance while the low-income group because of financial limits make out of pocket payments. The horizontal scheme, on the other hand, involves both contributive and non-contributive health protection. According to the International Labour Organization (2014), the non-contributive scheme involves social insurance for unemployed and low-income people. While the contributive scheme involves social insurance when people working in the formal sector contribute to healthcare. The contributive scheme equally involves community-based health insurances such as health mutual and health micro insurance.

To sum up, a standard health insurance system is mainly made of public or social insurance, private insurance and community based insurance. Countries usually adopt more than one scheme according to their economic development and demographics.

Some literature argued that universal health insurance is based on social solidarity and benefits the entire population including the one working outside the formal sector. The aim is to share the risk between individuals and extend the protection of the members (Mills, 1983 and ILO, 2014).

Health insurance is one of the most complex and costly sectors in the economy of a country. In developed countries, the government's subsidizes health through social security, and the majority of the population contributes through taxation. In these countries, the national health system has usually three features: a) health financing is paid through the national budget b) there is a universal coverage for all layers of the population with no distinction of income, social status and occupation and c) health providers facilities and infrastructure are paid by the government (Wagstaff,2009).

However, when the government taxation is weak, there is no social protection for all, what opens doors to commercial health insurance (Gnwali et al, 2008). In this sense, high premiums and competitive markets are considered as discriminatory criteria for sick and poor people (Preker, 2007). According to Gottretand and Schieber (2006), private insurance is not the best fit for low-income countries, as the majority of the population cannot afford to pay high premiums. Bennett and Gilson (2001) go further by promoting community-based insurance as the best scheme for low-income countries. Universal health coverage appears to be inequitable in developing countries as the majority of the population works in the informal sector.

Concerning private health insurance, a number of studies have shown the limits of the market with or without government intervention. The private market of health insurance is exposed to market failure for many reasons. First costly services leave a little margin for insurers to make profit per dollar and second, unjustified medical care create even more expenses (Pauly, 1974 and Arrow, 1985). The moral hazard theory or cream skimming refers to private insurers who select customers with less risks in order to minimize costs. Individuals with serious conditions, elders and children are likely to be dismissed or charged more what makes universal coverage practically impossible in the private market (Summers, 1989). Furthermore, information asymmetry from both insurers and consumers represents a big barrier for market equilibrium. Supply does not meet demand when insurers apply the selection criteria and when consumers dissimulate preexisting health conditions.

The practicability of private insurance is limited at many levels for diverse reasons; many, however, believe it's the solution for developing countries where people pay directly for health services (Kutzin & Barnam, 1992; Berman, 1992; Sarris, 2002).

Out of pocket, payments represent at least half of health expenditure in developing countries, and governments have difficulties in reversing the trend (Contandriopoulos,1992 ; Musgrove, 1996). In addition, Preker and Harding (2002) criticized private monopoly of health insurance in low-income countries as it is exposed to corruption and low quality of services. Further, some scholars suggested the involvement of third parties to complement or substitute public and private schemes (Dror and Firth, 2014).

Community Based Health Insurance (CBHI) usually is operated by private and nonprofit organizations usually by communities or social groups. It provides a risk pooling which covers all or part of member's healthcare (Bennett, 2004). Contributions are set accordingly to the type of benefit packages regardless of the employment status; what makes it relevant for low-income countries (Mondal, Kanji et al, 2010; Fan, Karan et al, 2012). In Burkina Faso for instance, CBHI over the past years has led to an increase of the percentage of the population accessing healthcare (Bennett and Gilson, 2001; Gnali, 2008). Extreme poverty, however, is a limit especially when members are not able to make prepayments (Tabor, 2005 and Preker, 2007). Another advantage is that CBHI is without intends of profit and the packages are designed based on beneficiaries' needs (Bennett, Creese and Monarch, 1998). On this, Baeza and Montenegro (2002) argued that small risk pools are not always cost sustainable, as the contribution is unlikely to cover expensive health costs.

On the other hand, for decades, foreign aid has been the main source of healthcare financing in West Africa including Niger (Brautigam & Knack, 2004: Garett, 2007). Rodan (1961) referred to international aid as foreign capital inflow including long-term loans, grants and donations. The efficiency of international aid has been recently questioned. A number of authors claimed that international aid is a burden for donor countries, as it requires large shares of their budget (Rodan, 1961; Riddell, 1999; Easterly, 2009; Ryan, Macom, Moses-Eisenstein, 2012). Moreover, this situation was worsened when the global financial crisis of 2008 affected the GDP of donor countries (Dong, Knack and Rogers, 2013). Further, Moyo (2009) referred to foreign aid as "dead aid" since it creates an endless cycle of dependence on African countries. In fact, foreign assistance lasts for months or years, which is consequently not a sustainable solution. This cycle is often worsened by poor governance, financial mismanagement and lack of accountability (Brautigam & Knack, 2004).

A number of authors on the other hand opposed this view and defended the idea that foreign aid is beyond the simple giving of funds to poor countries. Bermeo (2010) argued that recently, donors look at indirect ways to achieve aid without dealing directly with the government. Moreover, aid agencies take into consideration the good governance of recipient countries before allocating funds (Winters and Martinez, 2015; Heinrich, Kobayashi et al, 2016). Further, international aid is more efficient when donor countries study in detail the components of aid, including the type of aid to allocate, its objectives, the targeted groups, and the nature of the resources. In this sense, Jones
and Tarp (2016) explained that when foreign aid is well allocated it improves democratization in beneficiary countries. Koch and Schulpen (2017) through their wage pyramid also discussed the benefits of foreign aid in developing countries. They explained that wages from foreign aid have a three level effect on recipient countries:

- The individual level effect involves the international competitive salaries paid to nationals working for aid agencies.
- The meso level effect involves the surrounding of aid agencies staff who directly and indirectly benefit from the competitive wages
- The macro level effect discusses the impact of these competitive wages on the labour market of recipient countries. In fact, in a long run it creates an inflationary effect on wages as foreign organizations usually pay higher wages than public institutions.

Health insurance in Niger is a mix of public and private sector and only covers 10% of the population (Loutou, 2009). Health coverage is not obligatory for all segments especially the ones in the informal sector. The health insurance system is broken down into three main categories:

a) The government offers social protection to public workers through the National Fund of social security (Caisse Nationale de Sécurité Sociale, 2009) and other government's health insurance mechanisms. Public health insurance in Niger essentially covers workers from the formal sector who pay taxes, which leaves 80% of the population without public health insurance (Loutou, 2009).
b) Commercial health insurance on the other hand, offers services mostly for workers in the private sector. Moreover in Niger, there is an unequal access to health insurance between urban and rural areas (Lipton, 1976 and Ensor, 1997).

c) Community based insurance is based on mutual aid of a group of people who make contributions in order to benefit health protection. In 2003, the government created the "Cellule d'Appui au Développement des Mutuelles de Santé" (CADEMS), a public institution dedicated to the promotion of health mutuals in Niger. CADEMS promotes community health insurance through feasibility studies, the listing and the monitoring of existing institutions.

Healthcare is among the many challenges Niger faces, since public healthcare experienced recurrent shortage of medicine and equipment (Hahonou, 2015). The fragile healthcare system resulted from a lack of public financial resources, which was worsened by financial mismanagement and a deficit in the healthcare budget (Herdt, Olivier de Sardan, 2015). Niger hardly meets the 15% health budget required by the Abuja Declaration of 2001. Consequently, about 70% of the population makes out of pocket payments for healthcare, considering that 61 % of the inhabitants live below the poverty line (Hahonou, 2015)[1]; out of pocket payment, however, contributes to the impoverishment of populations in developing countries (Gilson, 1997; Letourmy, 2008). Further studies suggested that in Niger, the informal sector and rural areas face the most difficulties in accessing healthcare and health insurance (Roukayatou, 2004; Loutou, 2009). In addition, Mainardi (2014) discussed the disparities of public health service across Niger as 50 % of medical staff works in Niamey the capital. In this sense, some authors defended the role of non- governmental organizations is critical in correcting the shortcomings of public institutions (Ridde, Diarra and Moha, 2011).

The majority of developing countries are facing difficulties in funding healthcare and providing health insurance to populations, especially the poorest segments of the population. The total healthcare expenditure by inhabitants in Niger was about 26 USD in 2013, which reflects the challenges in financing the sector (USAID, 2017). Moreover, 80% of the population, which does not have health insurance, contributes to 56% of the total healthcare expenditure. To overcome this situation, the Nigerien government's healthcare development plan of 2011- 2015 aimed at

[1] In the aftermath of independence, particularly in the early 1970s The Nigerien government adopted a strategy of social protection and health insurance covering the entire population. The system enabled to offer free healthcare for citizens without distinction of socio professional background. Face to economic defies and the growing population the healthcare system has been weakened over time and public insurance was restructured to cover workers in the public sector (Boyer, Delesvaux, Foirry, 2000; Kailou, 2001; Loutou, 2009).

increasing healthcare financing through the reduction of direct payments and the increase of the public healthcare budget (Ministry of Health, 2012). Recently, the new healthcare development plan of 2016-2020, aimed at implementing a strategic plan for universal health coverage (UHC). The strategic plan of health insurance of 2012 suggested that, universal health coverage seems to be the response for the low health insurance coverage rate. While the increase of funding seems necessary, other factors such as the implementation of health policies, the involvement of the population and the development of community health insurance are equally important (Ministry of health, 2012).

In relation to the low health insurance coverage in Niger, this research identified reasons for the low coverage and provided empirical information, which could be used to improve health insurance, especially for the poor populations. The study equally looked at the impact of path dependency for healthcare policies, corporate social responsibility and the influence of culture in the development of health insurance.

1.3 Objectives of the research

1.3.1 General objective

The general objective of the study is to identify reasons for the low health insurance coverage in Niger, in the perspective of proposing suitable mechanisms for attaining universal health coverage.

1.3.2 Specific objectives

i. Investigate reasons for the low insurance coverage in Niger.
ii. Identify the impact of path dependency on health insurance policies.
iii. Identify the application of CSR from the perspective of private health insurance.
iv. Understand the role of culture in the development of health insurance in Niger.
v. Identify the coverage and attitude of the informal sector towards health insurance.
vi. Propose equitable health insurance schemes for populations in Niger.

1.4 Research questions

1.4.1 Research question

In the perspective of attaining universal health coverage, what are the equitable health insurance schemes for populations in Niger?

1.4.2 Specific research questions

i. How is the system of health insurance structured in Niger?
ii. What is the influence of health insurance policies on the development of health insurance?
iii. Which segments of the population are covered by government health insurance?
iv. What are the main sources of funding for health insurance?
v. What is the role of private insurance and its application of CSR?
vi. What is the role of community based health insurance?
vii. How does culture influence the development of health insurance?

1.5 Overview of the thesis

Chapter 1: Introduction

The thesis was organized in seven chapters. Chapter 1 presented an overview of the research and addressed the research objectives and research questions. Then the thesis was organized into three parts. Part 1, 2 and 3 included five chapters and respectively discussed literature review, research methodology and data analysis. Then chapter 7 on conclusions focused on the contributions of this study and implications for future research.

Part 1: literature review

This part involves two chapters. Chapter 2 reviewed the philosophical and theoretical literature in relation to this study. The views of Adam Smith and Marx on capitalism were discussed in relation to public and private insurance. The second section of the chapter discussed the

theoretical framework of the research including culture, CSR and path dependency. The concept of CSR was discussed in connection to commercial insurance in this study. The concept of culture was reviewed in relation to the informal sector and the lack of awareness about health insurance. Then the theory of path dependency was discussed in connection to public insurance and the role of government in developing health coverage.

Chapter 3 reviewed literature on health insurance and its developments in Niger. The chapter started with discussing the role of social justice in health insurance. Section 1 equally reviewed the prevalence of out of pocket payments, health insurance financing and the coverage of the informal sector in Niger. Then, section three reviewed studies on health insurance systems in various countries by comparing them to the one in Niger. Further, section 4 discussed pro-poor mechanisms including community insurance and micro-health insurance. Last, section 5 focused on the relevance of culture, CSR and path dependency for health insurance in Niger.

Part 2: Methodology

Part 2 focused on the research methodology. Chapter 4 divided into five sections extensively presented the methodology of this study. Section 1 discussed philosophical perspectives and the involvement of critical theory as paradigm for the research. Section 2 justified the use of critical theory as methodology for this study against others methodologies in qualitative research. Then, section 3 focused on the research process including the conceptual framework, data collection, sampling and ethical considerations. Section 4 presented the process of data analysis and the coding process. Finally, section 5 discussed the research limitations and the application of rigour in this study.

Part 3: data analysis and recommendations

This part contained two chapters. Chapter 5 on data analysis presented the analysis and results of interviews, focus groups and questionnaires. Section 1 presented the thematic analysis of the two series of interviews. Then, section 2 discussed the analysis of the two focus groups, which happened in three stages including discourse, thematic and comparative analysis. Section three detailed the analysis of the questionnaire for the informal sector and discussed result in relation to the questions asked during the survey. Section three equally, presented results of the online

survey with medical practitioners. The last section of chapter 5 summarized the research findings and compared them with literature.

Chapter 6 on recommendations presented the links between literature and findings. In the light of answering the research question, four main recommendations have been made. The mix of mechanisms for the funding of health insurance. The development of health insurance through educating populations and creating awareness. The third recommendation concerned the extension of private insurance. Finally, a recommendation has been made for the extension of public insurance and mechanisms have been proposed for the informal sector.

Chapter 7: conclusion, research evaluation and contributions

Chapter 7 is the concluding chapter of the thesis. Section 1 summarized the research and how each chapter contributed in answering the research question. Section 2 discussed the contribution to knowledge and presented the distinct contribution of this study , discussing the role of culture, CSR and path dependency in universal coverage in Niger. Contrary to most literature on Niger focusing on financial limitations, this research presented an innovative point of view by discussing the concepts of path dependency, CSR and culture. The methodological contribution involved the use of triangulation to analyse data including thematic, discourse and comparison analysis. Then, the practical contribution involved the extension of health insurance to the informal sector. To offer universal coverage in Niger, this research proposed a reform of health insurance policies, the development of community-based insurance and the extension of public and private insurance. The last section of chapter 7 discussed the research limitations including the time span and the number of interviews. In relation to ethnography as methodology, the researcher justified the use of focus groups in substitution to observation.

Part 1: literature review

Chapter 2 Philosophical and theoretical literature review

2. 1 Introduction

Theory has a crucial role as it guides the entire research process. Creswell (2008) considered theory as the philosophical assumption that defines reality (ontology), epistemology, methodology and methods. "In a qualitative research, one does not begin with a theory to test or verify. Instead, consistent with the inductive model of thinking, a theory may emerge during the data collection and analysis phase or be used relatively late in the research process as a basis for comparison with other theories" (Creswell, 1994:94). Denzin and Lincoln (2005) also believed that theory equates a paradigm of inquiry as it determines the methodology and methods of the research. A theoretical review examines theories in relation to a particular phenomenon. For this research, the concepts of CSR, culture, path dependency, social contract and social justice in addition to the systematic literature review in chapter 3 enabled defining the conceptual framework for the study (Windsor, 2017).

This chapter started with the philosophical background of the theories of capitalism and socialism, in connection to public and private insurance in this study. The opposing views of Adam Smith and Marx were mainly reviewed. Secondly, the chapter discussed the theoretical framework including CSR, culture and path dependency. Section 2 started with definitions of CSR and its evolution from the 1970's. Next, the concept of Caroll (1979) CSR pyramid was reviewed. Then the following section examined the impacts of strategic philanthropy for private insurance. Section 3 discussed culture as social determinants for access to healthcare. Section 4 discussed the theory of path dependency in relation to health policies. The last section of this chapter discussed the theories of social contract and social justice in relation to public insurance.

2. 2 Philosophical review

This section presented the philosophical background of capitalism and communism. The philosophical background, prior to literature review, guided the theoretical framework of this study. The views of Adam Smith (1723-1790) and Karl Marx (1818-1883) especially were reviewed in relation to public and private insurance. On one hand, the concept of capitalism, was discussed in relation to private insurance. On the other hand, communism, which is the root of socialism, was discussed in connection to public insurance in this study. In fact based on the socialist theory, the state offers basic needs to populations including healthcare. Furthermore, the theories of social contract and social justice were equally linked to the role of the state.

2.2.1 Adam Smith and the theory of free trade

Adam Smith (1723-1790) is considered as the father of economics notably for his vision of capitalism as an economic system in opposition to mercantilism that prevailed in Europe from the 16th to the 18th century. Born in Kirkcaldy, the Scottish economist is essentially known for his work on *"The theory of Moral Sentiments"* (1759) and "An inquiry to the Nature and causes of the Wealth of Nations" (1776). In the latter, he insisted on wealth and the economic growth of nations. According to him, freedom of mind and social relationships are connected with progress and opulence (Rothschild and Sen, 2006); thus, the nation is better off when individuals are free to think, bring ideas and work together.

He also discussed the involvement of government as well as the role of individuals in the economic growth. In book 5 of the Wealth of Nations, Smith discussed public finance including a detailed explanation of expenses and revenues and how government collects public money through taxes. He believed that the role of government could be summarized in three points: a) "the first duty is that of defending the society from the violence and injustice from the violence and injustice of other independent" (book 5: 141), b) the government equally ensures the protection of every member of the society from injustice and oppression and c) third, the government has the responsibility of "erecting and maintaining public institutions" that would benefit the nation (book 5:169). Like Hobbes (1588-1679), he believed in "sovereignty by institution" where governments regulate the life of people through laws and coercive power.

However, he argued that the government should limit its intervention in the economy and focus on fighting monopolistic tendencies. Smith indeed saw capitalism as the ideal economic system and consequently defended the theory of "laissez-faire", later on applied by classical liberal economists including Hayek (1899-1992), Say (1767-1832) and Ricardo (1772-1823).
In book 4, "of the System of Political Economy," Smith discussed government intervention in the economy and criticized restriction measures such as tariffs (chapter 2). He advocated free trade against mercantilism, with an increase of import and export in a manner that benefits domestic economy. Apart from the infant industry theory that protects new industries and measures against monopolies), he criticized all practices to regulate the economy (Wealth of Nations 1937:147 and 425.

For Smith, the interests of individuals and those of the nation fit perfectly and are two sides of the same coin. He believed in a providential hand from God having an influence on people actions. This metaphor refers to members of society who, in the effort of increasing their own interests accidentally contribute to the welfare of society. Thus, the hand reconciles self-interest with the common good (Mc Loskey 2006). For Stigler (1976), the invisible hand is the "crown jewel" of the wealth of nations as individuals encouraged by the pursuit of interest under conditions of competition also serve the society. Oslington (2011), noted that in the "theory of moral of sentiments", (part 4, section1), the invisible hand equally refers to the rich who led by consumption has a beneficial role in the market economy. Back to "the wealth of nations ", (book4), Smith mentioned the desire of merchants to sell at home rather than abroad for greater returns. Grampp (2000) however claimed that keeping capital stock at home is in contradiction with Smith's view of free trade.

Free trade is defined as "international buying and selling of goods, without limits on the amount of goods that one country, and without special taxes bought from a foreign country" (Cambridge dictionary 2014). Within a narrowed definition, it is when goods and services are bought and sold between countries without tariffs, quotas or other restrictions (OECD, 2004).
Adam Smith was considered as one pioneer of the free trade theory. He explained how individuals in the search of self-interest contribute to the opulence of the nation, which is the essence of capitalism. He believed in international trade where British merchants exchange

goods with neighbouring countries and the rest of the world; they would then export goods for which they have an absolute advantage of production and import the other goods. Ricardo (1772-1823) who followed his footsteps believed in free trade especially when a country exports goods for which it has a comparative advantage. Hume (1955) later explained that trade helps poor nations but does not harm the wealthier ones.

International trade helps to fight monopolies, which are bad for competition and great enemy to management (Smith, 1776, 1937:147). Moreover, it increases productivity, specialization, division of labour and knowledge sharing with the world (Smith, book 4, 7). Smith and Ricardo theory of international trade inspired many others Liberals, Hayek for instance believed that free markets help individual decisions and are more efficient than government's planning. Keynes, despite his critics on Adam Smith, recognized the importance of free markets. He claimed: "There is no objection to be raised against the classical analysis of the manner in which private interest will determine what in particular is produced, in what proportion" (1936:378-397). This explanation in relation to Say's law, supports that offer driven by self-interest creates its owned demand.

George Henry (1839-1897) on the other hand argued that free trade does not concern the "working-man" who has no share in the increase of wealth. Moreover, the reduction of the "cost of commodities" does not make the life of common people any easier (Henry, 1886:22.7). This argument is closely linked to Marx's criticism of capitalism as a political economic system that favours the wealth ones.

More recently, Sachs (2005) insisted on how the increase in trade would tackle extreme poverty across the globe. Bannister and Thugge (2001) also outlined the benefits of international trade on poverty alleviation since trade liberalization allows a) access to goods, as prices are more competitive b) an increase in the number of unskilled workers, c) an increase in the government's revenues and d) the increase of innovation and investment.

Liberalism

Liberalism refers to economic freedom. 'It is hard to say what liberals such as Locke, Smith, Montesquieu and Stuart Mill have in common as they do not agree about the legitimacy of welfare and the virtues of democracy' (Ryan, 1993:291). Locke (1689, 1823) for instance believed in a state where individualism is important as far as individuals have the right over the

state. Ryan (1993) defined liberalism as a set of political theories, which emphasizes on the rights of individuals. It is also "a practical theory of building democratic policies and securing individual liberty" rather than a conception of man and society (Satori, 1987:379). Economic liberalism, on the other hand, is when the state abstains from intervening in the economy.
The Liberal theory essentially focuses on the concepts of self-interest and individual freedom. Therefore, in a society of liberalism, individuals are free to make decisions in accordance to their needs. According to J S Mill's harm principle, every adult with a good mental state should be free of its own actions and decisions. Liberalism despite the freedom given to individuals does not stop individuals to obey the state (Hobbes, 1651). Early liberals like Smith believed in a limited intervention of government in the economy while some others defended its intervention.

The classical school of thought is associated with Adam Smith, and his main followers, Ricardo, Say and Malthus. The classical view could be summarized in three main points including a) the concept of invisible hand b) self-interest and c) the self-regulation of the economic system. Then, the approach of "laissez-faire" applies to the concepts of supply, demand, the equilibrium of prices and the labour market.
Economic liberalism is when the state abstains from intervening in the economy, as the market is self-regulating. According to Say (1803), the motive, which impels a man to give his services to another, is self-interest. He requires a reward for the services rendered. The right of exclusive private propriety is then indispensable to the establishment of exchange among men. Like Smith, he also believed that the division of labour contributes to the wealth of society as well as the application of knowledge, which is essential for creativity, and the progress of society. He was among the first classical economists who insisted on the importance of the entrepreneurial spirit in economy (Bruyart & Julien, 2001; Steiner, 2002). He equally insisted on the importance of free market and criticized the damage caused by trade protectionism.
The supply and demand principle was the centre of his work. He stated, "A product is no sooner created, than at the instant it affords full extend market of its own" (1803, chapter 15). Supply creates its own demand, in other words, all produced goods will find a market. The value and price of the produced goods, therefore, is subjected to the relation between the supply and the demand. Rothbard (1970) similarly stated that in a free market, everyone earns accordingly to his ability in satisfying consumers. Say's law was however criticized by many including Keynes

who claimed that supply does not precondition demand, rather, is equal to demand what constitutes the ideal state of the market. JS Mill (1848) also agreed with the theory of market equilibrium when he argued that under-consumption led to the Great depression of 1930.

On International Trade, Ricardo (1772-1823) like Smith believed that free trade benefits a country and its people. Nevertheless, he thought international trade and domestic trade do not benefit the economy in the same way. He believed absolute advantage should be applied in the domestic market where a country would sell goods they efficiently produce and import goods they are less specialized in. Then, his theory of comparative advantage could be linked to Marx's labour theory of value since the value of good is equal to the cost of production. In fact, Marx thought all costs of production and value of goods are entirely defined by the cost of labour.
According to Malthus (1798), Ricardo should have also considered the aspect of demand and supply in the theory of cost. Demand is the will of buying combined with the power to purchase, while supply the will and the quantity of commodity (based on the cost of labour).
Malthus, in fact, believed that an increase in demand leads to an increase of prices and inversely (1798:64). His conception of supply and demand is widely used in modern economy and has been notably a great concern for neoclassicals (Rankin, 1980; Thweatt, 1983; Hollander, 1997).

J S Mill defined international trade "as an efficient employment of the productive forces of the world" (1848:3:16). This definition refers to the division of labour and specialization, supported by Smith and Ricardo. He added: "commerce is virtually a mode of cheapening production" (1848, 4:1) what benefits consumers who pay less and sellers who make more profits. Like Smith, his defence of laissez-faire is based on the general welfare (Riley, 1998). In Mill's view, laissez-faire also concerns individuals' liberty and the right of private ownership. He condemned the redistribution of wealth, as "substance should not be held by law rather by voluntary charity" (1848, 4:11).

Neo-liberalism is a new paradigm of economic theory and a foundation for capitalist societies (Clarke, 2005). Modern liberalism similarly to classical liberalism defends free markets with an optimal exchange of goods and services (Friedman, 1962; Norberg, 2005); it also promotes the entrepreneurial spirit introduced by Adam Smith's invisible hand. While some neoliberals

conform to the traditional idea of laissez-faire, Keynes defended the role of government to regulate the market and minimize risks. Inspired by the great recession of 1930, he thought governments should intervene to stabilize the economy, what would prevent socialization of the economy, preconized by Marx (Keynes, 1936, Ludwig 1920).

Nozick (1974) also believed intervention is necessary for the protection of individuals' rights; he believed that the main reason for the state involvement in economy is to create a decent and equitable society (Rawls 1993 and Beveridge, 1994). Furthermore, Harvey (2005) noted that the intervention of state does not prevent entrepreneurial freedom. Friedman (1912- 2006) despite his critics on Keynesians, approved the intervention of government in "cases in which strictly voluntary exchange is either exceedingly costly or because of monopoly and similar market imperfections" (1962:28).

Capitalism

Capitalism is derived from the theory of free trade; it is a social system based on private ownership of the means of production and characterized by the pursuit of material self-interest (Riesman, 1998:19). Moreover, "the dependence upon an intense appeal to the money is the main motive force of the economic machine" (Keynes1926: 4). For Stenberg (2015), Capitalism is based on private property, self-interest, and "laissez-faire". In contrast, others identified capitalism as a system of alienation and inequality. Rogge (1979) criticized the unequal distribution of wealth, and affirmed that no businessman could deny receiving favours from government, therefore, could not fight against the government, as he is part of the problem.

Mingardi (2016) on the other hand praises capitalism for mobilizing even the tiniest knowledge that results in the improvement of production and the welfare of society. Moreover, it stimulates innovation, creates opportunities and increases life chances in society (Massy, 1991; Schumpeter, 1942).

2.2.2 Karl Marx, communism and socialism

Karl Marx (1818-1883), German philosopher, historian and economist is considered as the figure of communism. His work notably *Das Kapital* and the *Communist Manifesto* constituted the basis of Marxism and the foundation of socialism.

Communism is a historical process characterized by class struggles between bourgeoisie and proletariat. It is equally the final stage of society's evolution from feudalism, capitalism to socialism (Hindess, 1975; Okey, 2003). Marx believed in the creativity of people, however, condemned free market, as it promotes private property (Melotti, 1977; Woff, 2003). Marx's ideas were later lead by Engels and other communist thinkers such as Georgi Plekhanov (1856-1918), founder of the Russian Marxism. Plekhanov inspired Russian communism and particularly Lenin, with the idea of proletariat struggle against the bourgeoisie, notably with his work

socialism and the political struggle (1883). Like his predecessors, Plekhanov criticized classic bourgeois economy defended by Smith and Ricardo.

Then, contrary to Marx, Hayek held that freedom was not solely the ban of alienation but "a condition in which coercion of some by others is reduced as much as possible" (Hayek, 1960:11). In his view, freedom is not egalitarianism but the liberty to achieve for oneself through social mobility.

Further, Like Smith (1776), Keynes recognized individuals as social beings however his individualism "induces an attitude of humility toward the impersonal and anonymous social process by which individuals help to create things greater than they know "while Smith's individualism "is the product of an exaggerated belief in the powers of individual reason" (Hayek, 1960:81). In other words, for Keynes the concept of individualism is weaker than the one promoted by Smith, since individual knowledge could not be dissociated from the one of society.

Marxism and the Communist Manifesto

The Communist Manifesto, 1848, co-authored with Engels (1820-1895) is the symbol of communism and essentially discussed class struggles as well as communism and its historical evolution.

The first part of the Communist Manifesto focused on the two rival classes of society, the bourgeoisie and proletariat. The Bourgeoisie emerged from the evolution of feudal society where the middle class provided the means of production. Later on, with the industrial revolution, "modern bourgeoisie" gained, even more, power by extending markets beyond borders while proletariat was then perceived as the revolutionary class destined to change society (Marx, 1844). Society was therefore contrasted between those who accumulate the means of production and the others who are deprived from it (Marx, 1859).

Marx's alienation theory took its source from the study of capitalist society where the working class was oppressed by the bourgeoisie. The worker man by working is then subjected to an external force, which is labour. Moreover, the more powerful the alien object is the poorer he becomes (Tucker, 1978). Labour appears then as "self-sacrifice" and "mortification" since it transforms the worker to a simple being with animal functions. According to Marx, alienation would only end when proletariat defeats bourgeoisie, what then would lead to the suppression of classes, and the instauration of communism as an economic system. In the Marxist view, communism does not deprive man of the power to appropriate the products of society, however, deprives him to subjugate the labour of others (Tucker, 1978). Furthermore, Marx stated that communism is the positive transcendence of private society, as a real appropriation of the human essence by and for the man. Communism, therefore, is the complete return of man as a social being (Engels, 1888).

The second section of the book discussed common points between proletariat and communism. Communism defends the emancipation of proletariat as well as the ownership of labour by labourers and not by the owner of property.

The third part of the book was an evaluation of the socialist and communist literature. He studied different socialist movements and their link with class struggle. Reactionary socialism was part of the feudal society and bourgeoisie was the elite of society. Even with the supremacy of bourgeoisie, class antagonism did not exist. Conservative or bourgeois socialism promoted class differences by giving the bourgeoisie all the advantages of modern society. Critical-Utopian socialists, on the other hand, did not consider historical facts and the evolution of society in correlation with economic structures. In Marx's view, society changes only through class revolution.

Part 4 discussed the communist position against various opposing views. It equally revealed the agenda of communists, which aimed to fight for the rights of workers. Through the Manifesto, communists publically defended the proletarian revolution and the end of private property (Schumpeter, 1949; Rostow, 1959; Lefort, 1988).

Communism and Socialism

Derived from Marxism, both communism and socialism prioritize the benefits of the community over personal interest (Kennedy & Galtz, 1995; Burkett, 2003). In fact, Marx claimed that communism is the positive expression of the abolition of private property (Hardt, 2010). Mises (1922) described communism as the attempt to achieve the greatest possible equality in the distribution of wealth guided by the consideration of social utility or social justice. In this sense, collectivism is the perfect adaptation of communism, as it prescribes the paternity of the state, which could be traced back to Rousseau's social contract, and the submission of the individual to the general will (Grofman, 1988). Ball (1895) considered socialism as any theory of social organization, which abandons the legitimate liberties of individuals for the interests of the community.

Mises (1922) had another idea of socialism which "in its strongest and purest form has no longer anything in common with the idea of redistribution" rather social justice (Mises, 1922:63). Ehrke (2000) however rejected this view since social democrat parties protect the weak against injustice and the risks of the market through government redistribution measures such as taxes and social security. Similarly, Liberals, have criticized the role of the state in directing the economy. Mises (1922, 2:17) stated: "if the conflict between the common interests of the whole and the particular interests of the individual really existed, men would be quite incapable of collaborating in society".

In other words, the interests of the individual and the society are inseparable; society in its whole, functions by the collaboration of individuals seeking their own interest. Further, he accused socialist theory to be created by "those who find economic life alien" to society and by confusing economic changes with the anarchy of production. In fact, for liberals, capitalism reflects freedom for both individuals and society.

Hayek (1944) in addition, criticized German socialism for controlling individuals' lives in the name of social equality. In The road to serfdom (1944), he warned European nations against the

dangers of socialism as it promotes the supremacy of the state over the freedom of individuals (Hayek, 1973; Block, 2011).

Marx and critics of capitalism

In the Economic and philosophic transcript (1844), Marx studied the writings of Smith, Ricardo, Mill and Malthus. He quoted, for instance, Smith on private profit:

"The consideration of his own private profit, is the sole motive which determines the owner of any capital to employ" (Smith, Vol 1 p 335).

Like Smith, he discussed the rule of capital over labour and the motives of the capitalist to produce in order to make profit. He equally stated that an increase of stock leads to an increase of wages what then is against the interest of capitalists (Trucker, 1978).

Contrary to Smith, he thought capitalism and the desperate search of profit physically and mentally dehumanized workers and mostly benefits the capitalists. The working people become then a commodity and fall to be even poorer (Marx, 1844). Smith, on this believed that work is natural behaviour for individuals in the quest to fulfil their self-interest, while Marx considered it as an extrinsic element and mean of human exploitation. He declared: "the worker has the misfortune to be a living capital. Moreover, man and capital are aliens to each other. However, the workingman exists as a worker only when he exists for himself as a capital" (Second Manuscripts, 1948). In other words, the working class could be only able to leave the state of alienation when they work for themselves and earn their own profit.

In the Anthesis of capital and labour, second manuscript, he criticized Smith and Say on the "existence of human being". According to him, it is not about "how many workers are maintained by a given capital, but rather how much interest it brings" to them. Proletariat should stop being exploited and should earn freedom through class struggle in order to benefit labour (Postone & Galambos, 1995; Tomich, 2004; Harvey, 2010).

In A critique of political economy (1867), Marx analysed the writings of classical economists notably Smith and Ricardo. He criticized Ricardo's conception of the world as a set of economic laws. In fact, capitalism is not only about money, commodities and profit but also the division of classes where one group is dominant (Morisson, 2006).

Moreover, the exchange between capital and labour depends on social classes, but the classical political economy nearly touches the true relation of things, without, however, consciously formulating it as sticks in its bourgeois skin (Marx, 1867, Vol 1 chapter 110). Moreover, Liberal economists belong to "a state of society in which the process of production has the mastery over man instead of being controlled by him" (Marx, 1867, Vol 1, chapter 1).
The critic of capitalism was also developed in the theory of human nature (Marx, 1845). Human nature is based on "social relations" rather than the traditional interpretation of species. Capitalism nevertheless, alienates individuals to external forces, which goes against their nature of conscientiousness. In Marx's view, feudal societies should not evolve into capitalism, rather communism. He defined communism as "the appropriation of the human essence through the intermediary of the negation of private property" (Marx, 1848:24). Thus, private propriety would be replaced by common propriety.

Further, it is interesting to compare Marx's alienation theory with Durkheim's Anomy and its effect on society. In The Division of labour (1893), Durkheim discussed how the division of labour could weaken human behaviours and create social changes. Anomy or the absence of norms in society negatively affects individuals. The capitalist system notably division of labour deprives individuals from their human functions what then result in deviant behaviours such as suicide (Durkheim, 1897). He stated: "It is this anomic state that is caused, as we shall show, of the incessantly recurrent conflicts, and the multifarious disorders of which the economic world exhibits, so sad spectacle" (Durkheim, 1897 (1952:248)).His concept of normlessness is similar to Marx's alienation theory as frustration and lack of purpose destroy the individual.

Marx, Weber and social stratification

Max Weber (1864-1920) is considered as a great figure of sociology besides Marx and Durkheim. He is particularly known for his works on social stratification and capitalism.
It is interesting to analyse Weber conception of society in relation to Marx social classes. Weber distinguished between the roles of economic power and political power in society whereas Marx believed they are related (Turner, 2009). In Marx's view, social classes are the results of political and economic factors favouring the class with the means of production. In contrast, Weber

thought honour is not necessarily linked to the class situation rather, to individual's achievement. In this sense, "both ownership and property could belong to the same group" (Turner, 2009:187). Weber's theory of social stratification is similar to Marx's theory of classes as he accepted that social differences derive from different class, status and power. However, he criticized the revolution of proletariat as the ultimate path for the instauration of communism as an economic system.

According to him, society is divided into four classes, the working class or proletariat in Marx's terms, the bourgeoisie, the white collars and finally the upper class. Classes are stratified according to their relation to production, acquisition of goods and services they could offer to the market (Weber, 1978:928). The upper class, for instance, provides the mean of production while the working class produces them.

Status, on the other hand, defines the consumption of each class; the more a class consumes the higher is its status (Parkin, 1971). Finally, classes are stratified within parties or social power. Weber understood by power, "the chance of a man or a number of men to realize their own will in a communal action" (Weber, 1922:926). In this sense, the social group of an individual determines his chances to succeed.

Weber's society stratification implies inequalities in society what goes against the communist theory, and similar to capitalism (Sorenson, 2000). In the communist view, social stratification would enhance differences between proletariat and bourgeoisie and the accumulation of means of production would give more power to the bourgeoisie to dominate the rest of society (Lipset & Bendix, 1991; Breen, 2004).

In addition, Weber had a non-economic explanation of the origins of capitalism. He thought capitalism is traced back to the protestant reformation (Weber, 1905; Giddens, 1971); the more one accumulated capital, the more he was perceived as an indication of salvation from God. His economic explanation of capitalism started in *Economy and society*, where he stated that the interest of economy is "represented exclusively by the possession of goods and opportunities for income" (Weber, 1922:927). Moreover, property is an "important basis for a groups' status, however, "because of this property; social honour may also be accord to the same people" (1922:932) what represented Marx's greatest fear.

Then, Weber's concept of bureaucracy is played off against the Marxist concept of class struggle (Turner, 2009). Based on Marx's theory of class, communism and bureaucracy are incompatible, as bourgeoisie would gain more power and the workingman subjected to routine and mechanization (Mc Donald, 1946, Montague 1884 and Mill, 1859).

2.2.3 Capitalism versus socialism

From philosophy to practice, the debate between socialism and capitalism as rival eco-political systems continues. De Laveleye (1883) affirmed that the greater error of the majority of Socialists is that they do not sufficiently take into consideration the fact that the great incentive to labour and economy is individual interest. To work, an individual must find primarily his own interest, key to his own happiness; therefore, collectivism is self-sacrificing for the desires of others (Wollstein, 1989). Moreover, liberalism "secures to every man the fruit of his labour, ingenuity by so encourages him to improve methods of work and production" (Bruce, 1887: chapter 5).

More recently, Schumpeter (1942:83) believed that the " fundamental impulse that sets and keeps the capitalist empire comes from the new consumed goods, the new methods of production, the new markets and the new forms of industrial organizations".

In defence to socialism, Kautsky (1918), discussed the dictatorship of proletariat, a term used by Marx to refer to the period of transition between capitalist societies to communist society. He explained that the term dictatorship should not be understood literally rather is a metaphor to explain the power of the proletariat as a political system. He equally criticized Bernstein (1899) for his revision on Marx, as he believed in evolutionary socialism where private property and capitalism increase wages and benefits the entire society.

Duhring (1833-1921) also revised the Marxist theory and found that proletariat struggle is unnecessary because political forces shape society. Thus, political conditions are the decisive cause of the economic situation and the reverse relationship represents only a reaction of a second order. He also believed that capitalism benefits the entire nation even the working person as it increases the wages.

In response, Engels (1877:2) contradicted this view: If political conditions are the decisive cause of the economic situation, and then the modern bourgeoisie could not have been developed in the struggle with feudalism (…) everyone knows that what happened was the opposite". Moreover, "private property makes its appearance in history as the result of robbery" thus do not benefit the working class. In this sense, Trotsky (1929) defended a permanent revolution in which the struggle of proletariat would be worldwide, and would involve the destruction of classes.

On the other hand, Hayek (1944) believed that the government should provide things that market could not, for instance, create money and regulations. Government intervention in his view should be limited as the market has a spontaneous order created by individuals' interaction. Boudreaux (2016) equally noted that the market increases individuals' ability to pursue their goals by harassing the cooperation of others. The rule of law safeguards freedom and is equally compatible with the stability of the economy. Under the rule of isonomia or equal law, individuals are bounded by the same regulations (Hayek, 1960). In The Road to Serfdom, he warned nations against the dangers total government intervention in both economic and social matters. In addition, he stated, "Liberalism is based on the belief that competition is the best way of guiding individual effort". Personal, political and economic freedom are interlinked and "economic freedom without political freedom would not be worth living" (Hayek, 1944: 25-33). Socialism, on the other hand, does not offer that privilege as power and economy are in the same ruling hands.

As a contemporary of Hayek, Nozick (1974) was equally an advocate of liberalism and individual freedom. His libertarianism was centred on a minimal state that ensures both individual property and freedom. When considering the role of individuals within society, he criticized Rawls (1979) on egalitarianism and common ownership. His theory of self-ownership recognized the freedom of individuals to take their own decisions and enjoy the product of their work; in this sense, individuals exclusively own their abilities, knowledge and private property. In this sense, self-ownership is the main foundation of liberalism and "it is unjust to forbid capitalist acts between consenting adults" (Nozick, 1974:163). Intervention in the economy, however, reduces welfare since it limits the decisions of individuals through high taxation or

inflexible regulations; the good state is, therefore, the one that accepts economic independence (Angell, 1913; Barr, 1993).

Keynes (1944) on the other hand advocated at some extent for government intervention. Inspired by the economic stagnation after world war two he believed government fiscal policy was no longer efficient and supported the intervention on the aggregated demand through more government spending. According to him, monetary policies would create more spending, the equilibrium of outputs and the decrease of unemployment. Hayek (1974) however criticized this theory because the injection of money creates boom and burst that causes labour and prices drop when, the supply of money stops (Hayek, 1974).

Raico (2008) considered that despite his opposition on laissez-faire, Keynes could still be classified as a "classical liberal" because he believed in free market. Lageux (1998) also accepted that Keynes position was ambiguous since on one side he wrote The End of Laissez-Faire (1926) and on the other was committed to free trade and capitalism.

On social questions, Keynes justified the intervention of government, as experts who work for the benefit of society understand what common people cannot understand the economy. He defended at some extent the theory of welfare state that reduces inequalities and improves living standards (Barr, 2004). It is important however to note that his interventionism is more economic than social. Overall, he defended interventionism only when the government brings a balance to the economy to rectify the failures of the market (Hazlitt, 1959; Bateman, 2015).

Mises (1922) furthermore acknowledged that economic and political liberties are undeniably linked and no government can guarantee freedom otherwise than defending the institutions of the market economy. He also believed that socialism could not make the economy because the scarce factors of production are nor sold or bought, what as result leads to chaos and poverty (Mises, 1922). According to him, interventionism is the third way between free market and socialism since it prevents both, the inefficiency of socialism and the excesses of capitalism. He claimed that interventionism does not abolish private ownership but only restrict it (Mises, 1930). The theory of government intervention is relevant to health insurance as the government is the legitimate entity that could regulate the competition among health care providers (Santerre, Grubaugh and Stollar, 1991). Further, Ruggie (1992) and Fledman, Escribano et al, (1998) considered that public intervention in healthcare is successful if it increases the welfare of people and produces great outcomes. Moreover, government intervention is justified when the state could achieve better than private markets and when market failures affect the consumer.

Despite antagonisms, both capitalism and socialism share the same end goals: a) equal opportunities for all. In the communist view, the government ensures social justice while capitalism gives the same economic liberties to all (Bruce, 1887), b) a better society. In communism individuals are equal with no distinction of class and capitalism offers a better way of life through social mobility and c) in both economic systems, the state is the ruling body ensuring equality of wealth and status for communism and equity of law and opportunities in capitalism (Bruce, 1887).

The theories of capitalism and socialism are important for this research. Socialism address the same rights for all individuals in society, which also concern the right to access healthcare regardless of the socio-economic group. Concerning health insurance in Niger, literature revealed an inequitable access between the formal and the informal sector (Loutou, 2009). Then, the theory of capitalism, which promotes self-interest and profit, reflects the behaviour of private insurance in Niger, which is costly and highly selective.

2.3 Theoretical framework of this research

The theoretical framework is a set of theories or concepts explaining the relationships between two or more variables with the purpose of understanding a problem or a phenomenon (Fain, 2004). For this study, the philosophical review, which focused on capitalism and socialism, enabled to choose the theories CSR in relation to capitalism; and the theory of path dependency in connection to the role of government in providing healthcare. Furthermore, based on the literature review on Niger, the notion of culture appeared to be a key element for universal coverage. This following section presented the theoretical framework including CSR, path dependency and culture.

2.3.1 The relevance of the CSR pyramid model

In relation to private insurance, one of the key sector in this research, the concept of corporate social responsibility was discussed in order to identify the involvement of commercial insurance in universal coverage in Niger.

2.3.1.1 Definitions of CSR

Bowen (1953) was among the first authors who wrote about CSR. He thought it was required for businessmen to align their decisions with the values of society. Further, a number of scholars claimed that it is difficult to define and measure CSR (Siegle and Wright, 2006; De George, 2008). Davis and Blomstrom (1966:12) however, attempted to defined corporate social responsibility (CSR) as a "person's obligation to consider the effects of his decisions and actions on the whole social system. Businessmen would then look beyond the firm's narrow economic interest". More recently, Ognni & Omojowo (2016) defined CSR as the intentional and unintentional consequences of business activities on society.

A number of scholars on the other hand believed that CSR should include ethical and philanthropic considerations (Mc Guire, 1964; Carroll, 1979; Dashlsurd, 2008). Foran (2001) gave a definition of CSR centred on stakeholder theory. According to him, CSR is a set of

practices and behaviours a business adapts towards its employers, environment and civil society. Further, Van Marrewijk (2003) focused on the ethical aspect of CSR, as he believed CSR is the degree of moral obligation a firm applies, which is beyond the simple obedience of laws.

According to Caroll (2015), CSR had three main trajectories over the past 50 years. In the 1960's CSR was perceived as a social movement alongside with civil rights and consumer rights. Then in the 1970's it started to be adopted and widely applied in businesses. From the 1980,'s CSR focused on the performance of business and started to be assessed in terms of ethics, stakeholders' management, sustainability and corporate citizenship. Business ethics involves the righteousness of business decisions and practices. Stakeholder management involves business practices and its effect on people who have a direct interest in the business. Then, corporate citizenship considers a business as a citizen, therefore, expects it to act accordingly to cultural, social and economic norms (Caroll, 2015). In this sense, Katsoulakos (2006) explored the idea of "good citizen", and explained that business practices should minimize harm and increase benefits for all stakeholders especially shareholders and the community. Campbell (2007) examined the motives that encourage businesses to apply CSR and argued that the maximization of shareholder's value is the main reason. He also clarified that financial strong businesses are more inclined to apply CSR. Then market competition and the trend of applying CSR equally played a role. Another motivating argument is public policies and the institutional
pressure that pushes firms to act socially responsibly. In a long run, CSR creates positive benefits for both business and society. Burke and Logsdon (1996) elaborated five dimensions of CSR that reflect the benefits of all stakeholders: a) centrality measures the relationships between the business' CSR politic and the business objectives. It is also about the direction, mission of a company and how it applies to others stakeholders b) specificity refers to the competitive advantage of a firm and the ability to differentiate its CSR strategy from other businesses c) proactivity expresses the readiness of a company to respond to social, economic and technological changes d) voluntarism is about taking the initiative to engage in philanthropic activities without the pressure of external entities and e) visibility is the ability to gain attention from internal and external stakeholders as the results of CSR activities.
Grunig & Hunts (1984) considered three CSR communication strategies that would strengthen relations between business and stakeholders. Information strategy is a one-way asymmetric

strategy that informs the public about the business activities. Then, response strategy is a two-way communication between the business and stakeholders about ethical and social responsibilities. Involvement strategy refers to the co-constructed CSR strategy with stakeholders. Valdor (2005) also thought that the involvement of stakeholder in CSR is crucial, as business should be accountable to all stakeholders. Overall, literature centred on CSR as the expectation beyond what is legally required (Caroll, 1999). Watters & Ott (2014) noted that few have been written about CSR for the non-profit sector. In their view, Non-profit organizations should also be encouraged and assisted in their efforts for CSR.

2.3.1.2 The concept of CSR pyramid

The theoretical model of CSR pyramid is traced back to the work of Caroll (1979, 1991), which is widely used in literature (Ahamad and Kelabi, 2014). He defined corporate social responsibility as the social responsibility of businesses involving a pyramid with four components including economic, legal, ethical and philanthropic components. The following definition is based on the economic element as Caroll (1979:500) explained:
"Before anything else, the business institution is the basic economic unit in our society. As such, it has a responsibility to produce goods and services that society wants and to sell them at a profit. All other business roles are predicated on this fundamental assumption".

a) The economic component deals with profit-making, which is the fundamental requirement for business. Thus, economic responsibility correlates with the ethic of capitalism, which is about maximizing profit for shareholders (Ehrenfeld, 2008).
b) The legal responsibility determines how the business complies with the law in the process of fulfilling its economic function.
c) Ethical responsibility refers to the normative expectations of society that a business has to meet. Caroll (1991) also noted that ethical responsibility involves the business responsiveness to societal and ethical changes.
d) Philanthropic responsibility involves voluntary and non-profit activities conducted by the business to serve the society. Ahmad and Kelabi (2014) stated that corporate philanthropy improves community resources and quality of life. In the same sense, Caroll

(1991) claimed that philanthropy is part of the social contract between business and the society.

Based on Caroll's (1991) definition, the three other elements of the pyramid are derived from the economic responsibility of a business. Furthermore, Caroll (1991) explained that business should implement decisions, actions, policies and practices accordingly to the four components of economic, philanthropy, legal and ethical responsibility.

One strand of the literature argued that the concept of CSR as we know it today has been coined by the work of Sethi (1975) which later influenced the work of Caroll (Idowu & Filho, 2008; Moh Issa, 2012; Khan & Mazhar, 2015). Sethi (1975) developed a three-level model that illustrates corporate social performance (CSP):

a) Social obligation involves the legal aspects and codified norms; b) social responsibility contrary to Caroll's conception has a narrow meaning as it focuses on ethics and social norms and c) social responsiveness refers to the business ability to adapt to societal changes and needs.

Inspired by the work of Sethi (1975) and Caroll (1979), Schwartz (2003) noted that the philanthropic component at the top of the pyramid is misleading since it could be understood as the most important element of the hierarchy. Schwartz defended the argument that philanthropy should be dismissed, as it is optional contrary to the ethical, economic and legal components. He believed the work of Caroll (1979) should be presented in a Three-Dimension Domain model of CSR with three components including economic, legal and ethical responsibilities. The economic domain involves profit maximization as the primary purpose of a business. The legal domain requires a business to comply with the law and avoid litigation. Moreover, businesses should anticipate changes in laws and accommodate with them. Third, the ethical domain has three components including:

a) *The conventional standard*, similar to Carroll's (1979) ethical component defines what the society expects the business to achieve in terms of ethics.
b) *The consequentialist standard* focuses on the business's decisions and how they affect both business and society's interests.
c) *The deontological standard* involves the decision-making process and how morality and ethical principles are applied.

Further, Frynas (2005) discussed three challenges for the implementation of CSR:

- He claimed that CSR should be tailored in accordance to countries and situations. In this sense, companies should take in consideration culture, policies and societal needs when implanting their CSR strategy (Visser, 2005).
- Further, he also noted that CSR strategy could fail when beneficiaries are not involved in the decision process.
- Failure could also occur when the CSR plan does not consider sustainable development.

Some authors believed that in an African context the implications of CSR are different from those in developed countries (Vogel, 2005; Visser, 2005; Newell & Frynas, 2007; Egri and Ralston, 2008). This view supports that African countries need CSR as a development tool rather than a business tool (Darton, 2004; Amaeshi et al, 2006; Viser, 2007; Priyanta, 2013). CSR would then contribute to development goals, sustainable development and giving back to the community.

On the other hand, Blowfield (2005) thought that business CSR still contributes to development goals. He noted that CSR is closely linked to the liberal idea of free trade as local and foreign companies create jobs and economic growth. Windsor (2006) also believed that CSR conciliates general welfare and private wealth; general welfare has to do with ethical and altruistic elements while private welfare deals with profits and legal responsibility.

2.3.1.3 Strategic philanthropy and health insurance

Before discussing the role of strategic philanthropy in health insurance, it is essential to understand the entities that are affected by it. Shareholder theory puts the interest of owners and profit maximization as key priorities (Freeman, 1984; Donaldson & Preston, 1995). Friedman (1970:7) defined shareholder theory as *"the one and only social responsibility of business, which is to use its resources and engage in activities designed to increase its profit; as long as it engages in an open and free competition, without deception and fraud"*. Overall, shareholder theory is about the financial wealth delivered to owners and the satisfaction of their requirements (Jensen & Mecking, 1976; Graver, 2007; Nordberg, 2008 and Macey, 2008). This view is however criticized by Freeman *et al,* (2004) because shareholder theory does not take into

consideration both social and economic goals. Stakeholder theory, on the other hand, deals with the impact of business' activities on both internal and external entities (Mitchell et al, 1997).

Some authors considered that stakeholder theory plays an equal role like shareholder theory in the use of strategic philanthropy (Bryson, 2004; Cohen, 2010, Kolk, 2016). Frederick (1994) argued that stakeholder perspective has become inevitable when it comes to CSR; as it defines the functionality of CSR. In this sense, based on Sethi's (1975) social responsiveness, business has the obligation to consider the needs of stakeholders. Further, by taking care of the interests of stakeholders, the business also meets its objectives (Smith and Malcom, 2010). Several authors have drawn the difference between philanthropic strategy and strategic philanthropy. Philanthropic strategy is a well-organized process and strategies of donating over a specific period of time (Barnett, 2000). Strategic philanthropy on the other is fully integrated into the mission and objectives of a business (Caroll, 1991; Webb and Mohr, 1998; Dean, 2003; Bartkus, 2004).

Some scholars claimed that corporate philanthropy is usually strategic philanthropy in order to improve the company's image or sales (Yankee, 1996 and Hilary, 2013). Drucker (1989:92) equally argued that the choice of philanthropy is purely self-interest. He stated: "*community responsibility is a concern for a healthy and viable community; it is not philanthropy for the pluralist institution. It is self-interest, the best way to discharge a community responsibility*". In other words, social responsibility is primarily a concern for the public institution; the involvement of business is only for meeting institutional requirements and most importantly for profit making.

Further, Blowfield (2005) discussed the role of CSR in development and thought companies could have a determining role in developing countries when there is a correlation between self-interest and societal interest. Prieto-Carron, Lund-Thomsen *et al,* (2006) also thought companies should go beyond their legal obligations and consider social and environmental concerns.

It is important to discuss the concept of strategic philanthropy since the research looks at the participation of private insurance in providing health coverage. It also identifies at which extent private insurance contributes to the development of health insurance in the Niger. A number of authors discussed the importance of strategic CSR for increasing profit and benefiting society (Werther & Chandeler, 2005; Siegel, 2006; Campbell, 2007; Maltz & Vitaliano, 2007). Further, Drucker (1984) discussed how a company through CSR could trade social problems into

business opportunities. Thus, private health insurance in Niger would likely incorporate strategic philanthropy to contribute to universal coverage and increase its market, which currently covers about 3% of the population (Caroll, 1991; Webb and Mohr, 1998; Loutou, 2009; Moreira, 2014).

2.3.2 The role of culture in access to health insurance

In a broad term, culture refers to a set of ideas and practices that vary and interact between individuals and the societal level. It also refers to the set of attitudes, norms and behaviors including irrational aspects of a group or organization (Tylor 1871; Hofstede 1991; Smith 2001; Schein, 2004).Idang (2015) explained that culture is specific to each group, which gives to it a distinctive identity from the one of another group. Keesing (1974) however argued that in recent years, it has been a challenge to define the concept of culture. In an attempt to narrow down the concept, Harris (1968:16) defined culture as "*behavior patterns associated with particular groups of people, which, customs to people's way of life*". This definition is close to Bourdieu's (1994) concept of habitus. The concept of habitus suggests that past socialization and internalization shape human action. Thus, individual action is fundamentally related to culture and directed by past learning and influenced by external structures (Swartz, 2002). The theory of habitus is based on three influencing factors including:

1. Primary habitus includes behavior that is shaped by family and education during childhood
2. Secondary habitus refers to behavior influenced by life experience and the interaction with others
3. Finally, class habitus explains how social class influences human behavior and lifestyle.

Some literature (Reckwitz, 2009 and Walther, 2014) clarified that the notion of habitus is derived from Bourdieu's grand theory of practice. Thus, the following equation explains how human behavior is influenced by three critical factors:

(Habitus x Capital)+ Field = Practice

Field represents the macro level or the environment in which an individual lives, which could be a society or group. The concept of *habitus* as previously mentioned refers to rules and habits

applied by an individual at the micro level. Then, *capital* or socioeconomic resources of individual define individual's actions (Walther, 2014).

In recent years, the theory of habitus has been applied in understanding the differential access to healthcare (Collyer, Willis and Harley, 2015). In relation to the concept of *capital*, Bourdieu (1984) considered that the unequal distribution of resources is the fundamental element of disparities in society. In addition, those inequalities are reproduced over time for the same segments of the population. Abel and Frohlich (2012) had a similar view using the concept of habitus. According to them, habitus is appropriate to explain the contribution of public institutions in the reproduction of unequal access to healthcare. They argued that the policies and decisions of government institutions contribute in reproducing social inequalities.

Glassie (1995) defined tradition as the continuous process that involves the creation of future from the past. He also clarified that culture and tradition are distinct features even though closely related. According to him, tradition is a temporal concept while culture resists time. Horner (1990) and Graburn (2002) had a similar view as tradition continue to preserve the features of culture through time. Horner (1990) called tradition the "reservoir" from which some aspects of the past are picked to fit the modern way of life. Some scholars (Van der Geest, 2004; Leonard, 2001) argued that even with the expansion of modern medicine, traditional medicine still holds a critical position in African countries. The concept of habitus is closely related to the use of traditional medicine, which is entrenched in societies as a cultural norm (Jones & Genao, 2003; Hyder & Morrow, 2000 and Abdullahi, 2011). On this, Paul (1955:15) stated: *"The habits and beliefs of people in a given community are not separate items but elements of a cultural system. This suggests that the most difficult task in health education is to change those cultural features which stand as symbols or expressions of the fundamental moral code".* This means that culture determines health behavior and which methods individuals use for healthcare. Because culture is entrenched in social norms, people are inclined to use the same health behaviors as the previous generations. Literature suggested that culture is a social determinant for healthcare (Finnemore, 1996; Rimal & Real, 2003; Rosen & Lotte-Hallman, 2015). In this sense, Asu, Gever *et al,* (2013) explained that traditional African medicine is widely used because it is embedded in social norms for centuries. Collyer, Willis *et al,* (2015) linked healthcare choices with

Bourdieu's concept of habitus using the equation: habitus + field= practice; they claimed that health behaviors are shaped by those of the society. Studies suggested the effects of cultural factors on health (Lai, 2007; Gupta, 2010; Levesque & Li, 2014). In relation to this research, culture has been included in the theoretical framework as some literature suggested the influence of culture on the access to health insurance in Niger (Loutou, 2009). Moreover, an important segment of the population favors traditional medicine (Sofowora, 2013).

Some scholars (Bass, 1990 and Schein, 1996) accepted that culture defines the interaction of members influences the norms and action of the institution. Hofstede (1991) also thought there is a link between cultural aspects and leadership; thus, social culture influences political tradition. When it comes to healthcare, the notion of leadership is crucial as policies influence the performance of the sector (Schein, 1996). These recent years, increasing interest has been devoted to the impact of corruption on the health sector (Vian, 2008; Gupta et al, 2002 and Lewis, 2006). Brinkerhoff (2004) argued that corruption is increased because of the lack of accountability. Fung et al, (2007) agreed with this view through their theoretical framework for corruption. They claimed that corruption is driven by three forces including the abuse of public power, corruption that becomes a social norm and finally the search for private gain.

2.3.3 The theory of path dependency

A broad definition of institutionalism refers to the decision making of an individual or a group. MacKinnon (2008) considered institutionalism as a theoretical framework for analyzing a particular institution. Historical institutionalism explains the gradual modification of policies over time. This approach manifests that institutions are created not for functionality reasons but inspired by pre-existing policies and institutions (Amenta and Ramsey, 2010). Peters, Pierre and King (2005) supported the argument that path dependency is deeply rooted in historical institutionalism. In fact, the institutionalist literature supports that policy-making systems are built on existing theories, as well as inspired by the organisations that made those policies. Further, Pierson (2000) held that each institution is path-dependent; consequently, path dependence and institutionalism are interlinked. This idea links with Giddens (1984) macro-level

model, as he argued that institutions are themselves manifested path dependence since each of them is the result of self-reinforcement from the model of others institutions.

In a broad conceptualization, path dependency refers to the argument that past event influence future events; Mahoney (2000) explained that institutional reproduction occurs in the absence of forces for institutional innovation. Camic (1979) and Collins (1994) contrasted this view by arguing that the theory of path dependency has a deeper sense than a simple copy and paste operation. Collins (1994, 1997) developed a three-dimension framework that justifies path dependency. *The utilitarian approach* is based on a self – reinforcing process when organizations use path dependency for instance for cost-cutting and result optimization. The *functional approach* consists in reproducing the functionalities of an institution as part of its whole system. For instance, government's institutions usually, are inspired and follow policies implemented by the state. Then, the *power approach* justifies policy reproduction for institutions that are monitored by powerful institutions. For example, Barkin (2015) explained that certain international organisations use an exclusive approach to humanitarian aid that privileges their own policies rather than the ones of host countries.

We understand that institutions consider self-reinforcement guided by an effective leadership to become better and equally improve their image (Smith and Malcolm, 2010). Similarly, Palthe (2014) developed a conceptual framework that proposes three basics elements that actors for institutional change consider. The *regulative* approach involves policies and rules that define an institution. *Normative elements* deal with the organization's norms and culture and finally *cognitive elements* with beliefs and ideas that which lead to innovation of policies. He clarified that regulative approach builds the legal legitimacy of the institution, the normative assesses the moral legitimacy and the cognitive element highlights the cultural legitimacy.

Kay (2005) also discussed this argument of policy reproduction. He raised a concern about how to assess what is path dependent about a specific policy or organization. He then insisted on the importance of actors to identify which level of policy to reproduce.

Criticisms have been raised concerning the practicability of path dependency (Hacker, 2002; Peters, Pierre *et al,* 2005). One of the limit concerns the policy initiation as any preexisting idea and policy is specific to a particular situation. The concern would be about how to adjust those theories to a new situation. Furthermore, there is a debate on how to adapt a policy that consistently changes over time and most importantly how to accurately implement it (Peng &

Heath, 1996; Lawrence & Shadnam, 2008 and Palthe, 2014). Wilsford (1994) who studied healthcare reform and path dependency in four developed countries including Germany, France the UK and US argued that historical institutionalism makes it difficult to reform healthcare systems, which have been working in a certain way for decades.

Pierson (1993:596) discussed the importance of path dependency on public management and policy development as: *"major public policies also constitute important rules of the game, influencing the allocation of economic and political resources, modifying the costs and benefits associated with alternative political strategies, and consequently ensuring political development"*.

Path dependency is important in understanding public policies. In his work, Bitran (2014) stated that in developing countries, health systems are segmented and separated by groups and income. Moreover, the path dependency of public policies through years resulted in a greater informality, small social security and low insurance coverage. Similarly, in a study conducted in Kenya, Okungu, et.al (2018) discussed the implication of policies for funding universal coverage for the informal sector in Kenya, which represents about 80% of the population. Literature in Niger suggested that the informal sector, which represents about 80% of the population, does not have insurance mechanisms. In this sense, a number of studies have linked the low coverage in the informal sector with public policies disfavoring this sector (Bennett, et.al 1998; Gumber, 2002).

2.4 The theory of social contract and social justice

2.4.1 The theory of social contract and public insurance

In order to discuss the role of the government within society it is crucial to define what the state is; in this sense, it is interesting to look at Hobbes (1651), one of the prominent philosophers who discussed the role of government in society. In the state of nature, because of the absence of law and authority, man's most fundamental desire is self-preservation. The primary state of nature or state of war is unlawful and violent and no man trusts another man. However, Hobbes believed it gets better when individuals apply reason since they are born with a sense of right and wrong. Contrary to Hobbes, Locke's (1689) state of nature is not as violent; he thought humans by

nature are rational individuals capable of living in society. He rejected the laws of nature and considered that knowledge and laws are learned.

Locke believed that "God has certainly appointed the government to restrain the violence of men" and to lead them into civil society (Locke, 1690 chapter 2: 13). Civil society exists when individuals resign their power to the community and "man has the title to perfect freedom, and an uncontrolled enjoyment of all rights of law equally with another man" (Locke, 1690, chapter 7: 87).

Both Hobbes and Locke accepted that human beings could not continue living in a state of nature, as the desire of self-interest would lead to anarchy and chaos. To enter civil society, people should agree on common authority and laws through a social contract. This contract would ensure the rights and security of every man as they give up self-justice to the community.

Aristotle (384 BC-322 BC) defined the state as a body of citizens ruling the purpose of life, and the more people construct the constitution, the more democratic the state is. In other words, the constitution defines the type and role of government. Fuchs (2011) defined social contract as the element that defines law and the obligation to conform to it. Further, Dahl and Lindkolm (1953) gave a utilitarian definition of the government as the agency in the division of labour which has the power to coerce all the others agents in society. Downs (1957) noted that economic decisions always reflect political choices. Indeed, many have discussed the degree of state involvement in the market economy. Rousseau (1762) also believed that social contract is the foundation of the state as "the voice of duty replaces physical impulse and right replaces appetite". He insisted on the fact that "men are born free and equal and for that reason, the work of government and laws should express the general will" (1762:195).

Paz-Fuchs (2011) affirmed that the traditional social contract justifies the existence of law and the obligation to conform to it while modern social contract promotes the welfare of society. Thus, institutions are responsible for distributing rights, duties and advantages in an equitable manner. Social contract would then concern aspect of the society such as educations, health and markets. Rawls' significant work, *A theory of justice* (1971) is considered as a pillar of the social justice theory; based on the theory of social contract, social justice promotes a fair society with equal opportunities for all. The Rawlsian social justice involves equity, distribution of primary goods including liberty, opportunity, income and wealth (Rawls, 1971:303 and Charmaz, 2011).

One could argue that Rawls' egalitarian stance of society makes a parallel to Rousseau's view of "men are born all equal". In addition, Rawls (1971) viewed society as cooperation between individuals whom the abilities and private ownership are assets for society. He rejected Nozick's theory of self-ownership for two reasons:

1. On the basis that individuals are equal, they must share their private ownership including economic property.
2. Distributive justice would then correct social and economic inequalities.

In that sense, "all values, liberty, opportunity, income and wealth are to be distributed equally to everyone's advantage" (Rawls, 1971:64).

Further, Rawls distributive justice was based and justified by three principles.
The principle of justice considers individuals equal with the same civil and political rights. The principle of social and economic inequalities reveals social disparities caused by differences in jobs or social classes. In this sense, Kangas (2000) also claimed that none would be doomed to the same miserable position for life and everybody should have the possibility to compete on equal terms. Third, the difference principle accepts that socioeconomic inequalities could only exist if they benefit the least favored of society. Okun (1975) also considered Rawlsian justice as fairness and agreed that social equality and economic efficiency correlate. He strongly defended the distribution of resources, which increases consumption and efficiency of the market.
Wegner (1987) on the other hand, claimed that distributive justice is an illusory utopia as social redistribution makes people, who are in average social positions believe that the rewards they get is proportionate to their social position. This idea is, nevertheless, inadequate as it limits the potential of individuals and reinforces their dependence to social equity. Similarly, Hayek (1984) did not see any moral justification for social justice as it favours equality over individual merit. Sharing a comparable view, Nozick (1974:149) said that "what each person gets, he gets from others who give to him in exchange for something. In a free society, diverse persons control different resources and new holdings arise out of the voluntary exchanges". In his libertarian view, a fair society is the one that protects individual merits and property rights.
The veil of ignorance is the concept behind Rawls' distributive justice. It refers to a situation of uncertainty and risks for the lowermost of the society. The government, which is behind the veil, conceals reality by offering security, wealth and freedom to the worst off in society (Roemer,

2002). One can consequently argue that the veil of ignorance prevents populations of knowing their veritable socio-economic positions in society. Then, Carlsson and Lyttkens (2010) believed that health could be perceived as primary good in Rawl's view. In this sense, access to health insurance would be made easy regardless of socio-economic differences. In this sense, numerous scholars (Miller, 1976; Daniels, 1981; Sen, 1992; Korobkin, 1998 and Cookson, 2000) asserted that social justice influenced the creation of social health insurance in developed countries. Follesdal (2015) yet thought that distributive justice is not appropriate for developing countries where resources are already limited.

The philosophy of social contract is the foundation for social welfare that represents a contract between the state and society (Rich, 1999). In this sense, a number of scholars accepted that social contract theory is entrenched in public health (Waugh, 1993; Welie, 2012 and Bhugra *et al,* 2015). Agreeing with this argument, Hill (1996) and Paz-Fuchs (2011) held that public healthcare is a form of social contract as it is both a private and a common good. Moreover, it involves the right of individual and the responsibility of the state. By analogy to the Hobbesian theory, Fahnestock (2010) argued that health is a natural right and citizens expect the state to provide healthcare. Thus, a mutual agreement between citizens and the state would enable a good functioning of the system. Further, a number of authors agreed that based on the social contract theory, it is the responsibility of the state to provide health insurance (Hull, 1996; Benabou, 2000; Carrin, 2006; Smith, 2014). In relation to public insurance in Niger, it is interesting to look at the notion of social contract, especially when less than 10% of the population is covered by public insurance (Loutou, 2009; Ministry of health, 2012).

2.4.2 Social justice

Fitzpatrick (2011) made the argument that welfare theory is derived from social justice, which aims at eliminating social problems and inequalities. Spicker (2014) agreed with this approach since the role of social policies is to improve the welfare of society. One strand of literature argued that the theory of welfare is traced back to the 19th century when laissez-faire was challenged by interventionism (Spicker, 1998; Midgley and Tang, 2001). In this sense, the state promotes the wellbeing of both individual and the society. Esping-Andersen (1999) defined social welfare as a system of democratic government offering a guarantee of collective social

care to its citizens, concurrently with the maintenance of a capitalist system of production. Little (1957) criticized this view, as social welfare does not take into consideration the needs of each individual rather the ones of the average in society. Buck (1975) similarly thought society is not the aggregation of individuals but the relationship between individuals who express their own interests. Further, the principle of social welfare concords with the theory of distributive justice that justifies government intervention in removing social inequalities, what then makes society better off (Piachaud, 2008 and Witcher, 2013; Rawls 1970).

Paz-Fuchs (2011) affirmed that the traditional social contract justifies the existence of law and the obligation to conform to it while modern social contract promotes the welfare of society. Thus, institutions are responsible for distributing rights, duties and advantages in an equitable manner. Social justice would then concern aspect of the society such as educations, health and markets. Rawls' significant work, *A theory of justice* (1971) is considered as a pillar of the social justice theory; based on the theory of social contract, social justice promotes a fair society with equal opportunities for all. The Rawlsian social justice involves equity, distribution of primary goods including liberty, opportunity, income and wealth (Rawls, 1971:303 and Charmaz, 2011). One could argue that Rawls' egalitarian stance of society makes a parallel to Rousseau's view of "men are born all equal". In addition, Rawls (1971) viewed society as cooperation between individuals whom the abilities and private ownership are assets for society. He rejected Nozick's theory of self-ownership for two reasons:

3. On the basis that individuals are equal, they must share their private ownership including economic property.
4. Distributive justice would then correct social and economic inequalities.

In that sense, "all values, liberty, opportunity, income and wealth are to be distributed equally to everyone advantage" (Rawls, 1971:64).

Further, Rawls distributive justice was based a1nd justified by three principles.

The principle of justice considers individuals equal with the same civil and political rights. *The principle of social and economic inequalitie*s reveals social disparities caused by differences in jobs or social classes. In this sense, Kangas (2000) also claimed that none would be doomed to the same miserable position for life and everybody should have the possibility to compete on equal terms. Third*, the difference principle* accepts that socioeconomic inequalities could only exist if they benefit the least favored of society. Okun (1975) also considered Rawlsian justice as

fairness and agreed that social equality and economic efficiency correlate. He strongly defended the distribution of resources, which increases consumption and efficiency of the market.

Wegner (1987) on the other hand, claimed that distributive justice is an illusory utopia as social redistribution makes people, who are in average social positions believe that the rewards they get is proportionate to their social position. This idea is nevertheless inadequate as it limits the potential of individuals and reinforces their dependence to social equity. Similarly, Hayek (1984) did not see any moral justification for social justice as it favors equality over individual merit. Sharing a comparable view, Nozick (1974:149) said: "*what each person gets, he gets from others who give to him in exchange for something. In a free society, diverse persons control different resources and new holdings arise out of the voluntary exchanges".* In his libertarian view, a fair society is the one that protects individual merits and property rights.

The veil of ignorance is the concept behind Rawls' distributive justice. It refers to a situation of uncertainty and risks for the lowermost of the society. The government, which is behind the veil, conceals reality by offering security, wealth and freedom to the worst off in society (Roemer, 2002). One can consequently argue that the veil of ignorance prevents populations of knowing their veritable socio-economic positions in society.

Then, Anderson and Lyttkens (1999) believed that health could be perceived as primary good in Rawl's view. In this sense, access to health insurance would be made easy regardless of socio-economic differences. In this sense, numerous scholars asserted that social justice influenced the creation of social health insurance in developed countries (Miller, 1976; Daniels, 2001; Sen, 1992; Korobkin, 1998 and Cookson, 2000).

Follesdal (2014) yet thought that distributive justice is not appropriate for developing countries where resources are already limited. Concerning healthcare, some literature argued that social justice is the foundation of public health when the state secures sufficient health dimensions for everyone (Powers, Faden, et.al, 2006; Day, 2006; Cummiskey, 2008). Further social justice helps combatting social determinants of health inequalities (Marmot, 2005; Gostin, 2006). On this, in Niger, some literature showed that income and informality are social factors determining the access of health insurance (Roukayatou, 2004; Loutou, 2009).

2.5 Conclusion

This chapter presented the philosophical and theoretical review that guided this study. The philosophical background of the theories of capitalism and socialism were discussed in relation to public and private insurance in this study. The traditional debate between capitalism and socialism is ongoing, most neo-classics like Hayek advocated for a minimal state, which would have little power regarding economic affairs. On a gradual scale concerning government intervention, liberals are usually right wing as they promote laissez-faire and individual welfare while Keynes is somewhere in the middle as he claimed that the state is the guardian of the economy and intervenes in bad times like periods of recession. Contrary to the general belief, the Keynesian theory is not in total contradiction with the classical theory as it equally recognizes free market and entrepreneurship.

This chapter equally reviewed the three theories forming the theoretical framework for this study. CSR was reviewed in relation to private insurance, one of the main actors for the development of health insurance in Niger. Next, the review of literature suggested that culture could be a determinant of access to healthcare in developing countries including in Niger. Then the theory of path dependency was reviewed in relation to health policies. In addition to the theoretical framework, the theories of social contract and social justice were reviewed in connection to public insurance. The theory of social contract determines the role of the state, for this study the role of government in Niger in terms of policies and investment is crucial in developing health coverage for all. Rawl's theory of social justice, promotes the full involvement of government in both economic and social affairs. His theory inspired by Marxist philosophy fits perfectly with social liberalism, which involves the fair distribution of wealth in addition to full employment (Bortis, 1997). For this study, the theory of social justice was discussed in relation to the low health coverage for the informal sector. Overall, this chapter explored the relevant theories for this research, while the practical applications on Niger were discussed in chapter 3.

Chapter 3: Health insurance and its developments in Niger

3.1 Introduction

This chapter focused on the systematic literature review of health insurance and its developments in Niger. The chapter reviewed literature in Niger and studies in other countries, and reviewed the concepts of CSR, culture and path dependency in relation to the research's theoretical framework. The first part of this chapter focused on health insurance in Niger and discussed the role of health insurance in meeting the requirements of social justice. Then the prevalence of out of pocket payments in Niger and others developing countries was discussed. Part one of the chapter also reviewed literature on the access of health insurance for the informal sector. The second part of the chapter reviewed literature on different health insurance systems and their differences in developing countries including Niger. Third, the chapter discussed studies on pro-poor health insurance mechanisms in relation to the informal sector in Niger. Part four of the chapter discussed the implications of CSR, culture and path dependency in the development of health insurance in Niger. The role of culture was addressed as a barrier for health coverage, notably because of traditional medicine and education. Further, part four focused on the implications of CSR for private insurance. This part equally discussed the role of path dependency of policies in the development of health coverage, including health insurance financing policies, the impact of policies for the informal sector and the importance of policies reforms for the extension of public and private insurance.

3.2 Health insurance in Niger

3.2.1 Health insurance and social justice

Universal health insurance (UHC) is based on social solidarity and benefits the entire population including the one working outside the formal sector. The aim is to share the risk between individuals and extend the protection of the members (Mills, 1983 and ILO, 2014). Health insurance offers healthcare at affordable prices while improving the health and lives of people (Bovbjerg & Hadley, 2007). Health is a universal right recognized by international laws such as the United Nation Declaration of human right of 1948, which inspired policy makers in implementing healthcare policies (Pillay, 2008; Nunes & Rego, 2011; Rumbold, Baker, et.al, 2017).

Health insurance then, goes beyond the simple offering of health insurance as it equally reflects social justice, which is about offering the same advantages and burdens for all. Public health is not limited as an instrumental activity of solely providing health services but also, a way of insuring the right to health (Beauchamp, 1976). Ruger (2014) equally explained that based on Rawl's theory of social justice, health disparities are normal, however equal distribution of healthcare is required when there is an unequal access to health services. On this, Powers, Farden, et.al (2006) argued that society's obligation to provide universal health coverage relies on the moral respect of individuals, thus social justice is a foundation of public health policy. Social justice within the context of public health ensures a sufficient dimension of health for everyone (Penaranda, 2015).

In Niger, a number of legislative texts stipulated the equal right to healthcare. Based on the article 13 of the constitution of November 2010, healthcare is a universal right; further, the article 146 of the constitution of 25 November 2010 indicates the equal rights of health services and the right for subventions in case of sickness. In Addition, the health development plan of 2011-2015 focused on the development of health mutual insurance (Ministry of social protection, 2011). Despite its effort to offer healthcare to populations, the government faces difficulties in reducing healthcare disparities among different social groups especially between the formal and informal sector (Roukayatou, 2004; Fisher & Lerner, 2013; Ministry of health, 2012). On

healthcare disparities, Sen (1999) argued that there is a serious injustice when the less privileged groups have also to face the most difficulties in accessing healthcare.

Historically, universal coverage and access to healthcare have been challenging in Niger, as 80% of the population does not have health insurance and faces difficulties in accessing good quality healthcare (Loutou, 2009; Ocket, Doudou et.al, 2017). The informal sector about 78% of the total populations does not only represents the majority of the population but equally the sector, with the least health insurance coverage (Ministry of Health, 2012; National Institute of Statistics, 2015). Multitudes of factors including poverty worsen the low health insurance coverage in the country as 62% of the total population lives under the poverty line. This factor affects the ability of populations to pay for health insurance and costly drugs. Moreover, direct payments affect the performance of the overall healthcare system, especially when the cost for healthcare determines the quality of services (USAID, 2017). In addition, the lack of health insurance institutions limits the development of the sector, especially when most institutions are centered in the capital city, Niamey (National Institute of Statistics, 2015). Despite the progress of commercial insurance in the largest cities, private insurance has a low impact as it covers about 3% of the population (Loutou, 2009). Then, the low development of health mutual insurance for both the formal and the informal sector is another explanatory factor for the low coverage of health insurance in the country (Health Ministry, 2012). The improvement of healthcare requires research; a study conducted on health research in Niger revealed that literature and research have to be improved in order to influence the development of healthcare (Doudou, Gagara, Weber, et.al, 2017). The study equally revealed that foreign institutions carried out the majority of research, with 64% of foreign authors against 36% of Nigerien ones.

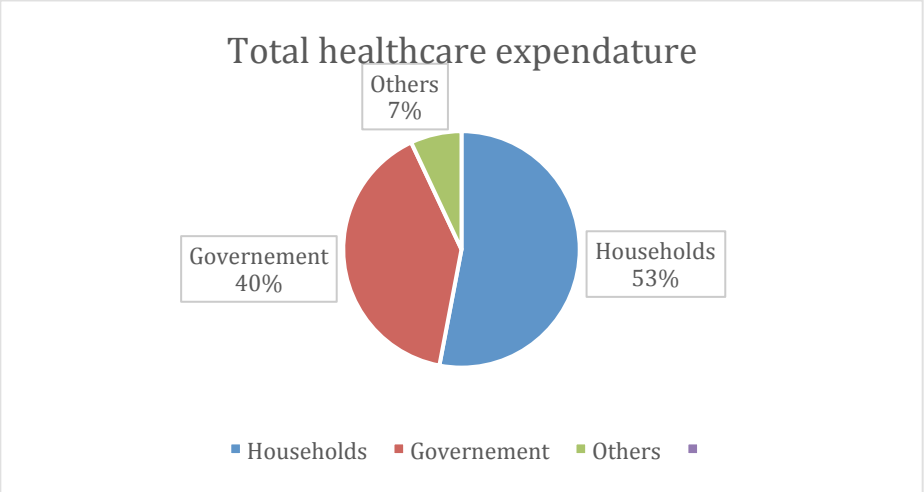
Universal health coverage enables access to healthcare and drugs at affordable prices, while protecting populations from financial risks (Oxfam, 2013). The Nigerien government's initiative implemented in 2005 aimed at offering free healthcare and drugs for pregnant women and children under five years. The program however, since its implementation is limited by funding and technical challenges (Morestin, Belaid et.al, 2010). This initiative despite its limits reflects the principles of universal health coverage and the efforts of the government to offer healthcare for poor populations. Since its implementation, healthcare has increased from 24% in 2003 to

58% in 2012 (Ministry of health, 2017). These numbers reflect an increase in the use of healthcare for women and children; however, the program does not offer a long-term healthcare plan for the majority of the population. Furthermore, only 20% of the total population has health insurance, which reflects the necessity to extend health insurance to the rest of the inhabitants (Loutou, 2009). In this perspective, there is a need to develop health insurance, especially when universal health coverage improves the health of people and the overall economy of the country (OECD, 2016).

3.2.2 Out of pocket payments

Out of pocket payments are direct payments made by individuals to healthcare providers for the use of service. A narrowed definition categorizes out of pocket payments into five main domains including medication, provider fees, contraception, checkup and facilities fees (Xu, Evans et.al, 2006). Unregulated out of pocket payments, which is a characteristic of developing countries, tend to increase the costs of healthcare as prices fluctuate depending in the healthcare. In addition, there is a negative relationship between out of pocket payments and life expectancy when populations lack of financial resources to pay healthcare (WHO, 2012; OECD, 2016). Further, out of pocket payments lead to catastrophic spending, when health expenditures absorb the biggest part of household's revenues in comparison to other basic needs such as food (Mahal et.al, 2011; Oyibo, 2011).

Figure 3. 1 Total health expenditure in Niger in 2012



Source: WHO, 2012

In Niger, households finance about 53% of the total health expenditure, which represents the highest portion of healthcare expenses against 40% for the government and 7% from other sources (WHO, 2012). Out of pocket payment however, contributes to the impoverishment of populations, especially in low-income countries (Gilson, 1997; Letourmy, 2008).Considering the economic situation of Niger, when more than half of the population lives with less than one dollar a day, out of pocket payment seems inappropriate as the main source of healthcare funding (Barry, Ntamatungiro & Lopes,2017). Further, Akazili (2017) stated that the lack of health insurance increases out of pocket payments and catastrophic spending. Inversely, when health insurance is available for the poorer segments of the population, it leads to a decrease out of pocket payments while meeting the costs of healthcare (Xu et. al, 2003). In this sense, health insurance in addition of offering social protection becomes a factor of economic development (Strittmater & Sunde, 2013).

Evidence suggested that the reduction of out of pocket payments depends on healthcare policies and the decisions made by policy makers. The work of Wan Putch and Almualm (2017), insisted on the importance of appropriate health policies in the reduction of out of pocket payments in developing countries. In fact, poor healthcare policy leads to poor public healthcare services that rises out of pocket payment and everyone pays the same amount for healthcare services regardless to income, what leads to catastrophic spending.

A study conducted in Bangladesh suggested that policy makers should consider the determinants for out of pocket payments in order to implement effectively the solutions to build financial protection against health expenditure (Mahmud, Sarker, et.al 2017). In relation to identifying the determinants of out of pocket payments, a report from the ministry of health in 2012 outlined the following factors for Niger:

a) A low government budget allocated to healthcare, lead to a low health insurance coverage. This is due to a limited capacity of the country to mobilize both internal and external funds.
b) Poverty is the second limitation as the average health expenditure by individuals is 26 USD per annum (USAID, 2016). In this sense, low revenues limit the capacity of

individuals to make prepayment for health insurance schemes (Spaan, Tromp, McBain, et.al, 2012).

c) The lack of a strategic plan for the development of universal coverage is another limitation. Most official reports addressing the challenges for attaining UHC lack of proposing suitable solutions. Moreover, there are few regulations and legislations for out of pocket payments (Loutou, 2009; WHO, 2012).

3.2.3 The informal sector and health insurance

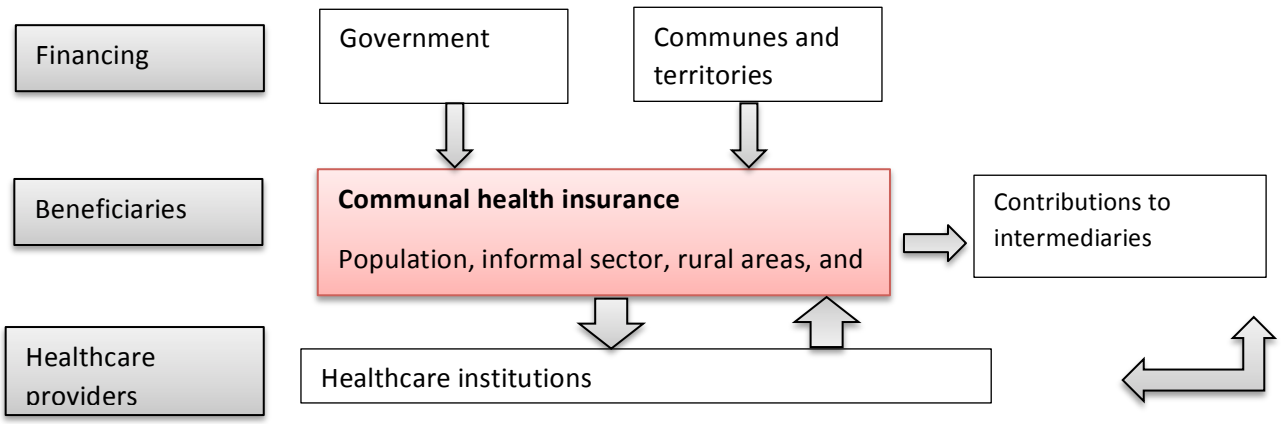
The Informal sector is a characteristic of developing countries and refers to the part of the population working in unregulated sectors. Contrary to the formal economy, there is no tax payments, social security and labour regulations (Palmer, 2004). Bangasser (2000) indicated that the informal sector was not significantly discussed until the 1970's and then raised multitude of questions. A number of studies resulted in a pessimistic approach to the role of informal sector in the economy; Livingstone (1997) however explained that the informal sector is dynamic and crucial for economic growth in sub-Saharan Africa. Todaro (2000) equally noted that the informal sector includes both rural and urban populations and that the growth of this sector is concomitant to economic development. Further, studies have suggested that the informal sector is the larger part of the labour force in developing countries and in most cases unable to have health insurance (Creese & Bennett, 1998; Ginneken, 1993; Gumber, 2002). In addition, it is challenging to find and implement schemes to ensure these populations (Peters, Gary et al, 2008).

In Niger, the informal sector contributed to 60% of the total GDP in 2015 and 75% of the segment lives in urban areas (Ministry of employment and Social Security, 2014; UNDP, 2017). Evidence equally have shown that 2/3 of the population is living in rural areas and the majority works in the informal sector (National institution of Statistics, 2015). Evidence, however indicated few research for the development of health coverage for the informal sector; even though some studies suggested that it is the largest group without health insurance coverage (Roukayatou, 2004; Loutou, 2009). On this issue, the government recently took actions for the development of health coverage. As part of the National Policy of Social Protection of 2011, the

communal health insurance project aimed at offering health insurance to populations in all 266 communes of the country and focused on three main goals:

- Plan a national mechanism for universal health coverage.
- Implement policies and legislations for the creation of universal health coverage.
- Conduct pilot studies in some communes, which will then serve as reference for the implementation of the project in others communes (Him & AGK, 2014).

Figure 3. 2 Plan for communal health insurance system



Source: adapted from Him & AGK, 2014; Ministry of health, 2017

The plan for communal health insurance scheme will focus on offering health insurance for the informal sector, rural areas and students. The government will be the main actor of funding alongside with communities and populations. Based on this plan, the government will gather and monitor the funding. However, since the mechanism implies that internal funding will be the main source, one could ask the involvement of foreign financing, since the national healthcare budget mainly relies on external funding (Ridde, 2008; Sardan, 2011). The mechanism based on prepayments, on one-hand would enable beneficiaries to pay contributions to third parties who will then collect and transfer resources to healthcare providers who provide health services. On the other hand, funds provided by the government, communes and territories would mostly cover the less privileged including students and poor households, mainly through subventions. The government equally intends to gradually create a national funding mechanism including resources from communes, departments and regions. This national funding mechanism would be

a shift from community insurance to a national health insurance system (Ministry of Health, 2017).

The project outlined the mechanism of the future communal health insurance, however lacked of details on funding mechanisms, which is the main challenge, due to limited financial resources in the country (Roukayatou, 2004; Him & AGK, 2014). In addition, most literature on Niger is focusing on limited funds for healthcare and the involvement of foreign aid, rather than investigating opportunities for increasing internal funding (Loutou, 2009; Ousseini, 2011; WHO, 2012, World Bank, 2018;) Further, since the beginning of the communal health insurance project in 2013, few progresses have been made aside of three pilot studies conducted notably in the commune of Falmey. On the other hand, the revision of healthcare policies and financing strategies have been poorly explored as for today (Him & AGK, 2014; Ministry of health, 2017).

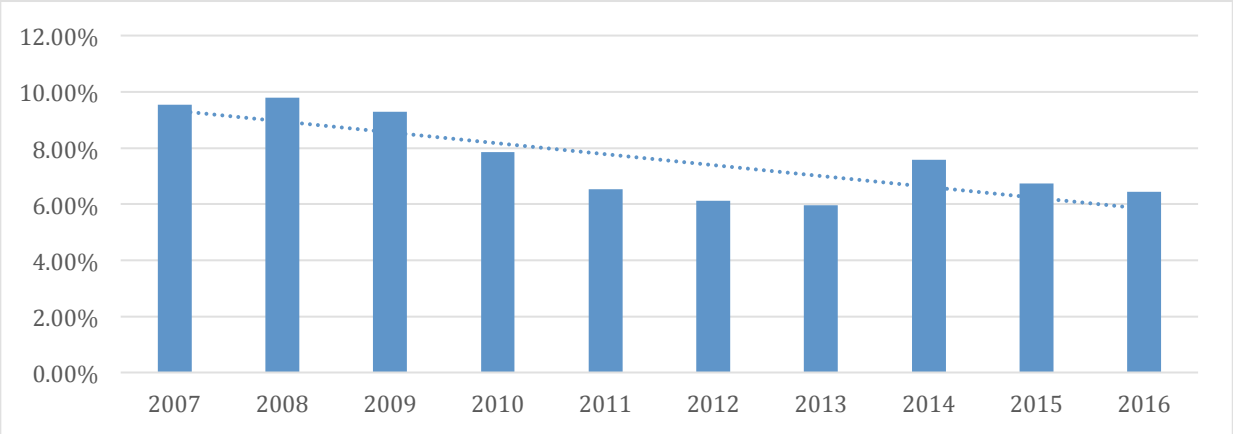
3.2.4 Healthcare financing in Niger

Health financing is "*the system of fund generation or credit, fund expenditures and flow of funds to support health services system. Finances may come from foreign or domestic sources and may be private or public in origin*" (WHO, 2016). It involves the basic function of revenue collection and pooling of resources (Schbier et al, 2006). A country's economic development affects the national health budget. According to Newhouse (1977), individual GDP is an indicator of development as it represents 92% of changes in health expenditures. Horty et al, (1997) on the other hand included institutional characteristics such as population growth rate and technology.
Health financing could be diverse and usually is a mix of different ways (World Bank, 2016). In Niger, health financing is a mix of public and private sectors, and funded through the national budget, local collectivities, households and contributions from profit and non-profit entities (Huber, Hohmann et al, 2003; Boidin, 2009).

a) General revenue is the government budget allocated to healthcare and generated by funds such as taxes and loans (Tanzi and Zee, 2000). As such, the resources of healthcare increase as the economy grows (Hourriez, 1992 and World Bank, 2016). In Niger, however, public insurance only covers workers in the public sector, which is about 12%

(Roukayatou, 2004). Health financing equally suffers from scarce governments' resources and accumulating debts; in 2009 for instance, the economic growth of -1.2% could not sustain the population growth of 3.3% (social security, 2010). Financial resources seem to be the explanatory cause for the lack of coverage in Niger since the government budget is low and the majority of the population makes of pocket payment for healthcare (Sery and Letourmy, 2006; Wagstaff, 2007).

Figure 3. 3 Evolution of government's budget of health (2007-2016)



Source: Adapted from Ministry of health, WHO, 2012

Scare financial resources limit the budget for health similarly to other sectors; for the ten last years, the budget for health never attained the 15% of the declaration of Abuja of 2001 preconized for ECOWAS countries. Moreover, in 2012, on the total investment for healthcare, the government financed 33.11% while financial partners invested 66.89%, which shows the dependence on external aid (WHO, 2012).

b) Community financing or community-based health insurance, on the other hand, offers the opportunity for the lowermost segments of the population to benefit health protection (Mladovsky, 2008; Shimeles, 2010). Local financing allows rural populations to contribute especially when combined with schemes such as microfinance (World Bank, 2016). Community financing could be classified in four groups including community pre-payment or mutual health organizations, community cost sharing, government health

insurance for the community and provider-based health insurance where a city or a specific hospital, for instance, organizes the prepayments (Jakab and Krishnan, 2004).

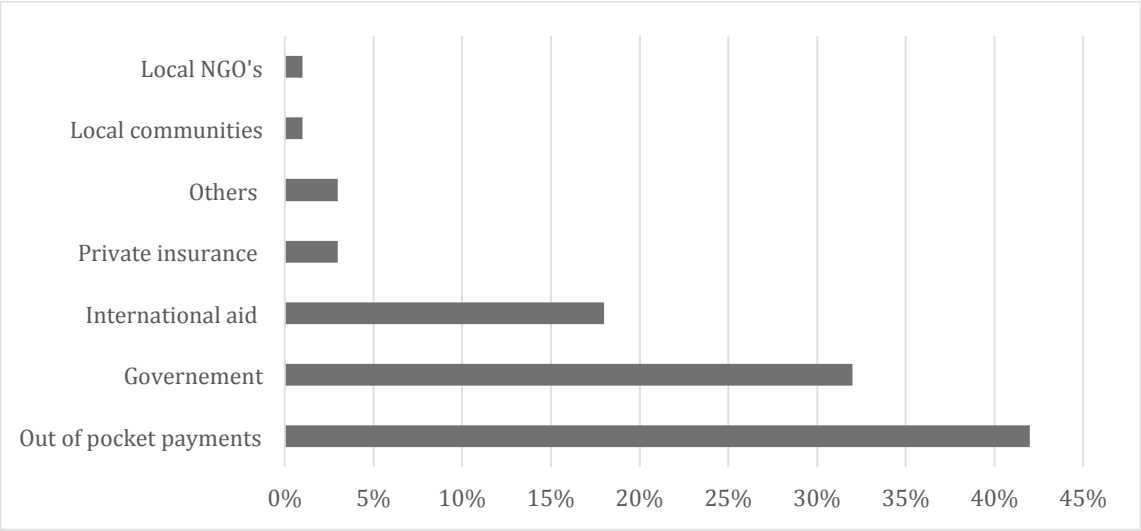
Community based insurance which is not well developed in Niger contributes to less than 2% of the total health expenditure for health insurance (National bureau of statistics, 2012).

c) Private health insurance provides health protection in exchange for premiums. It is usually a competitive sector with a wide range of insurance plans, which are not always affordable for all the social strata in Niger (Cutler, 1998; Parmar, 2012). In addition, high operating costs and adverse selection, automatically excludes poor populations. In Niger, for the last twenty years, commercial insurance covers about 3% of the total population working mostly in the private sector (Loutou, 2009).

d) The majority of people make out of pocket payment, which represents 42.47% of the total health expenditure in 2012 (Loutou, 2009). Out of pocket payments however are a major cause of impoverishment in developing countries (Wagstaff and Doorslaer, 2003).

e) External aid is a significant part of health financing as it represents 33% of the total health expenditure in 2006, (social security, 2010). In the form of donation and loans, external financing is widely criticized by some as it increases the need of assistance (Brautigam & Knack, 2004; Ravishankar et al, 2009). The absorptive capacity measures a country's ability to integrate external aid in its macro economy without major changes in the overall economy and trade balance. In West Africa, including Niger, the failure to meet the solvability leads to corruption and dependency (Schbier, 2006 and Moyo, 2009). Niger has a long tradition of external funding for healthcare, which makes it challenging to end (Elbadawi, 1999; Brautigam & Knack, 2004, Loutou, 2009). On this, a number of literature criticized the short time impact of international aid and the fact that it increases mismanagement, dependency and low taxation (Riddell, 1999; Palmer, 2004; Gupta, Powell & Yang, 2006). In their critical work, Delville and Tiken Alou (2011) argued that external aid in Niger, including funding and technical assistance increases the dependence of the government while reducing its responsibilities.

Figure 3. 4 Healthcare financing in 2012



Source: Ministry of health 2012

This figure illustrates the main sources of funding for healthcare in 2012. Most literature has shown that out of pocket payments from households are the main funding source of healthcare. The low government budget for healthcare and the critical economy of the country are the explaining factors of the high rate of out of pocket payments, which represents more than 40% of the total health expenditure. In addition, the inability of the government to provide health insurance for all lead to alternative mechanisms including traditional medicine, private insurance, health mutual, community based health insurance and direct payments (Kailou, 2005). The contribution of the government in 2012 represented about 32% of the overall expenditure, which shows the need to improve public funding. On this, some literature explained that low taxation is one of the causes of low healthcare budget as the biggest part of the population in the informal (Mullins, 2007; Besley & Persson, 2014). Further, international aid represents a fair share with more than 25% of the funding in 2012; Niger has always benefited of foreign and more recently was part of pilot countries of the declaration of Paris of 2005. The Declaration aimed at reinforcing mutual responsibilities of developed and developing countries, as well as, improving multilateral relations in order to improve results and the governance of recipient countries (OECD,2005).

Then, despite its growth, especially in urban areas, commercial health insurance only covers 3% of the total expenditure, while covering less than 4% of the population (Loutou, 2009; Ministry of health, 2010). The other sources represent about 5 % of the funding mainly include local communities, NGO and professional mutual health insurance (Kailou, 2005, Roukayatou, 2004).

3.3 Studies on health insurance systems

Universal health coverage recently has received substantial attention, especially for people outside the formal employment sector. Various health systems exist across the globe, however could be classified in two main groups, in developed and developing countries (Wagstaff, 2003; Xu, 2003).

Social insurance is a characteristic of Western European health insurance systems where membership is compulsory with a mix of mechanisms including employer-based insurance, private insurance and government coverage for those who cannot pay. In this sense, one could argue that social health insurance in Europe meets the Rawlsian model of social justice. In Western Europe, universal coverage is mainly attained through public insurance and is based on two funding systems (Carrin and James, 2005; Obermann et al, 2006; Wagstaff, 2009):

- Tax-financed systems applied in countries like Canada collect funds essentially through taxations, in this regard, Obermann et .al, (2006) noted that wealthy countries moved to social insurance when they were mostly urbanized, which still one of the limitations of developing countries.

- In a system of social health insurance, funds are raised both from taxes and non-taxes sources. Thus, social insurance involves the membership of the entire population including government.

On the other hand, social insurance in developing countries is solely compulsory for the formal sector. It usually includes obligatory (government insurance and employment-based insurance) and non-obligatory schemes (including health mutual and community based health insurance) (Obermann, Jowet et. al, 2006). Findings from this study suggested that health insurance in Niger

is non-taxed based and only compulsory for the formal sector. Thus, government insurance in Niger falls into the category of social insurance even though it does not cover the entire population (Abel Smith, 1992). While in developed countries, social insurance financially protects populations from health risks, developing countries encounter difficulties in offering financial protection (Carrin, Waelkens et al, 2005; Mahal, 2010). A study conducted in 59 developing countries has shown a relationship between the lack of social insurance and catastrophic spending (Xu, 2003).

Further, Pauly, Zweifel et al, (2006) argued that governments in West Africa struggle to provide universal health insurance while out of pocket payments are the main source for funding healthcare. They also explained that the improvement of health insurance is limited by poverty, low wages, and unemployment. In addition, tax-funded insurance is not efficient since the majority of the population in the informal sector has non-taxed income. Further, Domapielle (2014) explained that despite challenges, African countries are implementing mechanisms to increase the access to healthcare for poor populations through non-profit and for profit private insurance. Many authors equally suggested the potentials of private insurance, which is continually growing and becoming the dominant provider of health insurance in developing countries (Mackintosch, Channon et al, 2016; Sekhri & Savedoff, 2005).

Some literature suggested that CBHI is appropriate for African countries, which already have a culture based on redistribution and mutual aid (Hannoun, 1999; Ekman, 2004; Jutting, 2004; Bennett, 2004; Dong, Mugisha et al, 2004). Studies in Ghana have shown that health insurance system is a mix of district health mutuals, commercial insurance and non-profit insurance (Fenny, Kuse, et al, 2016). The current national health insurance adopted the act of 2003, which promotes the access of health insurance by districts, especially for poor households. However, despite the government's efforts, adverse selection exists since the lowermost have difficulties in contributing for payments (Asante & Aikins, 2008; Kandawire et al, 2015). Concerning social insurance, the study suggested that Ghana is trying to implement social insurance based on a mix of mechanisms. Evidence have suggested that Ghana and Senegal were the countries in West Africa with the most experience in terms of CBHI (Ndiaye, Soors and Criel, 2007).

3.4 Studies on pro poor health insurance mechanisms

In relation to the informal sector in this study, it is interesting to review studies on pro poor health insurance. To overcome the issues of love health coverage, in recent years, most developing countries adopted pro poor mechanisms to attain universal coverage (World Bank, 2018). Moreover, from an equity perspective, pro poor mechanisms play a crucial role in increasing the participation of populations to health coverage. A study in India suggested that these mechanisms are essential in correcting the shortcomings of public and private insurance (Ahuja, 2004). In some cases, governments apply waivers or exemptions to the lowermost populations by offering free healthcare (Burns & Mantel, 2006). In Niger, since 2005, the exemption of fee policy has been offering free healthcare for pregnant woman and children under five (Ministry of health, 2012). Even though the program encountered challenges, it presented foundations of social justice.

Community based insurance

Evidence suggested that community-based health insurance (CBHI) is an alternative for developing countries where the informal sector represents the majority of the population (Carrin, 1999; Sery and Letourmy, 2006). A study in Senegal showed that in average, members would contribute with $1/month to benefit basic health coverage (Ndiaye, 2007). In addition to offering financial protection for the poor, CBHI guides members to the appropriate healthcare providers according to their benefits packages. Some scholars, however, believed that CBHI hardly covers serious and costly conditions. Moreover, in developing countries infrastructures are usually unfit to meet the demand (Jutting, 2004). Souares et al, (2012) explained that besides financial resources, voluntary membership is an explanatory element of adverse selection in CBHI. In fact, when CBHI is obligatory, populations are motivated to enroll despite financial difficulties. Mladovsky (2014) also discussed another perspective of the lower adhesion for CBHI. A study conducted in Senegal revealed that the lack of trustworthiness, financial fraud and dissatisfaction for the quality of services are reasons for drop out. A study in Burkina Faso by Dong et al, (2009) equally confirmed this argument since 30 to 45% of unsatisfied members drop out from CBHI.

A number of studies, which promote the benefits of CBHI, contradicted these arguments; Jutting (2003) in Senegal; Shimless (2010) in Rwanda. Studies in Rwanda have shown the exceptional rise of health coverage to up to 90% since the implementation of CBHI into the national health system (Nicholson, Yates, et.al, 2015). Integrating CBHI into the national health system enabled a better allocation of resources and access to services and drugs (Schneider & Diop, 2001). In addition, some literature suggested that CBHI is appropriate for African countries, which already have a culture based on redistribution and mutual aid (Hannoun, 1999; Ekman, 2004; Jutting, 2004; Bennett, 2004; Dong, Mugisha et al, 2004) .

In West Africa, CBHI usually makes contracts with healthcare providers to ensure that members receive the appropriate services (Criel & Waelkens, 2005). Based on their work in Guinea and Burkina Faso, Robyn, Sauerborn et al, (2012) also argued that insurance providers should work closely with healthcare providers for better results. In terms of membership, studies in Guinea, Mali and Senegal suggested that adverse selection exists within CBHI when the lowermost have difficulties in contributing, however, this trend could be reversed with monthly payments (Chankova & Diop, 2008).

Micro-insurance

Health microinsurance is the protection of low-income people against specific perils in exchange for regular payments to the like hood of the risk involved (Churchill, 2006). Over 40 million people worldwide use health microinsurance (HMI), notably in India.

Several studies have shown the positive impacts of HMI on financially vulnerable households as it reduces out of pocket payments and protects the poor populations against financial risks (Jutting, 2009 and Werner, 2009; Meghan, 2010; Habib, Perveen ,et.al, 2016). Like CBHI, microinsurance is tailored for low-income populations with affordable premiums and packages. Many times, microinsurance is combined with other financial products such as microcredit and other types of loans what minimizes the costs and maximize benefits. In addition, Noble (2006) insisted on the importance of research in identifying populations' needs, opportunities, and limits for the implementation of insurance packages.

3.5 The relevance of culture, CSR and path dependency for health insurance in Niger

This section, in relation to the theoretical framework of this study focused on the concepts of CSR, path dependency and culture, which appeared as determining factors for health insurance in Niger.

3.5.1 Culture

Traditional medicine

Culture is concerned with shared values, norms that shape the attitudes and behaviours of individuals within a society (Bonner, 2009; Eliot, 2010). The past decades, literature has been exploring culture as one of the foremost factors influencing the access to healthcare. Culture is crucial in understanding perceptions and lifestyles about health; a number of studies discussed the influence of customary beliefs on the attitudes towards healthcare and the use of traditional medicine (Levesque, 2014; Sarfo, 2015). In a study in Tanzania, Swat et.al, (2009) argued that cultural determinants have an impact on health behavior, especially when the population relies on traditional medicine. In addition, they explained the utilitarian role of understanding culture in reducing health problems, health illiteracy.

Some studies discussed the culture-centered approach in the improvement of healthcare. A study indicated that traditional medicine is anchored in sociocultural believes in West Africa including Niger (Sofowora, 2010). Traditional medicine is defined as "the total sum of knowledge, skills and practices based on theories, beliefs and experiences of indigenous societies. It participates in the maintenance of health, diagnosis and treatment of physical and mental illness (WHO, 2014). The role of traditional medicine in primary healthcare is evident in African countries before and after independence (WHO, 2002, Romero-Daza, 2002, Falodun, 2010). In 2012, 24 countries including Niger implemented National Programs for traditional medicine, to enhance de collaboration between traditional and modern medicine. In Niger, traditional medicine is composed essentially of medicinal plants and the service of traditional healers; it is equally widely used as at least 60% of the population use it as primary health solution (WHO, 2007). A

study conducted by Hama, Ibrahim, et.al (2012) in the regions of Torodi and Tamou in Niger revealed that medicinal plant are mainly used as traditional medicine. Further, medico-ethnical studies in Niger have shown the relevance of habits and ancestral customs in the use of traditional medicine, which is preferred by populations especially in rural areas (Wezel, 2002; Manzo, Moussa, Ikhiri, 2016). However, the use of traditional medicine prevents populations to access modern healthcare, which is accessible through health insurance (Souna, Djibo, et.al, 2009).

Although the Nigerien government recognizes traditional medicine, there is no national budget allocated to it. Moreover, traditional medicine is not efficiently organized and scientifically validated (Gyasi, Mensah et al, 2011). If some literature argued that traditional medicine has always been part of the African culture some authors however considered that the lack of adequate healthcare systems explain the use of traditional medicine (Sissoko, 2006; Okigbo and Mmeka, 2006; Mooketsane and Phirinyane 2015). Nyika (2009) also agreed that traditional medicine is popular because it is affordable and more accessible than modern medicine.

Knowledge

Knowledge is equally an influencing factor regarding the low coverage of health insurance. The knowledge gap of the utility of health insurance is derived essentially from a limited awareness about health insurance. First, the high illiteracy rate, about 60% in Niger limits the population about knowing the advantages of healthcare and health insurance (Yontcheva and Masud, 2005). In their study, Cohen and Sebstaed (2006) argued that the limited exposure and understanding of health insurance should be reduced through education and awareness creation. Another study conducted in Kenya also suggested awareness about health insurance; especially in rural areas, which is a first step towards universal health coverage (Mathauer, Schmidt and Wenyaa, 2008). Further studies have shown the relationship between the level of education and access to health insurance. Thus, knowledge about healthcare increases the willingness to join health insurance (O'Donnell, 2007; Nutbeam, 2008; Cesur, Dursun, et.al, 2014). Similarly, a study in Ghana showed that poor health was related to low literacy and lack of health insurance (Duku, 2018). Moreover, the study revealed that 1/3 of people covered by health insurance did not have

sufficient health literacy. This suggests that health literacy is crucial for both insured and uninsured people for the efficient use of health insurance.

Further, Zimmerman and Woolf (2015) stated that education does not only determine the ability of individuals to understand healthcare; the level of education in addition reflects the social groups of individuals. One could understand that social group determines the level of education and the understanding of healthcare. A study in Senegal confirmed this correlation, as households with minimum level of literacy are less interested in joining health insurance (Jutting, 2001). Evidence have shown the importance of improving education and social mobility in Niger, in order to improve healthcare. Educating populations in this sense, in addition to literacy would influence change of health behaviors, especially in rural areas (World Bank, 2004; UNESCO, 2008). Then, a number of studies and literature indicated that populations are reluctant to join health insurance because they are not ready to pay a service they might not use in the future. In her work, Loutou (2009) equally explained that populations in Niger are reluctant in joining community insurance as they lack understanding the purpose of health insurance. Moreover, a lack of trust in health insurance providers refrain them from contributing.

Culture and good governance

Culture in addition to explaining the role of traditional medicine and awareness about health insurance, equally determines the efficiency of public health management. Lewis (2006) explained that in healthcare, good governance implies the effective and efficient function of the healthcare system, which includes the accountability of the public sector to justify the use of public funds in the development of the health sector. Culture determines good governance; studies have shown that countries with more corruption and financial mismanagement are less able to provide good public healthcare (Gupta, Davoodi, et.al, 2000; Kaufmann, Kraay, et.al, 2007). A study conducted by Transparency International in 2017, showed a lack of national budget transparency in Niger as the country scored 17/100. Moreover, the report indicated weak supervisory and law enforcement mechanisms for the evaluation of the national budget. In Niger, the use of public assets and the sale of government property for private gain and is a common

practice. In their study conducted on Niger, Blundy and Olivier de Sardan (2007) stated that the cycle is endless, as corruption exist even in the anti-corruption institutions.

3.5.2 Private insurance and corporate social responsibility

The notion of adverse selection is essential when it comes to health insurance. Adverse selection results from information asymmetry between insurance companies and insured people, and involves a strategic behavior from the most informed party. On the one hand, insurers set premiums based on sickness risk; and on the other hand, insured people are aware of sickness conditions unknown to the insurance company (Cutler and Zeckhauser, 1998). Usually, private companies select clients on their health risk and the ability to pay premiums (Pauly, 1976; Cohen & Siegelman, 2010). In developing countries, adverse selection occurs mostly through cost barrier, as poor segments are less likely to afford the payment of premiums (Pauly, 1978). The existence of adverse selection contradicts the notion of corporate social responsibility, when private insurance select clients based on the interests of the company. Some literature indicated that private health insurance hardly applies CSR activities and fails to consider the external decision of their activities; furthermore, most of the time it does not voluntarily provide services to the public (Wolf & Toebes, 2016).

Most literature suggested that in African countries including Niger, private for profit health insurance neglects the social aspect of health protection as it largely covers the upper-income populations (Sekhri, Savedoff, et.al, 2005; Drechler & Jutting, 2007; Pauly, Zweifel, et.al, 2010;). In his work, Jutting (2007) equally claimed that commercial health insurance underrates human rights, equity and redistribution. Similarly, in their work, Meng, Yuan, et.al (2010) argued that commercial insurance often does not cover the vulnerable groups. In this sense, the authors characterized vulnerable groups as those with low income, chronic diseases and rural populations. Similarly, literature on Niger indicated that the informal sector and rural areas are the segments of the population with the lowest rate of health coverage. In their work, Wadge, Sripathy, et.al (2017) confirmed this trend of exclusion of some segments when they affirmed that the health insurance system is fragmented in many developing countries. Evidence have shown that the health insurance system in Niger was mainly divided between the formal and

informal sector, with various sources of funding including out of pocket payments (Loutou, 2009). Further, some studies suggested that private insurance in Niger applies adverse selection, since premiums are unaffordable for the majority of the population (Roukayatou, 2004). Likewise, a study conducted in South Africa equally demonstrated that cost barrier is a systematic selection factor for private insurance (Barber, Kumar, et.al, 2018).Traditionally, private insurance in Niger does not include mechanisms for the informal sector even when individuals could afford to pay premiums. Moreover, the informal sector is unable to join commercial insurance in Niger, as it is mainly employment based and group based, where individuals are subscribed by groups based on their organisations (Loutou, 2009). In fact, unlike developed countries, private insurance in developing countries tends to be group insurance or employment based and automatically excludes the informal sector (Pauly, 2008). Despite its development over years, private insurance in Niger remained costly and extremely selective. In a report, the WHO (2005) indicated the low prevalence of commercial insurance, which covers about only 3% of the population over the two last decades.

Concerning the lack of CSR in private insurance, literature suggested solution to overcome the low contribution of commercial insurance in universal coverage. Some studies indicated the role of strategic philanthropy in giving back to the community. Strategic philanthropy has been well documented as the way of addressing both community's' needs and promoting business (Michael, Porter et.al, 2002; Yankee, 1996 and Shukla, 2013). Jagpal and Laskowski (2013) stated that strategic philanthropy could be an application of social justice. In this sense, while applying strategic philanthropy, a business uses specific goals and resources and collaborates with charities and communities to help certain groups of the population. Businesses including commercial health insurance would be better off applying strategic philanthropy to meet the expectations of all stakeholders (Walt and Buse,2000; Reich,2002).

Morgan, Ensor and Waters (2016) focused on the role of the private sector of healthcare in developing countries and its implication for universal health coverage. They held that improving the private sector should require a change of the sector as a whole, rather than individual providers. In this sense, one could argue that the government in Niger should create the right environment and policies for private insurance to apply corporate social responsibility. Moreover, the authors argued that private insurance usually reflects the performance of public

insurance and public policies. One could argue the performance of public health policies in Niger as private insurance does not have CSR activities and covers only about 3% of the population (Loutou, 2009). A study in South Africa suggested the extension of commercial insurance as an application of corporate social responsibility. Van den Heever (2012) explained that the development of private insurance could be optimized through effective policy framework, which will meet both the expectations of private and public insurance.

3.5.3 Health insurance policies and path dependency

This part discussed the involvement of health insurance reforms and the path dependency of policies in the extension of public and private insurance. The section moreover discussed policies reforms for extending health insurance to the informal sector.

Healthcare policies and the financing of health insurance

The role of the government in health system is crucial for many decades as it is involved in the organization, financing and delivery of healthcare. The large share of government financing does not only justify its power in healthcare; Geoffard (1994) noted that state intervention is necessary since the public sector is the only impartial entity that can supervise the quality of services and infrastructures. He summarized the role of the government in four points:

a) It is the institution that has the power and legitimacy to regulate the market and resources. Musgrove (1996) also justified the intervention of the state in healthcare mainly to correct the failures of the market and inequalities to access health services. b) It equally mandates laws and regulations for the private sector c) and, in some cases finances the health system with public funds and d) provides services indirectly or directly through national health services.

Others have a more balanced position concerning public intervention in healthcare. Desavigny and Adam (2009) thought that the health system requires both micro and macro perspectives. Their theory of "forest thinking" represents the entire health system as an organization with the involvement of both public and private entities. The "tree by tree" thinking reflects how each of them contributes to the system. In this sense, the government would, for instance, make regulations while communities would manage resources and technology. Van der Gaag (1995)

on the other hand, believed it is not about public or private sector, rather, about which functions fit best each of them.

Healthcare policy influences health insurance policies and their implementations. Kutzin (2013) explained that health insurance policies should promote universal health coverage protection against financial risks and an equitable distribution of the burden. In Niger, current policies seem to fail to insure equitable schemes for the entire population, as nearly 80% of the population is uninsured (Loutou, 2009). Further, Kutzin (2013) stated that to attain universal coverage, health-financing policy should be aligned to the reform of health systems, and the good management of resources. Then, health financing for universal coverage reflects how financial resources and polices influence universal coverage. Evidence suggested a path dependency of health insurance financing in Niger over decades including government funding, external aid and out of pocket payments (Roukayatou,2004; Loutou,2009; Health ministry,2012). Moreover, financial limitations and small pools for both public and private insurance limit the development of health insurance (Him & AGK, 2014). Laterveer, Niessen, et.al, (2003) discussed the importance of pro-poor health policies for developing countries. Similarly, the WHO (2009) suggested a change of health insurance policies in Niger. According to the report, health financing should be tailored to the history, and tradition of the country. Moreover, additional funds and mechanisms should be available, with the reduction of out of pocket payments.

Health insurance policies and the informal sector

Evidence have shown the marginalization of the poor in the access to health insurance. Frye (2005) discussed the importance of extending social insurance to the informal sector in developing countries. In addition, the author believed that health coverage reforms should be adapted to political will and the economy of a country in order to avoid the inverse effect of rise of costs that would be detrimental for the uninsured. Similarly, Carrin & James (2005) discussed the importance of enhancing revenue collection and pooling in order to extend health coverage to specific groups. In Niger, some literature suggested that the development of community-based insurance was the main mechanism to extending coverage to the informal sector; however the majority of the community insurance schemes are not sustainable (Kailou, 2003; Loutou, 2009; WHO, 2012). Some studies held that extending coverage to the informal sector is key to attaining universal coverage in developing countries. In this sense, Mc Intyre & Abiiro (2014)

thought that policy makers need to better explain health insurance policies to stakeholders for efficient implementations of reforms. Further, in a study in Nigeria, Adewole, Akanbi, et.al (2017) discussed the inclusion of stakeholders including the informal sector in health insurance reforms for a better implementations of reforms. Moreover, the authors believed that policies should consider the populations knowledge about health insurance.

Health insurance policies and extension of health insurance

Recently, literature has been focusing on health policies reforms and the extension of public and private insurance in developing countries (Han, 2012; Strasser, 2016). Reforms and new policies are the first step in the extension of health insurance; evidence however have shown the difficulty to make and implement new health insurance policies (Mc Intyre & Abiiro, 2014). The path dependency of health insurance policies appear to be a barrier for universal coverage, especially when they exclude some groups (Mc Intyre & Abiiro, 2014; Strupat & Klohn, 2018). To overcome this path dependency, Savedoff (2012) suggested that reforms should be adjusted to political action, economic and societal conditions.

Sekhri and Savedoff (2005) discussed the implications of policies for private health insurance and noted that when well regulated, private insurance markets share some features with public insurance, as they would aim to cover a bigger pool. Thus, the right regulations and taxation could encourage private insurance to extend its markets. In Niger, literature suggested that private insurance is not extending its market to poorer segments as it essentially covers the formal sector and their families (Loutou, 2009).

Further, some studies focused on the role of policies in extending public insurance to other segments of the population. A study conducted in Rwanda has shown the efficiency of political decisions in reforming the health insurance system. According to Chemouni (2018), Rwanda is the country with the highest insurance enrollment in Sub-Saharan Africa. This is mainly due to the political engagement and policies that make community based insurance compulsory. The extension of public insurance appears to be a way of attaining universal coverage. In addition, a study in Ghana have shown how the implementation of health insurance reforms and the extension of public insurance to the informal sector has led to an increase of demand for services, as well as the number of insurance providers. Moreover, these reforms reduced out of pocket payments from 42% to 34% in 2009. In Niger the reform of health insurance, policies

have been relatively slow during the last decade. A report from the WHO in 2011 suggested ongoing reforms to develop community based insurance in the country and the implementation of ten community based insurance since 2003.

3.6 Summary

This chapter extensively reviewed the system of health insurance in Niger including the financing of the sector and the prevalence of out of pocket payment, especially for the informal sector. The chapter equally explored the influence of culture, CSR and path dependency of health insurance policies in attaining universal coverage in Niger. The literature review revealed some challenges to reform the system of health insurance in developing countries including Niger. Moreover, it has been found that other factors in addition to financial resources limit the development of health coverage. The review has shown certain gaps in concern to Niger. Literature showed little evidence on the influence of CSR, culture and path dependency and their implications for Niger. Current literature mainly focused on financial limitations and out of pocket payments. Furthermore, few studies on Niger addressed solutions for the development of the informal sector. This literature review on the other hand, revealed a lack of substantial evidence on policies and reforms on health insurance in Niger.

This research would contribute to general literature by highlighting the role of CSR, culture and path dependency in the development of health insurance in Niger. In addition to financial resources, these three concepts appeared to be limitations for universal coverage. Concerning culture, populations in Niger seem to have limited awareness and knowledge about health insurance; however, it is crucial to include communities in the development and implementation of health coverage (Yontcheva & Masud, 2005; Loutou, 2009). Then, private for-profit insurance in Niger appeared to focus on the interests of shareholders rather than those of the communities, since corporate social responsibility is quasi-inexistent (Jutting, 2007). Then, the review of the system of health insurance showed that for years, health insurance policies in Niger focused on the formal sector from both the public and the private sector. The path dependency of policies excluded the informal sector and poorer segments from health coverage. This literature review

focused on the extension of health coverage for the informal sector including community-based insurance, private and public insurance.

Part 2: Methodology

Chapter 4: Research Methodology

4.1 Introduction

This chapter discussed the methodology, which is often defined as the overall research process including theoretical framework, data collection and analysis phases (Hussey &Hussey, 1997, Kothari, 2004). First, the chapter presented the philosophical underpinnings of the study including ontology, epistemology, and the choice of critical theory as paradigm of inquiry for this research. Next, the chapter described philosophical methodologies within qualitative research and the reasons ethnography was chosen for the study against other methodologies. The chapter equally presented the methodology of this study including the source of data, sampling, ethical considerations, methods of data collection and analysis. The last section presented how the researcher applied rigour and addressed the research limitations.

4.2 Qualitative research, philosophical perspectives and the implications of critical theory in this research

This section discussed the relationship between the research process and the choice of critical theory as paradigm of inquiry for this research (Crotty, 1998).

Qualitative research involves a rich description of experiences and meanings. A number of scholars thought it finds roots in interpretative approaches such as anthropology and sociology (Mead, 1935; Willis, 2009). Many also accepted that it requires an inductive approach that immerses the researcher in natural settings (Glertz, 1973; Hammersley and Atkinson, 1995). In this regard, Lincoln (2000:3) said: "*qualitative researchers study things in their natural settings, attempting to make sense of, or interpret phenomena in terms of the meanings people bring to them"*. This exploration of human experiences happens with language, the interaction with a particular social group and the interpretation of meanings (Fossey et al, 2002). Even though qualitative research is criticized in terms of validity, many authors believed it is the appropriate approach to explore a sensitive topic especially when methods of rigour are applied throughout the entire process (LeCompte and Goertz, 1982; Lincoln and Guba, 1985; Miller, 1986 and Griffin, 1985).

4.2.1 Paradigms of inquiry, ontology, and epistemology

Research is the processes through which people discover or confirm a reality; it is the systematic effort to gain new knowledge (Redman and Mory, 1923; Crotty, 1998).

Knowledge incorporates our stock of explanations and understandings of truth and reality, (Howell 2013). Popper (1902-1994) assumed that objective knowledge is based on certainty whereas subjective knowledge on beliefs and senses.

Further, Kuhn (1962) defined a paradigm of inquiry as the cluster of substantive concepts, variables, and problems attached with corresponding methodological approaches and tools. In other words, paradigms determine the ontology, epistemology, methodology and methods. Terre Blanche and Durrheim (1999) also argued that research paradigm relates theory and practice alongside those three dimensions.

Ontology is about the nature of reality and how to know about the world. As human beings, we give the world meaning based on our perception, personality, and background. Realistic or naïve ontology sees the world independently from human beliefs. Reality is observed and understood through the observation of events and experiments. In opposition, critical realism is mind-constructed and built on the interpretation of facts (Howell, 2013). In a systematic view, reality is constructed through time; the political history of a country, for instance, is made through variables processes and changes over time.

Aristotle (384-322 BC) viewed ontology as the science of being a being, thus human experience is built on the perpetual interaction with the world.

He stated that:

All men by nature desire to know [...], all the senses make us know and bring to light many differences between things. No one is able to attain the truth adequately, while on the other hand, no one fails entirely (Book 1 (A), 980a: 25; Book 2, 993 b: 1).

Men are born with the ability to acquire knowledge and they have the capacity to make sense of the world they study. An object has a meaning only when we understand it and know the "why" of it (Lear, 1998). Descartes (1596-1650) was convinced about the existence of humans as mental entities and was particularly interested in understanding what a person knows. The

interaction between the mind and the world and the daily experiences define our knowledge of the world or ontology (Smith 2004).

Furthermore, Husserl (Hua VI, 2) stated:

Each of us has life world meant as the world for all. Each has it with the sense of a polar unity of subjectivity relatively meant worlds, which, in the course of correction, are transformed into mere appearances of the world, life world for all.

In other words, human beings as mental entities have their own perception of the world based on personal interaction with it. We all live in the same world, yet our perceptions of reality differ. Husserl (1859-1938) viewed phenomenology as the science of consciousness since it gives importance to subjectivity. In this sense, we leave a world of scientific objectivity for perceptual objectivity.Husserlian phenomenology is centred on transcendental reduction, which is the process of reducing the information we get from observing the world into self-reflected information. Transcendental reduction leads us from a naïve attitude of observing object to studying them (Follesdal 2006).

4.2.2 Empiricism and rationalism

Empiricism is an ontological position that assumes that social phenomenon and their meanings have an existence that is independent to social actors (Bryman, 2008:19). Knowledge is learned through experience since humans are not born with innate knowledge. Locke (1632-1704) believed that knowledge could not derived from experience since one experience is not sufficient for generalization. Moreover, human knowledge is considered to be weak and limited (Howell, 2013:36). Objective knowledge, on the other hand, is based on immutable laws and experiments, what offers more accuracy and replicability.

Descartes (1596-1650), however held that we could understand the external world with our innate knowledge. The combination of the latter with experience always generates new knowledge. Rationalism is about the use of human reason, and people's different points of view, which then develop the truth (Easterby *et al,* 2012). Bacon (1620:244) also accepted that "empirical induction has been grossly overestimated by philosophers who have concentrated on the pre-theoretical stage" instead of interpretation of facts. Rationalism was not used for this study as the researcher focused on human experience rather than innate knowledge.

4.2.3 Critical realism

Critical realism is an ontological position socially constructed through falsification. “We cannot have a general criterion of truth” (Popper, 1992:143); thus reality could not be objective. In opposition to positivism, there is no a unique truth and any possibility can represent reality. In that sense, Cook and Campbell (1979) thought that ontology is based on interpretation. Moreover, the relationship between the subject and object captures phenomena that positivism could not identify (Easton, 2010). Instead of “testing hypothesis, post-positivistic research generates hypothesis through inductive reasoning” and the rigour is measured through trustworthiness (Gregor and Murnane, 2010:422). One could argue that critical realism represents a shift from positivism to interpretivism mainly for two reasons: a) It creates a breakdown with scientific knowledge through falsification and b) the rejection of immutable laws. Critical realism was used as ontological position for this research as the researcher used an inductive approach with the subject of research, especially during the interviews. Further, critical realism is appropriate as the study focused on the evolution of health insurance and determining factors affecting its development.

4.2.4 Epistemology and paradigms of inquiry

Epistemology is the process of knowledge acquisition and the relationship between the researcher and the researched. Ritchie *et al,* (2013) noted that the search of knowledge could be inductive when the observation of the world provides theories. The deductive logic, however, uses existing theories to understand the world. Abductive epistemology, on the other hand, involves a closer interaction between the subject and the object.

Epistemology involves truth and reality, two concepts that are quite challenging to define. Reality is the presentation of an object the way it is supposed to be and truth is about the subject and what we know about it (Montero, 2002: Horwich, 2009). In this instance, Kant (1781) made the distinction between the object seen with subjective reality and the one seen in objective reality. He used the term *Noumena* to refer to reality, totally separated from the mind in opposition to the phenomenological world.

Hussey & Hussey (1997) stated that epistemology is the process by which investigators increase knowledge through the use of reason and experience. Epistemology considers what types of things there are in the world and what parts the world can be divided into (Mc Queen &Mc Queen, 2010:151). In this sense, there are two main epistemological positions that explain the world. Positivist positions are characterized by objective ontology and positivist epistemology. While interpretive paradigms accept that, the world is changing and could be challenged with new theories as they involve constructivist ontology and interpretive epistemology (Scales, 2013). For this research, interpretivist epistemology is transactional and value mediated as the researcher had an inductive approach and interaction with the subject of research.

Table 4. 1 Main differences between positivism and interpretivism

Characteristics	Positivism	Interpretivism
Nature of reality	One single truth that can be discovered	There is no one single truth, reality is made of multitude of truths
Nature of knowledge	Deductive knowledge and distance with the object	Aim to understand new realities through inductive approach and relation with the subject
Research methodology	The research process is based on hypothesis and pre-existing theories	Rich data is gathered, analyzed and interpreted
Research techniques	Scientific and measurable methods	Qualitative methods
Sample and generalization	Usually large sample. Replicability of experiments and generalization	Small sample chosen for specific situations. Validity, transferability, and trustworthiness of research

Source: Adapted from Easterby-Smith *et al,* (2012); Howell (2013)

4.2.5 Phenomenologist paradigms

Interpretive paradigms "originated from the Chicago school in the 1920's and refocused social science on the ways in which meanings are constructed and managed by individuals" (Broom and Willis, 2007: 24).

Phenomenologist paradigms understand the meaning of human experiences and actions. Bryman (2001) noted that phenomenological research does not involve a consensus of which methodology and methods are used since the essence of post-positivist approaches is to challenge existing meaning.

Participatory paradigm "involves a co-created reality through the interaction between both the object and subject", (Howell, 2013). The researcher embraces the reality and becomes a subject among other subjects. Merleau-Ponty (1964:317) believed that participatory paradigm "is the way the outside world has invaded us and how we are meeting this invasion". Heron (1996:317) also shared a similar view since "worlds and people are what we meet, but the meeting is shaped by our own terms of reference". The researcher is engaged in both research process and interpretation what makes his involvement more significant compared to critical theory and constructivism. Heron and Reason (1997) believed that participatory paradigm is likely to be used by individuals who desire to make changes in society.

Next, constructivism "understands reality as being locally constructed and based on shared experiences". Because of that, "humanity alone is responsible for knowledge development" (Howell, 2013:90). Reality is subjective and constructed by individuals, depending on their values, experience and culture. Moshman (1982) identified three types of constructivism a) exogenous constructivism represents an external reality where knowledge is acquired from outside b) endogenous constructivism involves personal knowledge and perception of reality and c) dialectical constructivism is a two - ways process that involves social and individual interactions, where reality is mutually built (Rogoff, 1990). In terms of methodology, reality is discovered through the interpretation of the world. Like critical theory, constructivism is the analysis of reality; however, history and culture are not essential elements (Howell, 2013).

Then, critical theory is believed to be founded in the 1920's by the Frankfurt School. The most popular amongst them are Max Horkheimer (1895-1973) and Herbert Marcuse (1898-1979). Horkheimer criticized the classical theories of Kant and Hegel. In his essay "Traditional and critical theory" he did a systematic comparison between the positivist theory and critical theory.
He affirmed:

Today the knowledge of movements and tendencies affecting society as a whole is immensely important for materialist, but in the eighteen century, the need for knowledge was overshadowed by questions of epistemology and natural science (Horkheimer, 1972: 20). In this statement he explained that the traditional position was embedded in justification and objectivity rather than exploring new knowledge in a more flexible manner; critical thinking, however, appreciates the interconnections in society alongside the transformations that happen with time.

Critical theory aims to analyze and emancipate society (Wilmot, 1997). There is a "pursuit of liberation from external constraints and compulsions" (Howell, 2013: 82). Critical thinking allows the development of new thoughts. In fact, "enslaved" societies under totalitarian regimes will be born again. In opposition to the traditional theory, there is not a unique knowledge; rather it is embedded in history and social events. In this sense, Habermas (1978) also thought that truth is discovered through questioning and the challenging the existing theories. In his view, critical theory is characterized by a) the challenge of existing theories b) involving social actions especially the critique of sensitive areas such as politics and c) is influenced by historical, cultural and political changes.

Reality is based on the researcher understanding and interpretation of society, historical processes and culture. Ontology is defined as critical realism; reality evolves over time in accordance with changes in society. Then, there is a relationship between the object and the subject who has an inductive approach through the research. Finally, methodology is directed at interrogating values and assumptions, expositing injustice, challenging social structures and engaging in social action (Crotty, 1998:157).

4.2.6 The implications of critical theory for this research

Many believe critical theory started with the dialectical reasoning of Karl Marx (1818-1883). Marx assumed that capitalism resulted in a different kind of crisis including the division of labour, social classes and alienation; and the accumulation of crisis can only be resolved through political struggle (Fuchs, 2015). Dialectical analysis identifies those contradictions and aims at resolving them and its role in critical theory is essential. This research aims to understand the reasons behind the low health insurance coverage for the informal sector in Niger.

The ontology of Marx is based on materialism since class struggle aims to abolish social classes and critical theory based on material changes that will benefit all (Marcuse, 1937). In this sense, it is interesting to identify the reasons explaining the lack of health insurance for rural populations in Niger. Further, Hegel (1770-1831) also thought that society evolves through the antagonism of self-interest and common interest; this represents an interesting element for the study since private insurance only covers segments of the population, which increase their profit.

Critical theory challenges actual situations and in certain cases political institutions. A research that involves critical theory mediates power relations that are socially and historically constructed (Kincheloe and McLaren, 2009:453). Critical theory is appropriate for this research, as we are looking at social changes and the influence of governmental decision on health coverage. The research focuses on health insurance for both public and private and how it has evolved those last years. Moreover, the study focuses on a specific country, Niger and seeks to understand how values and culture especially traditional medicine plays a role in the development of health insurance (Howell, 2013). In addition, critical theory involves an inductive approach to the study for two reasons: a) the study of the health insurance will allow exploring new realities and identifying gaps through the case study in Niger and b) the data analysis will result in generating recommendations (Hinkelmann and Witschel, 2009).

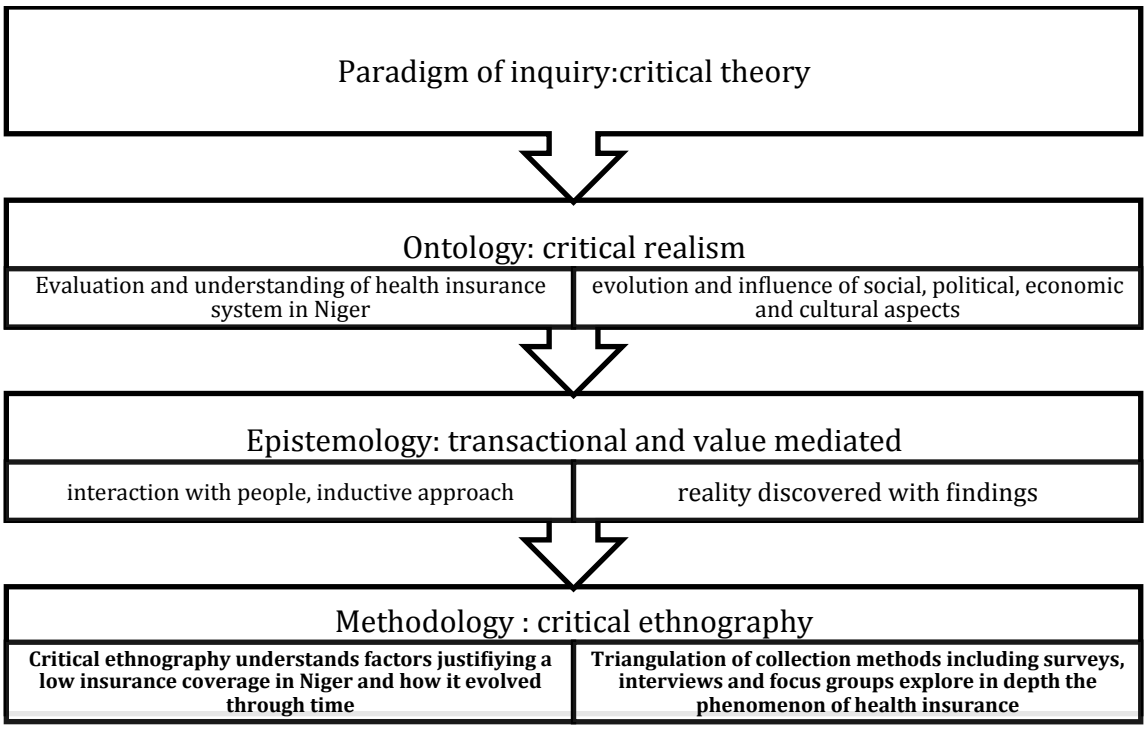
In relation to Marx dialectic, it is interesting to explore the capitalist production, in this case, private insurance to understand the impact of their actions on society. Critical theory involves the empowerment of people; in this regard the study identifies the root causes of the low health insurance coverage in Niger.

As mentioned earlier, critical theory is the paradigm of inquiry used for this study to explore the health insurance system in Niger and understand the reasons, which could explain that the majority of the population is uninsured. The choice of paradigm of inquiry is essential as it represents ways of looking at the world, which involves choosing approaches to observe and measure the phenomenon (Fossey *et al,* 2002). In other words, critical theory makes the connection between theories and the methods of data collection. For this research, with regard to critical theory interviews and focus groups enabled to explore in depth the differential access to health insurance in Niger and evaluate the involvement of the government in implementing universal coverage. Through those methods, the researcher explored the role of corporate social

responsibility, culture and the path dependency of health policies in the development health coverage. Then, the survey with the informal sector identified reasons explaining why this sector is the one with the least health coverage in the country.

Further, findings from the data confirmed the literature review which implied that the informal sector in is the segment with the lowest health insurance in the country, mainly because of government limited budget and cultural factors. In relation to the research question, questions asked during the data collection using critical theory enabled to grasp the reality of health insurance in Niger, its evolution and the potential solutions for improvement. The research questions aimed at identifying suitable health insurance schemes for populations in Niger. The research was conducted with critical thinking through praxis-combined literature and data to formulate recommendations.

Figure 4. 1 Critical theory and philosophical perspectives



Source: adapted from Howell (2013)

4.3 Philosophical methodologies in qualitative research

This section reviewed the main methodologies including grounded theory, hermeneutics, action research, and ethnography. Then, the use of critical ethnography for this study was explained in relation to critical theory and Marx dialectic.

Qualitative research involves the systematic collection and analysis of subjective data in order to identify the significance of human experience (Holloway, 2005:47; Burns and Grove, 2003). Subjectivity makes qualitative research unique especially because each element is studied in details and given a meaning. The researcher also plays a role in this since he is fully involved in the data gathering.

A research methodology is the "overall approach to the research process, from the theoretical underpinnings to the collection and analysis of data (Hussey and Hussey, 1997:54). Methodologies aim at self-reflection, mutual learning, and empowerment (Fossey *et al,* 2002). Myers (2009) noted that methodology is defined by the chosen paradigm for the research as the inquiry transfers assumptions to research design and data collection. Methodology is a scientific process that involves obtaining, organizing and analyzing the data (Kothari, 2004; Polit and Hubgler, 2004). Burns and Groove (2010) also agreed that methodology involves the design, the setting, the methodological limitations, data collection and analysis techniques. Moreover, qualitative methodology is considered dialectic because it discovers and interprets the world (De Vos, 2002).

4.3.1 Grounded theory

"The intent of grounded theory is to move beyond description and to generate theory" (Creswell, 2013: 83). The researcher relates core theoretical concepts that already exist with the collected data to create a substantive theory. "Grounded theory is a social science-based and involved about and with people" (Howell, 2012: 135). The credibility of grounded theory resides in the fact that every "new" theory is related to a specific situation. In that sense, Strauss and Corbin (1998:34) noted that because emergence is the foundation of grounded theory, a researcher could not enter an investigation with preconceived concepts. Moreover, Miller and Fredericks (1999) thought that grounded theory is based on naïve scientific model and is inappropriate for

qualitative inquiry. Charmaz (2006) contradicted that argument since grounded theory is the tool that legitimized qualitative research as a credible methodological approach. She argued that Glaser and Strauss aimed to move qualitative inquiry beyond descriptive studies into a real explanatory framework (Charmaz, 2006:6). Grounded theory was not used for this research, as generating theory was not the main goal, rather the researcher focused on the phenomenon of low health coverage and aimed at proposing recommendations through the interpretation of the data. Unlike grounded theory, ethnography is dependent on what the researcher aims to investigate (Silverman, 2016).

4.3.2 Hermeneutics

Hermeneutics is defined as the science of interpretation. There are different types of hermeneutics from Greek antiquity, Middle Ages and today's philosophy. In Greek antiquity, hermeneutics means the interpreter and Plato (428-348 BC) supposed that the philosopher knows what the Gods have said. Seebohm (2004:11) also thought, "The philosopher is the only one who is on the way to truth". As a philosophical methodology, hermeneutics consists in understanding and explaining phenomena and the researcher is capable of making his own interpretation. The objective of hermeneutics has evolved from the interpretation of texts to the understanding of societies. This study focuses on understanding insights of people and knowledge about health insurance; hermeneutics did not seem appropriate as it interprets culture primarily from texts or literature rather than directly from the people (Prasad, 2002).

4.3.3 Action research

Action research as a methodology is related to constructivism and participatory paradigms. The researcher participates in both data collection and analysis and reality is constructed through the close relationship between the subject and the object. Participatory observation is a practical application of action research as it provides "detailed information and in-depth understanding of values" (Howell, 2013:206). Action research did not seem appropriate for this study, as the researcher even though involved in the data collection was not an active actor in generating the

data. The investigator rather focused on the interpretation of the data (Savin-Baden & Howell-Major, 2013).

4.3.4 Ethnography and the research study

Ethnography is a qualitative methodology in which the researcher describes and interprets shared and learned values (Harris, 1968). The roots of ethnography are traced back in the 20th century and derived from anthropology or the study of societies. Maggs and Rapport (2000) noted that if early ethnography studied exotic cultures, modern ethnography focuses on near communities and their day-to-day situations.

Hammersley and Atkinson (2007) identified three features of ethnography: a) people's actions are studied in a day-to-day context b) data collection is rich and involves various methods of data collection and c) the data is collected within small groups, which allows an in-depth understanding and interpretation of results.

In addition, the ethnographer attempts to understand and interpret the social world the way members of that particular world do (Howell, 2013). Researchers conduct the study in the field and are involved in the research process. Observation is believed to be the main method for data collection as the researcher is also a participant (Forsey, 2010). Ethnography could be classified into four categories including:

a) Positivist ethnography involving a distance between the subject and the object.

b) Critical ethnography, on the other hand, is related to critical theory and aims to understand the world c) Post-Modern and Constructivist ethnography is related to constructivism and d) anthropological ethnography is about life experience of specific groups. The researcher has a strong relation with the field of work and the entire data collection occurred in natural settings. In this sense, one might question the reliability of ethnography. Rengert (1997:469), for instance, asserted, "ethnography is the least scientific of the research approaches since by definition involves small sample sizes that are difficult to replicate". Moreover, interpretation of data is always subjective. It is critical however to recall that no science is perfectly objective since they all require data, theory and most importantly interpretation (Lynch, 1985; Latour, 1987).

Critical ethnography is derived from critical theory and influenced by the Marxist theory of challenging political systems and understanding the relationship between the privileged and less privileged in society (Carspecken, 1996; Wilson & Chaddha, 2009).

According to Fisher (1986), critical ethnography addresses critics of society and its institutions; this study in the same sense looks at the role of government in promoting health insurance and how it affects the different segments of the population. Critical theory goes beyond the simple critic of society and aims to emancipate populations through the understanding of cultural, political and economic parameters that affect their behaviours (Thomas, 1993; Hancock, 1998; Savage, 2000; Grbich, 2012). For this study, critical ethnography has been chosen as philosophical methodology in accordance to the choice of critical theory.

Further, Cook (2005) stated that critical ethnography applies to healthcare and aims to bring social changes including health promotion. In this sense, critical ethnography will help to identify how social factors contribute to the access to health insurance in Niger, especially when health insurance is quasi inexistent for the informal sector. Critical ethnography equally enabled to identify the influence of culture, CSR and path dependency on the decisions of people when it comes to health insurance. Moreover, it will be interesting to understand the system of health insurance in Niger and the involvement of the government (Newhouse 1977).

Observation is usually used in ethnographic studies when the researcher is directly in contact with the field (Atkinson & Hamersley, 1994 and Hodges, 2008). For this study, observation was not used as a method of data collection as the reflection on interviews and focus groups immersed the researcher into the subject (Spradley, 2016). A number of authors held that interviews are as accurate as observation within an ethnographic study since they provide both spoken and unspoken insights from participants (Schensul, LeCompte, et.al, 2012; DiCicco-Bloom & Crabtree, 2006; Reeves, et.al, 2008). In this research, interviews were used to understand the pattern of health policies, CSR and culture and their influence on populations' decisions in regards to health insurance.

Then, during the focus groups, the researcher observed the power relations and group dynamics. Critical ethnography seemed appropriate, as cultural aspects influence the development of health insurance and the evolution of the sector through years. In addition, interviews and focus groups generated rich data that reflects the current health insurance practices in the country (Fetterman, 1988: Atkinson, 1995).

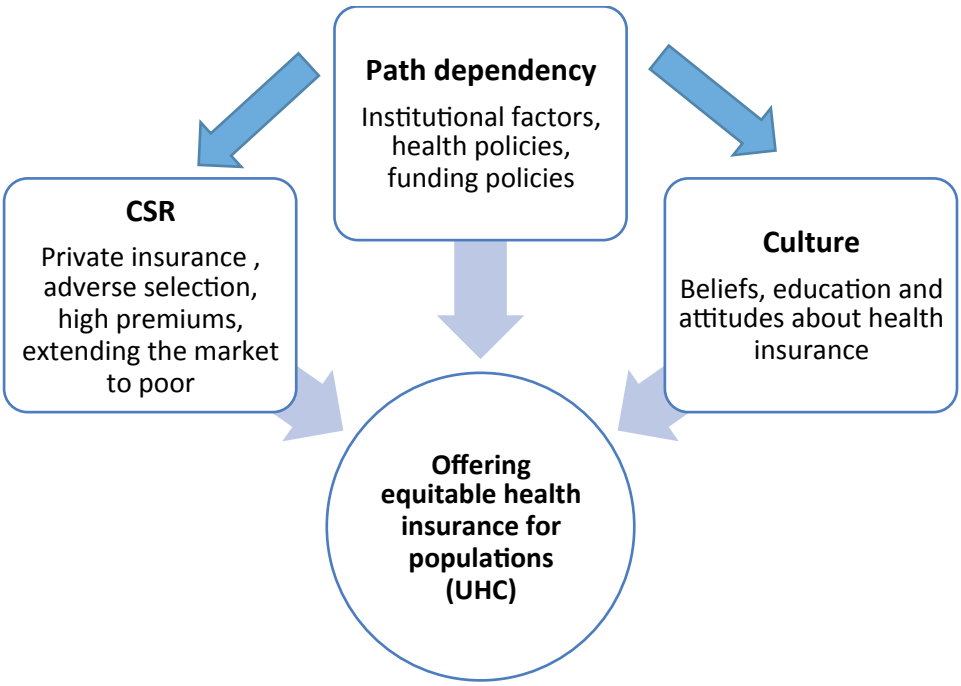
4.4 Research methodology

This section presented the research conceptual framework, which has been designed based on the literature review and the research questions. Then the process of data collection was presented in a detailed manner.

4.4.1 Conceptual framework

The conceptual framework of a study refers to the system of concepts, expectations and assumptions that inform the research (Robson, 2011). The conceptual framework brings focus on the research and equally makes the link between literature, methodology and results. For this research, culture, CSR, and path dependency of healthcare policies are determining factors in universal health coverage in Niger. Culture plays a role in the decision of an individual to join a health insurance scheme; influencing factors such as beliefs, education and perception about health insurance could determine the ability of populations to have health insurance. Other factors are those related to the institutional system and the government involvement in health insurance. The decision of the government to renew or apply the same healthcare policies defines the development of health insurance. For instance, the funding of healthcare is crucial in delivering health insurance and healthcare to populations, and without sufficient financial resources, health coverage is likely to be low. In addition to the public sector, it is interesting to assess the involvement of private insurance both for profit and non-for profit. Literature suggested that non-profit insurance is a potential solution for universal coverage, however, has limiting factors including low population enrolment and limited financial resources (Loutou, 2009). Further, private for profit insurance traditionally hardly applies CSR to clients and the community, which limits its participation in universal coverage (Pauly, 2003, 2007). Then, institutional factors such as laws, policies and legislations determine the development of commercial insurance through taxation for example; those factors equally define education and the willingness of population to join health insurance.

Figure 4. 2 Conceptual framework of influencing factors for universal health coverage



4.4.2 Data collection

4.4.2.1 Sources of data

A diary was used to record events throughout the entire process. Data collection began when the researcher sent the university letter to the managing directors of two commercial insurances and the ministry of health (Appendix B). The three institutions delivered permission for data collection, including a written letter from the ministry of health that allowed the researcher to conduct data collection from any public institution relevant for the study (Appendix A). The second phase consisted in sending the consent forms and interviews questions to the selected participants (Appendices H and I). The selection of participants was eased since each organization proposed a list of key informants able to address the subject under investigation.

Data collected at the ministry of health in Niamey (Niger Capital City) involved six participants who participated in both the interviews and the focus group. These participants were selected by the director of the department for the development of universal coverage based on their knowledge and expertise on health insurance.

Data collected from private insurance involved two commercial insurances, Caren and Sunu, two leading health insurance companies in Niger. They have been selected as they represent well the reality of commercial health insurance in Niger. Caren assurance established in 1988 is a member of the African Conference for assurance and covers about 23.97% of the market in Niger. Sunu assurance on the other hand covers 18.81% of the insurance market (Les Afriques, 2013, Journal no 256).

4.4.2.2 Sampling

Data collection for this study involved two series of semi-structured interviews, two focus groups and two surveys. The use of mix methods of data collection gave a greater understanding of the phenomenon and enabled to contrast different points of view (Creswell, 2006). Sampling involved four groups, including policymakers at the ministry of health, officials at two commercial insurance, and a questionnaire with the informal sector and a survey with medical practitioners.

The two series of interviews and focus groups involved twelve participants (Appendices D, E, and G). The interviews at the ministry of health involved six participants including five males and one female. All participants were selected based on their expertise on health insurance and primary healthcare. The same people participated in the focus group at the ministry of health as the researcher aimed at gaining insights from experts in the field. Five follow up interviews with additional people have been conducted after the first data collection at the ministry of health. The questions asked during the focus groups focused on the solutions for universal health coverage while, the interviews identified the explanatory factors for the low coverage. Then the interviews for private commercial insurance involved six participants out of whom, three were from Caren assurance and three participants from Sunu assurances and all were male. The interviews took place at their respective offices; however, the focus group involving the same people took place in a meeting room outside their companies.

The number of participants in the interviews and focus groups was relatively small with twelve individuals. In a research, a limited number of participants could be justified based on the nature of the study and the end objective. A study with less than twenty interviews is likely to explore

in depth a phenomenon (Crouch, McKenzie, et.al, 2006). For this research, in accordance to critical ethnography, in depth interviews were appropriate to identify the factors affecting the development of health coverage including the involvement of the government, private insurance and culture; and the potential solutions for attaining universal coverage. Furthermore, a small sample is justified when intensive interviews with experts inform about a particular phenomenon (Boyce & Neale, 2006). Participants for this research from both the ministry of health and commercial insurance have knowledge and expertise about health insurance in Niger.

The sample size for the survey with the informal sector involved 103 respondents from the region of Niamey. The questions were designed in the wat that the researcher explains the questions then ticked the boxes respondents have chosen (Appendix L). This sample is in accordance with Chi-square sample size since n>100. The analysis was conducted to determine association between categorical variables performed through chi-square and Fischer Exact tests. All the statistical tests were considered as statistically significant when p-value < 0.05.

The online survey with medical practitioners was used as a complementary method to others methods used. The survey with 30 responses on 64 initially sent mainly involved doctors and nurses. We also have to note that online survey was appropriate over paper survey because it was difficult for the researcher to contact participants (Appendix C). With the online survey however, it was easier for the researcher contacts to send it to their colleagues. Snowball sampling allowed existing subjects to recruit new subjects for the survey (Handcock, 2011; Johnson, 2014).

4.4.2.3 Ethical considerations

Any research involving data collection and analysis would have to follow ethical guidelines in order to be academically valid. A number of scholars shared techniques to address ethical issues in qualitative research. For this research, all three institutions gave permission, especially the ministry of health, which delivers a written permission (Mark, Eyssell & Campbell, 1999 and Dongre & Sankaran, 2016). The researcher also had ethical clearance from the University and an official letter approving the data collection.

At the individual level, all contributors participated on a voluntary basis and were informed about their rights and involvement for the data collection. By signing the consent form, each one

of them accepted to participate in the research. Moreover, the consent form was used as the certification for confidentiality and anonymity (Munhall, 1988). Further, the researcher respected the anonymity and confidentiality of participants since their names and other personal information were kept confidential. All participants were informed about the aim of the research and their implication to data collection and the research study. The researcher obtained the permission of individuals who signed the consent form and agreed that the withdrawal period is no later than two weeks after the data collection. They also accepted that any information they give might be included in the final report, as early as one month after the data collection. All interviews including focus groups were audio recorded in order to preserve the data and ease the data analysis (DiCicco-Bloom and Crabtree, 2006). The data collected in French was directly transcribed in English to avoid loss and misinterpretation (Temple and Young, 2004).

4.4.3 Methods of data collection

4.4.3.1 Triangulation of methods of data collection

The term triangulation refers to the use of two or more methods for data collection or analysis. Denzin (1978) identified four main types of triangulation including:

a) Investigator triangulation involves more than two researchers for the same study
b) Methodological triangulation uses more than one methodology to explore the phenomenon
c) Data triangulation refers to a use of various collection methods within the same study
d) Theory triangulation involves the use of various theories in relation to empirical findings of the research

Triangulation of data collection methods was used for the research mainly for two reasons. First, to examine the research question from more than one point of view data collection involved three different groups including policy makers, commercial insurance, the informal sector and medical doctors (Robson, 2002; Saunders and Thornhill, 2009; Maxwell, 2010 and Yin, 2009).Second data collection combined qualitative and quantitative methods including semi-structured interviews, surveys and focus group. Many authors believed that qualitative and quantitative methods complement each other's and strengthen final results (Bachiochi and Weiner, 2002; Lai

and Waltman, 2008). Qualitative research is often criticized in terms of rigour however, a number of scholars held that triangulation brings consistency and credibility to findings (Lincoln and Guba, 1985; Blaikie, 2000).

4.4.3.2 Methods of data collection for the research

4.4.3.2.1 Semi- structured interviews

Structured interview is a series of standardizing questions that are precise in answers. Results are replicable which make them the appropriate method for positivist studies (Corbetta, 2003). Qualitative research on the other hand privileges semi-structured and unstructured interviews (Edwards and Holland, 2013). Unstructured interviews generate rich data and are complex to analyze and replicate; usually used in anthropology and ethnographic studies they explore day-to-day experiences (Punch, 1998). Patton (2002) noted that even though questions are not asked in a specific order, unstructured interviews require preparation and most importantly, are a choice for the researcher. Semi-structured explore personal insights through planned questions that could be adapted through the process. Unlike structured interviews, the researcher has the possibility to ask additional questions to gain more understanding. Silverman (2001) thought that semi-structured interviews are appropriate for studies involving both public and community-based organizations.

For this research, semi-structured interviews were conducted for the ministry of health and the two commercial insurances with six individuals for each group. Semi-structured interviews were used because the researcher aimed to collect a specific kind of information and at the same time explore new realities (Turner, 2003). They equally aimed at exploring the influencing factors for low coverage of health insurance, especially for the informal sector, in addition of understanding the influences of culture, CSR, oath dependency of policies and funding on universal coverage in Niger. A set of ten questions were asked, eight questions were common to the two sets, in order to compare the position of the public and private sectors. In average, interviews lasted 45 minutes except one with the director of the division of universal health coverage (ministry of health) that lasted one hour. The questions were sent to participants days prior to the interviews in order to them to familiarize them with the topic. Moreover, during the interviews, additional

questions were often asked for clarification and when new topics were discussed (Galletta, 2013).

4.4.3.2.2 Focus groups

Focus group is a widespread data collection method in qualitative research and focuses on the interaction of a group discussing on a specific topic (Morgan, 1993 and Clark, 2010); it has the particularity to explore a social phenomenon and generate rich data through the interaction of participants (Goodwin and Heritage 1990). Focus group was chosen over observation for this study because it helps to get insights and experience for non-observable topics (Kitzinger, 1995). All participants from both commercial insurance and the ministry of health have been selected due to their professional skills and knowledge in terms of health insurance (Richardson and Rabiee, 2001).Focus groups were used to confirm data collected from interviews; in addition, the interaction among participants generated rich data and a diversity of opinions (Kruger, 1998). Further only three questions were asked as the researcher sought to discuss a particular point, on the potential solutions of developing health insurance in Niger. While the interviews explored the phenomenon, focus groups guided participants to discuss solutions for health coverage. In addition, comparing responses from the two focus groups helped to identify the most plausible solutions for universal coverage (Lincoln and Guba, 1985; Morse, 1995). The focus group at the ministry of health lasted 1h30 minutes. The power relation was homogenous since all participants felt free to talk and respected others speaking time. The group was composed of five male and one female all from the department of health insurance. The focus group with the two commercial insurances took place in a meeting room outside their respective offices and lasted about 1h25 minutes. The group was composed of three participants from each company, and all were males. The discussion was dynamic even though participants came from different companies. At many times, conflicting responses raised important issues for the study or confirmed some elements discussed during the interviews

4.4.3.2.3 Questionnaires

Questionnaires as a research method is a mean for "gathering information about the characteristics and actions of a large group of people" (Kraemer, 1993:77). Traditionally known as a quantitative method, survey has been recently well adopted in qualitative research (Bryman, 2006). The survey with the informal sector aimed at enquiring about the reasons of the low coverage for that segment. The survey equally intended to assess the attitude and willingness of population to join health insurance. The response rate was 103 individuals. Structured interviews seemed appropriate as the researcher was seeking specific information. Moreover, based on the level of education of some of the respondents it was practical to use close-ended questions in order to avoid deviation from the topic of research (Phellas, Bloch, et.al, 2011).

The second survey conducted for health practitioners was a complementary method for confirming results for others methods; in a mix method of data collection, quantitative data brings validity to the rest of the data (Zohrabi, 2013). Similarly to the others methods of collection, the questions for this survey aimed at assessing the system of health insurance and the potential solutions. The questions also incorporated elements of the research questions (see appendix C). The survey aimed at identifying the view of health practitioners on the access of health insurance and the involvement of the public and private sectors. . The low return rate was, however, a limit since 30 questionnaires were answered over 64 initially sent (Brown, 2001). The questionnaire designed in French was conducted via *surveymonkey.com* and included multiple choice, Likert scale and open-ended questions. Online questionnaire was chosen, as it was time-efficient for participants who were more inclined to participate since the web link was sent to their phone or via email. Traditionally, online surveys are associated with marketing surveys; however recently, they are growing rapidly for other areas including academic research (Lefever, Dal et al, 2006). Moreover, Survey monkey was useful since it enabled a better response rate compared to paper survey in the context of this research and prevented loss of data (Carbonaro and Bainbridge, 2000; Sheehan, 2001). In addition, the software systematically analysed the data and classified it into trends and patterns.

4.5 Data analysis

This section presents the process for data analysis for the research and the applied steps for the analysis of interviews, focus groups and the survey with the informal sector. This section does not include the result of the analysis of the data, which is discussed in the following chapter.

4.5.1 Data analysis and triangulation

Triangulation within data analysis involves the combination of three or more techniques to enable clearer understanding (Jick,1979). This study involved three methods of data analysis, including thematic analysis, discourse and comparative analysis for the qualitative data.

- Discourse analysis is about understanding talk or textual data, and deals with patterns in language use including for instance verbal space or recurrent words (Antaki, Billig et al, 2003; Goustos, 2004). Discourse analysis is traced back to Foucault (1972) who referred to discourse analysis as a particular way to reveal social realities. The Foucauldian discourse analysis marked a break with previous textual analysis since statements within cultural context generate the meaning of a specific situation (Waitt, 2005; Graham, 2005). Discourse analysis may also refer to studying spoken language and understanding meanings derived from it. Segments of data are then selected and analyzed in details. In this sense, the researcher examines words, semantics that characterize individuals' experiences. In addition, discourse analysis examines the interaction of a group of people and is widely used for focus groups (Cowan and McLeod, 2004). Arribas-Ayllon & Walkerdine (2008) however argued that conversation analysis is more appropriate in understanding the structural nature of talk.
- Thematic analysis is the process of reducing data and classifying it into codes. Codes that appear repeatedly are then incorporated to constitute themes (Grbich, 2013). Assigning themes to the classified data is the particularity of thematic analysis; it enables to explain different concepts in an organized manner (Patton, 1990; Boyatzis, 1998; Braun and Clarcke, 2006). In addition, it allows the researcher to determine and explain relationships between concepts what gives more insights and consistency to findings (Hayes, 1997; Braun &Clarke, 2006; Creswell, 2009).

4.5.2 Analysis of quantitative data

For the structured survey with the informal sector , the questions were designed based on the research questions and the elements of the conceptual framework including culture, CSR and path dependency. This questionnaire aimed at assessing the informal's sector towards health insurance and its willingness to contribute for health coverage. Similarly to the others methods of data collection, the survey equally assessed the concepts of CSR, path dependency and culture. The following questions were asked:

1. Health insurance is a mechanism that provides healthcare services, in a manner that protects individual from financial risks. Do you have health insurance? Yes _ No_

2. How would you rate health insurance
    - not important
    - important
    - very important

3. Are you willing to pay to have health insurance? Yes _ No_

4. Are you aware of any health insurance company? Yes _ No_

5. How do you think healthcare can be improved for the informal sector?
    - More government action
    - Contribution from the informal sector
    - External aid
    - All of the above

6. Do you think the decisions of the government influence the development of healthcare? (path dependency) Yes _ No_

7. Private commercial insurance usually covers people in the formal sector who pay for premiums each month. Does private insurance currently helps the informal sector. (CSR) Yes _ No

8. Do you think culture and traditional medicine determine the use of modern medicine? (culture) Yes _ No_

An anonymous interviewer administrated standardized questionnaire used to collect the data on a convenient sample of 103 participants practicing in the informal sector. The data collected

included the characteristics of the participants (age and gender), holding a health insurance at the time of the interview, the self-rating of the importance of health insurance, the willingness of the participants to pay to have a health insurance, the awareness of participant about health insurance company, the opinion of the participants towards ways for improving health care for the informal sector, path dependency measured the opinion of the participants towards government decisions on development of health care, the contributions of private health insurance to promote the informal sector, the impact of culture and traditional medicine on the use of modern medicine. The data collected were computerized through MS Excel and analyzed through the statistical package for social sciences (SPSS version 23). The data were summarized numerically (mean, standard deviation and median) and graphically (frequency tables for estimating proportions and graphics). Association among categorical variables determined through Chi-square and Fischer Exact tests. All the statistical tests were considered as statistically significant when p-value < 0.05.

4.5.3 Analysis of qualitative data

Data analysis is the process of reducing data through summarization and categorization and many approaches are available in qualitative research (Bernard, 2000). Many authors considered coding as the first phase of data analysis because it involves categorizing, classifying and sorting the data (Miller, 2000 and Grbich, 2013). Charmaz (2006) stated that coding is the pivotal link between data collection and data interpretation thus is the starting point in generating meanings and conclusions. A number of approaches have been developed for data analysis. Huberman and Miles (1994) advised reducing the data by breaking it into small chunks, then display it in categories and finally generate meanings from findings. Then, Creswell (2014) developed a similar approach consisting of sorting, coding and presenting results. Both content and thematic analysis use text analysis and identify words patterns (Mayring, 2000). Content analysis focuses on the description of the data while thematic analysis, in addition, interprets findings (Braun and Clarke, 2006). Thematic analysis is appropriate for the research, which involves different data collection instruments, with participants from different environments (Miles and Huberman 1994). Moreover, the research classifies findings according to similarities and differences (Miles and Huberman, 1994).Thematic analysis involves the reduction, simplification, and organization

of data and coding is the starting point. For this research data was first summarized for each interview, then coded and analyzed through Nvivo 12 Plus (Alhojailan, 2012). Thematic analysis was used for semi-structured interviews and consisted in the reduction of data, the generation of codes and the identification of themes.

Then, the analysis of focus groups happened in three phases. First, discourse analysis was used to study the language and interaction of the focus groups. Some scholars (Widdowson,2007; Cruickshank,2012) referred to discourse analysis as the study of language that incorporates the description, interpretation, and explanation of a particular phenomenon. Discourse analysis is about understanding talk or textual data, and deals with patterns in language use including for instance verbal space or recurrent words (Antaki, Billig et al, 2003; Goustos, 2003). Discourse analysis is traced back to Foucault (1972) who referred to discourse analysis as a particular way to reveal social realities. The Foucauldian discourse analysis marked a break with previous textual analysis since statements within cultural context generate the meaning of a specific situation (Waitt, 2005; Graham, 2005). The second phase of focus groups analysis used thematic analysis to identify themes. Finally, cross data analysis compared the themes between the two focus groups.

The overall data analysis for semi-structured interviews and focus groups is based on The Braun and Clarke (2006) thematic analysis ,involving an inductive approach since themes were generated by the data (Patton,1990). The Braun and Clarke (2006) approach involves six steps from data reduction to analysis. The first step is about familiarizing with the data by actively reading and searching for patterns. Then, the researcher identifies initial codes by categorizing repeating patterns. The following steps consist in searching, reviewing and naming themes. Finally producing the report describes and interprets the findings. Further, a multitude of analysis techniques is available to qualitative researchers including the following ones.

4.5.3.1 Coding of semi-structured interviews

Data reduction consists in reducing large amounts of data in units that can be examined and interpreted (LeCompte & Schensul, 1999). Miles and Huberman (1994: 11) defined data analysis

as “a form of analysis that sharpens, sorts, discards and organizes data in such a way that final conclusion can be drawn and verified”. In this regard, data reduction occurred in three phases for semi-structured interviews for both series 1 and series 2. The first phase reduced, sorted and categorized the large amount of data (LeCompte & Schensul, 1999). Then, the codes were organized into subthemes. The third phase transformed subthemes into themes. Then themes were reduced and classified into a thematic map which enabled a better understanding of relationships among themes (Atkinson, 1995; Charmaz, 1990).

4.5.3.1.1 Coding process of interviews (series 1): ministry of health

The themes generated through the coding process are closely linked to the questions aked to respondents at the ministy of health. The interview questions were designed in accordance with the research questions and equally included elements of the conceptual framework including CSR, culture and path dependency. The following questions were asked for the semi-structured interviews at the ministry of health:

1. How would you define health insurance today? How has it changed over the past ten years?
2. Are you covered by any insurance scheme? If yes, since when?
3. What is the contribution of private insurance? Which groups does it cover?
4. Does partnership/s exist between the government, private insurance and other agencies?
5. What do you think about non-profit insurance?
6. Do you think adverse selection exist? What is your position in this regard? Does private insurance applies corporate social responsability?
7. Should the government have more involvement in health insurance?
8. What is the role of path dependency of policies in the development of health insurance?
9. What is the role of culture in the low coverage rate of health insurance?
10. How can health insurance be improved in Niger?

The process of data reduction involved using raw data to generate final themes, which were later classified into a thematic map; the same process was applied for all six interviews from the ministry of health (Appendix J). In phase1, raw data was summarized for each of the six interviews. Then keywords and key facts were extracted from the reduced data (Miles and Huberman 1994). The next step consisted in generating initial codes from these key words. Some incidents appeared repeatedly in more than one question and interview.The following table illustrates how keywords were extracted from data and how they were then transformed into initial codes. This process has been applied to all interviews.

Table 4. 2 Example of how codes were generated from raw data for interviews series 1

Participants	Data (reduced)	Keywords ⟶	Codes
Interview 1 (Director of the division of universal health coverage)	"Health insurance is the financial risk related to health. In Niger, health insurance started to grow in the 2000's but already started since the independence when healthcare was free. During the independence days in 1960's, healthcare was free and everyone was covered. Private insurance covers people in international organizations. "	1. Health risk-universal coverage-ignorance 2. Government insurance for workers in the public sector 3. Community-based insurance is not developed 4. No Public-private partnership	*1. Challenges for the development of health insurance* *2. Segment who have government insurance* *3. Development of Community based insurance* *4. Public-private partnership*

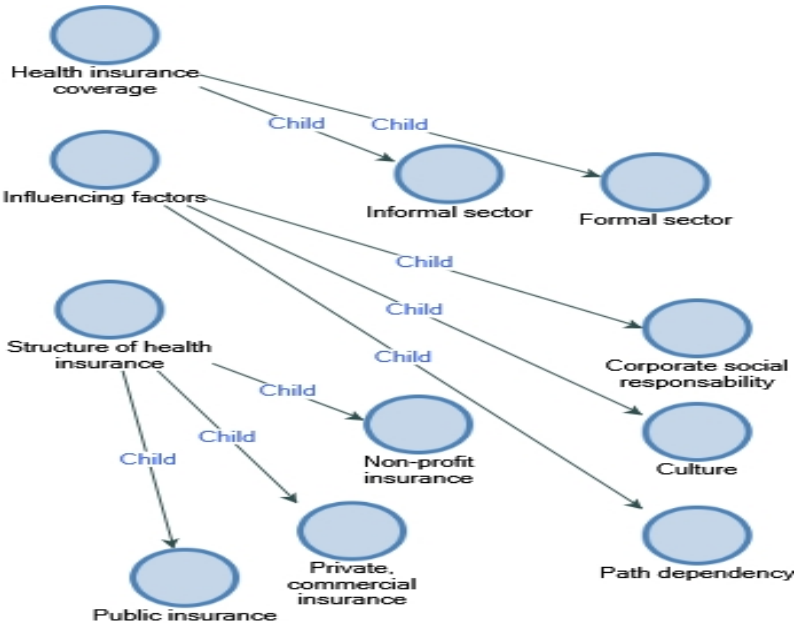
Source: adapted from Braun and Clarke (2006)

The phase 2 consisted in the transformation of codes into themes (Boyatzis, 1998). Twenty-six codes emerged from coding the six interviews, these codes were then organised into Nvivo 12 Plus to generate eight subthemes and three main themes including *Health insurance coverage, Influencing factors* and *structure of health insurance*. The theme *structure of health insurance* included *private insurance, public insurance and non-profit insurance* as subthemes. Next, the

theme *influencing factors* incorporated p*ath dependency, corporate social responsibility and culture*. Then, the theme *health insurance coverage* contained *informal sector* and *formal sector* as subthemes.

Phase 3 of the coding process classified the themes and subthemes into a thematic map which shows the relationship between the elements and the most prominent themes that were further used for the thematic analysis. Themes could be summarized into a thematic map that provides a clearer understanding of concepts (Braun and Clarcke,2006:82; Goulding,2002). The following thematic map illustrated the final coding stage for interview series 1 and showed the relationship between themes and corresponding subthemes (Braun & Clarke, 2006). The thematic map was generated in Nvivo software and used for the thematic analysis of the data.

Figure 4.3 Thematic map showing three mains themes



4.5.3.1.2 Coding process of interviews (series 2): private insurance

The themes generated through the coding process were closely linked to the questions asked to respondents from commercial insurance. The interview questions were designed in accordance with the research questions and equally included elements of the conceptual framework

including CSR, culture and path dependency. The following questions were asked for the semi-structured interviews for the two private insurance companies:

1. How would you define health insurance today? How has it changed over the ten past years?
2. Are you covered by any insurance scheme? If yes, since when?
3. What is the contribution of private insurance? Which group does it cover? What do you think about non-profit insurance and community-based insurance?
4. Does partnership/s exist (s) between the government, private insurance and other agencies?
5. What do you think about non-profit insurance?
6. Do you think adverse selection exist? What is your position in this regard?
7. How does your company apply CSR?
8. What is the role of path dependency on the development health insurance?
9. Do you adapt your premiums to groups?
10. Do you think people are willing to pay more for insurance coverage? What is the role of culture on the low coverage rate of health insurance?

The process of data reduction involved using raw data to generate final themes, which were later classified into a thematic map; the same process was applied for all six interviews from private insurance. In phase1, raw data was summarized for each of the six interviews. Then keywords and key facts were extracted from the reduced data (Miles and Huberman 1994). The next step consisted in generating initial codes from these key words. Some incidents appeared repeatedly in more than one question and interview.The following table illustrates how keywords were extracted from data and how they were then transformed into initial codes. This process has been applied to all six interviews.

Table 4. 3 Example of how codes were generated from raw data for interviews series 2

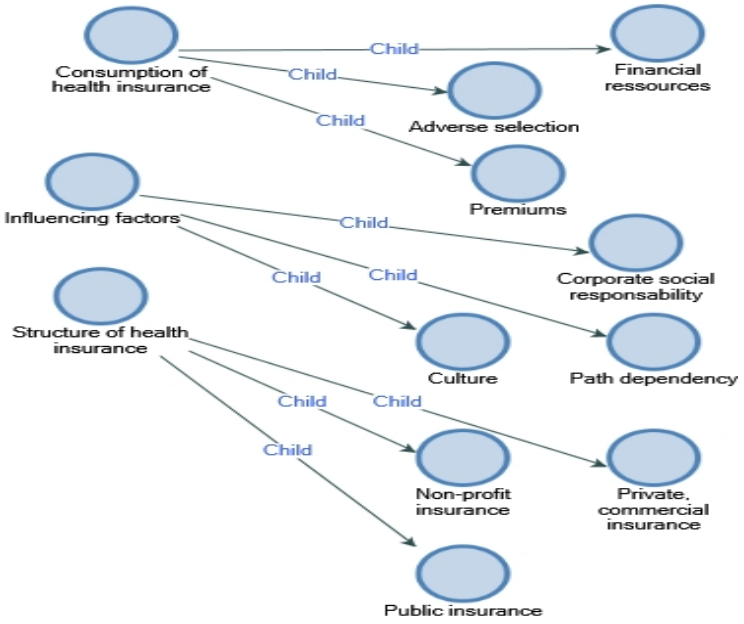
Participants	Data (reduced)	Keywords ⟶	Codes
Interview 7 (Account manager, Sunu assurances)	""Health insurance protects us from health risks. Moreover, we contribute to having the service. My employer covers me at 100% except for drugs and hospitalization since I started working here. Private insurance essentially covers workers from private organizations, NGO's and international organizations. "	1. Health risks-Contribute-Adverse selection-Needs-Financial limits-Premiums 2. Health insurance protects us 3. No partnership with government 4. Private insurance for workers in the private sector and foreign companies 5. People are ready to pay more for health	1. Contribution 2. Public-private partnership 3. Public insurance 4. Premiums and financial limits

Source: adapted from Braun and Clarke (2006)

Phase 2 consisted in the transformation of codes into themes (Boyatzis, 1998). Twenty-six initial codes emerged from coding the six interviews, these codes were then organised into Nvivo 12 Plus to generate eight subthemes and three main themes including *structure of health insurance, Influencing factors* and *consumption of health insurance*. The theme *structure of health insurance* included *private insurance, public insurance and non-profit insurance* as subthemes. Next, the theme *influencing factors* incorporated p*ath dependency, corporate social responsibility and culture*. Then, the theme *consumption of health insurance* contained *premium*, *financial resources* and *adverse selection* as subthemes.

Phase 3 of the coding process, classified the themes and subthemes into a thematic map which shows the relationship between the elements and the most prominent themes that were further used for the thematic analysis. Themes could be summarized into a thematic map that provides a clearer understanding of concepts (Braun and Clarcke,2006:82; Goulding,2002). The following thematic map generated in Nvivo software illustrated the final coding stage for interview series 2 and showed the relationship between themes and corresponding subthemes, which were used for the thematic analysis (Braun & Clarcke, 2006).

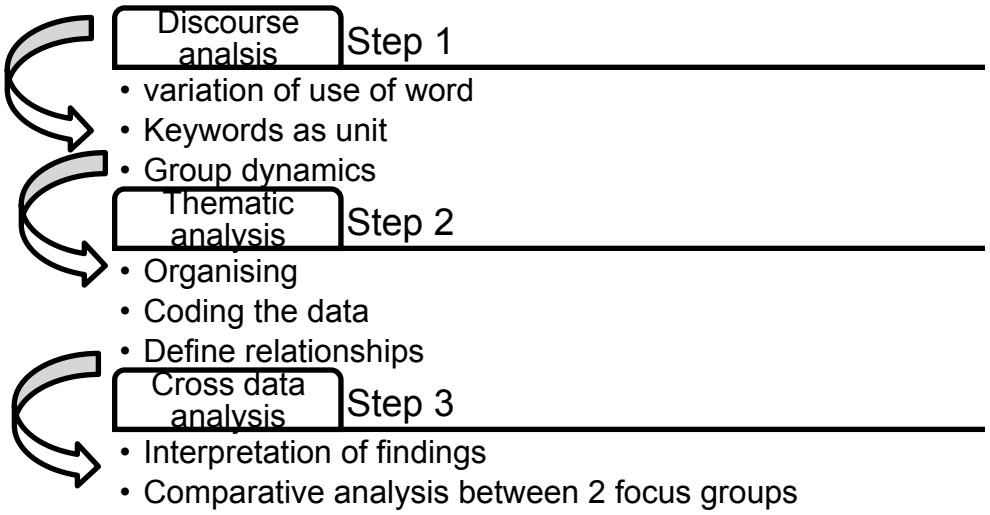
Figure 4. 4 Thematic map showing three mains themes



4.5.3.2 Analysis of focus groups

The analysis of focus groups developed in three stages included discourse, thematic analysis and comparative analysis. The first phase focused on verbal conversation and analyzed the groups' dynamics. Some literature considered that the interaction among members with different insights produces a richer and consistent data (Kitzinger, 1995, Morgan, 1998; Krueger and Casey, 2009). Discourse analysis was used to understand the use of language and focused on interpretation and explaining the use of key words during the discussions (Brown and Yule, 1983). The researcher used discourse analysis to highlight some issues related to the phenomenon (Johnstone, 2018). Critical discourse analysis was conducted with the use of analytical units such as point, wording labels, declarative sentence and exchange. The frequency of words was organised with Nvivo and the researcher interpreted the use of words (Scheflen, 1973; Ellis,2002; Gee, 2014). At the second phase, thematic analysis was used to sort and categorize the data and themes emerged from the frequency of keywords (Morgan, 1997 and Casey, 2000). Further, thematic analysis was also used to interpret and draw relationships between themes. The last phase of focus group analysis referred as cross data analysis focused on comparing themes between the two groups (Kidd and Parshall, 2000; Merriam, 2009).

Figure 4. 5 Analysis process for focus groups



Source: Adapted from Kidd and Parshall (2000); Elo and Kyngas (2007)

4.6 Research limitations and rigour

4.6.1 Research limitations

A limitation of a study is a bias that the researcher could not control (Price & Murnan, 2004). This study contained certain limiting circumstances, some of which were linked to the common limits of qualitative research. Recognizing the limitations, the researcher took the following measures. Firstly, the research bias could be an issue, especially when the person is involved in all stages of the research including research analysis and interpretation. Therefore, the researcher subjectivity including assumptions and perceptions could create potential bias. To address the subjectivity, the researcher kept a diary throughout the entire process, especially during data collection. During interviews and focus groups, for example, the researcher noted the attitude and positions of each participant to avoid any interpretation based on the researcher perception of the situation and people. In addition, the audio recordings of interviews and focus groups enabled not only to preserve the data , but also used as reference for data analysis as the researcher tried to interpret findings based on the interviews transcripts rather than the researcher owns assumptions. Further, to avoid bias and loss of data, the researcher directly transcribed the

collected data in French to English, by trying to keep the original meanings (Jamshed, 2014). The process was made easier since the researcher fluently speaks the two languages.

Second, the researcher experienced access challenges. It was quite challenging to find and recruit people for the interviews and focus groups especially in one of the commercial insurance. The researcher had to send several emails and phone calls over a period of 3 months in order to be introduced to the potential participants. On the other hand, access at the ministry of health was made easier when the researcher visited the department for the promotion of universal and explained the purpose of the research 1 month prior to the data collection. After the initial contact the purpose of the study and consent, forms were sent to the participants. Further, in some cases, the survey with the informal sector was time consuming as some respondents had a low rate of literacy; for this reason, the researcher had to explain the questions and tick the responses they chose.

Third, the researcher addressed some limitations concerning the size of samples. Interviews involved 12 participants who were the same people for the focus group. One might discuss the small sample, however, participants were selected based on their knowledge and expertise in health insurance, and seemed more appropriate to be interviewed. On this, Crouch, et.al (2006) explained that a sample size less than 20 participants intends an in depth inquiry of a phenomenon. In relation to critical ethnography, the research philosophical methodology, a small sample size seemed justified for carrying intensive interviews to get perspectives about health insurance. Since participants were experts and based on the limited number of people able to address the issue, the researcher chose a small sample with individuals with the know how to address the subject; especially when most of them are influencers in both public and private sectors of health insurance. In this sense, Hackshaw (2008) explained that there is not a notion of small sample as this depends on the objectives of the study. For this research the same people participated on both interviews and focus groups as the methods had different intends. The interviews intended to explore the system of health insurance, assess the reasons of low coverage and the implications of CSR, culture and path dependency. Then, the focus groups were dynamic interactions between participants that discussed the potential solutions for universal coverage. It was important to keep the same participants for the focus groups, as other participants would not have had an easy understanding of the phenomenon (Boyce and Neale, 2006).

Another limitation involved the choice of interviews over observation, which is traditionally used alongside with ethnography as philosophical methodology. Some authors held that interviews could substitute observation when the study focuses on understanding patterns and resolving serious problems (Schensul and LeCompte, 1982; DiCicco, et.al, 2006). This study through the use of interviews aimed at assessing the evolution of health insurance and propose solutions for the low coverage. In addition, the two focus groups through the interaction of participants and the involvement of the researcher as moderator possess elements of participant observation (Morgan, 1997).

4.6.2 Research rigour

Rigour is the set of evaluative criteria used to establish the quality of a research. Validity and reliability are the established standards to assess quantitative research. Qualitative research, on the other hand, is often considered lacking scientific rigour compared to quantitative research. In fact, it is a challenge to quantify individual experience and insights; which however does not make qualitative research inferior since there are criteria to assess its quality and acceptability (Agar, 1986; Marshall & Rossman, 2014).

A number of scholars developed techniques ensuring rigour for qualitative research (Payton, 1976; Guba, 1994; Lincoln & Guba, 1985; Agar, 1986; Sandelowski, 1986; Kirk & Miller, 1986). For this study, Guba & Lincoln (1985) model of trustworthiness was used; it this sense credibility gives authenticity to the research by presenting how the research was conducted. For this research, sampling was tailored to people who know about health insurance, moreover, the triangulation of data collection and analysis methods gave additional consistency to findings (Field & Morse, 1985). In terms of transferability, the results from the interviews and focus groups could be applicable to countries with similar health insurance system. Further, as quantitative methods, the questionnaires could enable the generalization of results from sample to population. Then, dependability insured the replication of the research phases, in this sense, procedures for research design, literature review, data collection, and data analysis and theory development were clearly presented in the thesis. Confirmability examines the axiological perspectives and subjective bias from the researcher, for this study, participants were carefully

chosen and their responses were wisely analysed. In addition, the chosen methodology, critical ethnography was in line with critical theory as paradigm of inquiry. Then, reflexivity was used to minimize subjective bias from the researcher (Krefting, 1991). To enhance objectivity and reflexivity, the entire research was documented in a diary; moreover, all interviews and focus groups were audio recorded.

Table 4. 4 Techniques used for establishing trustworthiness

Criteria	How it was applied for this research	Phase in which the techniques were used	References of the thesis
Confirmability	The research reflects the reality of health insurance in Niger; experienced informants participated in the study. The ministry of health and the two leading health insurance companies were appropriate in exploring realities. Confirmability also happened through the triangulation of data collection and analysis methods.	Literature review Data collection	Chapter 2 & 3 Chapter 4
Credibility	There is a concordance between the research findings and the reality of health insurance in Niger. In addition, there is a link between literature review, data collection and results. The validity of findings is robust through the triangulation of data collection and data analysis techniques. Then the researcher kept a diary throughout the entire data collection process to avoid personal bias and to analyze data with the maximum of objectivity as possible.	Literature review Research design Data collection Data analysis	Chapter 2 & 3 Chapter 1 & 4 Chapter 4 Chapter 5
Transferability	Participants were chosen based on their knowledge and experience in terms of health insurance and primary healthcare. The research findings could be transferred to other countries with a similar profile. In addition, the results of the survey could be	Data collection Data Analysis	Chapter 4 Chapter 5

	generalize to the population.		
Dependability	The participants and research sites were purposefully chosen in relation to the phenomenon of health insurance.	Data collection	Chapter 4
	Triangulation of data collection and analysis techniques brought reliability to the study. Interviews and focus groups were audio recorded in order to preserve the data. The survey was automatically analyzed by the software and confirmed results from the two other instruments of data collection.	Data analysis	Chapter 5

Source: adapted from Guba & Lincoln (1985)

4.7 Conclusion

In summary, this chapter presented detailed descriptions of this study‘s methodology. The literature review and research questions enabled the design of a conceptual framework used to guide questions for interviews, focus groups and surveys. Through praxis, the study linked theory and practice, when methodology was the pivotal point between literature review and the conceptual framework and on the other hand, data collection and data analysis. Furthermore, the choice of critical theory as paradigm of inquiry determined the use of critical ethnography and critical thinking during the data collection and analysis. A triangulation of methods of data collection including two series of interviews, two focus groups and two surveys generated consistent data, which equally enabled to compare views from different groups. Then, the results of the surveys could be transferred to the population. For the qualitative data, the sample was made up of 12 participants purposefully chosen for their expertise in health insurance. The triangulation of methods of data analysis produced consistent results with the used statistical variables for the survey with the informal sector. Then for the qualitative data, thematic analysis and discourse analysis generated key themes for the analysis and interpretation of data from interviews and focus groups. Further, the research limitations have been addressed; and rigour

was applied at various stages of the research through confirmability, transferability, credibility and dependability.

Part 3: Data Analysis and Recommendations

Chapter 5: Data Analysis

5.1 Introduction

This chapter presented the results in light of the research question, literature review and conceptual framework. The chapter first analysed qualitative data of the two series of interviews. Second, the data from the two focus groups was analysed in three stages including discourse analysis, thematic analysis and comparison analysis. The next section focused on the analysis of the two surveys. Then in regard to praxis, the last section presented the summary of findings in relation to the research question and literature review.

5.2 Thematic Analysis of interviews

5.2.1 Thematic analysis of interviews from the ministry of health

During the interviews in the ministry of health, participants described the limits for the attaining universal coverage including corporate social responsibility, path dependency of health policies and culture. At the same time, some interviewees explained that those same limits could be turned into opportunities in the quest of attaining universal coverage. They also discussed the structure of the health insurance system in Niger, notably the main source of funding and the evolution through the last decade. Next, the coverage of health insurance appeared as a critical element, as interviewees identified the different segments covered by public, private and non-profit insurance. In addition, most respondents acknowledged that the informal sector is the segment with the lowest health coverage. The following sections outlined the thematic analysis with its main themes and subthemes generated from the interviews from the ministry of health.

5.2.1.1 Influencing factors

When responding to the questions, 6/6 of the interviewees believed corporate social responsibility, path dependency and culture are determining factors for the development of health insurance.

5.2.1.1.1 Culture

Culture is the set of attitudes, values, beliefs and behaviours shared by a group of people. Schein (1990) distinguished three layers of culture including observable facts, values and under covered behaviours. During the interviews, many respondents discussed the role of culture, and how it influences people's attitudes regarding health insurance (Herkovits, 1948). Some interviewees agreed that traditions play a key role in the development of health insurance because *"people do not understand why they have to contribute each month in order to finance future diseases*" Interviewee 2 (assistant director in the division of universal health coverage). Moreover, some communities privilege traditional medicine because it embedded in their customs (Hofstede, 1994 and Noyes, 2009). . Interviewee 2 (Assistant director in the division of universal health coverage) claimed: *"many factors including lack of money, financial mismanagement, ignorance and the use of traditional medicine explain the absence of health insurance for the informal sector"*. Numbers of authors also pointed out that the correlation between a country level of corruption and the development of healthcare system (Kaufman, 1999; Tiongson, 2000 and Lewis, 2006). Overall, interviewees held that cultural influence from both the government and communities affect the development of health insurance.

5.2.1.1.2 Corporate social responsibility

Corporate social responsibility (CSR) was mentioned in many interviews. Some respondents thought that private insurance should be aware of CSR and the importance of their actions in society. Interviewee 3 (official in the unit of community health) said: "Commercial *insurance uses adverse selection and should be aware of the importance CSR. Of course, it is normal to make profits however based on the situation of our country; private insurance should be socially responsible"*. In this sense, Carter (2009) noted that social investment enhances companies' image. Dahlsurd (2008) also believed that CSR is part of the social contract and businesses should comply with it. Overall, respondents understood the need for private insurance to make profit however believed they could extend their market to the informal sector.

5.2.1.1.3 Path dependency of health policies

The majority of interviews indicated that financial resources represent a major limit to the development of health insurance mainly because the government budget is low, which explains the difficulty to providing insurance coverage for the entire population. Some participants also explained that the same decisions in terms of funding and health coverage are being applied through the years, which needs to be revised. Further, some interviews mentioned a government project for developing community insurance for populations. The project aims to deliver insurance coverage throughout the 266 communities, to all segments of the population without distinction of socio professional background. This implies that the government is aiming at promoting health coverage to a larger portion of the population including the informal sector. Interviewee 2 (assistant director in the division of universal health coverage) stated: *"CBHI is an interesting mechanism for our country; we have a project of implementing health insurance at communal levels. The aim will be to offer health coverage for people by geographical area regardless of their socio-professional background. It is only a project for now, but it looks promising"*. When asked for clarification about the funding. Interviewee 2 said that the project would be monitored by the government, and will be funded by multiple sources including public funds, households' contribution and external funds. In addition, the respondent explained that pilot studies would be held, and if outcomes were positive, new policies would be developed prior to the implementation of the project. The interviews revealed that the path dependency of health policies are primarily related to limited financial resources which leads the government to offer insurance coverage exclusively for workers in the public sector, while excluding the rest of the population. However, participants explained that the implementation of new funding policies and health policies would lead to improving health insurance.

5.2.1.2 Structure of health insurance

The theme structure of health insurance refers to the system of health insurance and the main actors involved in the funding and delivery of health insurance. Its subthemes including non-profit insurance, public and private insurance were discussed below.

5.2.1.2.1 Public insurance

Public insurance refers to government insurance and the populations that benefit from it. Interviewee 1 (director of the division of universal health coverage) stated: "*government insurance is limited to workers from the public sector; the majority of the population is not covered. The government should do more to cover a larger part of the population"*. Other interviewees shared the same view on the necessity for the government to cover other segments of the population. Interviewee 1 (director of the division of universal health coverage) also clarified that: "*health care funded by the government is free for children under five and pregnant woman, however it is not enough as the end goal is to attain universal coverage*". The majority of respondents accepted that public insurance by its nature should cover a larger part of the population and that more effort are required for doing so.

5.2.1.2.2 Private insurance

Private insurance or commercial insurance in opposition to public insurance is for profit and operated by the private sector. Interviewee 3 (official in the unit of community health) said: *"Commercial insurance covers about 3% of the population while at least 70% % of the population makes out of pocket payments"*. Some participants held that private insurance in Niger is destined for the most privileged, and automatically excludes the poor segments. Interviewee 2 (assistant director in the division of universal health coverage) added*: "Adverse selection is real with private insurance; their premiums are too high and unaffordable for the majority of people. I think they have no concerns about corporate social responsibility and the impact of their decisions."* Some interviewees believed that private insurance is not contributing enough in the development of health insurance as they apply adverse selection and are profit driven. In addition, some criticized the lack of corporate social responsibility and the impact of their activities on the community.

5.2.1.2.3 Non-profit insurance

Both for profit insurance and non- profit private insurance are classified under the umbrella of private insurance and are both voluntary schemes (Mossialos & Thomson, 2004). Unlike for profit insurance, non-profit, schemes are based on solidarity and aim to cover individuals at affordable or inexistent rate without perspectives of profit making (Griffin, 1989; Gertler, Solon, 2000). The interviews revealed the existence of three main categories of non-profit insurance in Niger including community based insurance, external aid and socio-professional health mutual. Interviewee 6 (official in the division of universal health coverage) said : *"the system of health insurance in Niger is composed by public insurance, private insurance, socio-professional health mutual and some community-based health insurance"*. It was noted from the interviews that socio-professional insurance covers mainly workers in the semi-sector who contribute from their salaries. Then, community insurance usually covers workers in the informal; based on the interviews, this scheme is not developed. Interviewee 2 (assistant director in the division of universal health coverage) explained that: *"Community-based insurance is not evolving in a spectacular manner. Many of them terminated because of small numbers of subscribers. Another limit is financial mismanagement; many cases of corruption have been reported"*. From this statement, one could assume that financial mismanagement equally occurs in non-profit insurance. Some interviewees also defined external aid as non-profit insurance as it provides healthcare for the lowermost or provide funds for improving healthcare.

5.2.1.3 Health insurance coverage

Health insurance coverage is the third theme that emerged from the coding of interviews series 1. It refers to both insured and uninsured segments of the population (Kuttner, 1999; Koh and Tavenner, 2013). Interviewee 3 (official in the unit of community health) said: "*health insurance coverage is summarized in four segments including the public sector workers, private sector workers, socio-professional groups and out of pocket payments"*. Based on the interview the coverage of health insurance was classified into two main groups including the formal and the informal sector.

5.2.1.3.1 Formal sector

The *formal sector* is characterized by waged labour and labour regulations such as working hours and minimum wages; it includes both private and public sector (Daniels, 2004). In developing countries, the proportion of the formal sector is relatively small compared to the one in the informal sector (Preker *et. al,* 2002). In relation to this, Interviewee 3 (official in the unit of community health) said: "*80% of the population is uninsured mainly because they are in the informal sector and not solvable throughout the entire year.* Interviewee 2 (assistant director in the division of universal health coverage) added: *"About 10% of the entire population has health insurance."* Based on the interviews it was noted that the formal sector is the main insured segment of the population as people are solvable and able to contribute for health insurance the entire year. This means that populations from the informal sector are excluded as they are unable to contribute in a regular manner.

5.2.1.3.2 Informal sector

The *informal sector* is a characteristic of developing countries and refers to the part of the population working in unregulated sectors. Contrary to the formal economy, there is no tax payments, social security and labour regulations (Palmer, 2004). Interviewee 2 (assistant director in the division of universal health coverage) stated: *"the informal sector in both rural and urban areas lack of health insurance. Some community insurance schemes are available, however there is no formal mechanism designed and monitored by the government".* This statement suggest that most of the informal sector makes out of pocket payment for health insurance; moreover, there is a shortage of schemes available for this segment, as some interviews stated that community insurance is not developed in Niger.

5.2.2 Thematic analysis of interviews from commercial insurance

During the interviews with private insurance, participants similarly to interviews series 1 referred to corporate social responsibility, culture and path dependency as determining factors for developing health insurance. The theme structure of the health insurance system is another common theme between the two series of interviews and similarly to interviews series 1 includes public insurance, private insurance and non-profit insurance as subthemes. Next, the consumption of health insurance appeared as a critical element for the development of private insurance. Premiums, adverse selection and financial resources have been identified as subthemes of consumption of health insurance.

5.2.2.1 Influencing factors

The theme influencing factors referred to the factors affecting the development of health insurance in Niger, including culture, corporate social responsibility and path dependency of health policies.

5.2.2.1.1 Culture

Culture is another common sub-theme mentioned by both groups. Some interviewees mentioned the necessity to educate the population on the importance of health insurance. Interviewee 11 (director of the health insurance service, Caren assurances) for example stated: *"health is a basic need just like security and education and the majority of people don't know about the utility of health insurance; the government has the responsibility to educate populations and provide health insurance."* As mentioned earlier, it seems that culture has a decisive role in the access to health insurance as it shapes health behaviours of communities and their willingness to be covered (O'Donell, 2007 ; Ingram, Lofthouse *et al*, 2013).

5.2.2.1.2 Corporate social responsibility

Participant 2 (enrolment specialist, Caren assurances) added: *"It is the responsibility of the government to develop health insurance and take the leadership. Private companies should be more involved in creating awareness, which would be our way to participate in changes and to have more people to subscribe"*. Most interviews revealed that the two commercial insurance involved in the study were not engaged in any form of CSR. Some interviewees referred *to creating awareness* as a future form of CSR , however most participants did not explain how they would engage in it

5.2.2.1.3 Path dependency

Participant 1 from commercial insurance (director of the health insurance service, Caren assurances) said: "*The impact of international organization is evident in our country. Many projects and programs are funded by foreign organizations because the government struggles to provide the basics to the population. International organizations are the principal source of health financing. NGO's and private insurance are important contributors to the development of healthcare"*. This statement points out the central role of foreign organisations in funding healthcare and the necessity of public institutions to reduce the dependency cycle. Furthermore, some interviews implied a path dependency of insurance policies focusing on workers in the formal sector. In concern to this , participant 1 from commercial insurance (director of the health insurance service, Caren assurances) said: *"the government covers the public sector and commercial insurance the private sector"*. This statement implies that the current system is not promoting health insurance for other segments.

5.2.2.2 Structure of health insurance

The theme structure of health insurance referring to the system of health insurance and the main actors involved in the funding and delivery of health insurance is the second common theme to the two series of interviews. Its subthemes including non-profit insurance, public and private insurance are discussed below.

5.2.2.2.1 Public insurance

On *public or government insurance*, the majority of interviewees agreed that government insurance is for workers in the public sector. Interviewee 12 (Provider service representative, Caren assurances) said that: *"public insurance covers mainly workers in public institutions and some semi-public organisations. There is no direct partnership between the government and private insurance. However, government regulates and monitors the sector through the service for the control of private insurance. The organisation controls private insurance in accordance with ECOWAS regulations".* Similarly, to interviews at the ministry of health, it was noted that government health insurance is not designed for the entire population, which equally reflects the link between access to health insurance and income inequality (Kaestner and Lubotsky, 2016). Another point of discussion confirmed by interviews is that government insurance is not based on social protection for all segments of the population, unlike social health insurance in some countries like France. On that issue, Carrin (2005) explained that it is a challenge for developing countries to have social insurance based on taxation since the majority of the labour force works in the informal sector.

5.2.2.2.2 Private insurance

Interviews with both companies revealed that *private insurance* covers essentially the private sector and international companies and clients are always subscribed by groups and sponsored by their employers[2]. Interviewee 7 (account manager, Sunu assurances) said*: "In Caren, 100% of our clients are employers from private companies, international organizations and NGO's. Basically, they are subscribed by groups of ten and their contribution is deduced on salaries. We offer coverage from 70 to 100% depending on the type of contract".* Moreover, members have the possibility to subscribe their close family members. Overall, private insurance targets solvable people and gives priority to the private sector. It was also noted that private insurance in Niger is employment-based which offers benefits for workers and their families (Cubbins and

[2] In general in Niger, private insurance results from the signature of a collective agreement or a "group insurance contract" between commercial insurance and clients; and negotiated by a union (Loutou, 2009). The article 1134 of the civil code regulates contracts of private insurance between companies and clients.

Parmer, 2001). Jensen & Morrisey (1990) noted that premiums of employement-based insurance or group insurance depend on the size of the group and the benefits package.

5.2.2.2.3 Non-profit insurance

Some respondents stated that non-profit insurance includes both community-based insurance and other types of health mutual provided by international organizations. Interviewee 11 (director of the health insurance service, Caren assurances) said: *"There is few non-profit insurance and the majority of them are financed by international organizations, which is not the ideal situation*". When asked for more clarification he added: "*Well, we rely heavily on foreign aid what makes us dependent and is not really sustainable. I think the government should take more responsibilities to develop the sector."* Based on this view, it seems that the non-profit sector, especially foreign organisations play a crucial role in the development of health insurance sector. In this regard, literature has also discussed the significant impact of the non-profit sector in development (Ron, Abel-Smith et al, 1990; Park, 2009).

5.2.2.3 Consumption of health insurance

5.2.2.3.1 Financial resources

Traditionally, public funds and private spending mainly fund health insurance. In developing countries, however, the government expenditure is not growing enough to lead to a decrease in out of pocket payments; moreover, a good number of countries depend on external funds (Baltagi and Moscone, 2010). During the interviews, financial resources were referred as a limit for the development of health insurance. Interviewee 11 (director of the health insurance service, Caren assurances) said*:" health insurance is not developed because people do not know it, but limited financial resources are the main challenge for the development of health insurance".*

5.2.2.3.2 Adverse selection

Adverse selection, which involves information asymmetry that favours one party over the other, was also described as a limitation. Usually, health insurers offer contracts accordingly to clients' health risks and their ability in paying premiums (Akerlof, 1970; Pauly, 1976; Rothschild and Stiglitz, 1976). When asked about adverse selection, the majority of respondents agreed that adverse selection exists in private insurance mainly because premiums are high, therefore unaffordable for most people. Moreover, private insurance is primarily employment-based which excludes the informal sector (Lewis, 2006).

5.2.2.3.3 Premiums

Interviews in both companies revealed that premiums are high and not accessible for the majority of the population. Interviewee 10 (enrolment specialist, Caren assurances) said: *"there is a link between the development of health insurance and the economic situation of the country. Most people cannot afford health coverage because they are poor"*. On this issue, some literature (Preker et al, 2002; Carrin et.al, 2005) suggested that premiums in the context of private insurance are not appropriate for developing countries mainly because financial resources are not transferred from the rich to the poor, rather from the healthy to the sick. Moral hazard theory, on the contrary, refers to excessive healthcare consumption (Arrow, 1963; Pauly, 1968 and Marshall, 1976). On this Interviewee 10 (enrolment specialist, Caren assurances) commented as follow: *"the consumption of health services changes according to situations like weather conditions, outbreaks or personal conditions. Health is important and people are willing to pay more to stay healthy"*. Interviewee 12 (Provider service representative, Caren assurances) stated: *"an increase of health consumption does not generate additional costs for us, but most likely an increase in demand. When a client exceeds the value of the premium, there is no reimbursement and additional coverage*". From this statement, one could understand that private insurance in Niger faces the phenomenon of adverse selection rather than moral hazard.

5.3 Analysis: focus Group ministry of health

5.3.1 Discourse analysis

The analysis process of the focus group was conducted in three phases. In the first phase discourse analysis was used to understand the use of language including the variation of meaning, patterns, keywords and contradictions; which then helped for the thematic analysis. The number of participants and questions could be relatively small when participants have specialized knowledge and experience (Krueger, 1994). The discussions started with a brief overview of the study and objectives of the research then the questions were asked as follow:

Question 1: At what extent foreign aid is involved in health insurance. What is path dependent about the funding of health insurance?

Participant 1 (director of the division of universal health coverage) said: *"International organizations have a big part in the funding of health insurance and healthcare in general. When it comes to health insurance, the government should do a big part or the biggest part. Development partners could not continue to be the main source of financing. They can give technical support and capacity building but not targeted as the main source of health financing in Niger. The development of healthcare is related to economic development and the development of health infrastructures. For instance, the country spends a lot on evacuation since there are no adequate infrastructures. Health insurance is certainly a sector that needs to be developed. For decades, Niger is receiving foreign assistance for all sectors including healthcare. The funding of health insurance is mainly through the national budget and external funding form various donors. The government budget for healthcare has been increasing the last years, for at least 4 years now."*

Participant 2 (assistant director in the division of universal health coverage) said: *"Partnerships are also very important for progress; it should include everyone, the government, private sector, communities and international partners. Financial and technical partners always had a crucial role in the development of healthcare in Niger for decades. This includes multilateral, bilateral aid, international organisations and non-governmental organisations".*

Participant 3 (coordinator for the development of health mutual): *"International aid is not sustainable and Niger is a country that relies on it for decades, since the day of independence. The ideal situation will be to stop relying on international aid but for now, the country needs those kinds of partnerships. Moreover, in terms of capacity building, it is interesting to follow the model of countries like France and Belgium that have a long experience in term of health insurance. We should learn from them and apply a mechanism of health insurance that is suitable for our country".*

Participant 4 (official in the unit of community health) said: *"Foreign assistance is one of the main funding source for healthcare in Niger. Multiple partnerships exist including donor countries and international organisations. There is a path dependency of the decision of the government to work with external partners as it continues to occur despite the change of leaders. It is difficult to cut short this tradition, however with time it will be possible".*

Participant 5 (official in the division of universal health coverage) said: *"Partnerships are necessary to develop health insurance and this at any level, between government's community, international partners and private sector. External aid is important, as the government does not have all the technical and financial capacity to develop healthcare. Few partnerships exist on the development of health insurance alone; usually it is included broadly in the development of healthcare."*

Participant 6 (official in the division of universal health coverage) said: *"Niger has been working with development partners for decades: and the country is learning from those partnerships to achieve the development goals. The project with the Belgian cooperation is an example of how international organizations are involved in projects in our country. I agree that it is not the ideal situation to depend on but for now, it is necessary. Developing partners should not be the main source of financing. They can give technical support and capacity building but not targeted as the main source of health financing in Niger. Moreover, Out of pocket payment is not appropriate since the majority of the population is poor. That is the main reason we work to implement community based insurance that would benefit the entire population".*

Participant 1 referred to international organizations as the main funding resource of health insurance, the majority of participants shared his view even though each of them used a different variation of language for the term "main funding resource". Participant 2, 3 4 and 5 referred to

the word *"main funding resource*" as *"partnerships"* and qualified them as important. This variation of wording refers to the same meaning, as participants believed that partnerships are linked with the funding of health insurance. Further, participant 1 and 3 used the word "but" as a contradiction to show that partnerships are necessary but are not sustainable or the ideal situation for the country, which is dependent of foreign aid. The words "political commitment" and "motivation" were regular patterns used by several participants or repeatedly used by the same person. Participant 3 and 4 believed more political commitment is needed for the development of health insurance while participant 1 thought the government is already committed to developing the sector and "cannot do it alone". This indicates that participants had different positions concerning the involvement of the government.

The majority of participants agreed that the government should be the principal actor in the development of health insurance. Some participants discussed the success story of Rwanda and how political commitment was crucial in providing health insurance to all segments of the population. Moreover, some participants raised the importance of partnerships with both local and international organizations considering that the government is not capable of providing all the resources for the development of health insurance. One major element mentioned in question 1 is the creation of the government's community based health insurance which, when implemented will offer access to health insurance to all segments without distinction of socio-professional sector.

Question 2: How to develop community-based health insurance for the informal sector?

Participant 1 (director of the division of universal health coverage*):* *"The existing organisations of community based health insurance are not monitored by the government. They do not work effectively and most of them do not survive. The government community health insurance project however is likely to be more sustainable if we achieve to implement it. The challenge would be to raise funds from both external and internal sources".*

Participant 2 (assistant director in the division of universal health coverage*):* *"If we succeed in implementing the system of community based health insurance, the biggest challenge would be to raise funds from the informal sector. It is our job in this department to develop those*

mechanisms and to present them to decision makers. Mechanisms should be tailored to collect contributions from populations in the informal sector including the ones in rural areas".

Participant 3 (coordinator for the development of health mutual*):* *"I also think that the system should be decentralized, each community health insurance would be then connected to specific hospitals and other healthcare structures. We have to design a system that would work effectively with healthcare structures. The process to attain universal health coverage would require the work of technicians in the ministries of health, finance and social protection. The involvement of populations is crucial, as they are the first beneficiaries. The process of health insurance development should include three elements: Technical work, political validation and popular acceptance. "*

Participant 4 (official in the unit of community health): *"It is crucial to create awareness about health insurance and educate the population. Partnerships should exist between communities and the government".*

Participant 5 (official in the division of universal health coverage): *"Partnerships are important for the development of health insurance because the government cannot do it alone. More partnerships are needed with the private sector, including the non-profit ones. The development of community based insurance and socio-professional mutual is essential in the development of health insurance".*

Participant 6 (official in the division of universal health coverage): *"For now, there is no concrete model on how to provide insurance for all, but the community based health insurance is strongly considered. Concerning the government monitored community insurance; financial resources would be put together and supervised by the government. More partnerships would exist between local sectors and institutions".*

When asked about the development of community based health organisations, participant 1 stated that the government does not monitor regular CBHI and the majority of them do not work effectively. He however, explained that the government's project for CBHI would be more "sustainable". This implies that regular CBHI organizations would continue to exist and develop as it is now, in addition, the government project for CBHI would be implemented. Participant 1 also stated that it would be a challenge to "raise funds" for the government CBHI as a big part of

the population has irregular income. Participant 2 also argued that it would be a challenge to raise funds especially from the "informal sector". The word "informal sector" even though mentioned few times was critical in the discussion, as the government project would essentially cover people in that sector. In this sense, participants 3 and 4 explained that "awareness" and "popular acceptance" were important in the development of health insurance. The patterns "informal sector", "awareness" and "population acceptance" even though formulated differently supposed that the population should be involved in the development of CBHI. Overall, participants discussed the existence of community-based health insurance organisations and mentioned the limits to their development including financial resources, human resources, and ignorance. Participant 5 (official in the division of universal health coverage) explained that there are 266 communes in the country and the government's community insurance project aims to create community health mutual for each commune. On this, participant 4 (official in the unit of community health) added: *"the project will not cover city or villages but municipalities"*. When asked clarification on the financing he stated: "*members will contribute over a period of time, maybe monthly. The government will also participate in the funding"*. On this, participant 6 (official in the division of universal health coverage) raised fundamental concerns about the funding: *"The challenge is to get money from the informal sector; irregular incomes are the main challenge we might face"*. In addition, the researcher noted that participants focused on discussing the project of the government monitored CBHI rather than discussing the development of existing CBHI organisations as initially asked.

Question 3: What will be the process for attaining universal coverage in Niger?

Participant 1 (director of the division of universal health coverage): *"Ideally it will be good to not rely on international aid. However, for now, Niger needs the experience of countries like France. Funding is also another element; Niger needs funding from developing partners for the implementation of projects. Health insurance system at the national level should be a mix of regimes and can be based on health mutual, social insurance that will cover a bigger segment of the population"*.

Participant 2 (assistant director in the division of universal health coverage): "*It is important to note that those international partnerships are done with the consent of the government. Even if numbers of projects are funded by external organizations, we work in*

partnership with those actors, for decision-making and implementation. No foreign organization could actually operate a project without our knowledge and consent. Health mutual at the communal level could contribute to attaining universal coverage but the mix of systems is the ideal situation for Niger".

Participant 3 (coordinator for the development of health mutual): *"I also agree that the government should not rely heavily on international aid. It is the responsibility of the government to provide health insurance and healthcare. We have been working for decades with foreign partners; it would be difficult to cut short our partnership. However, we could progressively reduce the dependence. Political commitment and partnerships are important for attaining universal coverage".*

Participant 4 (official in the unit of community health): *"insurance should be compulsory and it is the duty of government to educate populations and make the access easier. There is a correlation between the economic development of a country and access to healthcare. For instance, more than half of the population live at least 5 kilometres away from a health centre. When a country has more financial resources, it is more likely to improve the lives of people. Many ECOWAS countries are facing the same challenges in terms of healthcare. Political commitment is important to develop insurance, so are partnerships. There is the project for health insurance at the communal level in partnership with the Belgian cooperation. A pilot study will be conducted in one community in Niamey. People from the informal sector could access health insurance by contributing. The government and the Belgian cooperation would also provide funds. Partnerships are important".*

Participant 5 (official in the division of universal health coverage): "*The community health insurance project is interesting for us. If the pilot study is a success we would try to implement it to other areas and later on, across the country. This project is in partnership with foreign organizations. However, we also have socio-professional health mutual that insures workers by profession. For example, workers in the Nigelec (Nigerien Electricity Company) have their own insurance mechanism. The community based insurance project will be funded by the government, external actors and local communities. It looks promising. Your research is up to date since Niger needs to develop its health care system, especially for rural areas. We are conscious that*

health insurance is an important component of healthcare. This is the reason why my colleagues and I, are involved in finding long-term solutions".

Participant 6 (official in the division of universal health coverage): "*I am an optimist and believe Niger could attain universal health coverage. It has been possible for other countries and we could also succeed. It will be a long process but with the right leadership and mechanism, it is feasible. I agree that it is not the ideal situation, to be dependent but for now, it is necessary".*

When asked about the process of attaining universal health coverage, participants recognized the determining role of international organization in funding the sector. The term "international organisations" had many variations to different participants but referred to the same meaning (Phillips and Jorgensen, 2002). Participants 5 and 6 denoted it as "developing partners", using the connotation partners suggests that the government is not subordinate to those organisations rather has an equal-to-equal relation. On this issue participant 2 clarified that international organisations need the consent and approval from the government before implementing projects. These statements appeared to claim that the dependence to foreign organizations does not diminish the sovereignty of the state. This point raises an important issue on the dependence of developing countries to external aid, which was confirmed by the use of the terms "reduce dependence" by participant 2 and "long term solutions" by participant 4. For this question, discourse analysis mainly addressed the social concern of dependency to foreign aid (Foucault, 1972).

Overall, the majority of participants accepted that attaining universal coverage would be a long process, however, stayed optimist about the outcomes. Many of them insisted on the importance of government involvement especially in terms of financing the sector. The majority of participants thought that the process should include three elements: Technical work, political commitment, partnerships and community involvement.

Discourse analysis was used primarily to analyse the use of language, which helped the researcher to explain and interpret the discussion. It was also used to understand the group dynamics. It was noted that participants were relatively free to talk regardless of their position in the organization even though the director of the division of universal health coverage had more interventions. Power relation was homogenous; participants respected the time of intervention of other members. Most of the time, they would complement responses from other participants.

Diverging views often lead to debates especially for question 3. One-half of participants thought that partnerships are necessary while the other half explained that government should take the lead before international organizations. In addition, it was interesting to see how participants were opened to discussing sensitive topics such as the inability of the government to provide health insurance. Overall, discourse analysis enabled to identify recurring patterns and contradictions, later on used to generate themes (Doucet and Mauthner, 1998; Cowan and McLeod, 2004).

5.3.2 Thematic Analysis

The thematic analysis of the focus group at the ministry of health derived from the discourse analysis in phase one, which enabled the identification of main codes, related to the three questions. The codes identified with the help on Nvivo 12 were generated based on the frequency of use in the participants' responses. The word frequency count enabled to identify *funding, informal sector* and *community-based insurance* as main themes. The thematic analysis of the focus groups helped exploring the potential solutions for the low coverage of health insurance while the thematic analysis for interviews explored the phenomenon.

5.3.2.1 Funding

On funding of health insurance, Participant 1 from the ministry of health (director of the division of universal health coverage) said: *"the development of healthcare is related to economic development and the development of health infrastructures. For instance, the country spends a lot for evacuation since there are no adequate infrastructures. Health insurance is certainly a sector that needs to be developed"*. In other words, a strong economy reflects a healthy public budget, which enables investments in the sector of health (Mullins, 2007).

It was concluded from the focus group that health insurance is not accessible to the entire population because of budget constraints. Like many developing countries, Niger has low fiscal revenue as the majority of the population is in the informal sector, consequently low taxation rate, combined with excessive borrowing result in public deficit (Fischer and Easterly, 1990). Further Participant 3 (coordinator for the development of health mutual) added: "*Political commitment and partnerships are important. International organisations aid is not sustainable"*.

The ideal situation will be to stop relying on international aid but for now the country needs those kinds of partnerships". This statement suggests that the country is relying on foreign for an extended period. On the other hand, the inefficiency of external aid is often linked to low taxation and misallocation of financial resources, which are characteristics of developing countries (Bastida & Benito, 2007). The theme *funding* is related to the path dependency of the funding of healthcare in Niger, this suggest that there is a path dependency on the funding of healthcare in Niger, and the decision of the government to rely on external aid.

5.3.2.2 Informal sector

The discussion at the ministry of health mentioned challenges related to the coverage of the informal sector. The discussion at the ministry of health revealed a government project to create community health insurance. Participant 2 from the ministry of health (assistant director in the division of universal health coverage) said: "*If we succeed in implementing the system of community based health insurance, the biggest challenge would be to raise funds from the informal sector. It is our job in this department to develop those mechanisms and to present them to decision makers. Mechanisms should be tailored to collect contributions from populations in the informal sector including the ones in rural areas*". This participant discussed the difficulty for the government to raise funds from the informal sector and a possible explanation to that might be income irregularity since people in that sector usually have unstable jobs (Pratap & Quintin, 2006). The *theme informal* sector suggests that there is a path dependency of government decision, as public insurance does not cover the informal sector. The government community insurance project implies that policies will change and promote the development of health insurance for the informal sector.

5.3.2.3 Community based insurance

Community-based health insurance (CBHI) is a voluntary mechanism based on solidarity (Atim, 1999; Jutting, 2004). There is a correlation between income inequality and access to healthcare, for this reason, Kaestner and Lubotsky (2016) assumed that CBHI are appropriate for low-income groups. In fact, low-income countries have difficulties in achieving universal health protection leaving rural areas and some urban communities paying for healthcare (Carrin, 1987;

Platteau, 1997 and Van Ginneken, 1999). Many believed that community health insurance is appropriate for low-income countries for many reasons. It offers financial protection for populations as it reduces out of pocket payments and improves standards of living of thousands of people (Gilson, 1997 and Preker et al, 2002). Participant 2 from the ministry of health (assistant director in the division of universal health coverage) said: *"If we succeed in implementing the system of community based health insurance, the biggest challenge would be to raise funds from the informal sector. It is our job in this department to develop those mechanisms and to present them to decision makers. Mechanisms should be tailored to collect contributions from populations in the informal sector including the ones in rural areas"*. This participant discussed the difficulty for the government to raise funds from the informal sector and a possible explanation to that might be income irregularity since people in that sector usually have unstable jobs (Pratap & Quintin, 2006). The theme *community based insurance* emerged as a potential solution to cover a greater part of the population.

5.4 Analysis: focus Group for commercial insurance

5.4.1 Discourse analysis

The analysis process of the focus group was conducted in three phases. In the first phase discourse analysis was used to understand the use of language including the variation of meaning, patterns, keywords and contradictions; which then helped for the thematic analysis. The number of participants and questions could be relatively small when participants have specialized knowledge and experience (Krueger, 1994). The discussions started with a brief overview of the study and objectives of the research then the questions were asked as follow:

Question 1: At what extent foreign aid contribute in the development of health insurance? What is path dependent about the funding of health insurance?

Partcipant1 (director of the health insurance service, Caren assurances): *"The impact of international organization is evident in our country. Many projects and programs are funded by foreign organisations because the government struggles to provide the basics to the population. International organizations are the principal source of health financing. Non-governmental*

organisations and private insurance are important contributors to the development of healthcare and health insurance. The funding mechanism has been the same for many years, with a variety of funding sources".

Participant 2 (enrolment specialist, Caren assurances): *"International organisations and non-governmental organisations have a big impact on developing countries and Niger is one of them. They give funding and monitoring for healthcare and I guess in terms of health insurance too".*

Participant 3 (provider service representative, Caren assurances): *"The majority of the population does not have insurance and pays for healthcare. International organisations help the less privileged to access healthcare". I think foreign organisations help populations to access better health care by investing in health structures and human resources. However, I don't think a lot has been done in terms of health insurance".*

Participant 4 (chief of the division of health insurance, Sunu assurances): *"The government works with international organisations for the development of many sectors including health insurance. International organisations like UNICEF are very involved in development for Niger, for many years. There is a path dependency for partnerships and funding of healthcare. But there are also regional organisations that contribute as well, for example, ECOWAS". As a member of ECOWAS, Niger follows the organisation's requirements when it comes to healthcare". Like my colleague said the priority is given to primary healthcare rather than the development of health insurance".*

Participant 5 (responsible for reimbursement, Sunu assurances): *"International organisations are one of the main sources of funding. They participate in the development of the country in general and to health insurance. They work in collaboration with the government. Foreign organisations especially Non-governmental organisations are considered as the private sector. But up today we do not have any type of direct collaboration with them".*

Participant 6 (account manager, Sunu assurances): *"International organizations contribute to the development of many sectors like education, nutrition and also health insurance. Even though their action affects thousands of people, it is not sustainable, over the years. Many projects funded by international organizations did not last".*

When asked about the role of international organisations in the development of health insurance, the majority of participants believed that foreign organisations are the main source of funding for healthcare. Participants referred to the financial role of those organisations as "principal source" of funding (participant 1) or "source of funding" by participant 5. Then, the term "impact" appeared to be a keyword since participant 1 and 2 agreed that foreign organizations have a big impact on the development of healthcare. This statement answers the current question since international organisations have a big impact on the development of health insurance. Some participants; however, discussed the impact on healthcare rather than health insurance; participant 2 and 4 argued that international organisations participate to the development of healthcare in general without focusing on health insurance. This argument contradicts the view of participants from the focus group at the ministry of health who stated that the government works with international organisations for the development of health insurance. Further, participant 2 claimed that foreign aid helps the "less privileged", the use of this term implies that international aid affects most the lowermost of the population (Abrahamsen, 2004). This statement confirms the argument raised by some participants in the first focus group who said that the majority of population, essentially in the informal have no health insurance. In addition, participant 6 claimed that international aid is not "sustainable", a point that has been raised by participants in the first focus group.

Overall, Participants agreed that international organisations play a role in the development of healthcare and health insurance at some extent. They also agreed that foreign organisations are the main source of funding for healthcare for many years. It was equally understood that there is path dependency for the funding of health insurance as foreign partners have been playing a crucial role. Then, financial mismanagement was equally mentioned as a limiting cause for the funding of health insurance.

Question 2: Could private insurance extend its market to the informal sector? How will you apply CSR in this context?

Participant 1 (director of the health insurance service, Caren assurances): *"It is a challenge for commercial insurance to cover the informal sector as perceiving premiums is difficult and people are not always solvable. It would also require a lot of work to implement new funding mechanisms for this sector. Awareness should be created on the importance of health insurance,*

and private insurance could contribute to that through advertisement. However, that would be limited to the formal sector. This would be our way to apply corporate social responsibility".

Participant 2 (enrolment specialist, Caren assurances): *"It is the responsibility of the government to develop health insurance and take the leadership. Private companies should be more involved in creating awareness that would be our way to participate in changes and to have more people to subscribe. Workers from the private sector from both local and foreign companies would join more. But like my colleague said it is a challenge with the informal sector".*

Participant 3 (provider service representative, Caren assurances): *"It will be difficult for the informal sector to join private insurance. The service we offer now is employment-based where employers in most cases pay premiums. With the informal sector, we can also apply the system of group insurance but getting the contributions would be difficult. I also think that the government should create a system of health insurance for the informal sector. Otherwise, the government could then encourage the creation of community based health insurance and monitor their functioning".*

Participant 4 (chief of the division of health insurance, Sunu assurances): *"The private sector should contribute to the development of health insurance but we cannot afford to be fully dedicated to the informal sector; the government should be the first actor to ensure healthcare services to all. Public institutions should definitely take more responsibilities in this domain".*

Participant 5 (responsible for reimbursement, Sunu assurances): *"Partnerships between the public and the private sector could be a good solution. Private insurance should diversify the market and consider the informal sector. Delivering better services to existing clients and extending our services to the informal sector would be a way to apply corporate social responsibility. As mentioned including the informal sector which will be challenging and will require new policies and mechanisms adapted to the group".*

Participant 6 (account manager, Sunu assurances): *"It is possible to include the informal sector, especially people who are able to pay premiums. Business people for example, could pay their premiums through their unions. Farmers could join agricultural cooperatives to access*

health insurance. Private insurance could integrate the informal sector at some extent but the government should be the one organising health insurance for the poor classes".

When asked about the possibility for commercial insurance to include the informal sector, the majority of participant used the word "challenge" to refer to the extension of services to the informal sector. Participant 1 explained that it would be difficult to perceive premiums from this sector, as most people are not "solvable". The word solvable is closely linked to premiums as private or commercial insurance select its clients on their ability to pay the insurer (Pauly, 1976). Participant 3 used the term "it will be difficult" instead of "challenge" as other participants to express the problematic of including the informal sector. In terms of frequency, the statement "responsibility of the government" was used by 2/3 of the participants including participant 2, 3, 4, and 6. The use of this term expresses the importance of the government to take the leadership in the development of health insurance for the informal sector. Similarly, to the focus group in the ministry of health, participants from commercial insurance believed that the government should provide insurance coverage for the informal sector; in this sense participants admitted that commercial insurance would have a limited role in providing insurance services to this sector. Participant 1 and 2 from Caren insurance implied that the role of commercial insurance would be limited to creating "awareness" on the importance of health insurance. Participant 4, 5 and 6 from Sunu insurance believed that private insurance at some degree could include the informal sector. To express the possibility of including this sector, participant 4 used the statement "not fully dedicated" to the informal sector and participant 5 used "consider" the informal sector. Then participant 6 clarified that the extension of services would only be possible for the ones who "can pay premiums". As mentioned earlier, the payment of premiums is a critical element for private insurance. During the discussion participant did not explain how their companies apply corporate social responsibility to the informal sector. Participants form Sunu assurance imply the possibility to apply CSR for the informal sector able to pay premiums. One could understand that Sunu Assurance is ready to extend their services to the rest of the community while making profit (Caroll, 1971). Furthermore, the responses indicated that private insurance does not apply CSR to the informal sector primarily because the segment is not part of the market; in addition, private companies do not seem to carry philanthropic activities to the community (Loutou, 2009).

Overall, most participants agreed that it would be challenging to include people from the informal sector mainly because the majority is not solvable throughout the entire year. During the discussion, two opposing views emerged. Participants from Caren assurance explained that there is no possibility to include the informal sector in private insurance while participants from Sunu assurance contrasted this view by accepting the possibility for some groups who have financial resources to pay premiums.

Question 3: What would be the path for Niger to attain universal coverage?

Partcipant1 (director of the health insurance service, Caren assurances): *"Rwanda is an ideal example as the majority of the population is insured. It is all about government determination and the good use of resources. Besides, non-profit insurance like community-based insurance could be a solution. Niger could learn from the experience of Senegal and Ghana. Changes would take time, but if all actors put in efforts, things could happen."*

Participant2 (enrolment specialist, Caren assurance): *"Partnerships with local entities and communities are crucial in the development of health insurance. Populations have to be involved in the process. And like my colleague said, community insurance seems to be the best option".*

Participant 3 (provider service representative, Caren assurances): *"The government has to invest more in health insurance and take the leadership for its development. Private insurance can contribute to changes but the big part should be done by our leaders."*

Participant 4 (chief of the division of health insurance, Sunu assurances): "*Partnerships are important to develop health insurance and private insurance companies should participate in the change as well. Besides, the government should also encourage the development of private insurance through the implementation of new taxation policies. If we have less constraint on that side, we would be more able to improve our services and maybe consider including the informal sector as well".*

Participant 5 (responsible for reimbursement, Sunu assurances): *"Everyone should participate in the changes, the government first and private insurance too. The population should be educated and encouraged to have health insurance. But the government should first offer the mechanism for health insurance and healthcare infrastructures".*

Participant 6 (account manager, Sunu assurances): *"Health insurance is not well developed. There is a lot to do. Some countries like Ghana, Senegal, and Rwanda are doing well for health insurance. We can maybe improve by studying their weakness and strengthens".*

When asked about the path to attain universal health coverage, participant 1 and 6 mentioned the success stories of countries like Senegal and Rwanda that could be used as example. Participant 1 used the word "learn" from to illustrate examples of countries that are achieving insurance coverage and to point out the need to study and apply their strategies. Participant 6 used the statement "not well developed" to assess the current situation and the need to improve it, and then, similarly participant 1 mentioned the example of some countries as an alternative way to learn for the future. The word "partnerships" was used by participant 2 and 4 as another alternative for the improvement of health insurance. Further, the role of government like in question 2 occurred to be required for the improvement of health insurance. On this, participant 1 discussed the good use of "resources" while participant 3 thought the state should "invest more". The use of these two terms refers to funds in a different manner; the use of "resources" implies the management of available funds while "invest more," suggests that the state should allocate additional financial resources to the sector. Participant 4 had another interpretation of the involvement of government when he held that softer "government policies" would encourage commercial insurance to extend its market; this affirmation suggests that the government's policies influence the performance of the market (Rothschild & Stiglitz, 1978). Participants 3, 4, 5 and 6 addressed the role of private insurance in the quest of universal coverage; participant 4 from Sunu said that private insurance "should participate" to changes while participant 3 from Caren stated it "can contribute" to it. This indicates that the two companies have different approaches concerning the involvement of commercial insurance. Participant 3 justified this view by stating that the government should take the "leadership" which then seems to justify the minimum involvement of private insurance.

Overall, participants thought the process towards universal coverage should include population education and government involvement. Creating awareness would inform people about the importance of health insurance, thus will encourage them to be covered. The second point was political commitment and the necessity for the government to fund and monitor the mechanism of health insurance nationwide. While participants discussed alternatives for the development of health insurance it was noted that few has been said about the role of private insurance and CSR,

and how for-profit insurance could participate to the process. On this issue the focus group at the ministry of health on the other hand, suggested more CSR from private insurance.

5.4.2 Thematic analysis

The thematic analysis of the focus group at the ministry of health derived from the discourse analysis in phase one, which enabled the identification of main codes, related to the three questions. The codes identified with the help on Nvivo 12 were generated based on the frequency of use in the participants' responses. The word frequency count enabled to identify *international organisation (foreign aid), awareness* and *government* as main themes. The thematic analysis of the focus groups helped exploring the potential solutions for the low coverage of health insurance while the thematic analysis for interviews explored the phenomenon.

5.4.2.1 International organisations

Partnerships are important for the development of health insurance. External aid represents a fair share of the funding of health insurance (Elbadawi, 1999; Brautigam & Knack, 2004). Many (Riddell, 1999; Palmer, 2004; Gupta, Powell & Yang, 2006 ;) criticized the short time impact of international aid and the fact that it increases mismanagement, dependency and low taxation.). Partcipant1 from Caren insurance (director of the health insurance service, Caren assurances) said: *"The impact of international organization is evident in our country. Foreign organizations fund many projects in our country because the government struggles to provide the basics to the population. International organizations are the principal source of health financing. NGO's and* private insurance are important contributors to the development of healthcare". It is understood that the decline for national resources is the main explanatory factor for the involvement of development agencies in the country. It is widely held view that the role of international organisations is not solely limited to providing financial resources as these organisations in some cases influence the process of national policymaking (Hansmann, 1980; Cassels, 1995; Mosse & Lewis, 2005). In fact, foreign organisations tend to export the regulations of donor countries or their own governance structure which in some cases do not adjust to needs of recipient countries. A study conducted by Okuonzi (1995) on user fees and drugs policies in Uganda, has revealed

how the conflicting positions of foreign organisations and public institutions threatened the sovereignty of the state. Martinusen & Pedersen (2003) similarly indicated that the impact of international aid is weakened when foreign organisations fail to collaborate effectively with the governing bodies of recipient countries. The theme international organisations also refers to foreign aid. During the discussion with private insurance, similarly to the focus group at the ministry of health. It has been noted that foreign aid and the funding of healthcare have been applied in the same way for years, which implies a path dependency of decisions for external funding for healthcare.

5.4.2.2 Awareness

During the focus group of private insurance, some participants thought creating awareness is part of the process of improving health insurance. Similarly, some participants from the focus group at the ministry of health thought mentality and culture play a role in access to health insurance (Herkovits, 1948). Partcipant1 (director of the health insurance service, Caren assurances) said: "Awareness should be created on the importance of health insurance, and private insurance could contribute to that through advertisement. But that would be limited to the formal sector". Then Participant 4 from the focus group of the ministry of health (official in the unit of community health) said: "It is crucial to create awareness about health insurance and educate populations. Partnerships should exist between communities and the government". This statement points out the importance of information sharing between public institutions and communities for the progress of insurance coverage. Furthermore, studies have suggested the importance of well-tailored communication strategies in public awareness, notably for health determinants (Niederdeppe, Lisa-Bu et al, 2008). In this regard, Rimmer & Kreuter (2006) believed that health communication is a key element in public policy, as policymakers should adjust their decision to the demand of populations. Marmot, Friel et.al, (2008) argued that health communication goes beyond the simple information as it promotes social justice and health equity. They argued that social determinants including income and social groups are explaining factors to the unequal access to healthcare, which could be reversed through health communication. Besides, some studies have put forward that successful health communication campaigns lead to an increase in the willingness to pay health insurance (Devadasan, Ranson et al, 2004; Ruchita & Bava, 2011). The discussion with the private insurance raised concerns on extending services to the informal

sector mainly because premiums are high and the system is designed for solvable workers in the formal sector (Pauly, 1978). Studies have suggested that the informal sector is the larger part of the labour force in developing countries and in most cases is unable to participate to the formal sector social insurance (Creese & Bennett, 1998; Ginneken, 1993; Gumber, 2002). Moreover, it is challenging to find and implement schemes to ensure these populations (Peters, Gary et al, 2008). The discussion with the private insurance raised concerns on extending services to the informal sector mainly because premiums are high and the system is designed for solvable workers in the formal sector (Pauly, 1974). Studies have suggested that the informal sector is the larger part of the labour force in developing countries and in most cases is unable to participate to the formal sector social insurance (Creese & Bennett, 1998; Ginneken, 1993; Gumber, 2002). Moreover, it is challenging to find and implement schemes to ensure these populations (Peters, Gary et al, 2008). The discussion revealed that private insurance should be involved in creating awareness about health insurance including for the informal sector. About this, some participants indicated that culture; especially traditional customs and lack of education are barriers for the promotion of health insurance. Further, participants did not mention any existing or upcoming CSR activities.

5.4.2.3 Government

The theme *government* refers to the effort of the government in providing health insurance for all. Participant 3 from private insurance (provider service representative, Caren assurances) stated: *"The Government has to invest more in health insurance and take the leadership for its development. Private insurance can contribute to changes but the big part should be done by our leaders."* This statement clarifies that the government is not satisfactorily involved in the development of health insurance, as foreign organisations are the main sources of funding. On this, studies suggested that good governance is an ingredient for poverty reduction and development (Grindle, 2004). Participant 5 from the ministry of health (official in the division of universal health coverage) said: "*It's possible to get there with motivation and most importantly political commitment. Partnerships are necessary to develop health insurance at any level, between government's community, international partners and private sector"*. This statement referred to the critical role of government in health insurance and the need for public authorities to be dedicated to the improvement of the sector. One can understand that the improvement of

the sector includes both practical and policies reforms. In this sense, health policy revision and enforcement would be a starting point for the development of the sector. It seems, however, that the situation of health insurance in Niger reflects poor public reforms, which then result in declining public services (Walt & Gilson,1994). Batley and Larbi (2004) also agreed that sub-Saharan countries apply little policy enforcement to their health systems. Another strand of literature however argued that health reforms are more difficult to implement than the ones in other sectors (Walt and Gilson, 1994).

5.5 Phase 3: Cross data analysis of focus groups

The following table summarizes the themes generated from the focus groups. *Funding, informal sector* and *community insurance* are the main theme for the focus group for the ministry of health. International organisations, awareness and government were specific to the focus group for private insurance. We have to note that while themes are specific to each focus group, some of them have been addressed for the two discussions; this enabled to make a comparative analysis.

Table 5. 1 Table summarizing findings from the two focus groups

Themes	Ministry of health	Private insurance
Funding	The Discussion revealed that Foreign aid is one of the main funding source for healthcare And health insurance for many Decades, which indicated a path dependency of decisions and policy for the funding of health insurance.	Funding was equally a key term for this focus group. Participants linked international organisations as a critical source of funding.
International organisations		The discussion with private insurances similarly to the other focus group indicated the path dependency between the development of health insurance and external aid, notably international organisations.

Informal sector	Participants indicated that the informal sector is the largest segment of the population without health insurance. Until recently there was a path dependency of government decisions and policies towards this sector.	The informal sector was not a key theme for this focus group; however, participants indicated that the informal sector is the largest uninsured group and that awareness is a key element in developing health insurance for that sector.
Community insurance	Most participants indicated that community insurance is a potential solution for attaining universal coverage.	Community insurance was not extensively discussed. Participants indicted more government action to develop health insurance. There was not emphasize of the role of CSR from the perspective of private insurance.
Awareness	The concept of awareness and culture not been exclusively discussed. Some participants discussed the role of culture as a barrier however did not specifically proposed solutions As for the focus group with private insurance.	Awareness was pointed as a main barrier for the development of health insurance, therefore the importance of educating populations about it. The theme awareness had a close link with culture and the role of private insurance through CSR.
Government	The involvement of the government has been qualified as a key element in promoting health coverage. Participants explained that policies and mechanism would evolve in order to promote the extension of insurance to the informal sector.	Participants emphasized on the role of the government and its responsibility in developing health coverage. Moreover, the need to reform policies and the path dependency of health insurance policies.

The aim of the focus group was to explore certain phenomenon in depth including the involvement of foreign aid and the path dependency of funding; the development of health insurance for the informal sector considering the concept of CSR, culture and community insurance; and finally the potential solutions for attaining universal coverage.

- **To what extent foreign aid contribute in the development of health insurance? What is path dependent about the funding of health insurance?**

The two focus groups revealed that foreign aid has been a main source of funding for healthcare and health insurance for an extended period. Participants also suggested a path dependency of decisions, funding and partnerships between the government and international organisations.

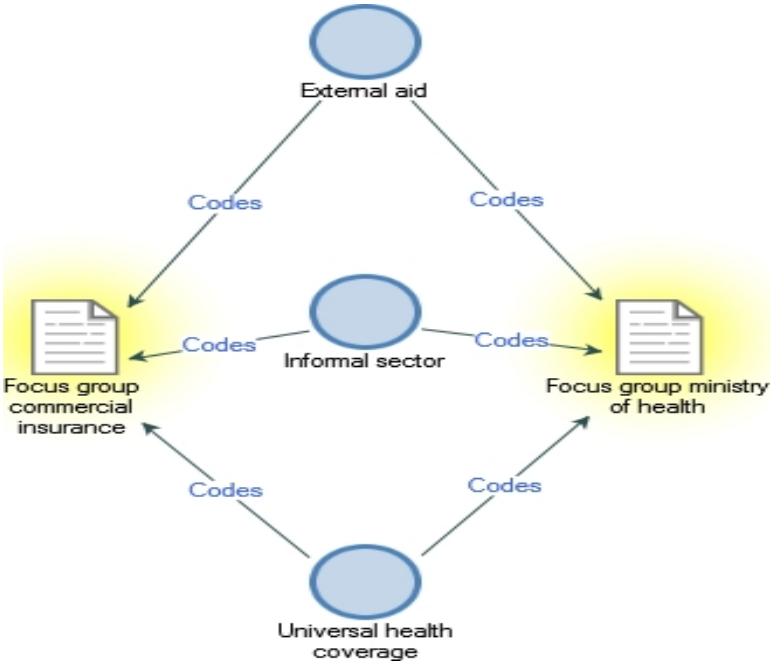
- **How to develop health insurance for the informal sector? Applying community insurance (public insurance) and CSR (private insurance).**

Both focus groups indicated that the informal sector both in rural and urban areas is the segment of the population with the lowest rate of health coverage. Further, the two discussions revealed the need to implement mechanisms for the informal sector. While participants from the ministry proposed community insurance across the country, participants from private insurance believed awareness and education on health insurance are crucial. Concerning CSR, participants from the ministry believed that private insurance should apply more CSR and extend their market the informal sector. On the other hand, most participants from private insurance disputed the challenge to include the informal sector.

- **What will be the process for attaining universal coverage in Niger?**

Overall, based on the responses from the two focus groups, health coverage needs to be extended to the informal sector. The focus group at the ministry of health suggested the key role of community insurance as well as the importance of CSR for private insurance, which could extend the services to new market. On the other hand, participants from private insurance believed the government should invest more in health insurance and reform health policies. Further, based on the two discussions it appeared that CSR, culture, path dependency and the informal sector are key elements for attaining universal coverage.

Figure 5. 1 Shared main themes from the two focus groups



Further, the analysis of themes organised in Nvivo generated three key elements for the development of health insurance including external aid, informal sector and universal health coverage. The comparative analysis of themes generated through Nvivo similarly from the summary of the focus groups implied that external aid (path dependency of funding) and the informal sector are important elements for universal coverage.

5.6 Analysis of surveys

This section presents the data analysis for the survey with the informal sector. The survey aimed at identifying the coverage, knowledge and willingness of the informal sector to join health insurance. Then the second survey with health practitioners, used as a complementary method was analysed directly through *Survey monkey*. This survey aimed at getting insights on the structure of health insurance and potential solutions for universal coverage.

5.6.1 Analysis of the survey for the informal sector

5.6.1.1 Methodology

A standardized questionnaire was used to collect the data on a convenient sample of 103 participants practicing in the informal sector. The data collected included the characteristics of the participants (age and gender), holding a health insurance at the time of the interview, the self-rating of the importance of health insurance, the willingness of the participants to pay to have a health insurance, the awareness of participant about health insurance company, the opinion of the participants towards ways for improving health care for the informal sector, path dependency measured the opinion of the participants towards government's decisions on development of health care, the contributions of private health insurance to promote the informal sector, the impact of culture and traditional medicine on the use of modern medicine. The data collected was computerized through MS Excel and analysed through the statistical package for social sciences (SPSS version 23). The data was then summarized numerically (mean, standard deviation and median) and graphically (frequency tables for estimating proportions and graphics). Association among categorical variables performed through chi-square and Fischer Exact tests. All the statistical tests were considered as statistically significant when p-value < 0.05.

5.6.1.2 Characteristics of the study participants

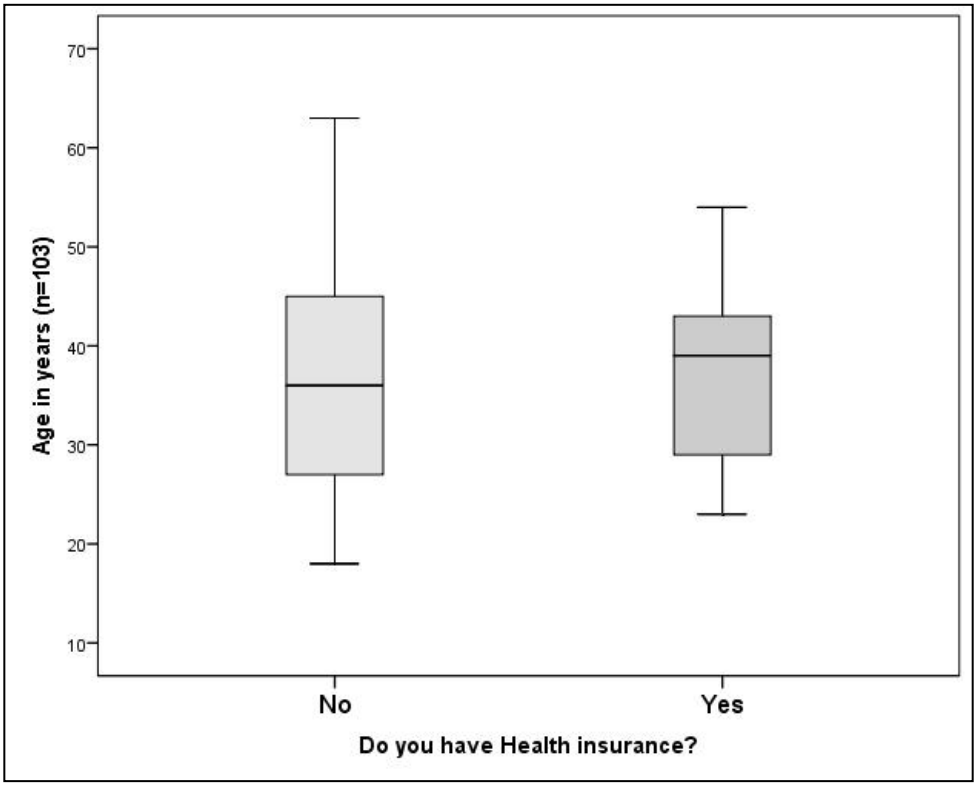
Of the 103 participants interviewed, the majority were males 68.0% (70/103) and the remaining 32.0% (33/103) were females. They were aged 18 to 63 years with average (median) age of 36 years.

5.6.1.3 Participants having health insurance

Of the 103 participants, only 9.7% (10/103) had a health insurance. The proportion of health insurance holders was higher in females (12.1%, 4/33) than in males (8.6%, 6/70). According to

their age, the health insurance holders were older than those who did not have health insurance with average age of respectively 39 and 36 years (figure 5.2).

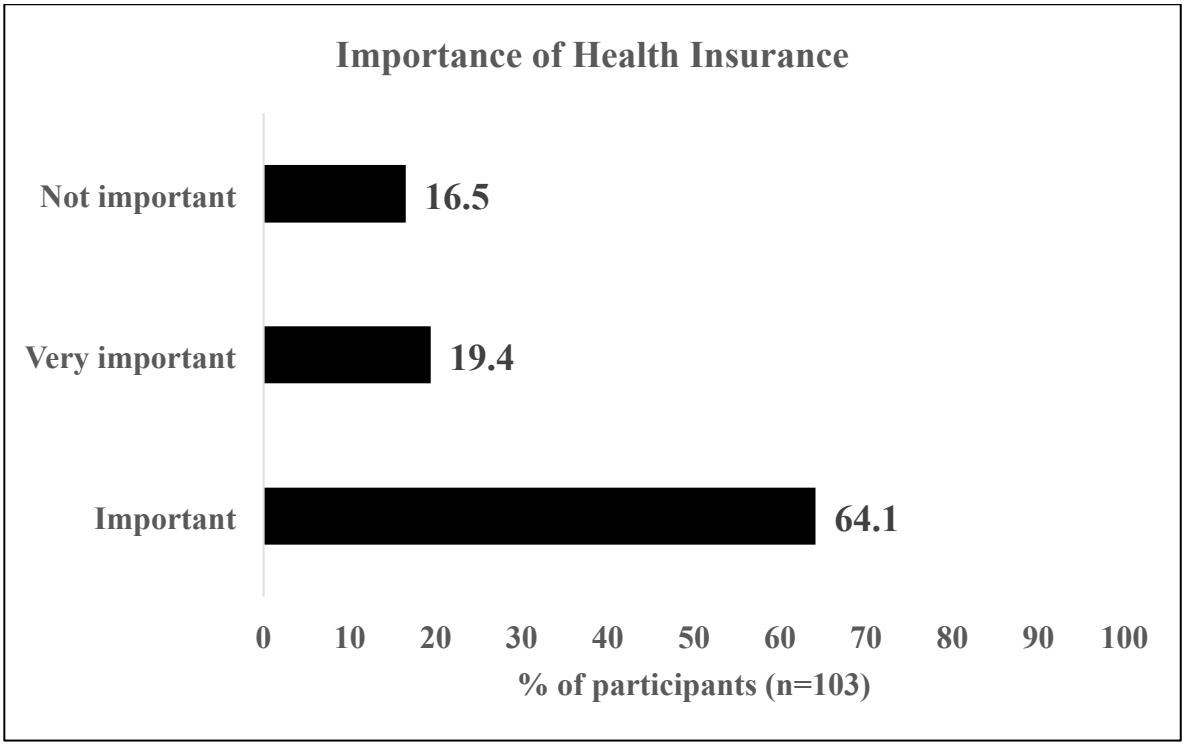
Figure 5. 2 Age distribution of the participants (n=103)



5.6.1.4 Importance of health insurance as reported by the participants

This variable was coded as "Very important", "Important" and "Not important". Those who responded that holding health insurance is very important or important were 83.5% (86/103) and the remaining 16.5% (17/103) responded that having health insurance was not important (figure 5.3).

Figure 5. 3 Importance of Health Insurance as reported by the study participants (n=103)



5.6.1.5 Willingness to pay to have health insurance

According to the gender, the proportion of females willing to pay for health insurance was lower than males with respectively 72.7% (24/33) and 81.4% (57/70) but there was no statistical significant association (p=0.315) between gender and the willingness to pay for health insurance. The willingness to pay for health insurance was higher in those aged below ≤ 36 years than in the group of > 36 years with respectively 80.8% (42/52) and 76.5% (39/51) but there was no statistically significant difference (p=0.595) between the two age groups regarding their willingness to pay for health insurance (table 5.2).

Table 5. 2 **Willing to pay for health insurance by gender and age of the participants (n=103)**

	Willingness to pay for health insurance				
Variable	**No**	**Yes**	**Total**	**% yes**	***p-value***

Gender (n=103)					
Female	9	24	33	72.7	0.315
Male	13	57	70	81.4	
Total	22	81	103	78.6	
Age group (n=103)					
18-36 years	10	42	52	80.8	0.595
37-63 years	12	39	51	76.5	
Total	**22**	**81**	**103**	**78.6**	

5.6.1.6 Awareness of the study participants on health insurance company

Of the 103 participants who were asked if they were aware of any health insurance company only 24.3% (25/103) responded "yes" as revealed by figure 3. 80.0% (8/10) of those who were aware about a health insurance were those holding a health insurance. The Fisher's Exact Test revealed highly statistically significant association (p=0.000) between awareness of a health insurance and having a health insurance (table 2). Females were predominant among those who were aware of a health company than males with respectively 27.3% (9/33) and 22.9% (16/70), however there was no statistical significant association (Pearson Chi-Square=0.238, p= 0.626) between gender and being aware of a health insurance company (table 2). Those who were aged > 36 years and aware of a health insurance company were 27.5% (14/51), the age group ≤ 36 years aware of a health insurance company were lower (21.2%, 11/52) but there was no statistically significant difference (p=0.456) between the age of the participants and their awareness about a health company.

Figure 5 . 4 Distribution the study participants (n=103) towards their awareness of a health insurance company

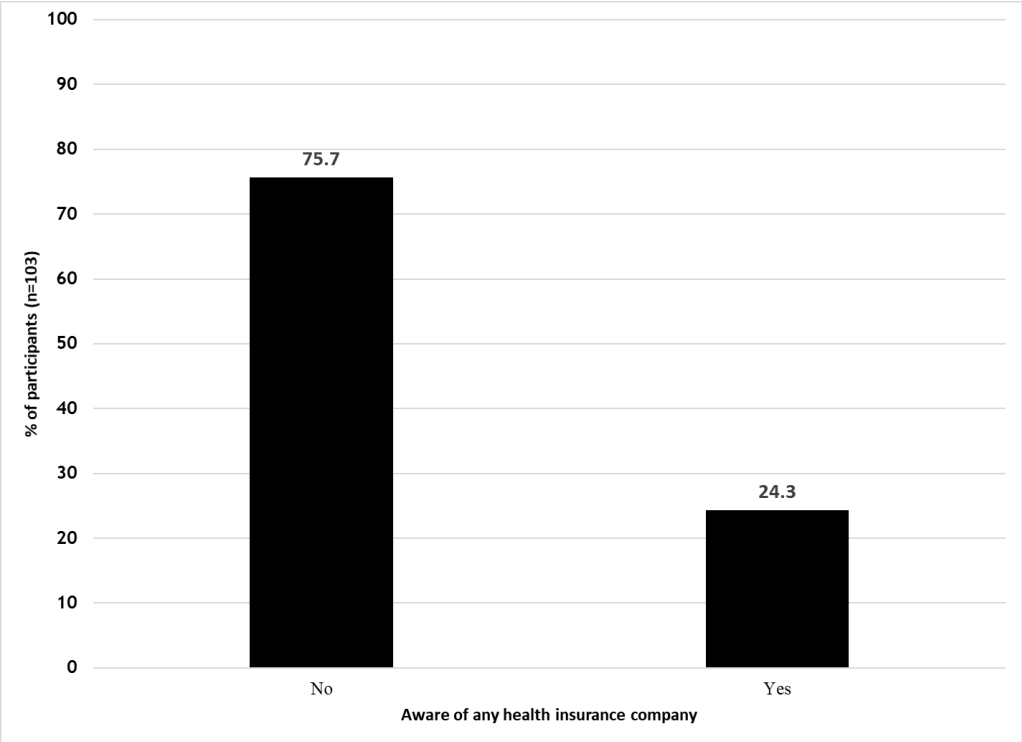


Table 5. 3 Awareness of a health insurance company by holding health insurance, gender, age group and rating the importance of health insurance (n=103)

	Being aware of a health insurance company				
Variable	**No**	**Yes**	**Total**	**% yes**	***p-value***
Have health insurance (n=103)					
No	76	17	93	18.3	0.000*
Yes	2	8	10	80.0	
Gender (n=103)					
Female	24	9	33	27.3	0.626
Male	54	16	70	22.9	
Age group (n=103)					
18-36 years	41	11	52	21.2	0.456
37-63 years	37	14	51	27.5	

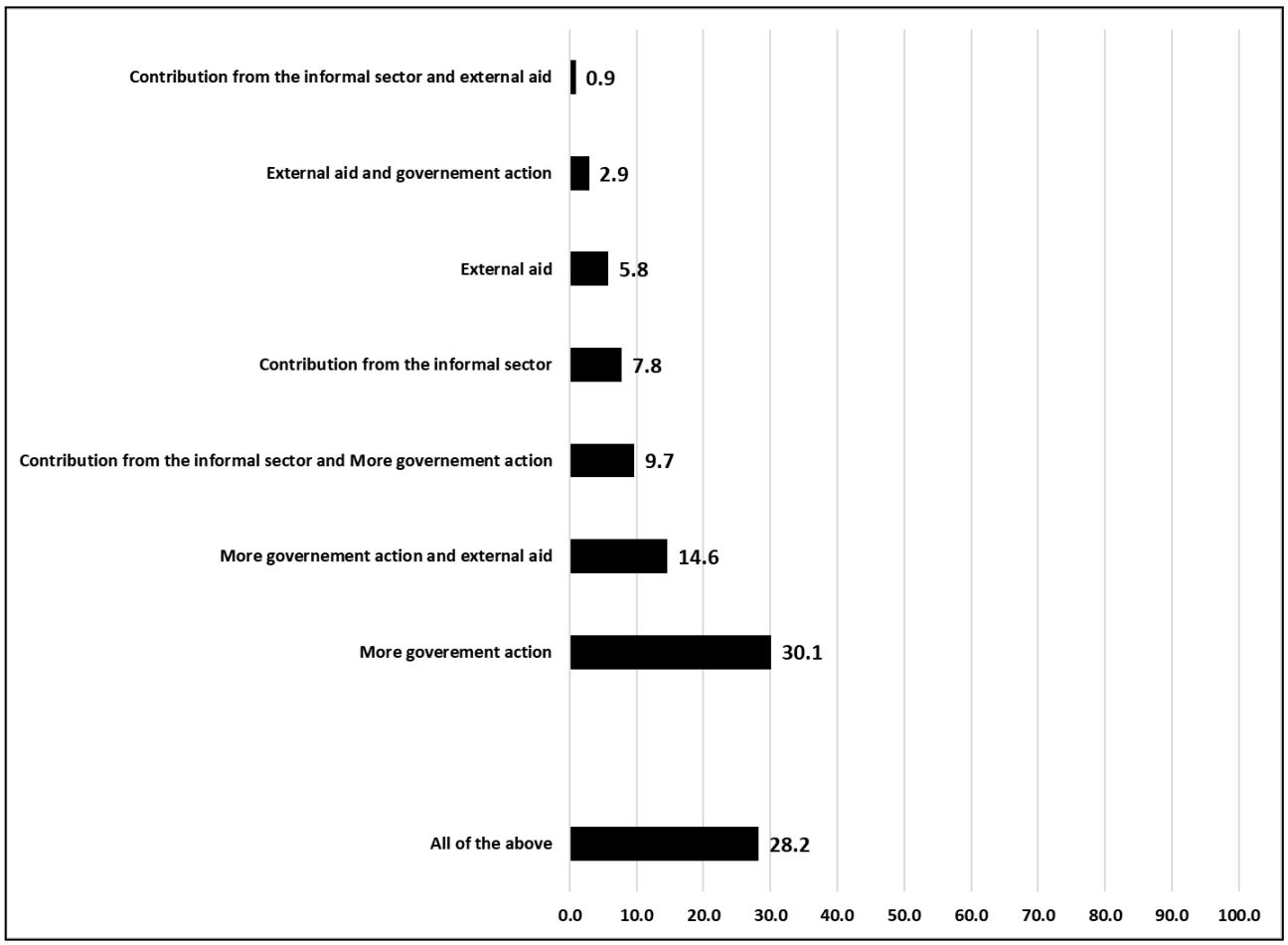
Rate the importance of HI (n=103)				
Important	52	14	66	21.2
Very important	11	9	20	45.0
Not important	15	2	17	11.8

*tested trough Fischer Exact Test

5.6.1.7 Ways for improving health care for informal sector

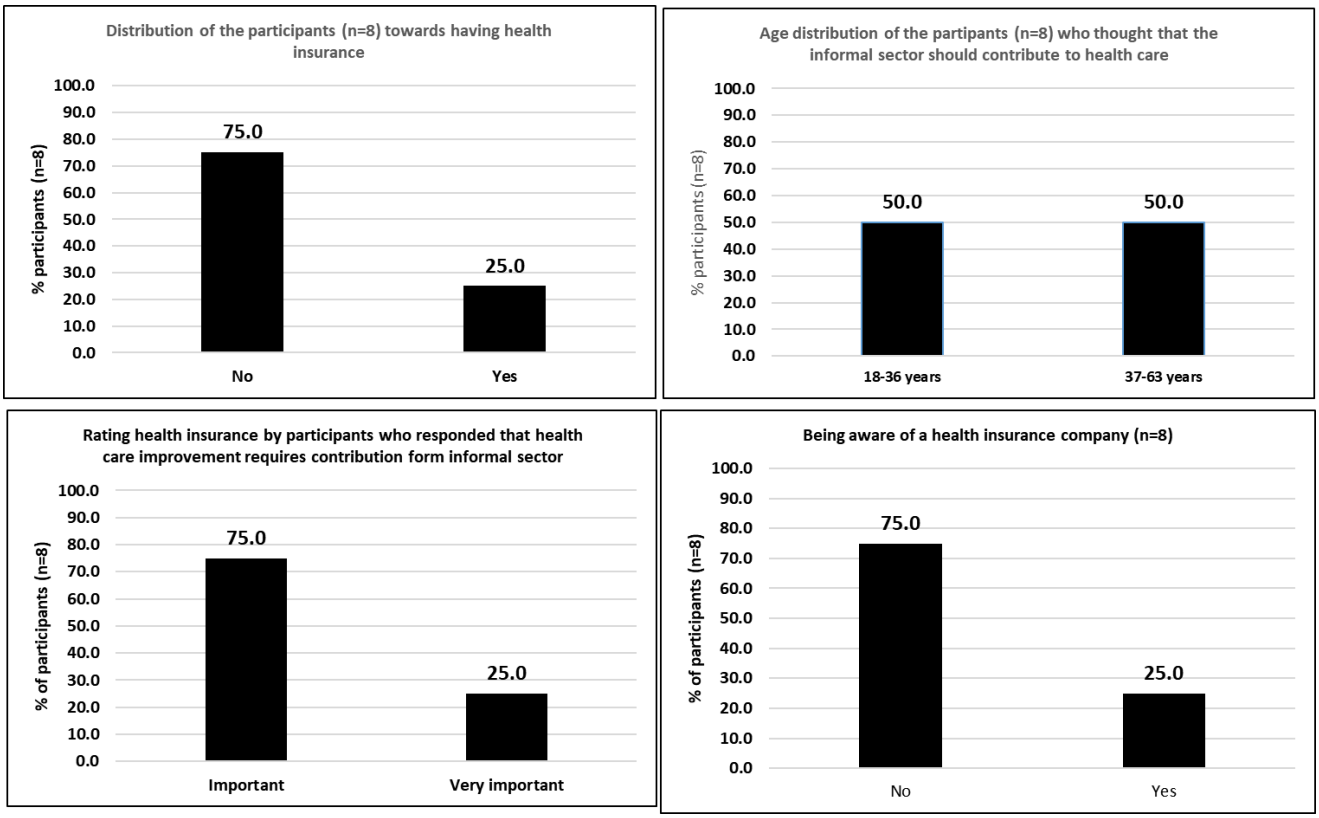
Participants were asked "how health care can be improved for informal sector?" Figure 4 revealed that 30.1% (31/103) reported that it is the responsibility of the Government and 28.2% (29/103) responded that the health care improvement could be reached through a public-private partnership. It was important to note that 7.8% (8/103) thought that the improvement of the health care should have the contribution of the informal sector.

Figure 5. 5 Ways for improvement of health care for the informal sector as reported by the study participants (n=103)



Of the eight who reported that the informal sector should contribute to the improvement of health care, all were males and willing to pay to have health insurance, 25.0% (2/8) had rated health insurance as very important and 75.0% (6/8) rated it as important despite only 25.0% (2/8) reported having health insurance (figure 5.6).

Figure 5. 6 Characteristics of the eight participants who reported that health care improvement required contribution of the informal sector



5.6.1.8 Barriers to the improvement of health care

Path dependency

Of the 103 participants, 80.6% (83/103) reported that the decisions of the government influence the development of healthcare, while 19.4% (20/103) though the contrary.

Private insurance helping (promoting) informal sector (CSR)

When asked if "private insurance currently helps the informal sector" the majority (90.3%, 93/103) of the participants responded "no" and 9.7% (10/103) responded that currently private health insurance was helping the informal sector.

Impact of culture and traditional medicine on the use of modern medicine

Of the 103 participants, more than half (67.0%, 69/103) responded that culture and traditional medicine hampered the use of modern medicine, whereas 33.0% (34/103) claimed the contrary.

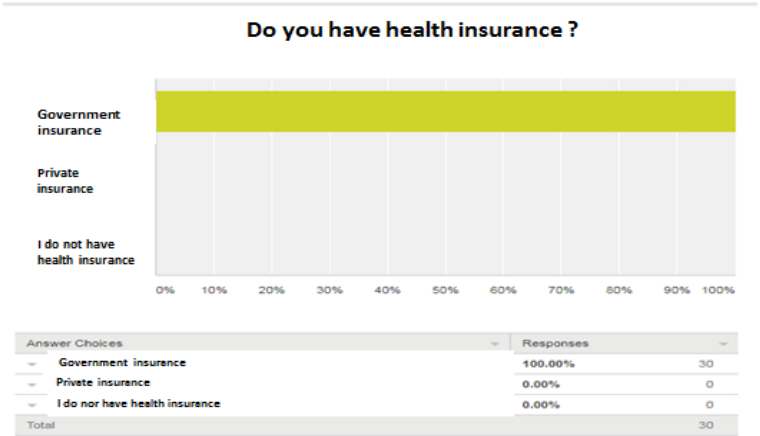
5.6.2 Analysis of survey with health practitioners

Ten questions were asked including seven multiple-choice questions, two Likert scale questions and one open-ended question at the end of the survey. The survey was designed in French, as participants were all francophone (see appendix C). The survey results were then interpreted and presented in English. In addition, survey monkey including the classification of responses in percentages, graphs, and trends, which was useful for interpretation, automatically analyzed the survey results. Questions were asked as follow:

5.6.2.1 Do you have health insurance?

100% of the respondents have health insurance and are covered by the government insurance. None of the respondents is covered by private insurance. This result implies that medical doctors, working for the public sector are all covered by the government insurance even though some of them also work within the private sector.

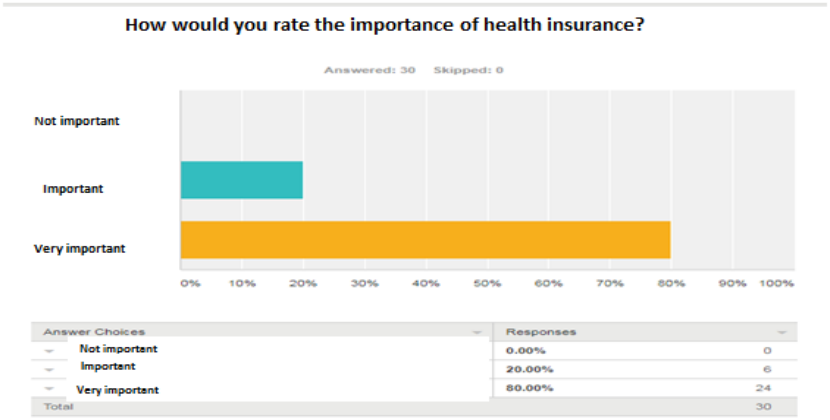
Figure 5. 7 Do you have health insurance



5.6.2.2 How would you rate the importance of health insurance?

When asked about the importance of health insurance, 80% of the respondents thought health insurance is very important, 20% ranked is as important and 0% of the respondents thought it was not important. This result is in accordance with the sample groups; medical practitioners are in fact in contact with patients and are aware of the importance of health insurance for the improvement of primary healthcare.

Figure 5. 7 how would you rate the importance of health insurance?

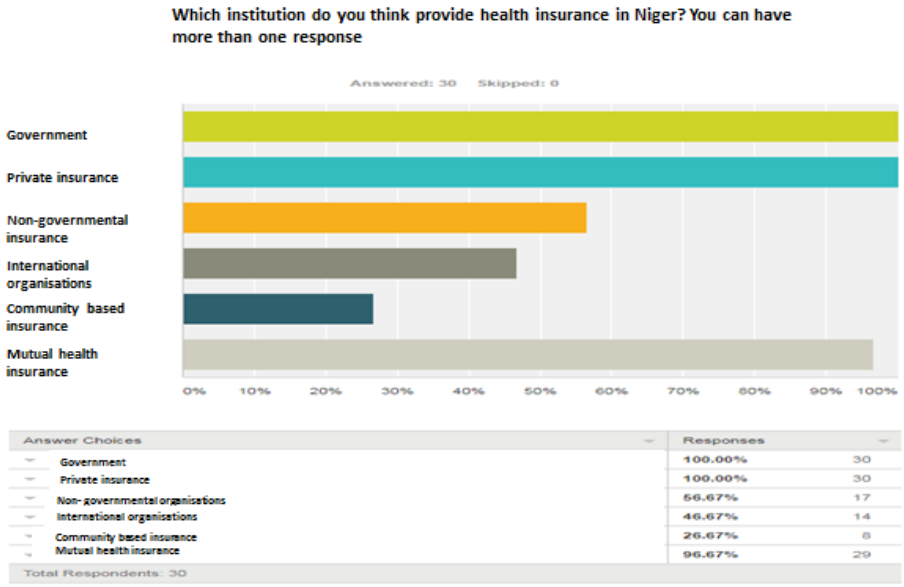


5.6.2.3 Which institution(s) do you think provide health insurance in Niger?

This question offered six- response options; the aim was to identify the differences in trends in order to recognize the main organisations which deliver health insurance. The trend in this question would help confirming or contrasting results from interviews and focus groups. This question offered multiple options, 100% of the respondents thought government and commercial insurance offer health insurance. Based on this result we can argue that government insurance and commercial insurance are the leading institutions in providing healthcare. Next, socio-professional health insurance covering workers in the semi-public sector is the third leading institution with a response rate of 96.67%. Then foreign-funded health insurance comes next with a response rate of 46.67% for international organizations and 56.67% for NGO'S. It seems that community-based health insurance has a lower contribution since 26% of respondents

thought it contributes to health insurance. These results also confirm the role of foreign aid in the development of health insurance. The overall trend suggested that health insurance for the formal sector including government insurance, commercial insurance and socio-professional health mutual is prevailing compared to health insurance for the informal sector, which includes community based insurance and foreign-funded health insurance.

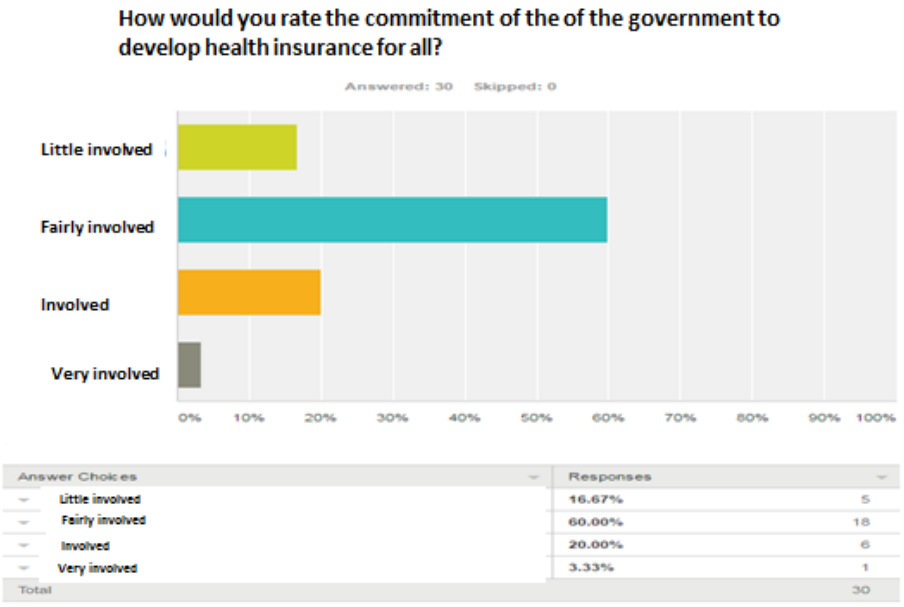
Figure 5. 8 which institution (s) do you think provide health insurance?



5.6.2.4 How would you rate the commitment of the government to develop health insurance for all?

When asked about the involvement of government to develop health insurance for all layers of the population, 60% of respondents thought that the government is fairly involved when 20% of them thought it is very involved. Then, 16.67% believed that the government is not involved enough and 3.33% believed it is very involved. Based on these numbers, it seems that participants are quite satisfied with the role of government in health insurance. This result is rather different from interviews and focus groups when, the trend reflected dissatisfaction with the role of government in the development of health insurance. During the interviews, in particular, a number of participants believed that the government should do more in terms of financing and policies to develop the sector

Figure 5. 9 how would you rate the commitment of the government to develop health insurance for all?

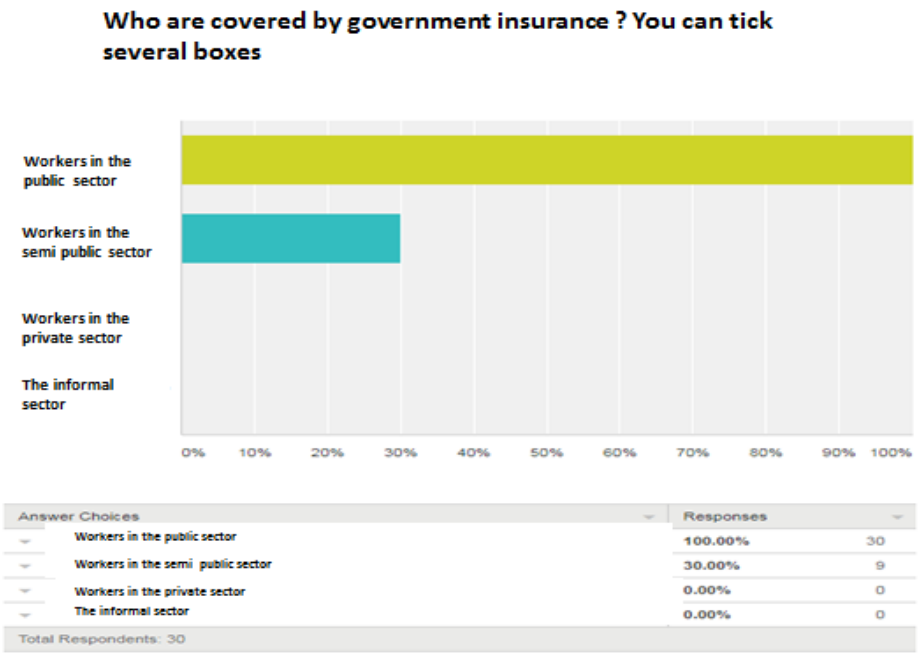


Answer Choices	Responses	
Little involved	16.67%	5
Fairly involved	60.00%	18
Involved	20.00%	6
Very involved	3.33%	1
Total		30

5.6.2.5 Who is covered by government insurance?

This question offered more than one response option. 100% of respondents thought public insurance covers workers in the public sector while 30% thought it also cover the semi-public sector. This result was however different from interviews as participants made the distinction between public insurance for workers in the public sector and socio-professional insurance that covers workers in the semi-public sector. It is important; however, to note that some workers in the semi-public sector are covered by the social security which is a public institution which, in this case concords with the choice of some respondents from the survey (Abdou, 2010). Then, none of the respondents believed that public insurance covers directly the informal sector and the private sector. This result was similar to the ones from interviews, when participants affirmed that public insurance covers workers in the public sector and private insurance mostly the ones working in the private sector.

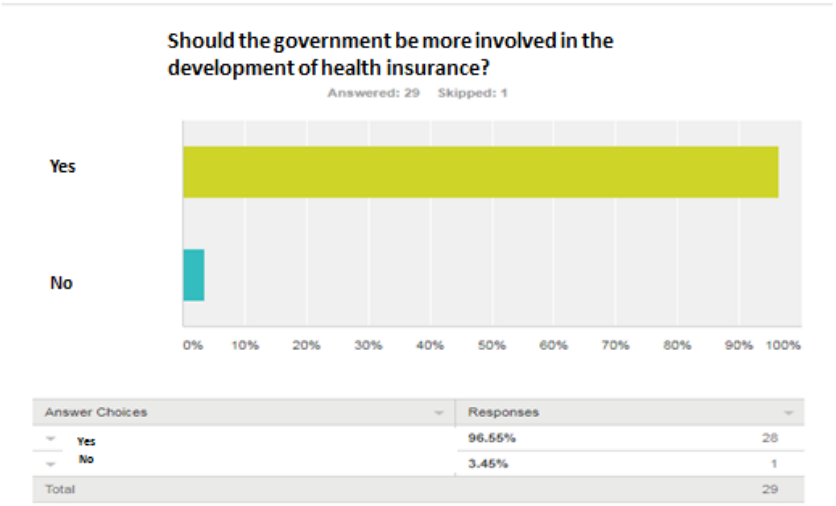
Figure 5. 10 who are covered by government insurance?



5.6.2.6 Should the government be more involved in the development of health insurance?

This question was designed to offer just one response option, as the researcher needed precise answers in order to assess the current performance of the government. 96.55% thought the government should do more for the development of health insurance while 3.45% thought there are no improvements to be made. The general trend suggested more government involvement, which confirms the position of a number of interviewees who claimed that more political commitment is needed for the improvement of health insurance.

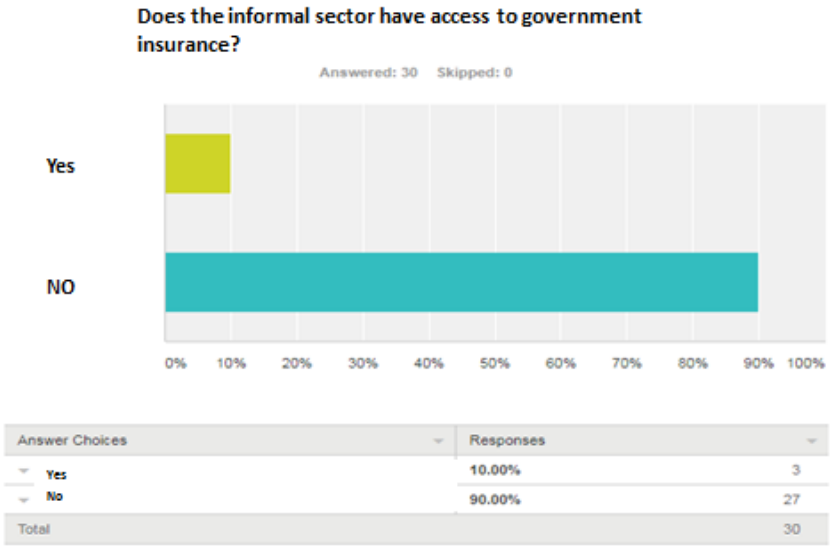
Figure 5. 11 should the government be more involved in the development of health insurance?



5.6.2.7 Does the informal sector have access to government insurance?

This question, similarly to the previous one, offered one response as it was critical to understand if the informal sector is directly covered by public insurance. 90% of the respondents believed that public insurance does not cover the informal sector while 10% believed so. This result confirmed a number of interviews when participants held that 80% of the population essentially form the informal sector was not covered by health insurance. Moreover, questions five and three of this survey confirmed that the informal sector was not covered by public health insurance.

Figure 5. 12 Does the informal sector have access to government insurance?

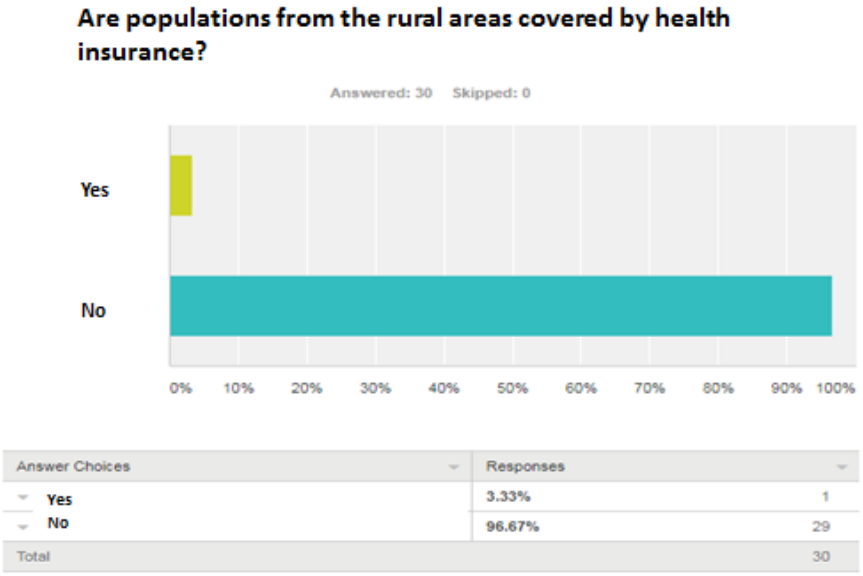


Answer Choices	Responses	
Yes	10.00%	3
No	90.00%	27
Total		30

5.6.2.8 Are populations from rural areas covered by health insurance?

96.67% of respondents believed that populations in rural areas are not covered by any formal health insurance scheme while 3.33% believed so. Based on those results we understand that rural areas have no specific insurance plan including public insurance. This results correlate with the previous question since rural areas are associated with the informal sector (Ratner, 2000). In addition, this confirms the argument of some participants from interviews who stated that the majority of health infrastructures are centered in the capital Niamey. We have to note in addition that interviews and question three of the survey suggested that community based health insurance and foreign-funded insurance were the mechanisms, which so far protect the informal sector. In this sense, for this question, we can assume that rural areas are not covered by public insurance, however, have alternative mechanisms including CBHI and foreign-funded insurance.

Figure 5. 13 Are populations from rural areas covered by health insurance?



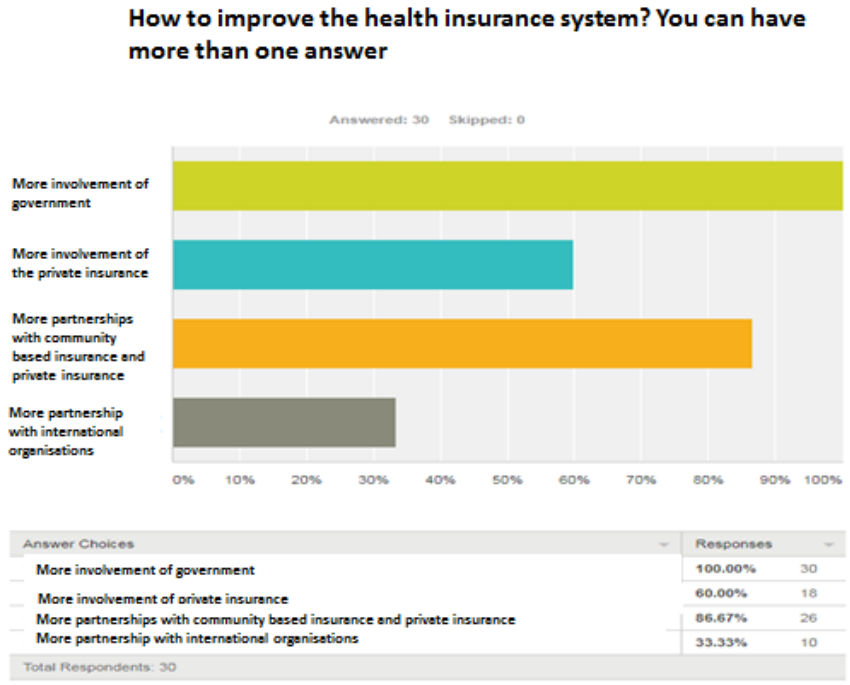
Answer Choices	Responses	
Yes	3.33%	1
No	96.67%	29
Total		30

5.6.2.9 How to improve the health insurance system?

This question helped identifying which mechanisms are more likely to contribute to the improvement of health insurance. The question offered many response options. All respondents, 100% thought that the government should do more for the development of health insurance. 60% considered that private insurance should participate in improving the system. Then, 86.67% believed in the involvement of communities and 33.33% in the importance of partnerships with international organizations. Similarly, to interviews, the results of this question presumed that more political involvement and action was needed in the quest of attaining universal coverage. In addition, some interviews suggested that CBHI is a good option for the informal sector. Another aspect is the involvement of private insurance; 60% of respondents thought that private insurance should be more involved. This argument correlated with some interviews at both the ministry of health and commercial insurance, when some participants claimed that there are few public

private partnerships and that private insurance should consider extending its services to the informal sector.

Figure 5. 14 How to improve the health insurance system?



5.6.2.10 Do you have any further comments?

This open-ended question aimed at getting more insights and suggestions however, as it was optional, only six participants responded. One respondent said that *"the access to health insurance is heterogeneous and depends on factors such as social group, financial resources, and geographical location"*. Another respondent discussed the importance of health insurance and said: "*health insurance guarantees a good access to healthcare. The majority of my patients are not covered, therefore make out of pocket payments, but it is a question of informal or formal sector, the government should improve the system for everyone. Some of my patients are from the public sectors; sometimes they would pay their own bills because the process of reimbursement is too long"*. This comment suggested that patients covered by public insurance sometimes pay their bills when the reimbursement process from government institutions to healthcare structures

is long. Another one suggested more community involvement in the process of developing health insurance. In addition, he explained that populations in rural areas are the most in need of healthcare and health insurance; he also discussed the role of government in creating insurance plans for this segment. Further one respondent said that the government was not involved enough in delivering health insurance for all, that health insurance was not designed on the basis of universal coverage. Moreover, one also said that more financial resources are needed to develop health insurance for all, and last another respondent thought that more partnerships with foreign organizations are required for the development of the sector. The general trend suggested that health insurance was not developed in Niger and more efforts were needed especially from the government.

5.7 Summary of findings

5.7.1 Key findings and research questions

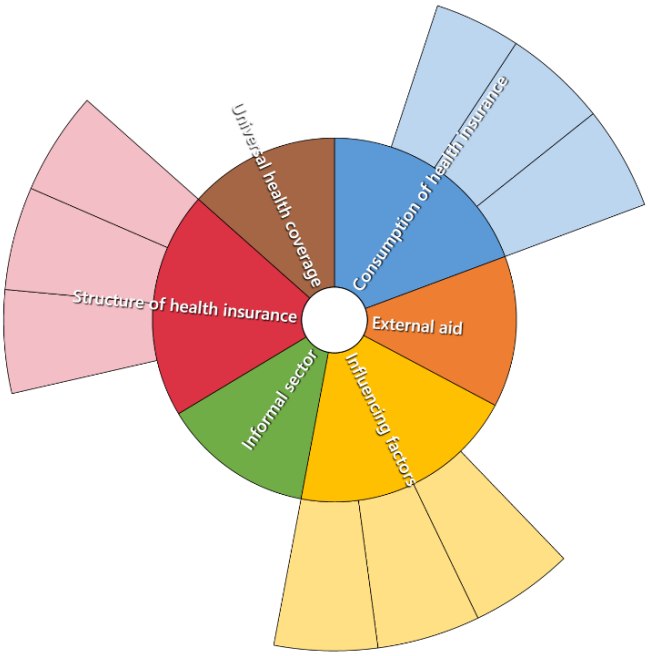
a) **The analysis of the data generated key themes essential for answering the research questions.**

To assess the key themes generated from interviews and focus groups, the researcher merged the themes in Nvivo plus (Appendix K). Three prominent themes appeared including the structure of health insurance, influencing factors and consumption of health insurance:

The structure of health insurance concerned the institutions that offer health insurance. The data revealed data the public insurance; private insurance, Socio-professional insurance and nonprofit insurance are the main institutions delivering health insurance in Niger. In addition external aid was identified an active actor, especially for the funding of healthcare. Literature similarly suggested that public and private insurance were the main providers of health insurance in Niger (Loutou, 2009, social security, 2010). The consumption of health insurance referred to the different groups and their consumption of health insurance. During the interviews and focus groups, it was noted that health insurance mainly covers the formal sector including the public, semi-public and private

sectors. The informal sector is the biggest group with uninsured people in Niger. The research findings validated some literature claiming that health insurance covers only about 20% of the population mainly in the formal sector (Roukayatou, 2004; Braverman Kumanyika, et.al, 2011; Ocket, Doudou et.al, 2017). Both interviews and focus groups referred to influencing factors affecting the development of health insurance including CSR, culture and path dependency of health policies. Literature review on the other hand mainly addressed financial resources as factors influencing the development of health insurance (Kailou, 2001; Ousseini, 2011; WHO, 2012). In addition to financial limitations, this research identified others limiting factors including path dependency of policies, CSR and culture.

Figure 5. 15 Prominent themes generated from interviews and focus groups



b) The survey with the informal sector revealed four essential key points:

When asked about health coverage, 97% of the respondents ,all from the informal sector, affirmed that they do not have health insurance. This result matched the literature review of this study that suggested that the majority of the population, especially in the informal sector is uninsured (Loutou, 2009). The importance of health insurance has also been

assessed and 83.5% of respondents rated health insurance as important or very important. This result showed that populations recognize the importance and need to have health coverage. Concerning the willingness to pay for health insurance, 78.6% of respondents stated that they were willing to pay for health insurance. This result is crucial as literature suggested that out of pocket payments from households represent 40% of the total expenditure for healthcare (Kailou, 2001). This implies that the informal sector has the capacity to pay for health insurance. When asked about the existence of a health insurance, only 24.3% were familiar with a health insurance company. This result suggested that people from the informal sector were not exposed to health insurance and its importance. Some literature suggested that most people from the informal sector are uninsured (Kailou, 2001, Roukayatou, 2004); however, most literature did not address the explanatory factors for this low coverage.

c) **Then, the researcher summarized three key points from the survey with health practitioners:**

When asked about the main institutions providing health insurance, most respondents referred to the government, private insurance and external aid. The result of this survey confirmed the findings from interviews and focus groups. In addition, literature also suggested that public insurance, private insurance and external aid are the main source of funding of health insurance after out of pocket payments (WHO, 2012; Him & AGK, 2014). 96.67% of respondents stated that the informal sector was not covered by a formal scheme (This question referred to health insurance provided by the government). This result confirmed findings from the other methods of data collection and literature review. When asked about public insurance, 100% of respondents said that workers in the public sector are covered by government insurance. This result was similar to interviews and focus groups which showed that public insurance is primarily designed for workers in the public sector.

d) Further, the research findings informed the research questions as follow:

1) How is the system of health insurance structured in Niger?

Based on findings from interviews and focus groups, the system of health insurance is mainly composed of public, private insurance, external aid and out of pocket payments from households. Findings equally revealed while non-profit insurance is developed for the formal sector through Socio-professional insurance; there are no formal mechanisms for people from the informal sector.

2) What is the influence of health insurance policies on the development of health insurance? (path dependency)

Findings suggested a path dependency for the funding of health insurance and healthcare of the country with the fair share of international organisations through decades. Moreover, interviews at the ministry of health implied that health insurance policies focus essentially on the formal sector. The government project to develop community insurance, however suggested the implementation of new policies, which will favor the informal sector.

3) Which segment of the population is covered by government health insurance?

Based on the responses from interviews from the ministry of health, government or public health insurance mainly covers workers in the public sector at 80% with no contributions from salaries. Interviews from private insurance and surveys confirmed these results, since most participants believed that the government should do more to cover the biggest part of the population.

4) What are the main funding sources for health insurance?

Similarly, to the literature review, interviews from the ministry and private insurance revealed that external aid plays a crucial role in the funding of health insurance over decades. Further, government's funds and out of pocket, payments are equally key funding sources.

5) What is the role of private insurance and its application of CSR?

Findings suggested that the application of CSR for private insurance is quasi inexistent. Interviews and focus groups from commercial insurance revealed that private insurance does not apply CSR for segments outside its segments. Moreover, most respondents did not think it is possible for private insurance to extend services to the informal sector.

6) What is the role of community based health insurance?

Overall, findings suggested that community insurance was not developed in Niger, however it appeared to be a potential solution for attaining universal coverage. The interviews and focus group at the ministry of health notably indicated the government's project to implement community insurance across the country.

7) How does culture influence the development of health insurance?

Results from this study explored the influence of culture in the access and development of health insurance in Niger. While most literature focused on financial limitations, the research findings suggested that traditional medicine and education were barriers to universal coverage.

5.7.2 Research findings and literature

Most literature on Niger focused on financial resources as the main barrier for the development of health insurance (Loutou, 2009; Him & AGK, 2014; Ocket, Doudou et.al, 2017; Barry, Ntamatungiro & Lopes, 2001). This research in addition of considering financial resources, explored the influence of culture, CSR and the path dependency of policies on the development of health insurance in Niger. Concerning CSR, the research findings have shown that social responsibility is not well developed for commercial insurance. Some literature suggested the benefits of CSR in the development of healthcare. Smith (2009) asserted that the application of CSR should be derived from philanthropy, not advertise compassion for a greater portion of the market. Other literatures on the other hand support stategic CSR when it helps addressing social problems (Abreu, 2005; Carter, 2009). In their work, Macassa, Francisco, et.a.l (2017) discussed the potential role of CSR in reducing health challenges and the contribution of healthcare

companies in creating changes in society. They equally asserted that public health take little actions on developing CSR policies. Moreover, the argued that policy makers should explore the possibilities for healthcare companies to contribute to CSR. This research findings, similarly suggested more involvement from private insurance.

In relation to the role of public health, the study findings suggested a path dependency of health insurance policies and funding. Literature similarly has shown the role of path dependency of health policies in the development of healthcare (Wilsford, 1994; Smith, 2005; Wilsford & Brown, 2010; Zelmer, 2014). A study in Egypt highlighted the role of path dependency in the development of universal coverage (Fouda & Paolucci, 2017). The authors identified patterns of decisions over the years and the involvement of historical institutionalism. Similarly, the findings of this research have shown a path dependency of health insurance policies favoring the formal sector over the informal sector, and this throughout decades. Moreover, results showed a path dependency of the funding of health insurance mainly involving government fundings, out of pocket payments and external aid. The findings equally informed of the role of culture and tradition in access to health insurance. Little literature on Niger however addressed the role of culture on universal coverage. General literature and studies however have shown the role of cultural barriers in the access to health coverage (Hartley, 2004; Szczepura, 2005; Barr, 2005; McKee, Balabanova, et.al, 2015).

Further, the literature on Niger suggested that the informal sector is the biggest uninsured segment in Niger which makes mainly out of pocket payments for healthcare (Roukayatou, 2004; Loutou, 2009; WHO; 2012). While most literature informed about the low coverage in this segment, few have explored the key reasons for low coverage other than financial resources. The research findings explored the involvement of culture and CSR for this sector; moreover, results assessed the willingness of this segment to pay for health insurance. In addition, most literature on Niger did not address solutions of health coverage for the informal sector. This study, through the research question attempted to propose suitable mechanisms for that segment.

5.8 Conclusion

This Chapter extensively discussed the analysis of the data from the three methods of data collection including two focus groups, two surveys and two series of interviews. Through praxis the comparison of findings with literature review and research questions enabled to identify gaps in literature. Recommendations in relation to the research question will be discussed in chapter 6.

Chapter 6: Discussion and recommendations

6.1 Introduction

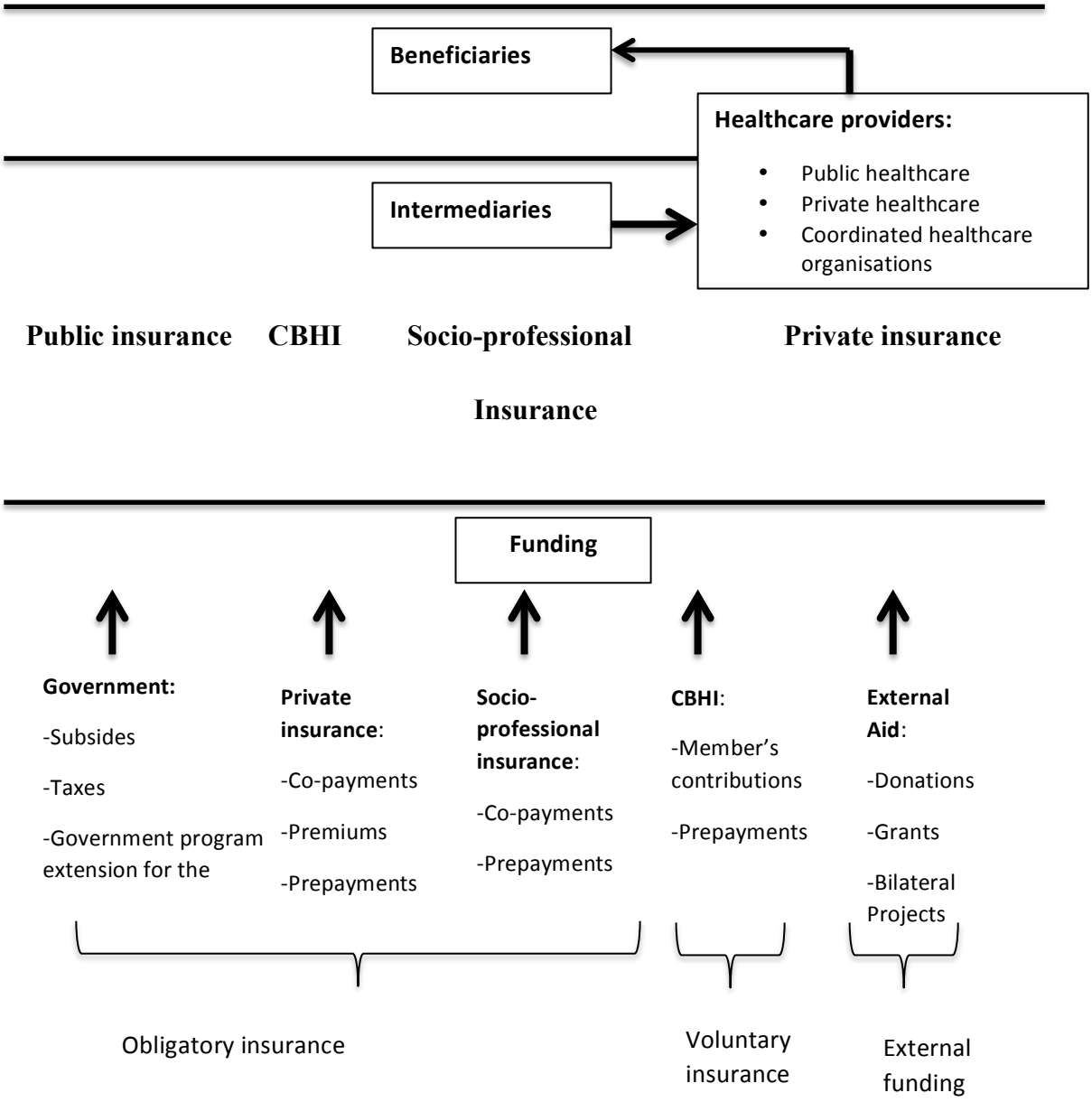
This chapter presented the links between literature and findings in order to answer the research question. Recommendations have been made in relation to corporate social responsibility, culture and path dependency. Some suggestions focused on social contract and the responsibility of the state to provide health coverage for populations. In the perspective of offering equitable schemes for populations in Niger, recommendations have been made to develop community-based insurance and extend public and private insurance to poorer segments.

6.2 Research question revisited

The research question and the research objectives are the core elements that drive the research study. It is important to identify the relationship between existing theories and research findings in order to identify gaps, which then would enable to answer the research question (Creswell, 2014). For this study, the research question aimed at identifying equitable health insurance mechanisms for populations in Niger. In order to answer the question, the researcher through praxis compared the collected data with literature review. Literature informed that the informal sector and poor populations in Niger, about 80% of the population are uninsured and make out of pocket payments for healthcare. While most literature on Niger focused on the financing of health insurance, the literature review of this study identified gaps of the influence of CSR, path dependency and culture for an equitable access to health coverage in Niger. On the other hand, collected data for this study confirmed literature on the low coverage especially for the informal sector. The majority of participants from the informal sector in this study showed interest in joining and paying for health insurance. Furthermore, culture influences the access of health insurance when traditional medicine and education appeared to be limitations. Results equally showed that commercial insurance which is costly and reserved for the formal sector currently does not apply CSR activities. Then, data similarly to literature confirmed the path dependency of health insurance policies in Niger, in terms of funding and covering exclusively the formal

sector. Attaining universal health coverage is a long and meticulous process for most countries even though it appears to be feasible for systems based on taxation with strong economy. For developing countries, UHC is attainable when institutions put funds together in addition to a strong political commitment (Carrin, James and Evans, 2007). In the case of Niger, a mix of mechanisms seems appropriate for the development of health insurance as both literature and data indicated limited financial resources. The following figure shows how the funding of health insurance could be strengthen with multiple actors.

Figure 6. 1 Proposed model for funding



This model proposed five main funding resources including government, private insurance, socio-professional health mutual, CBHI and external aid. A mix of mechanism seemed appropriate to raise sufficient funds, which would offer equitable access to health coverage to all segments of the population (Xu, Evans, et.al, 2003; Hsiao and Heller, 2007).

- **Government insurance:** findings revealed that workers in the public sector do not contribute for health insurance. In this sense, government insurance could be funded through taxes and contributions from workers. This would enable public workers to have a better insurance coverage; then the initial budget allocated to them would be used to cover other segments of the population. The government could also subsidies private insurance companies that decide to extend their market to the informal sector.
- **Private insurance:** private for profit insurance would continue to be funded as it is actually including the system of co-payments and prepayments. It would be interesting to include solvable people from the informal sector as some evidence showed their capacity to pay for health insurance (Carrin, 2002; Jofre-Bonet & Kamara, 2018). Similarly to the system of employment-based insurance, farmers could, for instance, contribute through their cooperatives, which will then subscribe them by groups to regular private insurance.
- **Socio-professional insurance:** As for today, Socio-professional insurance works with adherents' payments. The number of adherents from the public and semi-public sector should increase in order to cover a greater portion of people.
- **Community based insurance:** CBHI is based on member's contributions. The development of CBHI could happen through an increase of members, thus populations should be encouraged to join (Criel, Blaise, Ferette, 2006). Even if community based insurance is a voluntary scheme, it could be made mandatory for the populations in the informal sector who have regular income. Evidence has shown the efficiency of CBHI in Rwanda for integrating the informal sector to health insurance. The adherence rate spectacularly increased from 7% in 2003 to 86% in 2009 (Rwanda Health Ministry, 2010).
- **External aid:** Foreign funding for healthcare is rooted for many decades what makes it difficult to interrupt. However, it could be progressively reduced and replaced by

capacity building programs that would help the country implementing sustainable solutions. Moreover, the creation of internal funding could enhance the general revenue, in addition to taxes (WHO, 2005).

The transition towards universal coverage should be a shift from direct payments to indirect payments. Instead of making out of pocket payments, populations especially from the informal sector, should make contributions either to obligatory or voluntary insurance. Then, more partnerships between the government with private insurance (subsidizes) and with voluntary insurance (funding and capacity building) would accelerate changes. For now, the health insurance system is based on direct payment since most people make user fees payments. To attain universal coverage, the country should move to the stage of mix mechanisms, including more internal funding (Ravishankar et al, 2009).

6.3 The development of health coverage for the informal sector

Culture and awareness

Based on literature and the research findings, it is crucial to extend health insurance to the informal sector (Mathauer, Schmidt and Wenyaa, 2008). Despite the limits for the government to collect funds from this sector, new mechanisms seems appropriate in order to incorporate this sector into health coverage. Furthermore, out of pockets should be considerably reduced and replaced by pro poor schemes such community based insurance. In addition, the Nigerien government should strengthen the initiative for free healthcare for women and children (World Bank, 2017).

In relation to the theoretical framework of this research, cultural aspects should be addressed in order to develop health coverage especially for the informal sector. Both literature and findings indicated that populations outside the formal sector have little knowledge about health insurance. Awareness campaigns should be conducted in both rural and urban area, to inform the informal sector about the necessity of health insurance (Reshmi, 2012; Madhukumar, 2012). Literacy and the knowledge of health insurance go hand in hand; healthcare institutions educating populations about primary healthcare could integrate the creation of health insurance in their coverage. A

study in India has also shown the positive impacts of awareness campaign as it increased the understanding of health insurance and the level of enrolment.

The Nigerien government through its various services could reduce perceptions and believes which negatively influence the enrolment to health insurance. Most population because of tradition and perceptions are not willing to pay for a "future misfortune" (Ackah & Owusu, 2012). Findings of this research, however, showed that participants expressed their willingness to join health insurance when it was explained. Thus, Awareness raising is crucial in voluntary health insurance and a key tool for attaining universal coverage (Carrin & James, 2005).

The development of community based insurance

Community based insurance enables controlling the financing of healthcare through locally based prepayments. Literature and findings from this study have shown a small number of CBHI in Niger. Further, interviews from the ministry of health revealed the governmental project to integrate CBHI to social insurance. This suggests that the development of CBHI in Niger could happen at two levels: First, the number of community-based insurance should increase across the country in order to cover a maximum of person. Secondly, the government project for community insurance could be the backup of regular CBHI, by covering the lowermost segments (Hsiao, 2002).

The development of community-based insurance seems appropriate for the extension of health insurance for the informal sector. Studies have shown various challenges concerning the implementation of CBHI including low rates of participation, financial limitations and lack of healthcare infrastructures (Creese and Bennett, 1997; Wiesmann and Jutting, 2000). On the other hand, with the right solutions, these challenges could be turned into opportunities. The following elements could help for the development of CBHI in Niger:

- **Pooling:** The government should ensure that populations are educated and encouraged to have health insurance (Whitehead, Evans.et.al, 2001). Moreover, a drop off of the use of traditional medicine is likely to increase the demand for health insurance. Overall, an increase in the participation rate would raise the capital of community-based insurance,

hence better benefits packages for members. In terms of risk pooling, groups sampling would depend on the level of contributions and the type of coverage.

- **Human resources and infrastructure:** good healthcare infrastructures and services determine the efficiency of CBHI (Batusa, 1999). A partnership between CBHI and health institutions is crucial to ensure that insured patients receive the correct services in relation to their coverage scheme. In addition, the government should provide health infrastructure and staff in a homogenous manner across the country.

- **Type of coverage:** benefit packages would be adapted to the level of contributions. Low-contribution would cover basic packages while high contributions adapted to complementary packages that would cover serious and or chronic conditions. To cover the maximum of people, similarly to private insurance, CBHI would also cover family members.

- **Payments options**: payments could be made monthly or annually depending on the type of CBHI. To avoid adverse selection, contributions should be affordable for members and high enough for the CBHI to complete the co-payment (Musau, 1999).
- **Public insurance:** concerning the government's project to implement national community insurance, it would be interesting to make payments compulsory for certain segments in the informal sector and rural areas, which have the capacity to pay. Making the enrolment obligatory would increase the level of coverage; moreover, the prepayments would be a new source of revenue collection in addition to general taxes. Healthcare facilities and administrative process should equally be adjusted to the changes.

6.4 Extension of private insurance and corporate social responsibility

Both literature and the research findings indicated that the CSR activities of commercial health insurance in Niger are quasi-inexistent. Traditionally, developed countries do not use commercial insurance for universal coverage; however, when effectively used private insurance

could contribute to universal coverage in developing countries (Sekhri & Savedoff, 2004). In this sense, private insurance could be used as a transitional measure to move towards universal coverage. Based on the theory of social contract discussed in this study, the Nigerien government should be involved in the regulation and monitoring of the sector (World Bank, 2009). This would likely lead private insurance to reduce adverse selection, information asymmetry and improve the quality of services (Doetinchem, Schmidt, et.al, 2006).
Further, policy makers should develop a regulatory framework, which is adapted to the countries' institutional and economical capacities (Jutting & Drechler, 2005). In Niger, for instance, a revision of taxation policies could encourage commercial insurance to extend its market to the informal sector. As for today, commercial insurance does not cover the informal sector; but some interviews from Sunu assurance in the study suggested their willingness to integrate this segment. Extending the risk sharing could be adapted to different pools and groups including the informal sector. Furthermore, strategic CSR could be used to reduce adverse selection; in fact, an excess of adverse selection causes certain companies to be out of business (Jowett, 2004). By applying strategic CSR, however, private insurance would gain more profit and a long term giving back to the society (Husted, 2007; Jagpal & Laskowski, 2013).

6.5 Extension of government health insurance and reform of health policies

For decades, health coverage policies focused on the formal sector, new reforms seem appropriate to correct the path dependency of policies in order to offer equitable coverage for populations. The Nigerien government could learn from past mistakes and accordingly apply policies at the micro and macro level to strengthen health insurance (Russo, Bloom, et.al, 2017). Moreover, more political commitment and accountability seem necessary to effectively implement new policies.

The extension of public insurance to the informal sector equates to social justice and the equitable share of burdens and benefits of health coverage among people (Beauchamp, 1976). As for today, public health insurance is a non-contribute system for the public sector (Loutou, 2009); a contributing mechanism, however, seems more appropriate as it would improve the quality of the services and enable to cover more people. In this sense, public workers would pay

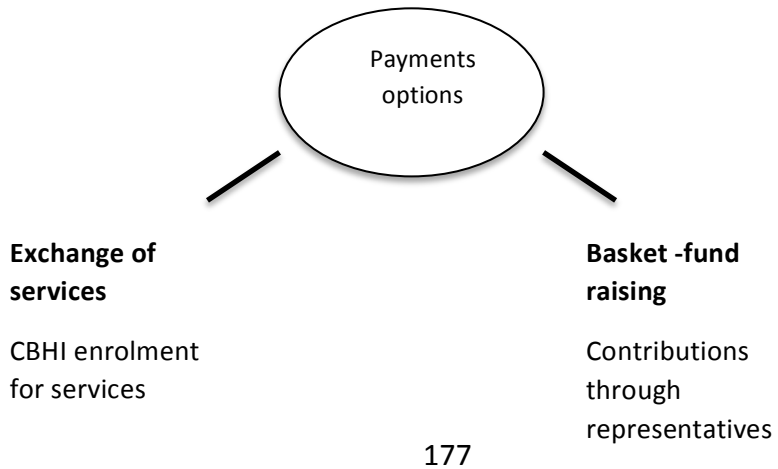
contributions directly from their salaries. In addition to covering public workers, public insurance could be extended to the informal sector. Interviews at the ministry of health revealed that the government aims to create a CBHI program that would benefit populations including the informal sector. The pilot study suggested that CBHI would be created by area and funded by members' contributions, the government and external funds. The actual health insurance system should be reformed to fully integrate the informal sector; this could be achieved with some of the following elements:

- CBHI would be implemented for each of the 266 communes across the country. CBHI would be more efficient when communities are involved and if health facilities are decentralized (Carrin and James, 2006).
- When it comes to payments, two scenarios would be applied to the two groups within the informal sector.

  Health coverage would be mandatory for people who have a regular income. Firstly, under a system of basket fundraising, they would subscribe to CBHI by groups. For example, farmers would be enrolled through the contributions they make to their cooperatives or retail business owners through their representatives. It is essential to develop subsystems covering different subgroups. Moreover, benefit packages and payments should be tailored to the capacity and needs of each group.

  Second, for those who have irregular or quasi-inexistent income, the government could implement mechanisms that would replace monetary payments. For instance, an exchange system would allow people to enroll to CBHI in exchange for their services to local councils or other public institutions.

Figure 6. 2 Proposed payments options for the informal sector



Integrating health insurance to poor communities requires community-specific solutions. The government should work hand in hand with them for the materialization of changes. The participation of population would complement the decentralisation of health facilities and the development of CBHI. The government extension for CBHI could be fully included in the national health system, similarly to Rwanda where it has been integrated to the social security (ILO, 2016).

6.6 Conclusion

In light of answering the research question, this chapter proposed recommendations based on literature and the research findings in order to offer equitable health insurance, a mix of funding mechanisms seems appropriate to increase financial resources. Then, cultural aspects such as awareness and change of perceptions about health insurance seem important in developing health coverage for the informal sector. The extension of private insurance through CSR activities would likely increase health coverage among populations. Further, extending public insurance to poorer segments is necessary, as part of the social contract between the state and society, the implementation of new health insurance policies would enable the creation of equitable health coverage schemes for different segments. Reducing the path dependency of policies would then create equity in the access to health coverage in Niger.

Chapter 7: Conclusions

7.1 Introduction

The aim of the research was to contribute to the literature by focusing on the development on health insurance in Niger and identifying equitable health insurance schemes for populations. The theoretical framework of corporate social responsibility, path dependency and culture has set new perspectives of the limits for the development of health coverage aside from financial limitations. The thesis argued that corporate social responsibility, culture and path dependency of health insurance policies limit the development of health insurance in Niger; and that these issues should be addressed in order to offer universal coverage to populations. The extension of public and private insurance to the informal sector appeared necessary to cover a greater part of the population. The development of CBHI and the education of population about health insurance are equally hastening strategies for UHC.

This chapter concluded the research study by discussing how each chapter has contributed in answering to the research question. Then part two discussed the contributions to knowledge. Next, methodological and practical contributions of the study have been discussed. Then, the last two sections of the chapter respectively examined the research limitations and its implications for future studies.

7.2 Summary of the research

Chapter 1 presented the background of the healthcare and health insurance situation in Niger. The chapter equally stated the problem statement and the research justification since health insurance needs to be developed in Niger. Chapter 1 equally stated the research objectives and research questions.

Chapter 2 presented the theoretical framework that guided this research. The concept of CSR pyramid and strategic CSR have been discussed in relation to commercial insurance in this study. Then the notion of culture has been discussed in light of its influence on the access of health

insurance for populations in Niger. The theory of path dependency has been reviewed in relation to the health insurance policies, and their replications over years. The chapter additionally discussed the theory of social contract and social justice, which justify the intervention of state in the sector of health insurance.

Chapter 3 on the literature review explored the health insurance system in Niger and its development. Section one analysed the application of social justice by exploring the extent of out of pocket payments and health insurance schemes available for the informal sector. The chapter equally assessed the funding systems of health insurance in Niger and the path dependency of the government decisions. Chapter 3 equally focused on the relevance of CSR, culture and path dependency of polices for health coverage. The literature review of this study revealed a gap in general literature addressing these three concepts, which influence UHC in Niger.

Chapter 5 focused on the analysis of the data, which mainly contributed to answering the research question. Through triangulation with thematic, discourse and comparative analysis, the data of interviews, focus groups and interviews was analysed and summarized in order to answer the research question. Through praxis, the findings were also compared to literature to identify differences and similarities.

Chapter 6 answered to the research questions by proposing recommendations to offer equitable insurance schemes for populations in Niger. The recommendations included a mix of mechanism for the funding of health insurance, the development of CBHI while tackling cultural limits affecting the enrolment of the informal sector, the extension of private insurance with more CSR activities and the extension of government insurance mainly through reform of health policies and new mechanisms for the informal sector.

Chapter 7 on research methodology outlined the process, which enabled to answer the research question. The chapter discussed philosophical underpinnings and the implications of critical theory as paradigms for this study. Critical theory and ethnography were appropriate for the study focusing on assessing the evolution of health insurance in Niger with the influence of CSR, path dependency and culture. The chapter equally discussed data collection including sampling, sources of data and ethical considerations. The two last sections respectively discussed the process of data analysis and how rigour was applied for this study.

7.3 Contributions to knowledge

The research revisited theories on the role of the state. A collaborative role for the state is encouraged because the government is the regulating body and also needs partnerships with other entities to develop the sector of health insurance (Bennett & Gilson, 2001; Ansell & Gash, 2007). Moreover, the study aligned with theories of social contract (Hobbes, 1689; Rousseau, 1762; Downs, 1957), as it suggested more political commitment in the sector of health insurance. In addition, this research confirmed that financial resources are the main challenges to the development of health insurance in developing countries (Sery and Letourmy, 2006; Wagstaff, 2007). Furthermore, the study confirmed the argument of Smed, Jensen et. al, (2007) and Stenberg, Elovainio et al, (2010) that low government budget for health is related to a low taxation rate**.**

This research made a distinct contribution by focusing on the development of health insurance in Niger, especially for the informal sector. On contrary to most literature on Niger, this research focused on the role of CSR, culture and path dependency in the equitable access to healthcare for populations. While most literature focused on financial limitations and the development of health coverage for the formal sector, this study identified additional limitations for the access to health insurance for the majority of the population. Offering health coverage including for poor groups promotes equity and social justice for all members of the society (Rawls, 1971; Adelman & Morris, 1973 and Palmer, 2004). Moreover, the change of path dependency of health insurance policies would favour all segments of the populations. The change of policies to cover all

segments would then meet the requirements of social contract, when the state holds the responsibility to offer basic needs to the population. Further this study contributes to knowledge by showing the necessity for commercial insurance to apply corporate social responsibility and extend the market to the informal sector, especially when people in the segment are willing to pay for health insurance. The study equally highlighted the importance to educate populations in Niger about the importance of health insurance; as well as reversing the use of traditional medicine that hampers the use of modern medicine.

7.4 Methodological contribution

The main methodological contribution of this study was realized through the triangulations of data collection methods and data analysis methods.

The use of ethnography as the research methodology defined which data collection instruments to use. Interviews, focus groups and questionnaires indicated the importance of culture and socio-economic factors in the development of health insurance (Harris, 2000). The combination of qualitative and quantitative techniques gave consistency to findings and provided validation of data (Sandelowski, 2000). In this sense, the questionnaire designed for health practitioners validated results from interviews and focus groups. In terms of sampling, four groups were purposefully chosen in order to identify differences and similarities.

Triangulation of data analysis techniques generated new information about the system of health insurance in Niger. The use of thematic analysis for interviews and focus groups allowed classifying data into themes, which then appeared to be determining factors in the development of health insurance. Another contribution from data analysis occurred with the combination of discourse, thematic and cross data analysis for the two focus groups, other studies could use mix of analysis techniques to explore data in depth. Discourse analysis enabled to understand language and to collect experience and insights (Onwuegbuzie, Dickinson *et al*, 2009). Next, thematic analysis categorized the main themes in order to facilitate the analysis of data. Then, cross data, analysis facilitated the comparison of findings from the two focused groups. On this, it has been noted that the two focused groups agreed that financial resources are the main limit to

the development of health insurance (Carrin, 2005). Overall, the mixed methods study combined qualitative and quantitative sampling, triangulations of data collection, and analysis techniques.

7.5 Practical contribution

The research has practical implications for policymakers in the area of health insurance, particularly the Nigerien government. It equally gave suggestions for any other entity that wishes to invest in the development of health insurance. The research proposed an extension of government insurance to the informal sector. Including the informal sector appears to be a necessity in the quest of attaining universal coverage in Niger. In the majority of West African countries, public insurance exclusively covers workers in the public sector (Palmer, 2004), it is important to reform this system by introducing an extension to the informal sector. The extension of public insurance to the informal sector could happen through the two proposed mechanisms of basket fund raising and exchange of services. Through the basket, fund raising mechanisms people form the informal sector could contribute to CBHI through their groups or cooperatives. The system of exchange of services would enable the poorest segment to benefit health coverage in exchange of services to local communities or councils. Moreover, the proposed model for the funding of health insurance with a mix of mechanisms is likely to increase revenues for health insurance. For instance, government insurance would become a contributive scheme for public workers what would generate more revenues. In Addition, the increase of budget would allow creating programs for the informal sector, which would equally contribute to the funding system. A mix of mechanisms including community based health insurance, Socio-professional health mutual, private insurance and public insurance was likely to ease the country's transition from user fee payment to universal health coverage.

Thus, an inflow of additional resources from various sources would encourage health insurance providers to cover a greater portion of the population. Another practical contribution concerned the extension of private insurance through the application of strategic CSR. Similarly, to the majority of developing countries, commercial insurance in Niger exclusively covers the formal sector; by extending coverage to the informal sector, private insurance could enlarge its markets and increase profit.

7.6 Limitations of the study

The research was limited in terms of time span. The collected data refers to little information on health insurance from the independence time in 1960 until now, as it focused on the last twenty years. During the data collection process, it was challenging to find consistent data for health insurance throughout the time from the postcolonial period. A future study might focus on the historical evolution of health insurance in Niger from the independence days until to day. In this, sense a study could explore in depth the evolution of path dependency of health insurance policies over a longer period.

Another limitation of the study was the small number of people who participated in the interviews and focus groups. This was explained by access reasons and the limited number of people who have consistent experience in the area of health insurance. Follow up interviews were conducted with other participants to confirm the trend of the initial interviews at the ministry of health and private insurance. Pilot interviews could have been undertaken instead of follow up interviews in order to save time.

Observation was not used as a collection method for this study as it was replaced by focus groups and interviews where the researcher had an inductive approach. Observation could be appropriate for future research aiming to explore the application of health coverage in healthcare and health insurance institution. For instance, a study could focus on the application of health insurance from various institutions including public, private insurance and CBHI; and assess the efficiency of each system locally by identifying the strengths and weaknesses.

This study discussed the Nigerien government project to create a national system of CBHI, however, did not assess it in depth, as it remains a project for now. After the implementation of the project, it would be interesting for future studies to assess the system in order to correct eventual failures. Moreover, concerning the government's project for CBHI, future studies could compare the system to the one in Rwanda, which was successfully implemented.

7.7 Implications for future research

The thesis explored literature related to health insurance in developing countries, notably Niger. Through the literature review chapters of this thesis, it has been noted that there is no abundant literature on the development of health insurance for the informal sector in Niger. This research could be a starting point for future research which aims to explore the area of health insurance coverage for the informal sector using the concepts of corporate social responsibility, culture and/ or path dependency. Evidence has shown the willingness of the rural community to have health coverage and participate in the development of health insurance (Mathiyazhagan, 1998; Morgan, 1993 and Bennett, 2004). Future studies may also consider the experience of Rwanda in terms of CBHI and apply similar ways to Niger and other African countries.

Further, there is a link between the research's paradigm of inquiry, findings and the theory of social justice. Critical theory was appropriate in assessing the role of the Nigerien government and the importance of eradicating inequalities in the access to health insurance. Then the theory of social contract insisted on the role of the government in creating equal opportunities for all populations including access to health (Cohen, 1987 and Perreira, 2013). Future studies related to the differential access to health insurance in Niger could include theories of social contract (Rousseau, 1762; Marx, 1848; Hayek, 1973; Nozick, 1974; Santilli, 1982 and Lessnoff, 1990) and social justice (Rawls, 1971; Sen, 1992; Miller, 1999; Freeman, 2006; Sabbagh and Schmitt, 2016).

References

Abdou, L.B. (2010) . Colonial effect or African cultural influence on corruption: A literary approach. *Journal of African studies and Development*, *2*(5), pp.109-113.

Abdullahi, A.A. (2011). Trends and challenges of traditional medicine in Africa. African Journal of Traditional , Complementary and Alternative Medicines, 8

Abel-Smith, B. (1992). Health insurance in developing countries: lessons from experience. Health policy and Planning, 7(3), pp.215-226.

Abel, T. and Frohlich, K.L. (2012). Capitals and capabilities: linking structure and agency to reduce health inequalities. Social science & medicine, 74(2), pp.236-244.

Abiiro, G.A. and McIntyre, D. (2012). Achieving universal health care coverage: Current debates in Ghana on covering those outside the formal sector. BMC international health and human rights, 12(1), p.25.

Abiiro, G.A., Mbera, G.B. and De Allegri, M. (2014) . Gaps in universal health coverage in Malawi: a qualitative study in rural communities. *BMC health services research*, *14*(1), p.234.

Abrahamsen, R. (2004). The power of partnerships in global governance. Third World Quarterly, 25(8), pp.1453-1467.

Abreu, R., David, F. and Crowther, D. (2005). Corporate social responsibility is urgently needed in health care. *Social Responsibility Journal*, *1*(3/4), pp.225-240.

Ackah, C. and Owusu, A. (2012). . March. Assessing the knowledge of and attitude towards insurance in Ghana. In *Reearch Conference on Micro-Insurance*.

Adelman, I. and Morris, C.T. (1973) . *Economic growth and social equity in developing countries*. Stanford University Press.

Adewole, D.A., Akanbi, S.A., Osungbade, K.O. and Bello, S. (2017) . Expanding health insurance scheme in the informal sector in Nigeria: awareness as a potential demand-side tool. *The Pan African medical journal*, *27*.

Agar, M. (1986). Speaking of ethnography: Qualitative research methods series 2. London: A Sage University Paper.

Akazili, J., McIntyre, D., Kanmiki, E.W., Gyapong, J., Oduro, A., Sankoh, O. and Ataguba, J.E., (2017). Assessing the catastrophic effects of out-of-pocket healthcare payments prior to the uptake of a nationwide health insurance scheme in Ghana. *Global health action*, *10*(1), p.1289735.

Akerlof, G.A. (1970). The market for" lemons": Quality uncertainty and the market mechanism. The quarterly journal of economics, pp.488-500.

Akonor, K. (2007). Foreign aid to Africa: A hollow hope. NYUJ Int'l L. & Pol., 40, p.1071.

Alaba, S.O. (2010) . Improving the standard and quality of primary education in Nigeria: a case study of Oyo and Osun states. *International Journal for Cross-Disciplinary Subjects in Education*, *1*(3), pp.156-160.

Alhojailan, M.I. (2012). Thematic analysis: A critical review of its process and evaluation. West East Journal of Social Sciences, 1(1), pp.39-47.

Amaeshi, K.M., Adi, A.B.C., Ogbechie, C. and Amao, O.O. (2006). Corporate social responsibility in Nigeria: western mimicry or indigenous influences?

Amenta, E. and Ramsey, K.M. (2010). Institutional theory. In Handbook of politics (pp. 15-39). Springer New York.

Angell, N. (1913). The great illusion: A study of the relation of military power to national advantage. GP Putnam's sons.

Anheier, H.K. (2006). Nonprofit organizations: an introduction. Routledge.

Ansell C, Gash A. (2008). Collaborative governance in theory and practice. Journal of public administration research and theory. Oct 1;18(4):543-71.

Antaki, C., Billig, M., Edwards, D. and Potter, J. (2003) . Discourse analysis means doing analysis: A critique of six analytic shortcomings.

Antonakis, J., Cianciolo, A.T. and Sternberg, R.J. (2004). Leadership: Past, present, and future. The nature of leadership, pp.3-15.

Arhin-Tenkorang, D. (2001). Health insurance for the informal sector in Africa: Design features, risk protection, and resource mobilization.

Arribas-Ayllon, M. and Walkerdine, V. (2008) . Foucauldian discourse analysis. *The Sage handbook of qualitative research in psychology*, pp.91-108.

Arrow, K.J. (1963) . Uncertainty and the welfare economics of medical care. *The American economic review*, *53*(5), pp.941-973.

Asante, F. and Aikins, M. (2008). Does the NHIS cover the poor. Ghana: Danida Health Sector Support Office.

Asenso-Okyere, W.K., Osei-Akoto, I., Anum, A. and Appiah, E.N. (1997). Willingness to pay for health insurance in a developing economy. A pilot study of the informal sector of Ghana using contingent valuation. Health policy, 42(3), pp.223-237.

Atim, C. (1999). Social movements and health insurance: a critical evaluation of voluntary, non-profit insurance schemes with case studies from Ghana and Cameroon. Social Science & Medicine, 48(7), pp.881-896.

Atkinson, P. (1995). Some perils of paradigms. Qualitative Health Research, 5(1), pp.117-124.

Ayoya, M.A., Bendech, M.A., Baker, S.K., Ouattara, F., Diané, K.A., Mahy, L., Nichols, L., Touré, A. and Franco, C. (2007). Determinants of high vitamin A supplementation coverage among pre-school children in Mali: the National nutrition Weeks experience. Public health nutrition, 10(11), pp.1241-1246.

Bachiochi, P.D. and Weiner, S.P. (2002). Qualitative data collection and analysis. Handbook of research methods in industrial and organizational psychology, pp.161-183.

Backlar, P. (1995). Will the "age of bureaucracy" silence the rights versus needs debate?. Community mental health journal, 31(3), pp.201-206.

Bacon, F. (1963). The Works of Francis Bacon, Vol. IV. London (1620), p.169.

Baeza, C., Montenegro, F. and Nunez, M. (2002). Extending social protection in health through community based health organizations: evidence and challenges. Universities Programme, International Labour Organisation/Strategies and Tools against Social Exclusion and Poverty, Geneva.

Bagnoli, A. and Clark, A. (2010) . Focus groups with young people: a participatory approach to research planning. *Journal of youth studies*, *13*(1), pp.101-119.

Baicker, K. and Chandra, A. (2006). The labor market effects of rising health insurance premiums. Journal of Labor Economics, 24(3), pp.609-634.

Bainbridge, J. and Carbonaro, M.D. (2000). Design and development of a process for web-based survey research. Alberta Journal of Educational Research, 46(4), p.392.

Baker, D. and Rho, H.J. (2009). Free Trade in Health Care: The Gains from Globalized Medicare and Medicaid.

Ball, S. (1895).Socialism. Robert Flint.

Baltagi, B.H. and Moscone, F. (2010). Health care expenditure and income in the OECD reconsidered: Evidence from panel data. Economic Modelling, 27(4), pp.804-811.

Baltussen, R., Stolk, E., Chisholm, D. and Aikins, M. (2006). Towards a multi□criteria approach for priority setting: an application to Ghana. Health economics, 15(7), pp.689-696.

Bangasser, P.E. (2000). The ILO and the informal sector: an institutional history. Geneva: ILO.

Bannister, G.J. and Thugge, K. (2001) International trade and poverty alleviation (Vol. 1). International Monetary Fund.

Barkin, J. (2015). International organization: theories and institutions. Springer.

Barnes, J. ed. (1995). The Cambridge Companion to Aristotle. Cambridge University Press.

Barr, D.A. and Wanat, S.F. (2005) . Listening to patients: cultural and linguistic barriers to health care access. *Family medicine*, *37*(3), pp.199-204.

Barr, M.S. (2004). Banking the poor: policies to bring low-income Americans into financial mainstream.

Barr, N. and Whynes, D.K. (1993). Current issues in the economics of welfare. Macmillan.

Barry, Ntamatungiro & Lopes ,(2017) . International Monetary Fund, 2017. IMF Country Report No.17/60

Bass, B.M. and Stogdill, R.M. (1990). Bass & Stogdill's handbook of leadership: Theory, research, and managerial applications. Simon and Schuster.

Bastida, F. and Benito, B. (2007). Central government budget practices and transparency: an international comparison. Public Administration, 85(3), pp.667-716.

Batley, R. and Larbi, G. (2004). The changing role of government: The reform of public services in developing countries. Springer.

Batusa, R. (1999) . January. Lessons learned with dairy cooperative based health insurance programs in Uganda. In *PHR study design workshop in Mombasa*.

Bauer, M.W., Bicquelet, A. and Suerdem, A.K. (2014). Text analysis: An introductory manifesto.

Bawa, S.K. and Ruchita, M. (2011). Awareness and willingness to pay for health insurance: an empirical study with reference to Punjab India. Int J Humanit Soc Sci, 1, pp.100-108.

Beaglehole, R. and Bonita, R. (2004). Public health at the crossroads: achievements and prospects. Cambridge University Press.

Beauchamp, D.E. (1976). Public health as social justice. Inquiry, 13(1), pp.3-14.

Beetham, D. (2013). Max Weber and the theory of modern politics. John Wiley & Sons.

Benabou, R., 2000. Unequal societies: Income distribution and the social contract. *American Economic Review*, *90*(1), pp.96-129.\

Bennett, S. and Gilson, L. (2001). Health financing: designing and implementing pro-poor policies. London: DFID Health Systems Resource Centre.

Bennett, S. (2004). The role of community-based health insurance within the health care financing system: a framework for analysis. Health policy and planning, 19(3), pp.147-158.

Bennett, S., Creese, A.L., Monasch, R. and World Health Organization (1998) . Health insurance schemes for people outside formal sector employment.

Benz, M. (2005). Not for the Profit, but for the Satisfaction?–Evidence on Worker Well□Being in Non□Profit Firms. Kyklos, 58(2), pp.155-176.

Bermeo, S.B. (2010) . Development and strategy: Aid allocation in an interdependent world.

Bernstein, E. and Steger, M.B.(1996). Selected Writings of Eduard Bernstein, 1900-1921. Humanities

Bertrand, J.T., Brown, J.E. and Ward, V.M. (1992). Techniques for analysing focus group data. Evaluation review, 16(2), pp.198-209.

Besley, T. and Persson, T. (2014) . Why do developing countries tax so little?. *Journal of Economic Perspectives*, *28*(4), pp.99-120.

Bhargava, A. (2005). The AIDS epidemic and health care infrastructure inadequacies in Africa: a socioeconomic perspective. JAIDS Journal of Acquired Immune Deficiency Syndromes, 40(2), pp.241-242.

Bitran, R. (2014) . Universal health coverage and the challenge of informal employment: lessons from developing countries.

Blaikie, N. (2000) . Using triangulation and comparative analysis to advance knowledge in the social sciences: The role of four research strategies. In *5th International Conference for Methodologists in Social Sciences, Cologne, Germany*.

Block, W.E. (2011). Hayek's road to serfdom.

Bloom, G., Kanjilal, B. and Peters, D.H. (2008) . Regulating health care markets in China and India. *Health Affairs*, *27*(4), pp.952-963.

Blowfield, M. and Frynas, J.G. (2005). Editorial Setting new agendas: critical perspectives on Corporate Social Responsibility in the developing world. International affairs, 81(3), pp.499-513.

Blundy and Olivier de Sardan (2011). The Eight Modes of Local Governance in West Africa. IDS Bulletin 2011 Institute of Development Studies

Boidin, B. and Djeflat, A. (2009). Spécificités et perspectives du développement durable dans les pays en développement. Mondes en Développement, (4), pp.7-14.

Borgarello, A. (2009). Les Filets de Sécurité Sociale au Niger.

Bossert, T. (1998). Analyzing the decentralization of health systems in developing countries: decision space, innovation and performance. Social science & medicine, 47(10), pp.1513-1527.

Bound, J., Brown, C. and Mathiowetz, N. (2001). Measurement error in survey data. Handbook of econometrics, 5, pp.3705-3843.

Bourdieu, P. (1994). Structures, habitus, power: Basis for a theory of symbolic power. Culture/power/history: A reader in contemporary social theory, 155, p.199.

Bovbjerg, R. and Hadley, J. (2007) . Why health insurance is important. *Health Policy Briefs. The Urban Institute. Washington, DC*.

Boyatzis, R.E. (1998). Transforming qualitative information: Thematic analysis and code development. sage.

Boyce, C. and Neale, P. (2006) . Conducting in-depth interviews: A guide for designing and conducting in-depth interviews for evaluation input.

Braun, V., & Clarke, V. (2006). Braun, V , Clarke, V .Using thematic analysis in psychology., 3:2 (2006), 77-101. *Qualitative Research in Psychology*, *3*, 77–101

Bräutigam, D.A. and Knack, S. (2004). Foreign aid, institutions, and governance in sub-Saharan Africa. Economic development and cultural change, 52(2), pp.255-285.

Breen, R. and Jonsson, J.O. (2005). Inequality of opportunity in comparative perspective: Recent research on educational attainment and social mobility. Annu. Rev. Sociol., 31, pp.223-243.

Brinkerhoff, D.W. (2004) . Accountability and health systems: toward conceptual clarity and policy relevance. *Health policy and planning*, *19*(6), pp.371-379.

Broom, A. and Willis, E. (2007). Competing paradigms and health research. Researching health: qualitative, quantitative and mixed methods, pp.16-30.

Brown, G. and Yule, G. (1983) . *Discourse analysis*. Cambridge university press.

Brown, J.D. (2001) . *Using surveys in language programs*. Cambridge University Press.

Bryman, A. (2006). Integrating quantitative and qualitative research: how is it done? Qualitative research, 6(1), pp.97-113.

Bryman, A. (2012). 2001. Social research methods.

Bryson, J.M. (2004). What to do when stakeholders matter: stakeholder identification and analysis techniques. Public management review, 6(1), pp.21-53.

Buck-Morss, S. (1975) . Socio-economic bias in Piaget's theory and its implications for cross-culture studies. *Human Development*, *18*(1-2), pp.35-49.

Bunker, R., Garvin, A., Gordon, D.L., Miller, M., Montagu, A.S., Vacher, H., Walton, J.K., Flyvbjerg, B., Hilson, G., Lyons, M. and Smuts, C. (2002). history/theory/administration. Perspectives, 17(1), pp.61-82.

Burkett, P. (2003). Ecology and Marx's vision of communism. Socialism and Democracy, 17(2), pp.41-72.

Burns, M. and Mantel, M. (2006) . Tanzania review of exemptions and waivers.

Burns, N. and Grove, S.K. (2010). Understanding Nursing Research-eBook: Building an Evidence-Based Practice. Elsevier Health Sciences.

Burnside, A.C. and Dollar, D. (1997). Aid, policies, and growth.

Buse, K., Mays, N. and Walt, G. (2012). Making health policy. McGraw-Hill Education (UK).

Bussey-Jones, J. and Genao, I. (2003). Impact of culture on health care. Journal of the National Medical Association, 95(8), p.732.

Camic, C. (1979) . The utilitarians revisited. *American Journal of Sociology*, *85*(3), pp.516-550.

Campbell, B. (2012). Corporate Social Responsibility and development in Africa: Redefining the roles and responsibilities of public and private actors in the mining sector. Resources Policy, 37(2), pp.138-143.

Campbell, J., Oulton, J. A., McPake, B., & Buchan, J. (2009). Removing user fees? Engage the health workforce. The Lancet.

Campbell, J.L. (2007) . Why would corporations behave in socially responsible ways? An institutional theory of corporate social responsibility. *Academy of management Review*, *32*(3), pp.946-967.

Campbell, R.R. and Campbell, W.G. (1953). The Economic Issues of Compulsory Health Insurance: Reply. The Quarterly Journal of Economics, 67(1), pp.125-135.

Capitalism, C. and Rogge, A. (1979). IibertyFtessLber\yCkssics.

Carbonaro, M. and Bainbridge, J., (2000) . Design and development of a process for web-based survey research. *Alberta Journal of Educational Research*, *46*(4).

Carrin, G. (2002). Social health insurance in developing countries: a continuing challenge. International social security review, 55(2), pp.57-69.

Carrin, G. (1987) . Community financing of drugs in sub□Saharan Africa. *The International journal of health planning and management*, *2*(2), pp.125-145.

Carrin, G., Waelkens, M.P. and Criel, B. (2005). Community□based health insurance in developing countries: a study of its contribution to the performance of health financing systems. Tropical medicine & international health, 10(8), pp.799-811.

Carroll, A.B. (1979). A three-dimensional conceptual model of corporate performance. Academy of management review, 4(4), pp.497-505.

Carroll, A.B. (1991). The pyramid of corporate social responsibility: Toward the moral management of organizational stakeholders. Business horizons, 34(4), pp.39-48.

Carroll, A.B. (1999). Corporate social responsibility: Evolution of a definitional construct. Business & society, 38(3), pp.268-295.

Carroll, A.B. (2015). Corporate social responsibility. Organizational dynamics, 44(2), pp.87-96.

Carspecken, P., (1996). Critical ethnography. Educational Research.: A Theoretical.

Cassels, A. (1995). Health sector reform: key issues in less developed countries. Journal of International development, 7(3), pp.329-347.

Cesur, R., Dursun, B. and Mocan, N. (2014). *The impact of education on health and health behavior in a middle-income, low-education country* (No. w20764). National Bureau of Economic Research.

Chankova, S., Sulzbach, S. and Diop, F. (2008). Impact of mutual health organizations: evidence from West Africa. Health policy and planning, 23(4), pp.264-276.

Charmaz, K. (1990) . 'Discovering'chronic illness: using grounded theory. *Social science & medicine*, *30*(11), pp.1161-1172.

Charmaz, K. (2006) . *Constructing grounded theory: A practical guide through qualitative analysis*. Sage.

Charmaz, K. and Belgrave, L. (2012). Qualitative interviewing and grounded theory analysis. The SAGE handbook of interview research: The complexity of the craft, 2, pp.347-365.

Chemouni, B. (2018). The political path to universal health coverage: Power, ideas and community-based health insurance in Rwanda. *World Development*, *106*, pp.87-98.

Christensen, R.K. and Tschirhart, M. (2011). Organization theory. SAGE Handbook of Governance, pp.81-93.

Chu, M.K.Y., Davoodi, M.H.R. and Gupta, M.S. (2000). *Income distribution and tax and government social spending policies in developing countries* (No. 0-62). International Monetary Fund.

Churchill, C.F. ed. (2006). Protecting the poor: a micro insurance compendium (Vol. 1). International Labour Organization.

Clarke, S. (2005). The neoliberal theory of society. Neoliberalism: A critical reader, pp.50-59.

Cohen, A. and Siegelman, P. (2010). Testing for adverse selection in insurance markets. *Journal of Risk and insurance*, *77*(1), pp.39-84.

Cohen, M.A. (2010). The narrow application of Rawls in business ethics: A political conception of both stakeholder theory and the morality of markets. Journal of Business Ethics, 97(4), pp.563-579.

Cohen, R.L. (1987). Distributive justice: Theory and research. Social Justice Research, 1(1), pp.19-40.

Colander, D.C. ed. (1984). Neoclassical political economy: The analysis of rent-seeking and DUP activities. Ballinger Publishing Company.

Collins, J.W. (1994). Is business ethics an oxymoron?. Business Horizons, 37(5), pp.1-8.

Collyer, F.M., Willis, K.F., Franklin, M., Harley, K. and Short, S.D. (2015). Healthcare choice: Bourdieu's capital, habitus and field. Current Sociology, 63(5), pp.685-699.

Colombo, F. and Tapay, N. (2004). Private health insurance in OECD countries.

Comstock, D.L., Hammer, T.R., Strentzsch, J., Cannon, K., Parsons, J. and II, G.S. (2008). Relational□cultural theory: A framework for bridging relational, multicultural, and social justice competencies. *Journal of Counseling & Development*, *86*(3), pp.279-287.

Contandriopoulos, A.P. (1992). Cost and equity in health system. International health: a north south debate. Washington DC, Pan American Health Organization.

Cook, K.E. (2005). Using critical ethnography to explore issues in health promotion. Qualitative Health Research, 15(1), pp.129-138.

Cookson, R. and Dolan, P. (2000). Principles of justice in health care rationing. Journal of medical Ethics, 26(5), pp.323-329.

Corbetta, P. (2003). Social research: Theory, methods and techniques. Sage.

Corbin, J. and Strauss, A. (1990). Grounded theory research: Procedures, canons and evaluative criteria. Zeitschrift für Soziologie, 19(6), pp.418-427.

Costa .Lopes, R., Dovidio, J.F., Pereira, C.R. and Jost, J.T. (2013). Social psychological perspectives on the legitimation of social inequality: Past, present and future. European Journal of Social Psychology, 43(4), pp.229-237.

Costa, J. and Garcia, J. (2003). Demand for private health insurance: how important is the quality gap?. Health economics, 12(7), pp.587-599.

Cowan, S. and McLeod, J. (2004). Research methods: Discourse analysis. Counselling and Psychotheraphy Research, 4(1), p.102.

Creese, A. and Bennett, S., (1997). Rural risk-sharing strategies. *World Bank Discussion Papers*, pp.163-182.

Creese, A. and Kutzin, J. (1997) . Lessons from cost recovery in health. Marketing education and health in developing countries, miracle or mirage, pp.37-62.
Creswell, J. W, 2012.. (1994). Research design: Qualitative and quantitative approaches. Thousand Oaks

Creswell, J.W. and Miller, D.L. (2000). Determining validity in qualitative inquiry. Theory into practice, 39(3), pp.124-130.

Creswell, J.W., Clark, V.L.P. and Garrett, A.L. (2008). Advances in mixed methods research.ll, J.W. (2014). A concise introduction to mixed methods research. Sage Publications

Creswell, J.W. (2009). Mapping the field of mixed methods research.

Creswell, J.W. (2014). *A concise introduction to mixed methods research*. Sage Publications.

Criel, B., Blaise, P. and Ferette, D. (2006). Mutuelles de santé en Afrique et qualité des soins dans les services: une interaction dynamique. *L'assurance maladie en Afrique francophone: améliorer l'accès aux soins et lutter contre la pauvreté*, pp.352-272.

Crotty, M. (1998). The foundations of social research: Meaning and perspective in the research process. Sage.

Crouch, M. and McKenzie, H. (2006) . The logic of small samples in interview-based qualitative research. *Social science information*, *45*(4), pp.483-499.

Cruickshank, J. (2012). The Role of Qualitative Interviews in Discourse Theory. Critical approaches to discourse analysis across disciplines, 6(1).

Cubbins, L.A. and Parmer, P. (2001). Economic change and health benefits: structural trends in employer-based health insurance. Journal of Health and Social Behavior, pp.45-63.

Cummiskey, D. (2008). Health care justice: The social insurance approach. In *International public health policy and ethics* (pp. 157-174). Springer, Dordrecht.

Cutler, D.M. and Reber, S.J. (1998). Paying for health insurance: the trade-off between competition and adverse selection. The Quarterly Journal of Economics, 113(2), pp.433-466.

Cutler, D.M. and Zeckhauser, R.J. (1998). January. Adverse selection in health insurance. In *Forum for Health Economics & Policy* (Vol. 1, No. 1). De Gruyter.

Cutler, D.M. and Zeckhauser, R.J. (2000). The anatomy of health insurance. Handbook of health economics, 1, pp.563-643.

Dafny, L.S. (2010). Are health insurance markets competitive?. The American Economic Review, 100(4), pp.1399-1431.

Dahl, R.A. and Lindblom, C.E. (1953). Welfare. New York, pp.341-344.

Dahlsrud, A. (2008) . How corporate social responsibility is defined: an analysis of 37 definitions. Corporate social responsibility and environmental management, 15(1), pp.1-13.

Daniels 1, R.C. (2004). Financial intermediation, regulation and the formal microcredit sector in South Africa. Development Southern Africa, 21(5), pp.831-849.

Daniels, N. (2001). Justice, health, and healthcare. American Journal of Bioethics, 1(2), pp.2-16.

Darton, D. (2004). Promising approaches and mechanisms. The Right Use of Money, p.135.

David Shaw PhD, C. (2013). Rigour in qualitative case-study research. Nurse Researcher (through 2013), 20(4), p.12.

Day, K., 2006. Active living and social justice: planning for physical activity in low-income, black, and Latino communities. *Journal of the American Planning Association*, *72*(1), pp.88-99.

De Herdt, T. and de Sardan, J.P.O. eds. (2015). *Real governance and practical norms in Sub-Saharan Africa: the game of the rules* (Vol. 7). Routledge.

De Laveleye, É. (1883). Progress of socialism. Contemporary Review, pp.561-582.

De Sardan, J.P.O. and Ridde, V. (2011). *Une comparaison provisoire des politiques d'exemption de paiement dans trois pays sahéliens (Burkina Faso, Mali, Niger)*. Lasdel.

De Savigny, D. and Adam, T. eds. (2009). Systems thinking for health systems strengthening. World Health Organization.

De Tocqueville, A. (1982). Alexis de Tocqueville on Democracy, Revolution, and Society. University of Chicago Press.

De Vos, Anna Susanna, ed. (2002).Research at grass roots: For the social sciences and human services professions. Van Schaik,

Dean, D.H.(2003). Consumer perception of corporate donations effects of company reputation for social responsibility and type of donation. Journal of advertising, 32(4), pp.91-102.

Degnbol-Martinussen, J. and Engberg-Pedersen, P. (2003). Aid: understanding international development cooperation. Zed Books.

Denzin, N., Lincoln. (2000). Handbook of qualitative research, 2.

Denzin, N.K. (1978). Triangulation: A case for methodological evaluation and combination. Sociological methods, pp.339-357.

Denzin, N.K. (2010). Moments, mixed methods, and paradigm dialogs. Qualitative inquiry, 16(6), pp.419-427.

Denzin, N.K. and Lincoln, Y.S. (2005). The Sage handbook of qualitative research. Thousand Oaks, CA: Sage Publication, pp.695-728

Devadasan, N., Ranson, K., Van Damme, W. and Criel, B. (2004). Community health insurance in India: an overview. Economic and Political Weekly, pp.3179-3183.

DiCicco□Bloom, B. and Crabtree, B.F. (2006). The qualitative research interview. *Medical education*, *40*(4), pp.314-321.

Dixon, A. and Mossialos, E. (2002). Health care systems in eight countries: trends and challenges. London School of Economics and Political Science.

Doetinchem, O., Schramm, B. and Schmidt, J.O. (2006). The benefits and challenges of social health insurance for developing and transitional countries. *Financing health care–A dialogue between South Eastern Europe and Germany. Series International Public Health*, *18*.

Domapielle, M.K. (2014). Health insurance and access to health care services in developing countries. Jurnal Studi Pemerintahan: Journal of Government and Politics, 5(1).

Donaldson, T. and Preston, L.E. (1995). The stakeholder theory of the corporation: Concepts, evidence, and implications. Academy of management Review, 20(1), pp.65-91.

Dong, H., Mugisha, F., Gbangou, A., Kouyate, B. and Sauerborn, R. (2004). The feasibility of community-based health insurance in Burkina Faso. Health policy, 69(1), pp.45-53.

Dongre, A.R. and Sankaran, R., (2016). Ethical issues in qualitative research: Challenges and options. *International Journal of Medical Science and Public Health*, *5*(6), pp.1187-1194.

Doucet, A. and Mauthner, N. (1998). Voice, reflexivity and relationships in qualitative data analysis. Background paper for workshop on 'Voice in qualitative data analysis'. *Atlanta, Georgia QUIG accessed online*, *15*.

Dourgnon, P., Jusot, F., Sermet, C. and Silva, J. (2009). Immigrants' access to ambulatory care in France. Issues, 2.

Downs, A. (1957). An economic theory of political action in a democracy. Journal of Political Economy, 65(2), pp.135-150.

Downs, A. (1960). Why the government budget is too small in a democracy. World Politics, 12(4), pp.541-563.

Drechsler, D. and Jutting, J.P. (2005). *Private health insurance in low-and middle-income countries: scope, limitations, and policy responses*. Organisation for Economic Co-operation and Development.

Driscoll, D.L. (2011). Introduction to primary research: Observations, surveys, and interviews. Writing Spaces: Readings on Writing, 2, pp.153-174.

Dror, D.M. and Preker, A.S. eds. (2002) . *Social reinsurance: a new approach to sustainable community health financing*. The World Bank.

Dror, D.M. and Firth, L.A. (2014). The demand for (micro) health insurance in the informal sector. The Geneva Papers on Risk and Insurance-Issues and Practice, 39(4), pp.693-711..

Drucker, P.F. (1984). Converting social problems into business opportunities: The new meaning of corporate social responsibility. *California Management Review (pre-1986)*, *26*(000002), p.53.

Drucker, P.F. (1989). What business can learn from non-profits. Harvard business review, 67(4), pp.88-93.

Duku, S.K.O., Nketiah-Amponsah, E., Janssens, W. and Pradhan, M., 2018. Perceptions of healthcare quality in Ghana: Does health insurance status matter?. *PloS one*, *13*(1), p.e0190911.

Durkheim, E. (1897). Le suicide: étude de sociologie. F. Alcan.

Durrheim, K. and Terre Blanche, M. (1999). Research in practice. Cape Town: Cape Town.

Easterly, W. (2009). How the millennium development goals are unfair to Africa. World development, 37(1), pp.26-35.

Easton, G. (2010). Critical realism in case study research. Industrial marketing management, 39(1), pp.118-128.

Edwards, R. and Holland, J. (2013). What is qualitative interviewing? A&C Black.

Ehrenfeld, J. (2008). Sustainability by design: A subversive strategy for transforming our consumer culture. Yale University Press.

Ehrke, M. (2000). Revisionism revisited: the third way and European social democracy. Concepts and Transformation, 5(1), pp.7-27.

Ekman, B. (2004). Community-based health insurance in low-income countries: a systematic review of the evidence. Health policy and planning, 19(5), pp.249-270.

Elbadawi, I.A. (1999). External aid: help or hindrance to export orientation in Africa?. Journal of African Economies, 8(4), pp.578-616.

Eliot, T.S. (2010). *Notes towards the Definition of Culture*. Faber & Faber.

Elliott, S.J. and Gillie, J. (1998). Moving experiences: a qualitative analysis of health and migration. Health & Place, 4(4), pp.327-339.

Ellis, N.C. (2002). Frequency effects in language processing: A review with implications for theories of implicit and explicit language acquisition. *Studies in second language acquisition*, *24*(2), pp.143-188.

Elo, S. and Kyngäs, H. (2008). The qualitative content analysis process. Journal of advanced nursing, 62(1), pp.107-115.

Engelgau, M., Rosenhouse, S., El-Saharty, S. and Mahal, A. (2011). The economic effect of noncommunicable diseases on households and nations: a review of existing evidence. *Journal of health communication*, *16*(sup2), pp.75-81.

Engels, F. (1964). Preface to the English edition of 1888. Karl Marx and Friedrich Engels

Ensor, T. and Rittmann, J. (1997). Reforming health care in the Republic of Kazakhstan. The International journal of health planning and management, 12(3), pp.219-234.

Epps, T. (2008) . International trade and health protection: a critical assessment of the WTO's SPS agreement. Edward Elgar Publishing.

Esping-Andersen, G. (1999). Social foundations of post-industrial economies. Oxford University Press.

Fahnestock, J. (2010). Renegotiating the social contract: healthcare as a natural right. U. Pitt. L. Rev., 72, p.549.

Falk, I.S. (1952). The economic issues of compulsory health insurance: Comment. The Quarterly Journal of Economics, 66(4), pp.572-586.

Falodun, A. (2010). Herbal medicine in Africa-distribution, standardization and prospects. Research Journal of Phytochemistry, 4(3), pp.154-161.

Fang, H. and Gavazza, A. (2011). Dynamic inefficiencies in an employment-based health insurance system: Theory and evidence. The American Economic Review, 101(7), pp.3047-3077.

Feldman, R., Escribano, C. and Pellise, L. (1998). The role of government in health insurance markets with adverse selection. Health Economics, 7(8), pp.659-670.

Fenny, A.P., Kusi, A., Arhinful, D.K. and Asante, F.A. (2016). Factors contributing to low uptake and renewal of health insurance: a qualitative study in Ghana. Global Health Research and Policy, 1(1), p.18.

Ferguson, J. and Gupta, A. (2002). Spatializing states: toward an ethnography of neoliberal governmentality. *American ethnologist*, *29*(4), pp.981-1002.

Fern, E.F. (2001). Advanced focus group research. Sage.

Ferree, M.M. (2009). Inequality, intersectionality and the politics of discourse. The discursive politics of gender equality, pp.86-104.

Fetterman, D.M. ed. (1988). Qualitative approaches to evaluation in education: The silent scientific revolution. Praeger Publishers.

Field, P.A. and Morse, J.M. (1985). Nursing research: the application of qualitative methods. Rockville: Aspen.

Finnemore, M. (1996). Norms, culture, and world politics: insights from sociology's institutionalism.

Fischer, S. and Easterly, W. (1990). The economics of the government budget constraint. The World Bank Research Observer, 5(2), pp.127-142.

Fischer, S. and Summers, L.H. (1989). Should governments learn to live with inflation?. *The American Economic Review*, *79*(2), pp.382-387.

Fisher, C.B. and Lerner, R.M. (2013). Promoting positive development through social justice: An introduction to a new ongoing section of applied developmental science.

Fitzpatrick, T. (2011). Welfare theory: an introduction to the theoretical debates in social policy. Palgrave Macmillan.

Flori, Y.A. and Geoffard, P.Y. (1994). Peut-on évaluer le cout d'une maladie? (No. 27).

Follesdal, A. (2014). Competing conceptions of subsidiarity. Nomos, 55, pp.214-230.

Follesdal, A. (2015). John Rawls' Theory of Justice as Fairness. In *Philosophy of Justice* (pp. 311-328). Springer, Dordrecht.

Fombrun, C.J., Gardberg, N.A. and Barnett, M.L. (2000). Opportunity platforms and safety nets: Corporate citizenship and reputational risk. Business and society review, 105(1), pp.85-106.

Foran, T. (2001). Corporate social responsibility at nine multinational electronics firms in Thailand. Report to California Global Corporate Accountability Project. Nautilus Institute.

FORSBERG, BIRGER C., JEROEN K. VAN GINNEKEN, and NICO JD NAGELKERKE. (1993) Cross-sectional household surveys of diarrhoeal diseases—a comparison of data from the Control of Diarrhoeal Diseases and Demographic and Health Surveys programmes." *International journal of epidemiology* 22, no. 6 (1993): 1137-1145.

Forsey, M.G. (2010). Chapter 4 Ethnography and the myth of participant observation. In New Frontiers in Ethnography (pp. 65-79). Emerald Group Publishing Limited.

Fossey, E., Harvey, C., McDermott, F. and Davidson, L. (2002). Understanding and evaluating qualitative research. Australian and New Zealand journal of psychiatry, 36(6), pp.717-732.

Foucault, M. (1972). The discourse on language. Truth: Engagements across philosophical traditions, pp.315-335.

Fouda, A. and Paolucci, F. (2017). Path dependence and universal health coverage: The case of Egypt. *Frontiers in public health*, *5*, p.325.

Frank, R.G., Glazer, J. and McGuire, T.G. (2000). Measuring adverse selection in managed health care. Journal of Health Economics, 19(6), pp.829-854.

Franke, R.H., Hofstede, G. and Bond, M.H. (1991). Cultural roots of economic performance: A research notea. Strategic management journal, 12(S1), pp.165-173.

Frederick, W.C. (1994). From CSR1 to CSR2: The maturing of business-and-society thought. Business & Society, 33(2), pp.150-164.

Freeman, I. and Hasnaoui, A. (2011). The meaning of corporate social responsibility: The vision of four nations. Journal of Business Ethics, 100(3), pp.419-443.

Freeman, R.E. (1999). Divergent stakeholder theory. Academy of management review, 24(2), pp.233-236.

Freeman, S. (2006). Distributive justice and the law of peoples. *Rawls's Law of Peoples: A Realistic Utopia?*, pp.243-260.

Freeman, S.R. ed.(2003). The cambridge companion to Rawls. Cambridge University Press.

Friedman, M., (1962). Capitalism and Freedom (Chicago, 1962).Friedman Capitalism and Freedom 1962.

Friedman, M. (2001). How to cure health care. Public Interest, (142), p.3.

Friedman, M. (2007). The social responsibility of business is to increase its profits. Corporate ethics and corporate governance, pp.173-178.

Fuchs, C. (2015). DIGITAL LABOR. The Routledge Companion to Labor and Media, p.51.

Fung, A. (2007). Democratic theory and political science: A pragmatic method of constructive engagement. *American political science review*, *101*(3), pp.443-458.

Fung, A., Graham, M. and Weil, D. (2007). Full disclosure: The perils and promise of transparency. Cambridge University Press.

Galletta, A. (2013.) Mastering the semi-structured interview and beyond: From research design to analysis and publication. NYU Press.

Garrett, L. (2007). The challenge of global health. foreign affairs, pp.14-38.

Gash, C.A.A. (2007). Collaborative governance in theory and practice. Journal of Public Administration Research and Theory, 18.

Gaynor, M., Haas-Wilson, D. and Vogt, W.B. (2000). Are invisible hands good hands? Moral hazard, competition, and the second-best in health care markets. Journal of Political Economy, 108(5), pp.992-1005.

Geertz, C. (1973). The interpretation of cultures (Vol. 5019). Basic books.

Geissler, P.W., Harris, S.A., Prince, R.J., Olsen, A., Achieng'Odhiambo, R., Oketch-Rabah, H., Madiega, P.A., Andersen, A. and Mølgaard, P. (2002). Medicinal plants used by Luo mothers and children in Bondo district, Kenya. *Journal of Ethnopharmacology*, *83*(1-2), pp.39-54.

Gertler, P. and Sturm, R. (1997). Private health insurance and public expenditures in Jamaica. Journal of econometrics, 77(1), pp.237-257.

Gertler, P. and Solon, O. (2000). Who benefits from social health insurance in developing countries? Draft. UC Berkeley..

Gibbs, J.P. (1965). Norms: The problem of definition and classification. American Journal of Sociology, 70(5), pp.586-594.

Giddens, A. (1971). Capitalism and modern social theory: An analysis of the writings of Marx, Durkheim and Max Weber. Cambridge University Press.

Gilson, L. (1997). The lessons of user fee experience in Africa. Health policy and planning, 12(3), pp.273-285.

Ginneken, W. (2003). Extending social security: Policies for developing countries. International Labour Review, 142(3), pp.277-294.

Glassie, H. (1995). Tradition. The Journal of American Folklore, 108(430), pp.395-412.

Glicken, M.D. (2003). Social research: A simple guide. Pearson College Division.

Gnawali, D.P., Pokhrel, S., Sié, A., Sanon, M., De Allegri, M., Souares, A., Dong, H. and Sauerborn, R. (2009). The effect of community-based health insurance on the utilization of modern health care services: evidence from Burkina Faso. Health policy, 90(2), pp.214-222.

Goldstein, G.S. and Pauly, M.V. (1976). Group health insurance as a local public good. In The role of health insurance in the health services sector (pp. 73-114). NBER.

Goodwin, C. and Heritage, J. (1990). Conversation analysis. Annual review of anthropology, 19(1), pp.283-307..

Gostin, L.O. and Powers, M. (2006). What does social justice require for the public's health? public health ethics and policy imperatives. *Health Affairs*, *25*(4), pp.1053-1060.

Goulding, C. (1998). Grounded theory: the missing methodology on the interpretivist agenda. Qualitative Market Research: An International Journal, 1(1), pp.50-57.

Goulding, C., 2002. *Grounded theory: A practical guide for management, business and market researchers*. Sage.

Graburn, N. (2002). The ethnographic tourist. The tourist as a metaphor of the social world, pp.19-39.

Graham, L.J. (2005). Discourse analysis and the critical use of Foucault.

Grampp, W.D. (2000). What did Smith mean by the invisible hand?. Journal of Political Economy, 108(3), pp.441-465.

Grbich, C. (2012). Qualitative data analysis: An introduction. Sage.

Grbich, C. (2013). Integrated methods in health research. Research methods in health: foundations for evidence-based practice, pp.312-322..

Grbich, C. (2013). Phenomenology. In *Qualitative Data Analysis. An Introduction* (pp. 92-104). SAGE, London.

Green, J. and Thorogood, N. (2004). Observational methods. Qualitative methods for Health Research. Sage Publications Ltd, pp.131-4.

Greener, I. (2009). Towards a history of choice in UK health policy. Sociology of Health & Illness, 31(3), pp.309-324.

Griffin, C.C. (1989). Strengthening health services in developing countries through the private sector.

Grimes, C.E., Henry, J.A , Maraka, J , Mkandawire, N.C. and Cotton, M. (2014). Cost-effectiveness of surgery in low-and middle-income countries: a systematic review. World journal of surgery, 38(1), pp.252-263.

Grindle, M.S. (2004). Good enough governance: poverty reduction and reform in developing countries. Governance, 17(4), pp.525-548.

Groen, A.J. and Walsh, S.T. (2013). Introduction to the field of creative enterprise. Technological forecasting and social change, 80(2), pp.187-190.

Grofman, B. and Feld, S.L. (1988). Rousseau's general will: a Condorcetian perspective. American Political Science Review, 82(2), pp.567-576.and the life chances of individuals. Social Science Research, 20(4), pp.397-420.

Grossman, M. (1972). On the concept of health capital and the demand for health. Journal of Political economy, 80(2), pp.223-255.

Guba, E.G. and Lincoln, Y.S. (1994). Competing paradigms in qualitative research. Handbook of qualitative research, 2(163-194), p.105.

Gumber, A. (2002). Health insurance for the informal sector: Problems and prospects. Indian council for research on international economic relations.

Gupta, S., Davoodi, H.R. and Tiongson, E. (2000). Corruption and the provision of health care and education services (No. 2000-2116). International Monetary Fund.

Gupta, S., Davoodi, H. and Alonso-Terme, R. (2002). Does corruption affect income inequality and poverty?. Economics of governance, 3(1), pp.23-45.

Gyasi, R.M., Mensah, C.M., Adjei, P.O.W. and Agyemang, S. (2011). Public perceptions of the role of traditional medicine in the health care delivery system in Ghana. Global Journal of Health Science, 3(2), p.40.

Habermas, J. (1978). Knowledge and human interests.

Hacker, J.S (2002). The divided welfare state: The battle over public and private social benefits in the United States. Cambridge University Press.

Hackshaw, A. (2008). Small studies: strengths and limitations.

Hahonou, E.K. (2015). Juggling with the norms: Everyday practice in an emergency service in Niger. In *Real Governance and Practical Norms in Sub-saharan Africa* (pp. 123-141). Routledge.

Hama, Ibrahim, et.al (2012). Utilisations de quelques espèces de Macromycètes dans la pharmacopée traditionnelle au Niger occidental (Afrique de l'Ouest). Journal of Applied Sciences · January 2012

Hamersley, M. and Atkinson, P. (1994). Symbolic Interactionism: Perspective and Method.

Hammersley, M. and Atkinson, P. (1995). Ethnography: Practices and principles. New York: Routledge. Retrieved December, 2, p.2008.

Han, W. (2012). Health care system reforms in developing countries. *Journal of public health research*, *1*(3), p.199.

Hancock, M. (1998). Unmaking the 'great tradition': Ethnography, national culture and area studies. Identities Global Studies in Culture and Power, 4(3-4), pp.343-388.

Handcock, M.S. and Gile, K.J., (2011). Comment: On the concept of snowball sampling. *Sociological Methodology*, *41*(1), pp.367-371.

Hannoun, C. (1999). Private or national health insurance for adult vaccination in developed countries? Vaccine, 17, pp.S99-S101.

Hansmann, H.B., (1980). The role of nonprofit enterprise. *The Yale law journal*, *89*(5), pp.835-901.

Hardt, M., (2010). The common in communism. Rethinking Marxism, 22(3), pp.346-356.

Harris, M. (1968). Emics, etics, and the new ethnography. The rise of anthropological theory: A history of theories of culture, pp.568-604.

Harris, M. (2001). *The rise of anthropological theory: A history of theories of culture*. AltaMira Press.

Hartley, D. (2004). Rural health disparities, population health, and rural culture. *American Journal of Public Health*, *94*(10), pp.1675-1678.

Harvey, D. (2005). Neoliberalism: A brief history.

Harvey, D. (2010) . A companion to Marx's Capital (Vol. 1). Verso Books.

Hassel, A. (2009). Policies and politics in social pacts in Europe. European Journal of Industrial Relations, 15(1), pp.7-26.

Hayek, F.A. (1944). A.(1944) The Road to Serfdom. Dymock's Book Arcade.

Hayek, F.A. (1973). Economic freedom and representative government. London: Wincott Foundation.

Hayek, F.A.V. (1960). Free enterprise and competitive order. Individualism and economic

Hayes, N. (1997). Theory-led thematic analysis: Social identification in small companies.

Hazlitt, H. (1959). The failure of the" new economics": an analysis of the Keynesian fallacies. Ludwig von Mises Institute.

Heinrich, T., Kobayashi, Y. and Bryant, K.A. (2016). Public opinion and foreign aid cuts in economic crises. *World Development*, *77*, pp.66-79.

Helms, R. (2008). Tax policy and the history of the health insurance industry. Using Taxes to Reform Health Insurance: Pitfalls and Promises, pp.13-35.

Henrich, J. (2015). Culture and social behaviour. Current opinion in behavioural sciences, 3, pp.84-89.

Herbert, S. (2000). For ethnography. Progress in human geography, 24(4), pp.550-568.

Heritage, J. (1995). Conversation analysis: Methodological aspects. Aspects of oral communication, pp.391-418.

Heritage, J. (2008). Conversation analysis as social theory. The new Blackwell companion to social theory, pp.300-320.

Heron, J. and Reason, P. (1997). A participatory inquiry paradigm. Qualitative inquiry, 3(3), pp.274-294.

Herskovits, M.J. (1948). Book Reviews: Man and His Works: The Science of Cultural Anthropology. Science, 108, p.636.

Hesselman, M., de Wolf, A.H. and Toebes, B. eds. (2016). *Socio-economic Human Rights in Essential Public Services Provision*. Taylor & Francis.

Hill, T.P. (1996). Health care: a social contract in transition. *Social Science & Medicine*, *43*(5), pp.783-789.

Him & AGK (2014). Argumentaire du Développement de la Couverture Universelle en Santé au Niger. COOPAMI

Hindess, B., (1975). Pre-capitalist modes of production. Taylor & Francis.

Hobbes, T. (1651). The English Works of Thomas Hobbes of Malmesbury. The Online Library of Liberty (Vol. 3:11, pp. 1–323).

Hoffman, B. (2003). The wages of sickness: the politics of health insurance in Progressive America. Univ of North Carolina Press.

Hoffman, C., Rowland, D. and Carbaugh, A.L. (2004). Holes in the health insurance system-who lacks coverage and why. The Journal of Law, Medicine & Ethics, 32(3), pp.390-396.

Hofstede, G. (1994). The business of international business is culture. *International business review*, *3*(1), pp.1-14.

Holcombe, R.G. and Boudreaux, C.J. (2016). Market institutions and income inequality. Journal of Institutional Economics, 12(2), pp.263-276.

Holloway, I. (2005). Qualitative research in health care. McGraw-Hill Education (UK).

Horkheimer, M. (1972). Critical theory: Selected essays (Vol. 1). A&C Black.

Horner, A.E. (1990). The assumption of tradition: creating, collecting, and conserving cultural artifacts in the Cameroon grassfields (West Africa). University of California, Berkeley.

Howell, K.E. (2013). An introduction to the philosophy of methodology. Sage.

Howell, K.E. and Shand, R. (2015). Leadership and culture in the Welsh Assembly: investigating path-dependency. Policy Studies, 36(5), pp.507-521.

Hox, J.J. and Boeije, H.R. (2005). Data collection, primary versus secondary.

Hsiao, W.C. and Heller, P.S. (2007). *What macroeconomists should know about health care policy* (p. 15). Washington, DC: International Monetary Fund.

Hsieh, H.F. and Shannon, S.E. (2005). Three approaches to qualitative content analysis. Qualitative health research, 15(9), pp.1277-1288.

Huber, G., Hohmann, J. and Reinhard, K. (2003). Mutual Health Insurance (MHO): Five Years' Experience in West Africa: Concerns, Controversies and Proposed Solutions. GTZ, Eschborn.

Hughes, D. and DuMont, K. (1993). Using focus groups to facilitate culturally anchored research. American Journal of Community Psychology, 21(6), pp.775-806.

Husserl, E. (2002). The shorter logical investigations. Routledge.

Hussey, J. and Hussey, R. (1997). Business research.

Husted, J.H. and Husted, G.L. (2007). *Ethical decision making in nursing and health care: The symphonological approach*. Springer Publishing Company.

Hyder, A.A. and Morrow, R.H., 2000. Applying burden of disease methods in developing countries: a case study from Pakistan. *American journal of public health*, *90*(8), p.1235.

Hyder, A.A. and Morrow, R.H. (2006). Culture, behavior, and health. Retrieved May, 5, p.2007.

Idang, G.E. (2015). African culture and values. Phronimon, 16(2), pp.97-111.

Idowu, S.O. and Leal Filho, W. (2009). Global practices of corporate social responsibility. Berlin: Springer.

Iriemenam, N.C., Dosunmu, A.O., Oyibo, W.A. and Fagbenro-Beyioku, A.F. (2011). Knowledge, attitude, perception of malaria and evaluation of malaria parasitaemia among pregnant women attending antenatal care clinic in metropolitan Lagos, Nigeria. *Journal of vector borne diseases*, *48*(1), p.12.

Isa, S. M., & Reast, J. (2012). Measuring Corporate Social Responsibility (CSR) With Multi-Dimensional Scales: A Caution on The Risks Of Conceptual Misspecification. In Proceedings of the 8th European Conference on Management, Leadership and Governance: ECMLG (pp. 302-310). Academic Conferences Limited

Jagpal, N. and Laskowski, K. (2013). THE PHILANTHROPIC LANDSCAPE.

Jakab, M., Preker, A. and Harding, A. (2002). Linking organizational structure to the external environment: experiences from hospital reform in transition economies. *Hospitals in a changing Europe*, p.177.

Jakab, M., Preker, A., Krishnan, C., Schneider, P., Diop, F. and Jutting, J. (2004). Analysis of community financing using household surveys. Health financing for poor people: resource mobilization and risk sharing. Washington, DC: World Bank, pp.201-30.

Jamali, D. (2007). The case for strategic corporate social responsibility in developing countries. Business and Society Review, 112(1), pp.1-27.

Jamshed, S. (2014). Qualitative research method-interviewing and observation. *Journal of basic and clinical pharmacy*, *5*(4), p.87.

Jeffreys-Jones, R. (2015). The Death of a Myth: How Socialism and the Left Succeeded in America. Reviews in American History, 43(2), pp.281-287.

Jensen, G.A. and Morrisey, M.A. (1990). Group health insurance: A hedonic price approach. *The Review of Economics and Statistics*, pp.38-44.

Jensen, M.C. and Meckling, W.H. (1976). Theory of the firm: Managerial behaviour, agency costs and ownership structure. Journal of financial economics, 3(4), pp.305-360.

Jessop, B. (2011). The state: government and governance. Handbook of Local and Regional Development, pp.239-248.

Jick, T.D. (1979). Mixing qualitative and quantitative methods: Triangulation in action. Administrative science quarterly, 24(4), pp.602-611.

Jo Hatch, M. and Schultz, M. (1997). Relations between organizational culture, identity and image. European Journal of marketing, 31(5/6), pp.356-365.

Jofre-Bonet, M. and Kamara, J. (2018). Willingness to pay for health insurance in the informal sector of Sierra Leone. *PloS one*, *13*(5)

Johnson, B. and Turner, L.A. (2003). Data collection strategies in mixed methods research. Handbook of mixed methods in social and behavioral research, pp.297-319.

Johnson, S., Kaufmann, D. and Zoido-Lobaton, P. (1999). Corruption, public finances and the unofficial economy (Vol. 2169). World Bank Publications.

Johnson, T.P. (2014). Snowball Sampling: Introduction. *Wiley StatsRef: Statistics Reference Online*.

Johnstone, B. (2018). *Discourse analysis* (Vol. 3). John Wiley & Sons.

Jones, S. and Tarp, F. (2016). Does foreign aid harm political institutions?. *Journal of Development Economics*, *118*, pp.266-281.

Jørgensen, M.W. and Phillips, L.J. (2002). Discourse analysis as theory and method. Sage.

Jost, T.S. and Hall, M.A. (2005). The role of state regulation in consumer-driven health care. American journal of law & medicine, 31(4), pp.395-418.

Jowett, M., Deolalikar, A. and Martinsson, P. (2004). Health insurance and treatment seeking behaviour: evidence from a low□income country. *Health economics*, *13*(9), pp.845-857.

Jutting, J.P. (2001). *The impact of health insurance on the access to health care and financial protection in rural developing countries: the example of Senegal*. The World Bank.

Jütting, J.P. (2003). Health Insurance for the Poor?

Jütting, J.P. (2004). Do community-based health insurance schemes improve poor people's access to health care? Evidence from rural Senegal. World development, 32(2), pp.273-288.

Kaestner, R. and Lubotsky, D. (2016). Health insurance and income inequality. *Journal of Economic Perspectives*, *30*(2), pp.53-78.

Kailou, M. (2001) Banque de données sur les mutuelles de santé en Afrique, Acteurs de Concertation, BIT/STEP, Dakar-Sénégal p. 12.

Kangas, O. (2000). Distributive justice and social policy: some reflections on Rawls and income distribution. Social Policy & Administration, 34(5), pp.510-528.

Kant, I., 1781. (1998). Critique of pure reason. Trans. Paul Guyer and Allen Wood. Cambridge, UK: Cambridge University Press.

Kaseje, D. (2006). Healthcare in Africa: Challenges, Opportunities and an Emerging Model for Improvement. *PLoS Medicine*, *8*, 20.

Katsoulakos, P. and Katsoulakos, Y. (2006). Corporate responsibility and sustainability management. 4CR Working Papers.

Kaufmann, D., Kraay, A. and Mastruzzi, M. (2007). Measuring corruption: myths and realities.

Kautsky, K. (1918). The capitalist class (Vol. 2). National Executive Committee, Socialist Labor Party.

Kautsky, K. and Stenning, H.J.(1964). The dictatorship of the proletariat (Vol. 96). Ann Arbor: University of Michigan Press.

Kay, A. (2005). A critique of the use of path dependency in policy studies. Public administration, 83(3), pp.553-571.

Keesing, R.M. (1974). Theories of culture. Annual review of anthropology, 3(1), pp.73-97.

Kemm, J., Parry, J. and Palmer, S. (2004). Health impact assessment: concepts, theory, techniques and applications. Oxford University Press.

Kennedy, G.A. (2006). On rhetoric: A theory of civic discourse.

Kennedy, M.D. and Galtz, N. (1996). From Marxism to post communism: Socialist desires and East European rejections. Annual Review of Sociology, 22(1), pp.437-458.

Keynes, J.M. (1926). Laissez-faire and Communism. New Republic, Incorporated.

Keynes, J.M. (1944). Mary Paley Marshall. Economic Journal, 54, pp.268-84.

Keynes, J.M.(1936). The general theory of money, interest and employment. Reprinted in The Collected Writings of John Maynard Keynes, 7.

Khan, F.S. and Mazhar, S.S. (2015). Corporate Social Responsibility: Understanding the Legal Framework and Philanthropic Indian Companies. International Journal of Management, Innovation & Entrepreneurial Research, 1(2), pp.32-36.

Kidd, P.S. and Parshall, M.B. (2000). Getting the focus and the group: enhancing analytical rigor in focus group research. Qualitative health research, 10(3), pp.293-308.

Kieny, M.P. and Evans, D.B. (2013). Universal health coverage.

Kimchi, J., Polivka, B. and Stevenson, J.S. (1991). Triangulation: operational definitions. Nursing research, 40(6), pp.364-366.

Kincheloe, J.L., McLaren, P. and Steinberg, S.R. (2011). Critical pedagogy and qualitative research. The SAGE handbook of qualitative research, pp.163-177.

Kirk, J. and Miller, M.L. (1986). Reliability and validity in qualitative research. Sage.

Kitzinger, J. (1995). Qualitative research. Introducing focus groups. BMJ: British medical journal, 311(7000), p.299.

Koch, D.J. and Schulpen, L. (2017). Unintended effects of international cooperation: A preliminary literature review. In *Paper presented at the unintended effects of international cooperation*.

Koh, H. and Tavenner, M. (2013). Connecting to health insurance coverage. Jama, 309(18), pp.1893-1894.

Kolk, A. and Rivera-Santos, M. (2016). The state of research on Africa in business and management: Insights from a systematic review of key international journals. Business & Society, p.0007650316629129.

Korobkin, R. (1998). Determining health care rights from behind a veil of ignorance. *U. Ill. L. Rev.*, p.801.

Kothari, C.R. (2004). Research methodology: Methods and techniques. New Age International.

Krefting, L. (1991). Rigor in qualitative research: The assessment of trustworthiness. American journal of occupational therapy, 45(3), pp.214-222.

Krueger Richard, A. and Anne, C.M. (1994). Focus groups. A practical guide for applied research.

Krueger, R.A. and Casey, J., 2009. Successful focus groups: practical guidelines for research.

Krueger, R.A. and Casey, M.A. (2014). Focus groups: A practical guide for applied research. Sage publications.

Kruger, R.A. (1998). Moderating focus groups. Focus group kit, 4.

Kunreuther, H., Meyer, R., Zeckhauser, R., Slovic, P., Schwartz, B., Schade, C., Luce, M.F., Lippman, S., Krantz, D., Kahn, B. and Hogarth, R. (2002). High stakes decision making: Normative, descriptive and prescriptive considerations. Marketing Letters, 13(3), pp.259-268.

Kuttner, R. (1999). Health insurance coverage.

Kutzin, J. and Barnum, H. (1992). Institutional features of health insurance programs and their effects on developing country health systems. The International Journal of Health Planning and Management, 7(1), pp.51-72.

Kutzin, J. (2013). Health financing for universal coverage and health system performance: concepts and implications for policy. *Bulletin of the World Health Organization*, *91*, pp.602-611.

Kyu, H.H., Maddison, E.R., Henry, N.J., Mumford, J.E., Barber, R., Shields, C., Brown, J.C., Nguyen, G., Carter, A., Wolock, T.M. and Wang, H. (2018). The global burden of tuberculosis: results from the Global Burden of Disease Study 2015. *The Lancet Infectious Diseases*, *18*(3), pp.261-284.

L'horty, Y., Quinet, A. and Rupprecht, F. (1997). Expliquer la croissance des dépenses de santé: le rôle du niveau de vie et du progrès technique. *Économie & prévision*, *129*(3), pp.257-268.

Lagueux, M. (1998). Was Keynes a liberal and an individualist? Or Keynes reader of Mandeville. Cahiers d'économie politique/Papers in Political Economy, pp.255-263.

Lai, E.R. and Waltman, K. (2008). Test preparation: Examining teacher perceptions and practices. *Educational Measurement: Issues and Practice*, *27*(2), pp.28-45.

Lai, M.F. and Lee, G.G. (2007). Relationships of organizational culture toward knowledge activities. *Business process management journal*, *13*(2), pp.306-322.

Lake, D.A. (1988). Power, Protection, and Free Trade: International Sources of US Commercial Strategy, 1887-1939. Cornell Univ Pr.

Laterveer, L., Niessen, L.W. and Yazbeck, A.S. (2003). Pro-poor health policies in poverty reduction strategies. *Health Policy and Planning*, *18*(2), pp.138-145.

Lavigne Delville, P. (2011). Vers une socio-anthropologie des interventions de développement comme action publique.

Lawrence, T.B. and Shadnam, M. (2008). Institutional theory. *The international encyclopedia of communication*.

LeCompte, M.D. and Goetz, J.P. (1982). Problems of reliability and validity in ethnographic research. Review of educational research, 52(1), pp.31-60.

LeCompte, M.D. and Schensul, J.J. (1999). Designing and conducting ethnographic research (Vol. 1). Rowman Altamira.

LeCompte, M.D. and Schensul, J.J. (2012). *Analysis and interpretation of ethnographic data: A mixed methods approach* (Vol. 5). Rowman Altamira.

Lederman, L.C. (2010). The impact of health communication on the culture of college drinking. Health communication, 25(6-7), pp.603-604.

Lefever, S., Dal, M. and Matthiasdottir, A. (2007). Online data collection in academic research: advantages and limitations. British Journal of Educational Technology, 38(4), pp.574-582.

Lefort, C.(1988). Democracy and political theory. Polity Press.

Leonard, K.L. (2001). African traditional healers: The economics of healing.

Lerner, M.J., Miller, D.T. and Holmes, J.G. (1976). Deserving and the emergence of forms of justice. Advances in experimental social psychology, 9, pp.133-162.

Les Afriques (2013), Journal no 256. L'assurance au Niger Une niche à milliards, avant la grande embellie. 2013

Lessnoff, M. (1990). Introduction: social contract. *Ders.(Hg.): Social Contract Theory. Oxford*, pp.1-26.

Letourmy, A. (2008). On the development of health insurance in low-income countries: the case of African countries. Comptes rendus biologies, 331(12), pp.952-963.

Levesque, A. and Li, H.Z. (2014). The relationship between culture, health conceptions, and health practices: A qualitative–quantitative approach. *Journal of cross-cultural psychology*, *45*(4), pp.628-645.

Levy, H. (1998). Who pays for health insurance? Employee contributions to health insurance premiums.

Lewis, M. (2006). Governance and corruption in public health care systems.

Lima□Nunes, A., Pereira, C.R. and Correia, I. (2013). Restricting the scope of justice to justify discrimination: The role played by justice perceptions in discrimination against immigrants. *European Journal of Social Psychology*, *43*(7), pp.627-636.

Lincoln, Y.S. and Guba, E.G. (1985). Naturalistic inquiry (Vol. 75). Sage.

Lind, C. (2007). The power of adolescent voices: co□researchers in mental health promotion. Educational Action Research, 15(3), pp.371-383.

Lipset, S.M. and Bendix, R. (1991). Social mobility in industrial society. Transaction Publishers.

Lipton, M. and Ravallion, M. (1995). Poverty and policy. Handbook of development economics, 3, pp.2551-2657.

Little, K. (1957). The role of voluntary associations in West African urbanization. *American Anthropologist*, *59*(4), pp.579-596.

Liu, S.S, Luo, X. and Shi, Y.Z, (2003). Market-oriented organizations in an emerging economy: A study of missing links. Journal of Business Research, 56(6), pp.481-491.

Livingstone, D. (1997). The Limits of Human Capital: Expanding Knowledge, Informal Learning and Underemployment. POLICY OPTIONS-MONTREAL-, 18, pp.9-13.

Locke, J. (1952). (1689). An essay concerning human understanding.

Locke, J. (1988). Locke: Two treatises of government student edition. Cambridge University Press.

Locke, J. (2002). John Locke: essays on the law of nature: the Latin text with a translation, introduction, and notes; together with transcripts of Locke's shorthand in his journal for 1676. Oxford University Press.

Logsdon, J.M. and Yuthas, K. (1997). Corporate social performance, stakeholder orientation, and organizational moral development. In From the Universities to the Marketplace: The Business Ethics Journey (pp. 3-16). Springer Netherlands.

Longhurst, R. (2003). Semi-structured interviews and focus groups. Key methods in geography, pp.117-132.

Loutou, ABK. (2009). La protection sociale au Niger : de l'assurance sante privée a l'émergence des mutuelles. Bulletin de droit comparé du travail et de la sécurité sociale

Maarse, H., Paulus, A. and Kuiper, G. (2005). Supervision in social health insurance: a four country study. Health Policy, 71(3), pp.333-346.

Macassa, G., da Cruz Francisco, J. and McGrath, C. (2017). Corporate Social Responsibility and Population Health. *Health Science Journal*, *11*(5).

Macdonald, G. and Bunton, R. (1992). Discipline or disciplines? Health promotion: Disciplines and diversity, p.6.

MacDonald, J.A. (2007). Agency design and post legislative influence over the bureaucracy. Political Research Quarterly, 60(4), pp.683-695.

MacKinnon, D. (2008). Evolution, path dependence and economic geography. *Geography Compass*, *2*(5), pp.1449-1463.

Mackintosh, M., Channon, A., Karan, A., Selvaraj, S., Cavagnero, E. and Zhao, H. (2016). What is the private sector? Understanding private provision in the health systems of low-income and middle-income countries. The Lancet, 388(10044), pp.596-605.

Madhukumar, S., Sudeepa, D. and Gaikwad, V. (2012). Awareness and perception regarding health insurance in Bangalore rural population. *International Journal of Medicine and Public Health*, *2*(2).

Maggs□Rapport, F. (2000). Combining methodological approaches in research: ethnography and interpretive phenomenology. Journal of advanced nursing, 31(1), pp.219-225

Mahmud, Sarker, et.al (2017). BMC Health Services ResearchBMC series – open, inclusive and trusted

Mahoney, J. (2000). Path dependence in historical sociology. Theory and society, 29(4), pp.507-548.

Mahoney, J. and Thelen, K. (2010). A theory of gradual institutional change. Explaining institutional change: Ambiguity, agency, and power, 1.

Mamane, A., Bhatti, J.A., Savès, M., Alioum, A., Jutand, M.A., Hadiza-Jackou, D., Tessier, J.F., Dabis, F., Malvy, D. and Sasco, A.J. (2012). La prise en charge du cancer du sein au Niger: connaissances, attitudes et pratiques des professionnels de santé non médecins de Niamey, Niger (2010). Journal Africain du Cancer/African Journal of Cancer, 4(3), pp.156-163.

Manzo, L.M., Moussa, I. and Ikhiri, K. (2017). Phytochemical screening of selected medicinal plants used against diarrhea in Niger, West Africa. *International Journal of Herbal Medicine*, *5*(4), pp.32-38.

Marcuse, H. (2011). "The Affirmative Character of Culture"(1937). Cultural Theory: An Anthology, p.27.

Mark, M.M., Eyssell, K.M. and Campbell, B. (1999). The ethics of data collection and analysis. New Directions for Evaluation, 1999(82), pp.47-56.

Marmot, M., (2005). Social determinants of health inequalities. *The lancet*, *365*(9464), pp.1099-1104.

Marmot, M., Friel, S., Bell, R., Houweling, T.A., Taylor, S. and Commission on Social Determinants of Health (2008). Closing the gap in a generation: health equity through action on the social determinants of health. The lancet, 372(9650), pp.1661-1669.

Marshall, C. and Rossman, G.B. (2014). Designing qualitative research. Sage publications.

Marshall, J.M. (1976). Moral hazard. The American Economic Review, 66(5), pp.880-890.

Marshall, M.N.(1996). Sampling for qualitative research. Family practice, 13(6), pp.522-526.

Marshall, S. and Swenssen, H. (1999). A qualitative analysis of parental decision making for childhood immunisation. Australian and New Zealand journal of public health, 23(5), pp.543-545.

Marx, J.D. (1999). Corporate philanthropy: What is the strategy?. Non-profit and Voluntary Sector Quarterly, 28(2), pp.185-198.

Marx, K. (1848) .1978. Manifesto of the Communist Party, pp.469-500.

Marx, K. (1893). Capital Vol. II, ed. Frederick Engels (Chicago: Charles H. Kerr & Co., 1907), p.155.

Marx, K. (1970). (1859). A contribution to the critique of political economy.

Marx, K. and Engels, F. (1845). Ruling class and ruling ideas.

Marx, K. and Engels, F. (2009). The economic and philosophic manuscripts of 1844 and the Communist manifesto. Prometheus Books.

Marx, K., 1867. [1867] Capital: A Critique of Political Economy. New York: International.

Marx, K., Engels, F. and Puchner, M.(2011). The communist manifesto and other writings. Tantor Media, Incorporated.

Massey, D.S., Gross, A.B. and Eggers, M.L. (1991). Segregation, the concentration of poverty,

Masud, N. and Yontcheva, B. (2005). Does foreign aid reduce poverty?: empirical evidence from nongovernmental and bilateral aid.

Mathauer, I., Schmidt, J.O. and Wenyaa, M. (2008). Extending social health insurance to the informal sector in Kenya. An assessment of factors affecting demand. *The International journal of health planning and management*, *23*(1), pp.51-68.

Mathiyazaghan, K. (1998). Willingness to pay for rural health insurance through community participation in India. *The International journal of health planning and management*, *13*(1), pp.47-67.

Maxwell, J. (1992). Understanding and validity in qualitative research. Harvard educational review, 62(3), pp.279-301.

Maxwell, J.A. (2010). Using numbers in qualitative research. Qualitative inquiry, 16(6), pp.475-482.

Mayer, T.(1980). David Hume and monetarism. The Quarterly Journal of Economics, 95(1), pp.89-101.
McCloskey, D.N. (2006). Bourgeois Virtue. John Wiley & Sons, Ltd.

McGregor, S.L. and Murnane, J.A. (2010). Paradigm, methodology and method: Intellectual integrity in consumer scholarship. International journal of consumer studies, 34(4), pp.419-427.

McGuire, J.W. (1964). THEORIES OF BUSINESS BEHAVIOR..

McKee, M., Balabanova, D., Basu, S., Ricciardi, W. and Stuckler, D. (2013). Universal health coverage: a quest for all countries but under threat in some. *Value in Health*, *16*(1), pp.S39-S45.

McQueen, P. and McQueen, H. (2010). Key concepts in philosophy. Palgrave Macmillan.

McWilliams, A., Siegel, D.S. and Wright, P.M. (2006). Corporate social responsibility: Strategic implications. *Journal of management studies*, *43*(1), pp.1-18.

Mead, M. ed. (2002). Cooperation and competition among primitive peoples (Vol. 123). Transaction Publishers.

Meara, J.G., Leather, A.J., Hagander, L., Alkire, B.C., Alonso, N., Ameh, E.A., Bickler, S.W., Conteh, L., Dare, A.J., Davies, J. and Mérisier, E.D., 2015. Global Surgery 2030: evidence and solutions for achieving health, welfare, and economic development. *The Lancet*, *386*(9993), pp.569-624.

Melle, U. (1997). Husserl's phenomenology of willing. In Phenomenology of values and valuing (pp. 169-192). Springer Netherlands.

Melotti, U. (1977). Marx and the third world. Springer.

Meng, Q., Yuan, B., Jia, L., Wang, J., Yu, B., Gao, J. and Garner, P. (2010). Expanding health insurance coverage in vulnerable groups: a systematic review of options. *Health policy and planning*, *26*(2), pp.93-104.

Merleau-Ponty, M. (1964). The primacy of perception.

Meyer, J.W. and Jepperson, R.L. (2000). The 'actors' of modern society: The cultural construction of social agency. Sociological theory, 18(1), pp.100-120.

Meyer, J.W. and Rowan, B. (1977). Institutionalized organizations: Formal structure as myth and ceremony. American journal of sociology, 83(2), pp.340-363.

Midgley, J. and Tang, K.L. (2001). Introduction: social policy, economic growth and developmental welfare. International Journal of Social Welfare, 10(4), pp.244-252.

Miles, M.B. and Huberman, A.M (1994). Qualitative data analysis: An expanded sourcebook. sage.

Mill, J.S. (1844). Of the influence of consumption on production. Some Unsettled Questions of Political Economy.

Mill, J.S., (1848). Of the stationary state. Principles of political economy Book IV: Influence of the progress of society

Mill, J.S. (1994). Obligation. See Duty. Ethics: Freedom of expression-Personal relationships, 2, p.630.

Miller, D. (1999). *Principles of social justice*. Harvard University Press.

Miller, S.I. and Fredericks, M. (1999). How does grounded theory explain?. Qualitative Health Research, 9(4), pp.538-551.

Mills, A. (1983). Economic aspects of health insurance.

Mingardi, A. (2016). Thomas Hodgskin, Socialist or Anti-Privilege Libertarian? Journal des Économistes et des Études Humaines, 22(2), pp.139-163.

Ministère de la sante publique du Niger (MSP). (2012). Stratégie nationale de financement de la sante en vue de la couverture universelle en sante au Niger.

Mises, L.V. (1922). Socialism. Indianapolis, Indiana: Liberty Classics. Rpt. from previous editions of London: Jonathan Cape (1936).

Mitchell, R.K., Agle, B.R. and Wood, D.J. (1997). Toward a theory of stakeholder identification and salience: Defining the principle of who and what really counts. *Academy of management review*, *22*(4), pp.853-886.

Mladovsky, P. (2014). Why do people drop out of community-based health insurance? Findings from an exploratory household survey in Senegal. Social Science & Medicine, 107, pp.78-88.

Mladovsky, P. and Mossialos, E. (2008). A conceptual framework for community-based health insurance in low-income countries: social capital and economic development. World Development, 36(4), pp.590-607.

Molyneux, C., Hutchison, B., Chuma, J. and Gilson, L. (2007). The role of community-based organizations in household ability to pay for health care in Kilifi District, Kenya. Health policy and planning, 22(6), pp.381-392.

Mooketsane, K.S. and Phirinyane, M.B. (2015). Health governance in sub-Saharan Africa. Global social policy, 15(3), pp.345-348.

Morgan, D.L. (1993). Qualitative content analysis: a guide to paths not taken. Qualitative health research, 3(1), pp.112-121

Morgan David, L., (1997). Focus groups as qualitative research. *Qualitative Research Methods Series*, *16*(2).

Morgan, D.L. and Krueger, R.A. (1993). When to use focus groups and why.

Morgan, D.L. and Krueger, R.A. (1998). Developing questions for focus groups (Vol. 3). Sage.

Morgan, D.L. and Scannell, A.U. (1998). Planning focus groups (Vol. 2). Sage.

Morgan, R., Ensor, T. and Waters, H. (2016). Performance of private sector health care: implications for universal health coverage. The Lancet, 388(10044), pp.606-612.

Morrison, K. (2006) . Marx, Durkheim, Weber: Formations of modern social thought. Sage.

Morse, J.M. (1995). Qualitative research methods for health professionals (No. 610.73072 M6).

Moshman, D. (1982). Exogenous, endogenous, and dialectical constructivism. Developmental review, 2(4), pp.371-384.

Mosse, D. and Lewis, D. (2005). The aid effect: Giving and governing in international development.

Mossialos, E. and Thomson, S.M. (2002). Voluntary health insurance in the European Union: a critical assessment. International journal of health services, 32(1), pp.19-88.

Moyo, D. (2009). Dead aid: Why aid is not working and how there is a better way for Africa. Macmillan.

Moyo, D. (2009). Why foreign aid is hurting Africa. The Wall Street Journal, 11.

Mullins, L.J. (2007). Management and organisational behaviour. Pearson education.

Munhall, P.L. (1988). Ethical considerations in qualitative research. Western Journal of Nursing Research, 10(2), pp.150-162.

Murray, J.E. (2007). Origins of American health insurance: a history of industrial sickness funds. Yale University Press.

Musau, S.N. (1999). Community-based health insurance: experiences and lessons learned from East and Southern Africa. Partnerships for Health Reform, Abt Associates.

Musgrove, P. (1996). Public and private roles in health: theory and financing patterns.

Musgrove, P. (1999). Public spending on health care: how are different criteria related?. Health policy, 47(3), pp.207-223.

Mushkin, S.J. (1958). Toward a definition of health economics. Public health reports, 73(9), p.785.

Muzio, D. and Kirkpatrick, I. (2011). Introduction: Professions and organizations-a conceptual framework.

Myers, G. (1998). Displaying opinions: Topics and disagreement in focus groups. Language in society, 27(1), pp.85-111.

Naidoo, R. and Frye, I.(2005). The Role of Workers' Organizations in the Extension of Social Security to Informal Workers. *Comp. Lab. L. & Pol'y. J.*, *27*, p.187.

Nay, O., Béjean, S., Benamouzig, D., Bergeron, H., Castel, P. and Ventelou, B. (2016). Achieving universal health coverage in France: policy reforms and the challenge of inequalities. The Lancet, 387(10034), pp.2236-2249.

Ndiaye, P., Soors, W. and Criel, B. (2007). A view from beneath: community health insurance in Africa. Tropical Medicine & International Health, 12(2), pp.157-161.

Neudeck, W. and Podczeck, K. (1996). Adverse selection and regulation in health insurance markets. Journal of Health Economics, 15(4), pp.387-408.

Newhouse, J.P. (1977). Medical-care expenditure: a cross-national survey. The Journal of Human Resources, 12(1), pp.115-125.

Nicholson, D., Yates, R., Warburton, W. and Fontana, G. (2015). Delivering universal health coverage: a guide for policymakers. In *Report of the WISH Universal Health Coverage Forum*.

Niederdeppe, J., Bu, Q., Borah, P., Kindig, D.A. and Robert, S.A. (2008). Message design strategies to raise public awareness of social determinants of health and population health disparities. The Milbank Quarterly, 86(3), pp.481-513.

Nikolova, V. and Arsić, S. (2017). THE STAKEHOLDER APPROACH IN CORPORATE SOCIAL RESPONSIBILITY. Engineering management, 3(1), pp.24-35.

Norberg, J. (2005). In defence of global capitalism. Academic Foundation.

Nordberg, D. (2008). The ethics of corporate governance. Journal of General Management, 33(4), pp.35-52.

Normand, C. and Busse, R. (2002). Social health insurance financing. Funding health care: options for Europe, 59.

Nozick, R. (1974). Anarchy, state and utopia.

Nunes, R., Brandao, C. and Rego, G. (2011). Public accountability and sunshine healthcare regulation. *Health Care Analysis*, *19*(4), pp.352-364.

Nutbeam, D., 2008. The evolving concept of health literacy. *Social science & medicine*, *67*(12), pp.2072-2078.

Nyika, A. (2009). The ethics of improving African traditional medical practice: Scientific or African traditional research methods? Acta Tropica, 112, pp.S32-S36.

Nyman, J.A. (2003). The theory of demand for health insurance. Stanford University Press.

O'Donnell, O. (2007). Access to health care in developing countries: breaking down demand side barriers. Cadernos de Saúde Pública, 23(12), pp.2820-2834.

O'Donnell, O., Van Doorslaer, E., Wagstaff, A. and Lindelow, M. (2007). *Analyzing health equity using household survey data: a guide to techniques and their implementation*. The World Bank.

Obermann, K., Jowett, M.R., Alcantara, M.O.O., Banzon, E.P. and Bodart, C. (2006). Social health insurance in a developing country: the case of the Philippines. Social Science & Medicine, 62(12), pp.3177-3185.

Ocket, S., Doudou, M.H., Gagara, M., Weber, L., Labat, A., Jassen, W. and Dramaix, M. (2017) HEALTH RESEARCH IN NIGER: SITUATION ANALYSIS AND PERSPECTIVES. *Revue Marocaine de Santé Publique*, *4*(6).

Odeyemi, I.A. (2014). Community-based health insurance programmes and the national health insurance scheme of Nigeria: challenges to uptake and integration. International journal for equity in health, 13(1), p.20.

Ojua, T.A., Bisong, P.O. and Ishor, D.G. (2013). Theoretical overview and socio-cultural implications of urban dwellers patronage of trado-medical homes and services in Nigerian urban centres. *International Journal of Development and Sustainability*, *2*(1), pp.183-193.

Okello, F. and Feeley, F. (2004). Socioeconomic characteristics of enrollees in community health insurance schemes in Africa. CMS Country Research Series, (15).

Okey, R. (2003). Eastern Europe 1740-1985: feudalism to communism. Routledge.

Okigbo, R.N. and Mmeka, E.C. (2006). An appraisal of phytomedicine in Africa. KMITL Sci Tech J, 6(2), pp.83-94.

Okun, A.M., Fellner, W. and Wachter, M. (1975). Inflation: its mechanics and welfare costs. Brookings Papers on Economic Activity, 1975(2), pp.351-401.

Okungu, V., Chuma, J., Mulupi, S. and McIntyre, D. (2018). Extending coverage to informal sector populations in Kenya: design preferences and implications for financing policy. *BMC health services research*, *18*(1), p.13.

Okuonzi, S.A. and Macrae, J. (1995). Whose policy is it anyway? International and national influences on health policy development in Uganda. Health policy and planning, 10(2), pp.122-132.

Onwuegbuzie, A.J., Dickinson, W.B., Leech, N.L. and Zoran, A.G. (2009). A qualitative framework for collecting and analyzing data in focus group research. International journal of qualitative methods, 8(3), pp.1-21.

Oslington, P. ed., (2011). Adam Smith as theologian. Taylor & Francis.

Ousseini, A. (2011). Une politique publique de santé au Niger: La mise en place d'exemptions de paiement des soins en faveur des femmes et des enfants.

Pallas, S.W., Nonvignon, J., Aikins, M. and Ruger, J.P. (2014). Responses to donor proliferation in Ghana's health sector: a qualitative case study. *Bulletin of the World Health Organization*, *93*, pp.11-18.

Palmer, N., Mueller, D.H., Gilson, L., Mills, A. and Haines, A. (2004). Health financing to promote access in low income settings—how much do we know?. The Lancet, 364(9442), pp.1365-1370.

Palthe, J. (2014). Regulative, normative, and cognitive elements of organizations: Implications for managing change. Management and organizational studies, 1(2), p.59.

Panisset, U.B. (2000). An introduction to international health statecraft. International health statecraft: Foreign policy and public health in Peru's cholera epidemic. Lanham (MD): University Press of America.

Parkin, F. (1971). Class Inequalities and Political Order. Social Stratification in Capitalist and Socialist Societies.

Parmar, D., Souares, A., De Allegri, M., Savadogo, G. and Sauerborn, R. (2012). Adverse selection in a community-based health insurance scheme in rural Africa: implications for introducing targeted subsidies. BMC health services research, 12(1), p.181.

Parmar, D., De Allegri, M., Savadogo, G. and Sauerborn, R. (2013). Do community-based health insurance schemes fulfil the promise of equity? A study from Burkina Faso. Health policy and planning, 29(1), pp.76-84.

Patel, A.T. and Kumar, S. (2017). A Study of Awareness, Attitude and Factors influencing Personal Financial Planning for Residents of Gujarat.

Paul, B.D. (1955). Health, culture, and community. Russell Sage Foundation.

Pauly, M.V. (1968). The economics of moral hazard: comment. The American Economic Review, pp.531-537.

Pauly, M.V. (1978). Medical staff characteristics and hospital costs. *Journal of Human Resources*, pp.77-111.

Pauly, M.V., Withers, K.H., Subramanian-Viswana, K., Lemaire, J. and Hershey, J.C. (2003). *Price elasticity of demand for term life insurance and adverse selection* (No. w9925). National bureau of economic research.

Pauly, M.V., Zweifel, P., Scheffler, R.M., Preker, A.S. and Bassett, M. (2006). Private health insurance in developing countries. Health Affairs, 25(2), pp.369-379.

Pauly, M.V. and Herring, B. (2007). Risk pooling and regulation: policy and reality in today's individual health insurance market. *Health Affairs*, *26*(3), pp.770-779.

Pauly, M.V. and Blavin, F.E. (2008). Moral hazard in insurance, value-based cost sharing, and the benefits of blissful ignorance. Journal of Health Economics, 27(6), pp.1407-1417.

Paz-Fuchs, A. (2011). The social contract revisited: The modern welfare state. OVERVIEW AND CRITICAL REPORT. The Foundation for Law, Justice and Society in affiliation with The Centre for Socio-Legal Studies, University of Oxford www. fljs. org (dostp: 31.01. 2013).

Peñaranda, F. (2015). The individual, social justice and public health. *Ciencia & saude coletiva*, *20*, pp.987-996.

Peng, M.W. and Heath, P.S. (1996). The growth of the firm in planned economies in transition: Institutions, organizations, and strategic choice. *Academy of management review*, *21*(2), pp.492-528.

Perks, K.J., Farache, F., Shukla, P. and Berry, A. (2013). Communicating responsibility-practicing irresponsibility in CSR advertisements. *Journal of Business Research*, *66*(10), pp.1881-1888.

Peters, B.G., Pierre, J. and King, D.S. (2005). The politics of path dependency: Political conflict in historical institutionalism. The journal of politics, 67(4), pp.1275-1300.

Phellas, C.N., Bloch, A. and Seale, C. (2011). Structured methods: interviews, questionnaires and observation. *Researching society and culture*, *3*.

Phillips, L. and Jorgensen, M.W. (2002). *Discourse analysis as theory and method*. London: Sage Publications.

Piachaud, D. (2008). Social justice and public policy: a social policy perspective (pp. 33-52). Policy Press.

Pierre, J. and Peters, B. (2005). Governing complex societies: Trajectories and scenarios. Springer.

Pierson, P. (1993). When effect becomes cause: Policy feedback and political change. World politics, 45(4), pp.595-628.

Pierson, P. (2000). Increasing returns, path dependence, and the study of politics. American political science review, 94(2), pp.251-267.

Pierson, P. and Skocpol, T. (2002). Historical institutionalism in contemporary political science. Political science: The state of the discipline, 3, pp.693-721.

Pillay, R. (2008). Work satisfaction of medical doctors in the South African private health sector. *Journal of health organization and management*, *22*(3), pp.254-268.

Pinsonneault, A. and Kraemer, K. (1993). Survey research methodology in management information systems: an assessment. Journal of management information systems, 10(2), pp.75-105.

Pitkow, J.E. and Kehoe, C.M. (1996). Emerging trends in the WWW user population. Communications of the ACM, 39(6), pp.106-108.

Platteau, J.P. (1997). Mutual insurance as an elusive concept in traditional rural communities. The Journal of Development Studies, 33(6), pp.764-796.

Popper, K.R. (1992). Quantum theory and the schism in physics (Vol. 3). Psychology Press.

Porter, M.E. and Kramer, M.R. (2002). The competitive advantage of corporate philanthropy. *Harvard business review*, *80*(12), pp.56-68.

Posner, R.A. (1974). Theories of economic regulation.

Postone, M. and Galambos, L. (1995). Time, labor, and social domination: A reinterpretation of Marx's critical theory. Cambridge University Press.

Potvin, L. and Jones, C.M. (2011). Twenty-five years after the Ottawa Charter: the critical role of health promotion for public health. Canadian Journal of Public Health/Revue Canadienne de Sante'e Publique, pp.244-248.

Powell, W.W. and Steinberg, R. eds. (2006). The non-profit sector: A research handbook. Yale University Press.

Powers, M., Faden, R.R. and Faden, R.R. (2006). *Social justice: the moral foundations of public health and health policy*. Oxford University Press, USA.

Pratap, S. and Quintin, E. (2006). *The informal sector in developing countries: Output, assets and employment* (No. 2006/130). Research Paper, UNU-WIDER, United Nations University (UNU).

Preker, A.S., Carrin, G., Dror, D., Jakab, M., Hsiao, W. and Arhin-Tenkorang, D. (2002). Effectiveness of community health financing in meeting the cost of illness. Bulletin of the World Health Organization, 80(2), pp.143-150.

Preker, A.S., Langenbrunner, J. and Jakab, M. (2002). Rich-poor differences in health care financing. Social Reinsurance, p.21.

Preker, A.S., Scheffler, R.M. and Bassett, M.C. (2007). Private voluntary health insurance in development. Friend or foe.

Price, J.H. and Murnan, J. (2004). Research limitations and the necessity of reporting them.

Prieto□Carrón, M., Lund□Thomsen, P.E.T.E.R., Chan, A., Muro, A.N.A. and Bhushan, C. (2006). Critical perspectives on CSR and development: what we know, what we don't know, and what we need to know. International Affairs, 82(5), pp.977-987.

Pullman, M.E., Maloni, M.J. and Carter, C.R. (2009). Food for thought: social versus environmental sustainability practices and performance outcomes. *Journal of Supply Chain Management*, *45*(4), pp.38-54.

Radermacher, R., Dror, I. and Noble, G. (2006). Challenges and strategies to extend health insurance to the poor.

Rahman, S. (2011). Evaluation of definitions: ten dimensions of corporate social responsibility. World Review of Business Research, 1(1), pp.166-176.

Raico, R. (2008). Was Keynes a liberal?. The Independent Review, 13(2), pp.165-188.

Rasmussen, H.N., Wrosch, C., Scheier, M.F. and Carver, C.S. (2006). Self□regulation processes and health: the importance of optimism and goal adjustment. *Journal of personality*, *74*(6), pp.1721-1748.

Ratner, S. (2000). *The informal economy in rural community economic development*. University of Kentucky, Department of Agricultural Economics.

Ravishankar, N. Gubbins, P., Cooley, R.J., Leach-Kemon, K., Michaud, C.M., Jamison, D.T. and Murray, C.J. (2009). Financing of global health: tracking development assistance for health from 1990 to 2007. The Lancet, 373(9681), pp.2113-2124.

Rawls, J. (1993). The domain of the political and overlapping consensus. The idea of democracy, 246.

Rawls, J. (2009). A theory of justice. Harvard university press.

Reeves, S., Kuper, A. and Hodges, B.D. (2008). Qualitative research methodologies: ethnography. *Bmj*, *337*, p.a1020.

Reich, M.R. (2002). Public-private partnerships for public health. *Public-private partnerships for public health*, pp.1-18.

Reinhardt, U.E., Hussey, P.S. and Anderson, G.F. (2004). US health care spending in an international context. Health Affairs, 23(3), pp.10-25.

Reshmi, B., NAIR, N.S., Sabu, K.M. and Unnikrishnan, B. (2012). Awareness, attitude and their correlates towards health insurance in an urban south Indian population. *Management in health*, *16*(1).

Rich, R.F. (1999). Health policy, health insurance and the social contract. Comp. Lab. L. & Pol'y J., 21, p.397.

Richardson, C.A. and Rabiee, F. (2001). A question of access. *an exploration of the factors influencing the health of young males aged*, pp.15-19.

Ricoeur, P. and Tonoiu, V. (1995). Eseuri de hermeneutica. Humanitas.

Ridde, V., Morestin, F. and Belaid, L. (2010). Politiques contemporaines de gratuité des soins en Afrique. *Maux Choses Santé Acteurs Pratiques. Systèmes de Santé dans le Tiers-Monde*, pp.207-242.

Riddell, R.C. (1999). The end of foreign aid to Africa? Concerns about donor policies. African Affairs, 98(392), pp.309-335.

Ridde, V., Diarra, A. and Moha, M. (2011). User fees abolition policy in Niger: Comparing the under five years exemption implementation in two districts. Health Policy, 99(3), pp.219-225.
Romero-Daza, N., 2002. Traditional medicine in Africa. The Annals of the American Academy of Political and Social Science, 583(1), pp.173-176.

Rimal, R.N. and Real, K. (2003). Understanding the influence of perceived norms on behaviors. *Communication Theory*, *13*(2), pp.184-203.

Rimer, B.K. and Kreuter, M.W. (2006). Advancing tailored health communication: A persuasion and message effects perspective. *Journal of communication*, *56*, pp.S184-S201.

Robertson, R. and Turner, B.S. (1989). Talcott Parsons and Modern Social Theory—An Appreciation. Theory, Culture & Society, 6(4), pp.539-558.

Robson, C. (2002). The analysis of qualitative data. Blackwell.

Robyn, P.J., Fink, G., Sié, A. and Sauerborn, R. (2012). Health insurance and health-seeking behaviour: Evidence from a randomized community-based insurance rollout in rural Burkina Faso. Social Science & Medicine, 75(4), pp.595-603.

Robyn, P.J., Sauerborn, R. and Bärnighausen, T. (2012). Provider payment in community-based health insurance schemes in developing countries: a systematic review. *Health policy and planning*, *28*(2), pp.111-122.

Roemer, J.E. (2002). Egalitarianism against the veil of ignorance. The Journal of philosophy, 99(4), pp.167-184.

Romero-Daza, N. (2002). Traditional medicine in Africa. *The Annals of the American Academy of Political and Social Science*, *583*(1), pp.173-176.

Ron, A., Abel-Smith, B. and Tamburi, G. (1990). Health insurance in developing countries: The social security approach (Vol. 34). International Labour Organization.

Rose, N. and Miller, P. (1992). Political power beyond the state: Problematics of government. British journal of sociology, pp.173-205.

Rosén, I. (2015). The impact of culture on health: A study of risk perception on unhealthy lifestyles in Babati town, Tanzania.

Rosenstein-Rodan, P.N. (1961). International aid for underdeveloped countries. The Review of Economics and Statistics, pp.107-138.

Rossi, P.H., Wright, J.D. and Anderson, A.B. eds. (2013). Handbook of survey research. Academic Press.

Rostow, W.W., (1959). Economic Growth: A Non-Communist Manifesto.

Rothbard, M.N.(1970). Power & market: Government and the economy. Ludwig von Mises Institute.

Rothschild, E., Sen, A. and Haakonssen, K. (2006). The Cambridge Companion to Adam Smith.

Rothschild, M. and Stiglitz, J. (1976). Equilibrium in competitive insurance markets: An essay on the economics of imperfect information. The quarterly journal of economics, pp.629-649.

Rothschild, M. and Stiglitz, J.(1978). Equilibrium in competitive insurance markets: An essay on the economics of imperfect information. In *Uncertainty in economics* (pp. 257-280).

Rothstein, M.A. (2002). Rethinking the meaning of public health. The Journal of Law, Medicine & Ethics, 30(2), pp.144-149.

Roukayatou, K and Kailou, M. (2004). Inventaire des systèmes d'assurance maladie en Afrique, rapport du Niger. La concertation sur les mutuelles de santé en Afrique

Rousseau, J.J. (1762. 1968). The social contract.

Ruggie, M. (1992). The paradox of liberal intervention: health policy and the American welfare state. American Journal of Sociology, 97(4), pp.919-944.

Rumbold, B., Baker, R., Ferraz, O., Hawkes, S., Krubiner, C., Littlejohns, P., Norheim, O.F., Pegram, T., Rid, A., Venkatapuram, S. and Voorhoeve, A. (2017). Universal health coverage, priority setting, and the human right to health. *The Lancet*, *390*(10095), pp.712-714.

Russo, G., Bloom, G. and McCoy, D. (2017). Universal health coverage, economic slowdown and system resilience: Africa's policy dilemma.

Ryan, A, Liberalism 'in Robert, E.G. and Pettit, P., (1993) A companion to contemporary political philosophy.

Ryan, G.W. and Bernard, H.R. (2000). Data management and analysis methods.

Ryan, G.W. and Bernard, H.R. (2003). Techniques to identify themes. Field methods, 15(1), pp.85-109.

Ryan, O., Macom, J. and Moses-Eisenstein, M. (2012). Demand for programs for key populations in Africa from countries receiving international donor assistance. SAHARA-J: Journal of Social Aspects of HIV/AIDS, 9(3), pp.131-136.

S. Prakash Sethi. (1975). California Management Review Vol 17, Issue 3, pp. 58 – 64

Sabbagh, C. and Schmitt, M. (2016). Past, present, and future of social justice theory and research. In *Handbook of social justice theory and research* (pp. 1-11). Springer, New York, NY.

Sachs, J. (2005). The end of poverty: How we can make it happen in our lifetime. Penguin UK.

Saltman, R., Rico, A. and Boerma, W. (2004). Social health insurance systems in western Europe. McGraw-Hill Education (UK).

Sandelowski, M. (2000). Combining qualitative and quantitative sampling, data collection, and analysis techniques in mixed□method studies. *Research in nursing & health*, *23*(3), pp.246-255.

Santerre, R.E., Grubaugh, S.G. and Stollar, A.J. (1991). Government Intervention in Health Care Markets and Health Care Outcomes: Some International

Santerre, R.E. and Neun, S.P. (2004). Health Economics, 3. Thomson.

Santilli, P.C. (1982). The family and social contract theory. In *Philosophy, Children, and the Family* (pp. 17-28). Springer, Boston, MA.

Sarfo, F.S., Akassi, J., Antwi, N.K.B., Obese, V., Adamu, S., Akpalu, A. and Bedu-Addo, G., (2015). Highly prevalent hyperuricaemia is associated with adverse clinical outcomes among Ghanaian stroke patients: An observational prospective study. *Ghana medical journal*, *49*(3), pp.165-172.

Sarris, A. (2002). *The demand for commodity insurance by developing country agricultural producers: theory and an application to cocoa in Ghana*. The World Bank.

Sartori, G. (1987). The theory of democracy revisited.
Saunders, M., Lewis, P. and Thornhill, A., 2009. *Research methods for business students*. Pearson education.

Saunders, M.L. (2003). P. and Thornhill. Research methods for business students.

Savage, J. (2000). Ethnography and health care. BMJ: British Medical Journal, 321(7273), p.1400.

Savedoff, W.D., Sekhri, N. and World Health Organization (2004). Private Health Insurance: implications for developing countries

Savedoff, W.D., Ferranti, F.D. and Smith, A.L. (2012). Transitions in health financing and policies for universal health coverage. *Washington, DC: Centre for Global Development*.

Say, J.B. (1803). A Treatise on Political Economy, 3rd. US Edition. Philadelphia: John Grigg.

Schansberg, D.E. (2011). Envisioning a free market in health care. Cato J., 31, p.27.

Scheflen, A.E. (1973). *Communicational structure: Analysis of a psychotherapy transaction*. Indiana U. Press.

Schein, E., 2004. H. (2004). Organizational culture and leadership, 3.

Schein, E.H. (1990). Organizational culture (Vol. 45, No. 2, p. 109). American Psychological Association.

Schein, E.H. (1996). Culture: The missing concept in organization studies. *Administrative science quarterly*, pp.229-240.

Schensul, S.L., Schensul, J.J. and LeCompte, M.D. (1999). *Essential ethnographic methods: Observations, interviews, and questionnaires* (Vol. 2). Rowman Altamira.

Schneider, P. and Diop, F. (2001). Synopsis of results on the impact of community-based health insurance on financial accessibility to health care in Rwanda. *Health, Nutrition and Population Discussion Paper*, (28903).

Schneider, P. (2004). Why should the poor insure? Theories of decision-making in the context of health insurance. Health policy and planning, 19(6), pp.349-355.

Schumpeter, J. (1942). Creative destruction. Capitalism, socialism and democracy, 825.

Schumpeter, J.A. (1949). The communist manifesto in sociology and economics. Journal of Political Economy, 57(3), pp.199-212.

Schwartz, M.S. and Carroll, A.B. (2003). Corporate social responsibility: A three-domain approach. Business ethics quarterly, 13(4), pp.503-530.

Seebohm, T.M. (2004). Methodological Hermeneutics. Hermeneutics. Method and Methodology, pp.55-91.

Seifert, B., Morris, S.A. and Bartkus, B.R. (2004). Having, giving, and getting: Slack resources, corporate philanthropy, and firm financial performance. Business & Society, 43(2), pp.135-161.

Sekhri, N. and Savedoff, W. (2005). Private health insurance: implications for developing countries. Bulletin of the World Health Organization, 83(2), pp.127-134.

Sekhri, N. and Savedoff, W. (2006). Regulating private health insurance to serve the public interest: policy issues for developing countries. The International journal of health planning and management, 21(4), pp.357-392.

Selden, T.M. (1999). Premium subsidies for health insurance: excessive coverage vs. adverse selection. Journal of Health Economics, 18(6), pp.709-725.

Selvaraj, S. and Karan, A.K. (2012). Why publicly-financed health insurance schemes are ineffective in providing financial risk protection. Economic & Political Weekly, 47(11), pp.61-68.

Sen, A. (1992). *Inequality reexamined*. Clarendon Press.

Sen, A. (2000). Social justice and the distribution of income. Handbook of income distribution, 1, pp.59-85.

Sen, A.K. (2014). Collective choice and social welfare (Vol. 11). Elsevier.

Sepehri, A., Sarma, S. and Simpson, W. (2006). Does non□profit health insurance reduce financial burden? Evidence from the Vietnam living standards survey panel. Health economics, 15(6), pp.603-616.

Sery, J.P. and Letourmy, A. (2006). Couverture du risque maladie en Afrique francophone: état des lieux, défis et perspectives. *Gilles Dussault, Pierre Fournier, Alain Letourmy (éditeurs), L'assurance maladie en Afrique francophone: Améliorer l'acces aux soins et lutter contre la pauvreté. Banque Mondiale*.

Sgalitzer, H.A. (2013). Travelers' philanthropy: Understanding tourists' motivations to financially donate at sweetwater chimpanzee sanctuary. The University of Utah.

Shead, N.W., Derevensky, J.L. and Gupta, R. (2010). Risk and protective factors associated with youth problem gambling. *International journal of adolescent medicine and health*, *22*(1), p.39.

Sheehan, K.B. (2001). E□mail survey response rates: A review. *Journal of Computer□Mediated Communication*, *6*(2).

Shimeles, A. (2010). Community based health insurance schemes in Africa: The case of Rwanda.

Shortell, S.M. and Hull, K.E. (1996). The new organization of the health care delivery system. *The Baxter health policy review*, *2*, pp.101-148.

Sigerist, H.E. (1945). The need for an institute of the history of medicine in India. Bulletin of the History of Medicine, 17, p.113.

Silverman, D.A.V.I.D. (2001). Interpreting qualitative data: Methods for interpreting talk, text and interaction.

Simon, K.I. (2005). Adverse selection in health insurance markets? Evidence from state small-group health insurance reforms. Journal of Public Economics, 89(9), pp.1865-1877.

Simons, H. (2009). Case study research in practice. SAGE publications.

Sissoko, Y. and Dibooglu, S. (2006). The exchange rate system and macroeconomic fluctuations in Sub-Saharan Africa. *Economic Systems*, *30*(2), pp.141-156.

Slevitch, L. (2011). Qualitative and quantitative methodologies compared: Ontological and epistemological perspectives. Journal of Quality Assurance in Hospitality & Tourism, 12(1), pp.73-81.

Smed, S., Jensen, J.D. and Denver, S. (2007). Socio-economic characteristics and the effect of taxation as a health policy instrument. Food Policy, 32(5), pp.624-639.

Smith, A. (1976). An inquiry into the nature and causes of the wealth of nations (Glasgow Edition of the Works & Correspondence of Adam Smith, Vol. 2).

Smith, D.W. (2004). Mind world: Essays in phenomenology and ontology. Cambridge University Press.

Sofowora, A., Ogunbodede, E. and Onayade, A. (2013). The role and place of medicinal plants in the strategies for disease prevention. *African Journal of Traditional, Complementary and Alternative medicines*, *10*(5), pp.210-229.

Soors, W., Waelkens, M.P. and Criel, B. (2008). Community health insurance in sub-Saharan Africa: Opportunities for improving access to emergency obstetric care?. Reducing financial barriers to obstetric care in low-income countries.

Sorenson, O. and Audia, P.G. (2000). The social structure of entrepreneurial activity: Geographic concentration of footwear production in the United States, 1940–1989. American Journal of Sociology, 106(2), pp.424-462.

Souna, B.S., Djibo, H., Danhaoua, A.M. and Gbaguidi, F. (2009). Les limites du traitement traditionnel des fractures des membres (JIBIRA): à propos de 61 patients opérés à Niamey. *Médecine d'Afrique noire*, *56*(12), pp.652-656.

Spaan, E., Mathijssen, J., Tromp, N., McBain, F., Have, A.T. and Baltussen, R. (2012). The impact of health insurance in Africa and Asia: a systematic review. *Bulletin of the World Health Organization*, *90*, pp.685-692.

Spradley, J.P. (201)6. *The ethnographic interview*. Waveland Press

Stemler, S.(2001). An overview of content analysis. Practical assessment, research & evaluation, 7(17), pp.137-146.

Stenberg, K., Elovainio, R., Chisholm, D., Fuhr, D., Perucic, A.M., Rekve, D. and Yurekli, A. (2010). Responding to the challenge of resource mobilization-mechanisms for raising additional domestic resources for health. World health report.

Stigler, G.J.(1976). The successes and failures of Professor Smith. Journal of Political Economy, 84(6), pp.1199-1213.

Stogdill, R.M. (1950). Leadership, membership and organization. Psychological bulletin, 47(1), p.1.

Strasser, R., Kam, S.M. and Regalado, S.M. (2016). Rural health care access and policy in developing countries. *Annual review of public health*, *37*, pp.395-412.

Strauss, A. and Corbin, J.M. (1997). Grounded theory in practice. Sage.

Strittmatter, A. and Sunde, U. (2013). Health and economic development—evidence from the introduction of public health care. *Journal of Population Economics*, *26*(4), pp.1549-1584.

Strupat, C. and Klohn, F. (2018). Crowding out of solidarity? Public health insurance versus informal transfer networks in Ghana. *World Development*, *104*, pp.212-221.

Sudhinaraset, M., Ingram, M., Lofthouse, H.K. and Montagu, D. (2013). What is the role of informal healthcare providers in developing countries? A systematic review. PloS one, 8(2), p.e54978.

Summers, L.H., (1989). Some simple economics of mandated benefits. The American Economic Review, 79(2), pp.177-183.

Surveys, O. E. (2010). OECD Economic Surveys. Africa (Vol. 2010, pp. 1–128).

Swartz, D.L. (2002). The sociology of habit: The perspective of Pierre Bourdieu. OTJR: Occupation, Participation and Health, 22(1_suppl), pp.61S-69S.

Szczepura, A., Johnson, M., Gumber, A., Jones, K., Clay, D. and Shaw, A. (2005). An overview of the research evidence on ethnicity and communication in health.

Tabor, S.R. (2005). Community-based health insurance and social protection policy. World Bank, Washington: Social Protection Discussion Paper Series.

Temple, B. and Young, A. (2004). Qualitative research and translation dilemmas. Qualitative research, 4(2), pp.161-178.

The Communist Manifesto (London: Penguin, 2002 [orig. pub. 1888]), p.202.

Thomas, J. (1993). Doing critical ethnography (Vol. 26). Sage.

Tinghög, G., Carlsson, P. and Lyttkens, C.H. (2010). Individual responsibility for what?–a conceptual framework for exploring the suitability of private financing in a publicly funded health-care system. *Health Economics, Policy and Law*, *5*(2), pp.201-223.

Tomich, D.W. (2004). Through the prism of slavery: labor, capital, and world economy. Rowman & Littlefield Publishers.

Tones, K. and Green, J. (2004). Health promotion: planning and strategies. Sage.transition: Institutions, organizations, and strategic choice. Academy of management review, 21(2), pp.492-528.

Tucker, R.C. (1978). Manifesto of the Communist Party.

Turner, S. and Mazur, G. (2009) . Morgenthau as a Weberian methodologist. European Journal of International Relations, 15(3), pp.477-504.

Tylor, E.B. (1871). Primitive culture: researches into the development of mythology, philosophy, religion, art, and custom (Vol. 2). J. Murray.

UNICEF. (2013). At a Glance. Niger. Statistics.

Vaismoradi, M., Turunen, H. and Bondas, T. (2013). Content analysis and thematic analysis: Implications for conducting a qualitative descriptive study. Nursing & health sciences, 15(3), pp.398-405.

Van den Heever, A.M. (2012).June. The role of insurance in the achievement of universal coverage within a developing country context: South Africa as a case study. In *BMC public health* (Vol. 12, No. 1, p. S5). BioMed Central.

Van Der Gaag, J. (1995). Private and public initiatives: Working together for health and education. World Bank Publications.

Van der Geest, S. (1992). Is paying for health care culturally acceptable in Sub-Sahara Africa? Money and tradition. Social Science & Medicine, 34(6), pp.667-673.

Van der Geest, S. and Finkler, K. (2004). Hospital ethnography: introduction. *Social science & medicine*, *59*(10), pp.1995-2001.

Van Ginneken, W. (1999). Social security for the informal sector: A new challenge for the developing countries. International Social Security Review, 52(1), pp.49-69.

Van Marrewijk, M. (2003). Concepts and definitions of CSR and corporate sustainability: Between agency and communion. Journal of business ethics, 44(2), pp.95-105.

Varda, D.M., Chandra, A., Stern, S.A. and Lurie, N. (2008). Core dimensions of connectivity in public health collaborative. Journal of Public Health Management and Practice, 14(5), pp.E1-E7.

Vehovar, V., Batagelj, Z., Manfreda, K.L. and Zaletel, M. (2002). Nonresponse in web surveys. Survey nonresponse, pp.229-242.

Vian, T. (2008). Corruption and the consequences for public health.

Visser, W. (2006). Revisiting Carroll's CSR pyramid. Corporate citizenship in developing countries, pp.29-56.

Vogel, D. (2010). The private regulation of global corporate conduct: Achievements and limitations. Business & Society, 49(1), pp.68-87.

Von Bertalanffy, L. (1968). General system theory. New York, 41973(1968), p.40.

Wadge, H., Roy, R., Sripathy, A., Fontana, G., Marti, J. and Darzi, A. (2017). How to harness the private sector for universal health coverage. *The Lancet*, *390*(10090), pp.e19-e20.

Wagstaff, A. and Doorslaer, E.V. (2003). Catastrophe and impoverishment in paying for health care: with applications to Vietnam 1993–1998. Health economics, 12(11), pp.921-933.

Wagstaff, A. and Claeson, M. (2004). Rising to the challenges: the millennium development goals for health. World Bank

Wagstaff, A. (2007). Social health insurance re-examined (Vol. 4111). World Bank Publications.

Wagstaff, A. (2009). Social health insurance vs. tax-financed health systems: evidence from the OECD.

Waitt, G.R. (2005). Doing discourse analysis.

Walker, F.A. (1969). Compulsory Health Insurance:" The Next Great Step in Social Legislation". The Journal of American History, 56(2), pp.290-304.

Walt, G. and Gilson, L. (1994). Reforming the health sector in developing countries: the central role of policy analysis. Health policy and planning, 9(4), pp.353-370

Walt, G. and Buse, K. (2000). Partnership and fragmentation in international health: threat or opportunity?. *Tropical Medicine & International Health*, *5*(7), pp.467-471.

Walther, M. (2014). Setting the Bourdieuian Scene of Return: Habitus, Field and Capital. In Repatriation to France and Germany (pp. 24-115). Springer Fachmedien Wiesbaden.

Wang, A. (2008). Dimensions of corporate social responsibility and advertising practice. Corporate Reputation Review, 11(2), pp.155-168.

Waters, R.D. and Ott, H.K. (2014). Corporate social responsibility and the non-profit sector: Assessing the thoughts and practices across three non-profit subsectors.

Waugh, D. (1993). Social contracts and health care. CMAJ: Canadian Medical Association Journal, 149(9), p.1320.

Webb, D.J. and Mohr, L.A.(1998). A typology of consumer responses to cause-related marketing: From sceptics to socially concerned. Journal of Public Policy & Marketing, pp.226-238.

Weber, M. (1922). 1968 Economy and Society. New York: Bed-[1922] minster.

Weber, M. (1978). Economy and society: An outline of interpretive sociology (Vol. 1). Univ of California Press.

Weber, M (2002). The Protestant ethic and the" spirit" of capitalism and other writings. Penguin.

Wegener, B. (1987). The illusion of distributive justice. European Sociological Review, 3(1), pp.1-13.

Wegner, D.M. (1987). Transactive memory: A contemporary analysis of the group mind. In *Theories of group behavior* (pp. 185-208). Springer, New York, NY.

Weil, A. and Scheppach, R. (2010). New roles for states in health reform implementation. Health Affairs, 29(6), pp.1178-1182.

Welie, J.V. (2012). Social contract theory as a foundation of the social responsibilities of health professionals. Medicine, Health Care and Philosophy, 15(3), pp.347-355.

Werner, W.J. (2009). Micro-insurance in Bangladesh: Risk protection for the poor?. Journal of health, population, and nutrition, 27(4), p.563.

Werther Jr, W.B. and Chandler, D. (2005). Strategic corporate social responsibility as global brand insurance. *Business Horizons*, *48*(4), pp.317-324.

Wexler, L.M., DiFluvio, G. and Burke, T.K. (2009). Resilience and marginalized youth: Making a case for personal and collective meaning-making as part of resilience research in public health. Social science & medicine, 69(4), pp.565-570.

White-Chu, E.F., Graves, W.J., Godfrey, S.M., Bonner, A. and Sloane, P. (2009). Beyond the medical model: The culture change revolution in long-term care. *Journal of the American Medical Directors Association*, *10*(6), pp.370-378.

Whitehead, M., Dahlgren, G. and Evans, T. (2001). Equity and health sector reforms: can low-income countries escape the medical poverty trap?. *The Lancet*, *358*(9284), pp.833-836.

WHO Unicef, Unfpa, T. W. B. (2007). Maternal Mortality in 2005: estimates developed by WHO, UNICEF, UNFPA and The World Bank. *Bull World Health Organ*, *79*, 657–664.

Widdowson, H.G. (2007). Discourse analysis. Oxford: Oxford University Press.

Wiesmann, D. and Jütting, J. (2000). The emerging movement of community based health

Wiklund, L., Lindholm, L. and Lindström, U.Å. (2002). Hermeneutics and narration: a way to deal with qualitative data. Nursing Inquiry, 9(2), pp.114-125.

Wilkinson, G., Sager, A., Selig, S., Antonelli, R., Morton, S., Hirsch, G., Lee, C.R., Ortiz, A., Fox, D., Lupi, M.V. and Acuff, C. (2017). No equity, no triple aim: strategic proposals to advance health equity in a volatile policy environment. American Journal of Public Health.

Wilkinson, S. (2004). Focus Group Research. Qualitative research: Theory, method and practice, pp.177-199.

Wilkinson, S. (2011). Analysing focus group data. Qualitative research, 3.

Williams, A. and Cookson, R., 2000. Equity in health. *Handbook of health economics*, *1*, pp.1863-1910.

Willis, A. and Tayles, N. (2009). Field anthropology: application to burial contexts in prehistoric Southeast Asia. Journal of Archaeological Science, 36(2), pp.547-554.

Willis, J.W. and Jost, M. (2007). Foundations of qualitative research: Interpretive and critical approaches. Sage.

Wilsford, D. (1994). Path dependency or why history makes it difficult but not impossible to reform health care systems in a big way. *Journal of public policy*, *14*(3), pp.251-283

Wilsford, D. and Brown, L.D. (2010). Path Dependency: A Dialogue. *Journal of health politics, policy and law*, *35*(4), pp.681-688.

Wilson, H.S. and Hutchinson, S.A. (1991). Triangulation of qualitative methods: Heideggerian hermeneutics and grounded theory. Qualitative Health Research, 1(2), pp.263-276.

Wilson, W.J. and Chaddha, A. (2009). The role of theory in ethnographic research. Ethnography, 10(4), pp.549-564.

Windsor, D. (2001). The future of corporate social responsibility. The international journal of organizational analysis, 9(3), pp.225-256.

Windsor, D. (2006). Corporate social responsibility: Three key approaches. Journal of management studies, 43(1), pp.93-114.

Winters, M.S. and Martinez, G. (2015). The role of governance in determining foreign aid flow composition. *World Development*, *66*, pp.516-531.

Witcher, S. (2013). Inclusive equality. Policy Press.

Wolff, J. (2003). Why read Marx today? OUP Oxford.

Wollstein, G. (1989). Administration v. Leadership in the Hitler State. Philosophy and History, 22(1), pp.105-106.

Wood, D.J.(1991). Corporate social performance revisited. Academy of management review, 16(4), pp.691-718.

Woodfield, H. and Lazarus, E. (1998). Diaries: A reflective tool on an INSET language course.

Word, J. and Park, S.M. (2009). Working across the divide: Job involvement in the public and nonprofit sectors. *Review of Public Personnel Administration*, *29*(2), pp.103-133.

World Bank (2017). Tracking Universal Health Coverage: 2017 Global Monitoring Report

World Bank. (2016). World Development Indicators *2016*. *World Bank* (p. 180).

World Health Organization. (2011). World Malaria Report 2011.

Wright, J., Sim, F. and Ferguson, K. (2016). Multidisciplinary public health: Understanding the development of the modern workforce. Policy Press.

Xu, K., Evans, D.B., Kawabata, K., Zeramdini, R., Klavus, J. and Murray, C.J. (2003). Household catastrophic health expenditure: a multicountry analysis. *The lancet*, *362*(9378), pp.111-117.

Xu, K., Evans, D.B., Carrin, G., Aguilar-Rivera, A.M., Musgrove, P. and Evans, T. (2007). Protecting households from catastrophic health spending. *Health affairs*, *26*(4), pp.972-983.

Xu, K., Evans, D.B., Kadama, P., Nabyonga, J., Ogwal, P.O., Nabukhonzo, P. and Aguilar, A.M. (2006). Understanding the impact of eliminating user fees: utilization and catastrophic health expenditures in Uganda. *Social science & medicine*, *62*(4), pp.866-876.

Yang, Y., Powell, R. and Gupta, S. (2006). Macroeconomic challenges of scaling up aid to Africa: A checklist for practitioners. International Monetary Fund.

Yeasmin, S. and Rahman, K.F. (2012). Triangulation 'research method as the tool of social science research. Bup Journal, 1(1), pp.154-163.

Yin, R.K. (2009). Case study research: Design and methods fourth edition. Los Angeles and London: SAGE.

Yontcheva, B. and Masud, N. (2005). *Does foreign aid reduce poverty? Empirical evidence from nongovernmental and bilateral aid* (No. 5-100). International Monetary Fund.

Zelmer, J. and Hagens, S. (2014). Understanding the gap between desire for and use of consumer health solutions. *HealthcarePapers*, *13*(4).

Zimmerman, E.B., Woolf, S.H. and Haley, A. (2015). Understanding the relationship between education and health: a review of the evidence and an examination of community perspectives. *Population health: behavioral and social science insights. Rockville (MD): Agency for Health-care Research and Quality*, pp.347-84.

Zohrabi, M. (2013). Mixed method research: Instruments, validity, reliability and reporting findings. Theory and Practice in Language Studies, 3(2), p.254.

Zucker, L.G. (1987). Institutional theories of organization. Annual review of sociology, 13(1), pp.443-464.

Zwi, A.B., Brugha, R. and Smith, E. (2001). Private health care in developing countries

APPENDICES

Appendix A. Letter ministry of health

RÉPUBLIQUE DU NIGER
Fraternité – Travail – Progrès

MINISTERE DE LA SANTE PUBLIQUE
SECRETARIAT GENERAL
DIRECTION DES ETUDES ET PROGRAMMATION
DIVISION ETUDES ET RECHERCHES

Niamey, le 30 JAN 2017

LE SECRETAIRE GENERAL ADJOINT

A

Madame la Directrice de l'Organisation des Soins et Messieurs les Directeurs Généraux des Hôpitaux Nationaux.

N° 00346 /MSP/SG/DEP/DER

Objet : Autorisation sur le thème :
«Enquête ASSURANCE - MALADIE»

Dans le cadre de la préparation de sa Thèse, Melle NOMA MOUNKAILA RAYNATOU, Economiste de la Santé est autorisée de mener l'enquête **ASSURANCE - MALADIE** dans les Hôpitaux de la capitale.

Cette autorisation du Ministère de la Santé Publique est valable pour un an. renouvelable à compter de la date de sa signature et ne peut être utilisée que pour ce thème. Elle ne couvre que Melle NOMA MOUNKAILA RAYNATOU sur le terrain durant l'enquette. Il serait nécessaire de partager ces résultats avec les structures concernées et la DEP/MSP.

Je vous saurais gré des dispositions que vous prendriez pour leur faciliter la réalisation de cette activité.

Ampliations:
MSP.....a-t-c-r
SG..... ....ATCR
CHRONO.....02

HAMADOU Moussa

RÉPUBLIQUE DU NIGER
LE SECRETAIRE GENERAL ADJOINT
MINISTERE DE LA SANTE PUBLIQUE

Appendix B. University letter

To Whom It May Concern

This letter is to introduce Ms. Reynatou Noma Mounkaila a doctoral research student at the University Of Plymouth Graduate School Of Management in the UK. Ms. Noma Mounkaila is conducting research on the topic: Assessing the notion of health insurance: what is the most equitable scheme for Niger? The purpose of the research project (doctorate) is to identify and understand the impacts of health insurance developments in Niger.

We also wish to confirm that the university's Research and Ethics Committee has reviewed this study; any information obtained will be treated with the utmost confidentiality. In addition, organizations and individuals providing information will not be mentioned or disclosed, and participants will be provided with a summary of the interviews, analysis and interpretations of the research, if they so require.

The university relies on organizations and communities to assist research students in their data collection. We would therefore appreciate your assistance in this matter. If further is required do not hesitate to contact me.

Yours Sincerely,

Appendix C. Questions of Online questionnaire

Question1: Do you have health insurance (multiple choices, with one response option)
- Government insurance
- Private insurance
- I do not have health insurance

Question 2: how would you rate the importance of health insurance? (Likert scale with one response option)
- Not important
- Important
- Very important

Question 3: which institution(s) do you think provide health insurance in Niger? (Multiple-choice question, with more than one response option)
- Government
- Private insurance
- Non-Governmental Organizations
- International Organizations
- Community-based insurance
- Mutual health insurance

Question 4: how would you rate the commitment of the government to develop health insurance for all? (Likert-scale with one response option)
- Little involved
- Fairly involved
- Involved
- Very involved

Question 5: who is covered by government insurance? (Multiple choices with more than one response option)
- Workers in the public sector
- Public in the semi-public sector
- Workers in the private sector
- The informal sector

Question 6: should the government be more involved in the development of health insurance? (Multiple choices, with one response option)
- Yes
- No

Question 7: does the informal sector have access to government insurance? (Multiple choices, with one response option)
- Yes

- No

Question 8: are populations from rural areas covered by health insurance? (Multiple choices, with one response option)
- Yes
- No

Question 9: how to improve the health insurance system? (Multiple choices with more than one response option)
- More involvement of government
- More involvement of the private insurance
- More partnerships with community-based insurance and private insurance
- More partnership with international organizations

Question 10: Do you have any further comments? (Open-ended question)

Appendix D. Questions interviews series 1 (ministry of health)

1. How would you define health insurance today? How has it changed over the past ten years?
2. Are you covered by any insurance scheme? If yes, since when?
3. What is the contribution of private insurance? Which groups does it cover?
4. Does partnership/s exist between the government, private insurance and other agencies?
5. What do you think about non-profit insurance?
6. Do you think adverse selection exist? What is your position in this regard? Does private insurance applies corporate social responsability?
7. Should the government have more involvement in health insurance?
8. What is the role of path dependency of policies in the development of health insurance?
9. What is the role of culture in the low coverage rate of health insurance?
10. How can health insurance be improved in Niger?

Appendix E. Questions interviews series 2 (commercial insurance)

1. How would you define health insurance today? How has it changed over the ten past years?
2. Are you covered by any insurance scheme? If yes, since when?
3. What is the contribution of private insurance? Which group does it cover? What do you think about non-profit insurance and community-based insurance?
4. Does partnership/s exist (s) between the government, private insurance and other agencies?
5. What do you think about non-profit insurance?
6. Do you think adverse selection exist? What is your position in this regard?
7. How does your company apply CSR?
8. What is the role of path dependency on the development health insurance?
9. Do you adapt your premiums to groups?
10. Do you think people are willing to pay more for insurance coverage? What is the role of culture on the low coverage rate of health insurance?

Appendix F. Questions Focus group (ministry of health)

Question 1: At what extent foreign aid is involved in health insurance. What is path dependent about the funding of health insurance?

Question 2: How to develop community-based health insurance for the informal sector?

Question 3: What will be the process for attaining universal coverage in Niger?

Appendix G. Questions Focus group (commercial insurance)

Question 1: At what extent foreign aid contribute in the development of health insurance? What is path dependent about the funding of health insurance?

Question 2: Could private insurance extend its market to the informal sector? How will you apply CSR in this context?

Question 3: What would be the path for Niger to attain universal coverage?

Appendix H. Consent form for interviews

INTERVIEW CONSENT FORM

Invitation to Participate

You have been asked to participate in a doctoral study on Health insurance in Niger. Before you decide whether or not to take part, it is important for you to understand why the research is being undertaken and what it will involve. Please take time to read the following information.

Objective of the research

The objective of this research is to investigate health insurance in Niger and how it has evolved over time including both government and private for and non-profit health insurance.

Method

Semi-structured interviews utilize fixed questions that can be adapted during the interview process. Thus, they provides open discussion and unable a better understanding of the situation under analysis (Howell, 2013).

Participation in the Study

Your participation will consist in an interview of 30-40 minutes. You will be asked questions about the current situation of health insurance in Niger and how it has evolved over time. You will also be asked about the role of government and private sector in this regard.

Risks and benefits

There are no risks involved in taking part in this study, as your identity and information will be confidential. The benefit is that you share your experience and knowledge about the subject.

Privacy

Your privacy will be protected. All personal information and answers will be kept strictly confidentiality. Your name will not be used in any report that is published.

Audio Record Permission

The interview will be recorded and all information will be confidential. Your name and data will be confidential

I agree to be recorded with digital voice recorder ___Yes ___No

A summary of the research findings will be provided on request to all participants.

Inquiries

If you have any further questions or concerns, please feel free to contact Reynatou Noma at *raynatou.nomamounkaila@plymouth.ac.uk*

You can withdraw at any time during the focus groups and no later than two weeks following the data collection period. Your data will be used for data analysis and published in the final report

Interviewee Name and signature

_____

NAME

_____ Yes, I would like to take part in the semi-structured interview.

SIGNATURE DATE

Appendix I. Consent form for focus groups

Focus Group Consent

You have been asked to participate in a focus group undertaken for doctoral studies at Plymouth University UK. The purpose of the group is to better understand the role of government health insurance in Niger and the involvement of private insurance.

The information learned in the focus groups will be used to analyze factors contributing to the need of health insurance in Niger for all the layers of the population and the access to it.

You have been selected due to your knowledge and expertise in the area of health insurance and primary health care. You can choose whether or not to participate in the focus group. Your privacy will be protected and all information and given answers gathered in this focus group will be kept confidential. Furthermore the discussion will be recorded with digital voice recorder, and your responses will remain anonymous and no names will be mentioned in the report.

There is no right or wrong answers to the focus group questions. We want to hear many different points of view and would like to hear from everyone. We hope you can be honest even if your responses may be different from the group. In respect for each other, we ask that only one individual speak at a time. Finally a summary of the research findings will be provided on request to all participants.

You can withdraw at any time during the focus groups and no later than two weeks following the period of data collection. Your data will be used for data analysis and published in the final report.

If you have any further questions, please feel free to contact me at any time on *raynatou.nomamounkaila@plymouth.ac.uk*

I understand this information and agree to participate fully under the conditions stated above:

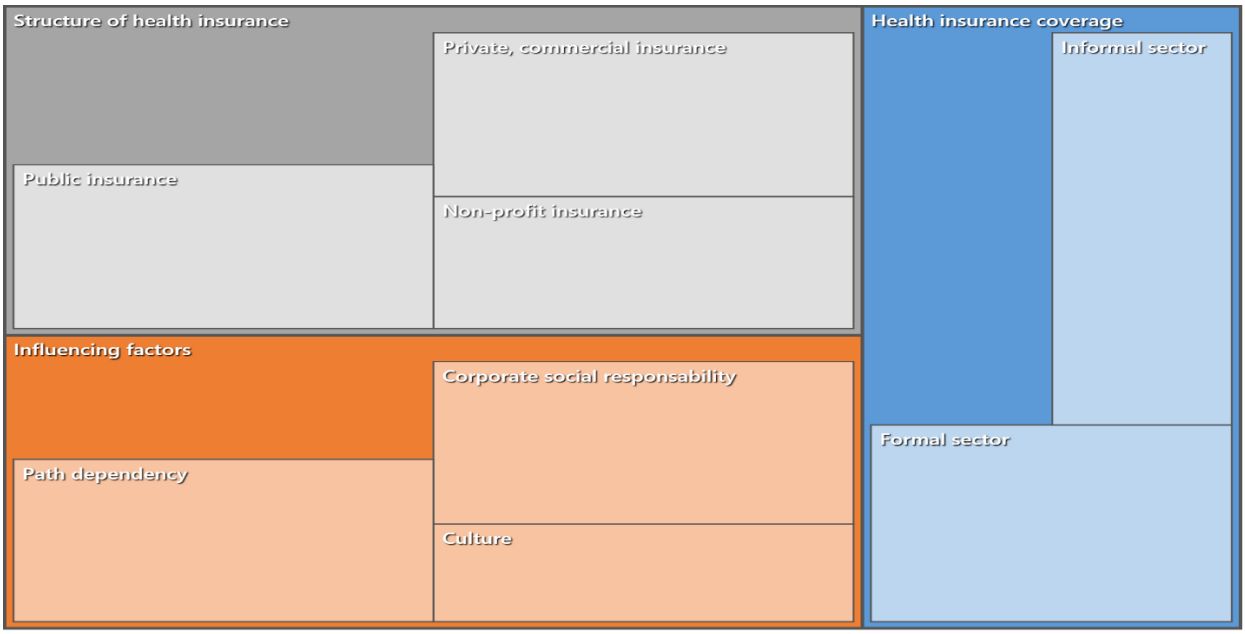
Signed:_____ Date:_____

Appendix J. Example analysis for interviews at the ministry of health:

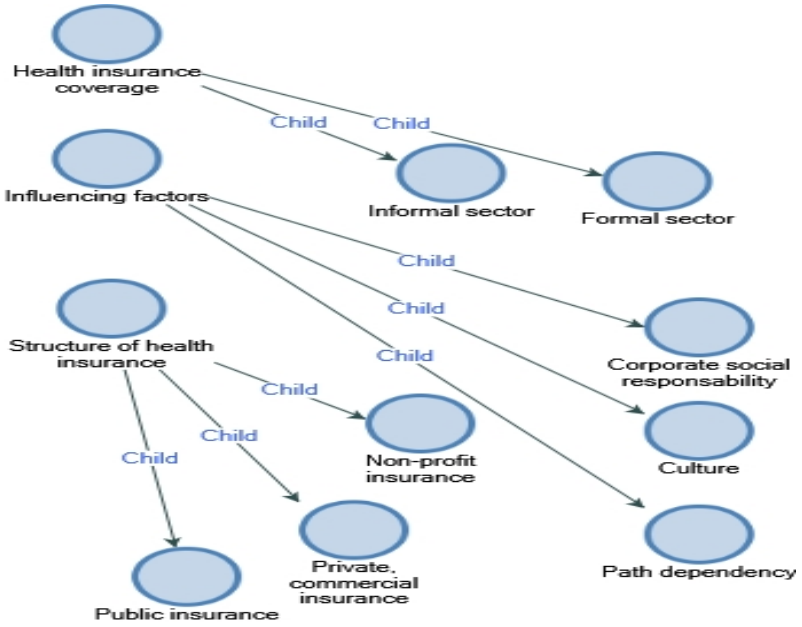
Step 1: Example of how codes were generated from raw data for interviews series 1

Participants	Data (reduced)	Keywords →	Codes
Interview 1 (Director of the division of universal health coverage)	"Health insurance is the financial risk related to health. In Niger, health insurance started to grow in the 2000's but already started since the independence when healthcare was free. During the independence days in 1960's, healthcare was free and everyone was covered.. "	5. Health risk-universal coverage-ignorance 6. Government insurance for workers in the public sector 7. Community-based insurance is not developed 8. No Public-private partnership	5. *Challenges for the development of health insurance* 6. *Segment who have government insurance* 7. *Development of Community based insurance* 8. *Public-private partnership*

Step 2: Hierarchy map showing three main themes and their subthemes (Nvivo)



Step 3: Thematic map with three main themes and subthemes for interviews series 1 (Nvivo)



Appendix K. Summary of qualitative data (3 Main themes)

Structure of health insurance (pink)
Consumption of health insurance (blue)
Influencing factors (CSR, path dependency and culture) (yellow)

Appendix L. Questions of questionnaire for the informal sector

1. Health insurance is a mechanism that provides healthcare services, in a manner that protects individual from financial risks. Do you have health insurance? Yes _ No_

2. How would you rate health insurance

    - not important
    - important
    - very important

3. Are you willing to pay to have health insurance? Yes _ No_

4. Are you aware of any health insurance company? Yes _ No_

5. How do you think healthcare can be improved for the informal sector?

    - More government action
    - Contribution from the informal sector
    - External aid
    - All of the above

6. Do you think the decisions of the government influence the development of healthcare? (path dependency) Yes _ No_

7. Private commercial insurance usually covers people in the formal sector who pay for premiums each month. Does private insurance currently helps the informal sector. (CSR) Yes _ No