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Working Paper

Long Way to Universal Health Coverage (UHC): Are Policy Dialogue Processes Appropriate to Negotiate Trade-Offs in Africa? The Cases of Benin and Senegal

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Long Way to Universal Health Coverage (UHC): Are Policy Dialogue Processes Appropriate to Negotiate Trade-Offs in Africa? The Cases of Benin and Senegal

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Authors' contributions: This paper stems from a joint idea by Elisabeth Paul, Remo Meloni and Denis Porignon. Elisabeth Paul performed the literature review and elaborated the first draft of the analytical grid, which was revised and approved by all authors. All authors contributed to the data collection and the country analysis. Elisabeth Paul wrote the first draft of the manuscript and all authors then contributed to enriching it and approved the final version.

Conflict of interest: Youssoupha Ndiaye and Farba Lamine Sall participated in the UHC policy dialogue in Senegal. The other authors declare no conflict of interest.

Ethical issues:
The PhD research protocol of Céline Deville, which encompasses this research, was approved by the national ethics committee in Senegal (Avis éthique et scientifique n° 37/MSAS/DPRS/CNERS dated 29th March 2016) and by the ethics committee of the University of Parakou (décision N° 0072 du 21 avril 2017 du Comité Local pour la Recherche Biomédicale de l'Université de Parakou) and later by the Ministry of Health (Authorisation n° 2495/MS/DC/SGM/DRFMT/SSER/SA dated 6th May 2019), in Benin. All interviewed persons and those who completed the electronic questionnaire were informed about the scope and the scientific nature of the research and gave their consent to participate in it. Responses were anonymised.

Single Overriding Communication Objective: We developed an analytical framework enabling to appraise the quality of policy dialogue processes for universal health coverage. Its application to the cases of Benin and Senegal, in Francophone West Africa, indicates that performance was poor in terms of many criteria, thus reducing the quality of the negotiation process and its results.

Abstract

The numerous stakeholders involved in the development of universal health coverage (UHC) policies are likely to have diverging interests about which dimensions to prioritize, hence the importance of ensuring an effective and transparent policy dialogue. This paper aims to investigate whether or not UHC policy dialogue processes are functioning well in Benin and Senegal. Based on a literature review, we have identified a number of characteristics guaranteeing the quality of policy dialogue processes, which we have integrated into an analytical grid. The quality criteria identified were classified along four dimensions: stakeholder participation, dialogue/negotiation process, quality of situation analysis and decision criteria, and results from the negotiation process. Based on data collected through documentary review, interviews, an electronic survey and the authors' own experience, we applied that analytical grid to the cases of Benin and Senegal. In both countries, the policy dialogue processes are largely imperfect in terms of many of the quality criteria identified. Decisions were made under strong political leadership, ensuring government coordination and ownership, and strong emphasis has been put on expanding financial risk protection. Yet, both countries perform poorly in a number of dimensions, especially with regards to conflicts of interest, transparency and accountability. None of them has really institutionalized a UHC policy dialogue process, and the UHC policymaking processes have actually bypassed existing health sector coordination mechanisms. The two countries perform well regarding the quality of situation analysis. A small (in the case of Benin) or broader (in the case of Senegal) governmental coalition managed to impose its views, given insufficient stakeholder participation. Policy networks were particularly influential in Senegal. Overall, there are important gaps that reduce the quality of UHC policy dialogue processes, hence explaining the weaknesses in their results in terms of transparency and accountability. Our analytical framework enables us to identify rooms for improvement with regard to country-led negotiation processes relating to UHC.

Keywords: Universal Health Coverage, Policy Dialogue, Deliberative Processes, Benin, Senegal, Western Africa

JEL Codes:

I13	Health Insurance, Public and Private
I18	Government Policy • Regulation • Public Health
H41	Public Goods
H51	Government Expenditures and Health
H53	Government Expenditures and Welfare Programs

Résumé *:*

Les nombreux acteurs impliqués dans l'élaboration des politiques de couverture santé universelle (CSU) sont susceptibles d'avoir des intérêts divergents sur les dimensions à privilégier, d'où l'importance de garantir un dialogue politique efficace et transparent. Ce papier de recherche a pour but d'examiner si les processus de dialogue politique sur la CSU fonctionnent ou non bien au Bénin et au Sénégal. Sur la base d'une revue de la littérature, nous avons identifié un certain nombre de caractéristiques garantissant la qualité des processus de dialogue politique, que nous avons intégrées dans une grille d'analyse. Les critères de qualité identifiés ont été classés selon quatre dimensions : la participation des parties prenantes, le processus de dialogue/négociation, la qualité de l'analyse de la situation et les critères de décision, et les résultats du processus de négociation. Sur la base des données recueillies par le biais d'une revue documentaire, d'entretiens, d'une enquête électronique et de l'expérience des auteurs, nous avons appliqué cette grille d'analyse aux cas du Bénin et du Sénégal. Dans ces deux pays, les processus de dialogue politique sont largement imparfaits en ce qui concerne bon nombre des critères de qualité identifiés. Les décisions ont été prises sous un leadership politique fort, assurant la coordination et l'appropriation par le gouvernement, et l'accent a été mis sur l'élargissement de la protection contre les risques financiers. Pourtant, les deux pays affichent de piètres performances dans un certain nombre de domaines, notamment en ce qui concerne les conflits d'intérêts, la transparence et la redevabilité. Aucun d'entre eux n'a réellement institutionnalisé un processus de dialogue politique en vue de la CSU, et les processus d'élaboration des politiques de CSU ont en fait contourné les mécanismes de coordination existants dans le secteur de la santé. Les deux pays obtiennent de bons résultats en ce qui concerne la qualité de l'analyse de la situation. Une petite coalition gouvernementale (dans le cas du Bénin) ou plus large (dans le cas du Sénégal) a réussi à imposer ses vues, compte tenu de la participation insuffisante des parties prenantes. Les réseaux politiques ont été particulièrement influents au Sénégal. Dans l'ensemble, il existe des lacunes importantes qui réduisent la qualité des processus de dialogue politique sur la CSU, ce qui explique les faiblesses de leurs résultats en termes de transparence et de redevabilité. Notre cadre analytique nous permet d'identifier les possibilités d'amélioration des processus de négociation menés par les pays en matière de CSU.

Introduction

Universal health coverage (UHC) is usually defined as the ability of all people who need health services to receive them without incurring financial hardship. It is commonly conceptualized as a "cube" representing how pooled resources for health are utilized, and encompassing three dimensions: population covered by a mechanism of prepayment, services covered, and degree of financial protection.[1] There is no "one-best-way" to move to UHC and, in fact, experience worldwide shows that the path towards UHC is a complex process, context-specific and path-dependent.[1–8] In particular, resource constraints require individual countries to determine their own definition of "essential" services to be included in their UHC package.[9]

As much debated in the current literature, countries are faced with critical trade-offs along and between the three dimensions of the "cube". The prioritization across the three dimensions of coverage is perhaps the most difficult political challenge on the path towards UHC.[10] Indeed, which 'implementation option' countries choose to engage with first place may have far-reaching consequences for the level and distribution of health in the country, and for financial risk protection.[11] Setting priorities and managing trade-off is complex and challenging, and depends on the existing context and social values of the country.[11,12] Priority setting needs to be done both at the "macro" level (major health problems and challenges to be tackled; systemic activities that shape the health system environment) and at the "micro" level (discrete choices on priority services, health technologies and interventions to invest in).[13–16]

Analyses of country progress on the path towards UHC converge on the fact that it is above all a political process, "emerging from negotiation rather than design"[17] involving many stakeholders who are likely to have diverging interests. This process needs high-level political leadership, inter-sectoral engagement and to be backed by citizen support.[4,5,7,17–20] This is especially critical in aid-dependent contexts such as is found in many Sub-Saharan countries, where policy development and decision-making processes in the health sector are likely to be influenced by a number of individuals and organizations through their control over financial resources and/or expertise, and which have claims to moral authority (using their "epistemic and normative power").[21]

Various categories of variables explain why policies change. Changes in institutions and ideas have been demonstrated to be important drivers of policymaking, but changes in policy networks – that is, the actors involved in policy-making, their relationships with each other, and the structure

formed by those relationships – is also a necessary intermediate step in these processes.[22] The recent literature on UHC points to the fact that a transparent and inclusive negotiation about the implications and trade-offs of various ways to define the elements of UHC – thus the strategies to choose – is needed, and that many criteria and values must be balanced in a transparent way to inform priority-setting.[20,23–26] This is actually the same preoccupation as the one for leading sound policy dialogue – that is, "… an evidence-informed, deliberative dialogue process among multiple stakeholders for vigorous and comprehensive policy and practice decision-making"[27] in the context of national health policies.[20,28] However, in many countries, such a transparent process for discussing how UHC could be achieved does not exist. On the contrary, it is likely that decisions are taken in a fragmented way – i.e. in various decision-making arenas and in a piecemeal fashion – and influenced by several stakeholders within the Ministries in charge of health, social protection and finance, but also involving other organizations such as development partners, labor unions and professional bodies such as federations of community health insurance schemes. The multiplicity of arenas and stakeholders, coupled with positive and negative use of power,[21,29] are very likely to reduce transparency in decision processes and with regard to reasons behind choices that might include, for instance, some categories of the populations and/or some types of services rather than others.

This paper aims to investigate whether policy dialogue or deliberative processes orienting the choice of UHC strategies are actually functioning well – in terms of a number of dimensions and characteristics identified in the literature – in two Western African countries: Benin and Senegal.

Methods

Based on a review of the recent literature on policy dialogue in the health sector[20,28] and deliberative negotiation processes in the context of UHC[16,24,26,30–32], we identified a number of ideal characteristics of policy dialogue processes utilized to establish priorities for UHC at the macro level. We then integrated these into the analytical grid proposed in Table 1. We have classified the various quality criteria encountered in the literature along four main dimensions:

(i) Participation of stakeholders: this dimension indicates whether the wide array of stakeholders interested in UHC have been involved in the UHC policymaking process; whether the government ensured the leadership of the policy dialogue; whether the number of people

involved in the process was manageable so as to allow true dialogue; whether stakeholders (e.g. non-governmental actors) had sufficient capacities to participate in the dialogue or at least, received technical support to do so; and whether a certain balance of power was facilitated.

(ii) The process of dialogue and negotiation: a number of characteristics relate to the quality of the process, in view of guaranteeing true participation by stakeholders.

(iii) Quality of situation analysis and decision criteria: beyond participation of stakeholders, a good UHC policy dialogue should rest on sound analytical work in order to ensure evidence-based policymaking; several dimensions of the situation should be analyzed, including population's perceptions, cost-effectiveness and equity.

(iv) Finally, we also intended to assess the results from the negotiation process in terms of transparency, accountability, transformation of strategies into actionable plans, prioritized dimensions of UHC, and overall quality of decisions taken, according to interviewed persons.

Table 1: Analytical grid: dimensions and characteristics of a performing policy dialogue process

Dimensions	**Characteristic**
Participation of stakeholders	
	Includes relevant stakeholders, among which:
	… policymakers and health planners
	… clients/citizens // those individuals affected // engagement on the part of (staff and) the public // population / beneficiaries // community representatives
	… the various levels of the health system
	… health service providers
	… intersectoral collaboration, especially the Ministry of Finance (MoF)
	… donors
	Government coordination and ownership
	Number of stakeholders: must be manageable for meaningful dialogue
	Adequate capacities / Capacity building (incl. at subnational level) / Adequate technical support
	Mechanism to ensure balance of powers

Process of policy dialogue	
	Adequate preparation (including description of expected outcomes)
	Secured time and resources
	Diverse communication channels / Informal and formal platforms employed for consensus building
	Good facilitation
	Mechanisms to identify and manage conflicts of interest
	Feedback and follow-up / problem resolution mechanism
	Institutionalized policy dialogue / deliberative process mechanism
Quality of situation analysis & decision criteria – Analytical work underlying the policymaking process / process is evidence-based	
	Includes population consultation
	Based on cost-effectiveness analyses
	Equity / priority to the worst-off
	Financial risk protection
	Takes account of values and other criteria
	Includes public health preoccupations
	Takes account of context
Results from the negotiation process	
	Transparency in decision-making, including with regard to criteria used
	Accountability
	Strategic planning: transforming priorities into plans
	The chosen UHC gives priority to…
	… expansion of covered populations
	… expansion of covered services
	… diminution of the share of expenditure paid directly by patients
	Quality of decisions taken (e.g. appropriate essential services)

Source: Authors based on a targeted literature review [11,14,20,22,24–41]

The countries included in this study were purposively selected for practical reasons, since they are the focus countries of a four-year research project led by several of the authors, enabling us to collect information on the UHC process over a certain time period. The analytical grid was filled by the authors based on data triangulated from the following sources: (i) a documentary review; (ii) interviews conducted during field missions in the two countries between 2017 and 2019 (interviews with twenty stakeholders in Benin and fifteen in Senegal); (iii) an electronic survey completed by 5 key informants in Benin and 6 in Senegal; and (iv) the authors' experience in their respective country. The paper concludes with

a critical appreciation of whether or not countries had the appropriate institutions in place to facilitate transparent negotiation on UHC trade-offs, and whether or not this led to good results.

Country contexts

Despite having relatively similar health needs and health systems, and despite a similar political commitment towards UHC on the part of their President, the two countries under consideration have chosen a different path towards UHC. While Senegal has opted for community-based mutual health insurance (CBHI) to expand protection for the informal sector, Benin is struggling to put in place a national health insurance system.[42] Table 2 presents a number of contextual characteristics and indicators with regard to the two countries. The main characteristics of the UHC policies are then described.

Table 2: Characteristics of the two countries

Characteristics/indicators	Benin	Senegal
Demographic & economic context: *		
- Population, total (2018)	- 11,485,048	- 15,854,360
- Gross domestic product per capita, PPP (current international $) (2018)	- 2,424.8	- 3,782.5
- People using at least basic drinking water services (% of population) (2017)	- 66.4	- 80.7
- People using at least basic sanitation services (% of population) (2017)	- 16.5	- 51.5
Health financing (2017): **		
- Out-of-pocket expenditure (% of current health expenditure)	- 44.98	- 52.40
- External health expenditure per capita, PPP (Int$)	- 16.37	- 23.91
- Domestic private health expenditure per capita, PPP (Int$)	- 42.90	- 89.16
- Domestic general government health expenditure per capita, PPP (Int$)	- 25.38	- 30.02
- Domestic general government health expenditure (% of general government expenditure)	- 4.58	- 3.89
- Current health expenditure per capita, PPP (Int$)	- 84.65	- 143.09

Health system outputs, outcomes & impact: *		
- Nurses and midwives (per 1,000 people) (2016)	- 0.6	- 0.3
- Physicians (per 1,000 people) (2016)	- 0.2	- 0.1
- Immunization, measles (% of children ages 12-23 months) (2018)	- 71.0	- 82.0
- Births attended by skilled health staff (% of total)	- 78.1 (2018)	- 68.4 (2017)
- Prevalence of undernourishment (% of population) (2017)	- 10.1	- 11.3
- Mortality rate, under-5 (per 1,000 live births) (2018)	- 95.5	- 43.6
- Maternal mortality ratio (modelled estimate, per 100,000 live births) (2017)	- 739.0	- 315.0

Sources: * World Bank, World Development Indicators
https://databank.worldbank.org/data/source/world-development-indicators
and ** Global Health Expenditure Database
http://apps.who.int/nha/database/Select/Indicators/en (consulted 19 Dec. 2019)

In Benin, the former President Yayi Boni launched an initiative aimed at achieving UHC in 2011, entitled *Régime d'Assurance Maladie Universelle*. A National Agency for Medical Insurance was created under the Ministry of Health (MoH) in 2012. However, this initiative was probably too ambitious and did not get sufficient support from domestic constituencies and development partners, and was dismissed by the new Government elected in 2016. The MoH also issued a National Health Financing Strategy in 2015, but this has not yet been translated into an operational plan. In addition to the national health sector plan which deals with the supply side of the health sector, the main policy launched by the new Government in 2016-2017 in the pursuit of UHC is the so-called "ARCH" (*Assurance pour le Renforcement du Capital Humain*) project. It targets informal sector workers and goes beyond the health sector to include other services to the population (training, microcredits, retirement). The financial protection policy also rests on the maintaining of existing (fragmented) mandatory health insurance regimes, and the promotion of private health insurance.[43,44] At the macro level, despite the existence of health sector coordination frameworks, and the theoretical supervision of the Ministry in charge of social affairs, the ARCH project is piloted by a committee under the tutorship of the Presidency. According to our field observations, its working barely involved policy dialogue and consultation with health and social protection sector actors and development partners. The pilot project is off-budget and information on its implementation is very hard to find. Note also that at the micro level, advisory health technology assessment is

performed by two MoH directorates (in charge of planning and hospitals) for the purposes of planning and budgeting, the pricing of health products, indicators of quality of care, reimbursement/package of benefits, but decision makers rely partly on their advice.[33]

In Senegal, in addition to the National Health Strategic Plan which promotes the expansion of quality health services, the UHC policy is mainly materialized through the so-called "CMU" (Universal Medical Coverage) strategy which was launched in 2013 and represents one of the main political projects of the newly re-elected President. The policy was developed by the Ministry of Health and Social Affairs (MoHSA) in line with previous experiences, but benefited a great deal from the support of the whole government through the national inter-ministerial steering committee of the CMU strategy, as well as from development partners. The CMU strategy aims, on the one hand, to better coordinate the existing (fragmented) health social insurance and health social assistance regimes and, on the other hand, to expand financial protection through decentralized community-based health insurance (this model was based on a USAID-funded pilot project). However, the strategy is under revision, and now is reoriented towards the promotion of departmental unions of community insurance, in line with the model piloted by the Belgian Development Agency since 2014 (field observations).[45] In 2019, the CMU Agency was transferred from the MoHSA to the Ministry in charge of community development and equity, so as to facilitate a separation of functions between payers and providers of health services, and to gather the management of major social protection programs under a single department.

Results

Analysis of the quality of the policy dialogue processes for UHC

Table 3 presents the results from our analysis of the quality of the policy dialogue processes for UHC along the dimensions and characteristics identified above.

Table 3: Analysis of the quality of policy dialogue processes in Benin and Senegal

Dimensions	Characteristic	Benin	Senegal
Participation of stakeholders			
	Relevant stakeholders, including…		
	… policymakers and health planners	F	+
	… clients/citizens // those individuals affected // engagement on the part of (staff and) the public // population / beneficiaries // community representatives	F	+
	… the various levels of the health system	F	+
	… health service providers	F	F
	… inter-sectoral collaboration, especially the MoF	F	F
	… donors	-	F
	Government coordination and ownership	+	+
	Number of stakeholders: must be manageable for meaningful dialogue	F	F
	Adequate capacities / Capacity building (incl. at subnational level) / Adequate technical support	F	F
	Mechanism to ensure balance of powers	-	F
Process of policy dialogue			
	Adequate preparation (incl. describe expected outcomes) // existence of a situation analysis	F	+
	Secured time and resources	F	F
	Diverse communication channels / Informal and formal platforms employed for consensus building	-	+
	Good facilitation	-	F
	Mechanisms to identify and manage conflicts of interest	-	-
	Feedback and follow-up / problem resolution mechanism	-	F
	Institutionalized policy dialogue / deliberative process mechanism	-	F
Quality of situation analysis & decision criteria – Analytical work underlying the policymaking process / process is evidence-based			
	Includes population consultation	-	F
	Based on cost-effectiveness analyses	+	F
	Equity / priority to the worst-off	+	+
	Financial risk protection	+	+
	Takes account of values and other criteria	F	F
	Includes public health preoccupations	F	F
	Takes account of context	F	F
Results from the negotiation process			
	Transparency in decision-making, including with regard to criteria used	-	-
	Accountability	-	-
	Strategic planning: transforming priorities into plans	F	+
	The chosen UHC gives priority to…		
	… expansion of covered populations	F	+
	… expansion of covered services	F	F
	… diminution of the share of expenditure paid directly by patients	+	+
	Quality of decisions taken (e.g. appropriate essential services)	F	F

Legend: + indicates a rather positive appreciation of the characteristic, - a relatively negative one, and F a fair one (that is, neither positive nor negative)

In Benin, the quality of the UHC policy process was appraised positively regarding the strong leadership by the government (the ARCH coordinating unit is under the Presidency), the quality of the situation underlying the UHC policy (especially, its focus on the worse-off), and its focus on reducing out-of-pocket expenditure. However, the process of UHC policymaking has been rated poorly, since actually there was hardly any policy dialogue around the choice of the UHC policy. The decisions were taken by a small governmental coalition, without participation from stakeholders and without proper communication with the public.

By contrast, Senegal adopted a much more participatory process to design its UHC policy, and is accordingly rated better along several quality criteria of the "participation" and "process" dimensions of our analytical framework. The quality of the situation analysis, the focus on the worse-off and the various strategies developed to expand CMU coverage (through CBHI but also various fee exemption and subsidization initiatives) also rated positively.

Transversal analysis

Yet, the analysis above shows that many quality criteria relating to policy dialogue processes, as identified through the literature, are not really met in the two countries under consideration. In both countries, decisions were made mostly by technocrats, under strong political leadership up to the level of the President of the Republic, ensuring strong government coordination and ownership. Moreover, both countries have placed strong emphasis on expanding financial risk protection to a larger part of the population, with special measures for the worst off, in order to improve equity. Yet, the two countries performed poorly in a number of dimensions: they failed to introduce mechanisms to identify and manage conflicts of interest, to provide feedback, follow-up or to help problem resolution; decision-making was not transparent (notably regarding the criteria used); and there is a lack of accountability regarding the results of the process.

Moreover, none of the two countries has really institutionalized a policy dialogue process around UHC decisions. Actually, the existing health sector coordination mechanisms have been bypassed to a certain extent, and were insufficiently involved in negotiating the trade-offs in regard to UHC – whereas the health sector has a crucial role to play in providing an appropriate supply of services to the insured population. The two countries differ in some respects, as shown in Table 3, with Senegal outperforming Benin at several levels. Benin used a more technocratic,

paternalistic approach, while still promoting a neoliberal policy. Senegal used a more communitarian, consensual approach – even if the initial chosen option did not take account of the evidence base on the poor capacity of CBHIs to enable expansion of health insurance on a voluntary base.

Our interviews indicate that the insufficient degree of participation, communication and dialogue with stakeholders contributes to explaining the populations' lack of ownership and trust towards the UHC policies decided by the government. For instance, in Senegal, the membership contribution to CBHIs is subsidized by the State (100% for the poor, 50% for the rest of the population), rendering it insignificant for most of the rural and informal population (less than 6 USD per year). The low penetration rate of CBHIs among the target populations can be explained by this lack of communication.

Discussion

The dimensions of quality processes identified through the literature review incidentally correspond to a large extent to the factors that influence policy reforms according to political scientists: those relative to institutions (processes, context), interests (actors, power), ideas (content, evidence, values) and policy networks.[22] If we apply the analytical grid of the "3Is" (institutions, interests, ideas) plus policy networks, we observe that it is mostly regarding the "ideas" dimension (quality of situation analysis & decision criteria in our framework) that the two countries under consideration are performing particularly well, since they designed their UHC based on an analytical work complemented by the values of the government. "Interests" (participation of stakeholders in our framework) are clearly an important factor influencing the decisions taken, since in both cases, a small (in the case of Benin) or broader (in the case of Senegal) governmental coalition managed to impose its views, without however ensuring sufficient participation on the part of other stakeholders. Policy networks have been particularly influential in Senegal since the government has been influenced by the CBHI and the USAID implementing agencies networks.[46] The "institutions" (process of policy dialogue in our framework) could be much improved in both countries, in particular in Benin.

The preoccupation with regard to ensuring sound policy dialogue, which is particularly relevant in the context of UHC negotiation, is actually not new: because of the complexity of the health sector, especially in aid-dependent

contexts, it is a continuation of sector-wide approaches and the implementation of aid effectiveness principles in the health sector.[47,48] Such a dialogue and partnership approach is supported by most influential global health actors through UHC2030, which provides a multi-stakeholder platform to promote collaborative working within countries and globally, in terms of health systems strengthening (https://www.uhc2030.org/). In many countries, health sector coordination mechanisms already exist – e.g. heath sector coordination committee, annual review of the health sector, evaluation of national policies or plans are some of the channels that can be used to boost inclusive policy dialogue. However, in the two Western African countries under consideration, existing coordination mechanisms of the health sector have been bypassed, to a certain extent, during the UHC policymaking process.

Beyond institutional partners, in contexts such as those of Benin and Senegal, where the informal sector is dominant in the economic structure, policy dialogue should be established with informal sector representatives. This is important to determine together what their health protection needs are, as well as their preferred modalities of participation in the financing of health services. In this dialogue, a more important place must be given to the populations, as potential members or members of CBHIs, patients or those accompanying them. Involving them in a dynamic policy dialogue may give meaning to their contribution to the pre-financing of the health system.

Conclusions

The literature points to a number of ideal characteristics that are supposed to ensure good quality policy dialogue or effective negotiation processes in the context of complex policymaking. These are relevant for the countries engaged towards UHC since the latter involves important trade-offs. Indeed, involving stakeholders in accountability mechanisms is a good way to improve commitments from both users and decisions makers on UHC. We have developed an analytical framework that enables us to assess whether or not UHC policymaking processes rely on a transparent and effective policy dialogue process that enables governments to take account of actors' perspectives and limit power influence, and are evidence- and value-based. Overall, the two case studies presented here show that, in practice, there are important gaps that reduce the quality of those processes, hence affecting the results in terms of transparency and accountability. The analytical framework enables us to identify room for

improvement in terms of the country-led negotiation processes for UHC in the two countries, and could also inspire other low- and middle-income countries in their attempt to progress towards UHC.

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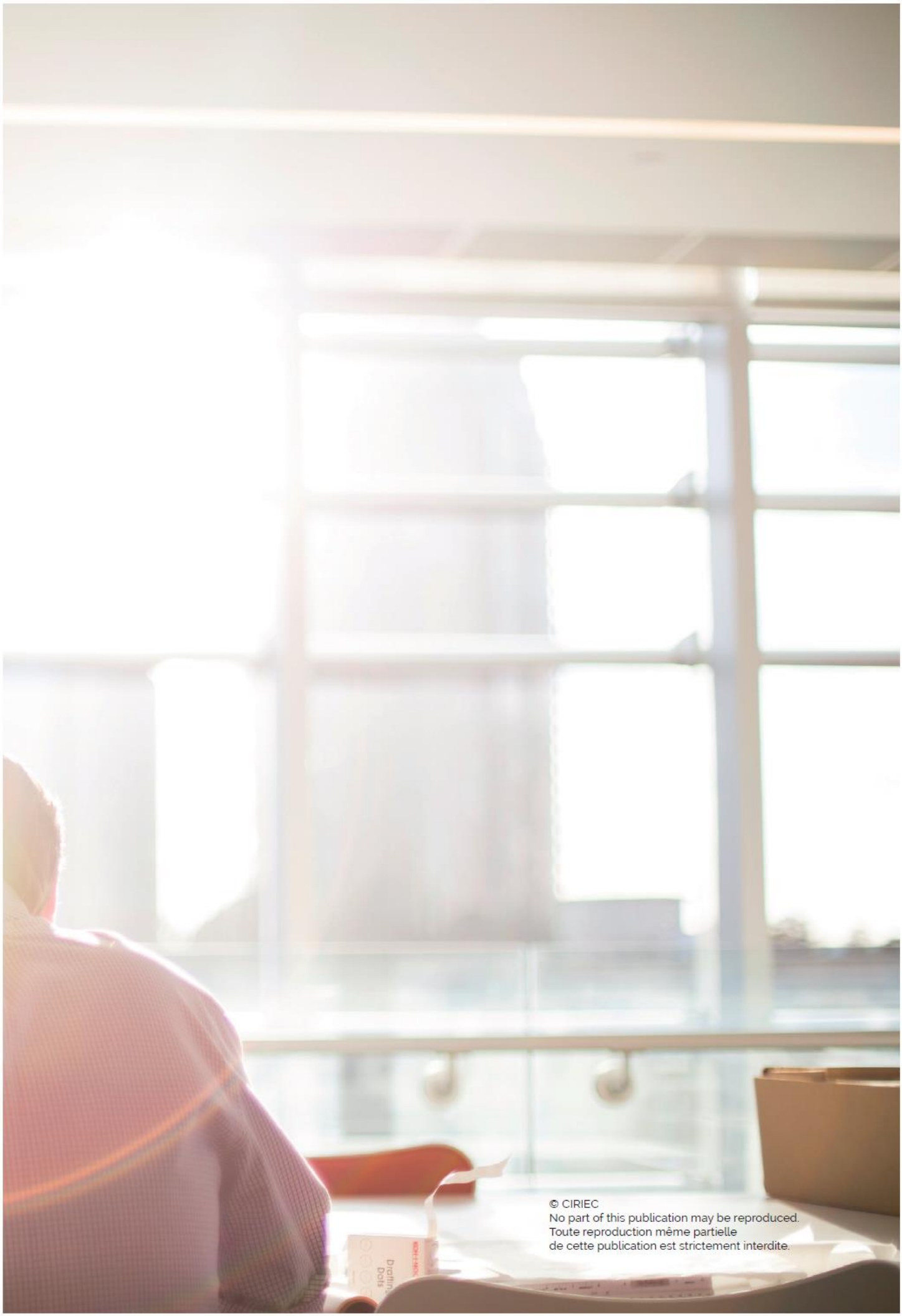

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