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ARTICLE

Health Care Financing Instruments during the Colonial Period in Senegal: The Historical and Institutional Nature of Policy Instruments

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Abstract

There has been limited research on African policy instruments' historical and institutional nature in health policy literature. However, in the field of health systems research, there are many examples that show the permanent use of financing instruments inspired by liberal (pro-market) ideas such as user fees, performance bonuses, or private practice of medicine in Africa. Through an analysis of archives (1840–1960), this article shows the presence of these instruments in the health system during the French colonial period in Senegal. Thus, this study shows that these financing policy instruments' institutional presence and longevity are part of a liberal approach that predates international organizations' contemporary (and liberal) promotion. This study uses a historical and institutionalist approach to understand the context, actors, and underlying factors that allowed for this historical continuity, resulting in the permanence of these instruments.

Keywords: policy instruments; history; institutions; health care financing; Senegal; colonial period

Introduction

Since 2023, an international engagement initiative (the Lusaka Agenda) has been underway to better align global health initiatives with countries' needs, with a particular attention to Africa.[1] This challenge of aligning policies is part of a colonial and postcolonial history that is essential to analyze. Yet, when it comes to financing health care systems, this type of study remains rare because historians have mainly focused their attention on analyzing epidemics, diseases, and patients, leaving aside health care systems and their policies.[2] For instance, although France continues to send hundreds of technical assistants to Africa, an analysis of its historical influence on health policies remains to be done. Senegal,

which was at the heart of France's colonial history (the last French physician to head Dakar's most prominent hospital was only replaced by a Senegalese official in early 2008[3]), is a particularly fertile policy history entry point for understanding the continuing influence of colonial legacies on policy instruments.

Policy instruments are tools governments use "to directly affect the nature, types, quantities and distribution of the goods and services provided in society."[4] These tools typically take the form of concrete government programs that are implemented to address problems and reach specific policy goals. The health care field adequately illustrates the complexity of policy instruments and their development over time. In Senegal, for instance, public funding for the health system and health insurance coverage is currently minimal.[5] It is generally only possible to receive treatment by paying out of pocket (OOP) for health care services and medication in public hospitals. The lowest socioeconomic classes continue to face significant barriers to accessing health care, and the overall health care financing structure does not favor them.[6] This difficulty is undoubtedly due to the proliferation of health policy instruments that are frequently inspired by liberal (pro-market) ideas promoted by international organizations.[7] These ideas gained momentum from the 1970s onward[8] and subsequently supported the spread of OOP user fees in health facilities, prompted by the World Health Organization (WHO) and United Nations International Children's Emergency Fund (UNICEF) in the 1980s.[9]

Literature Review

Historical analyses of these policy instruments began following the creation of the Bretton Woods institutions—an institution carrying ideas grounded in a liberal perspective.[10] However, it was when the influence of the World Bank took the lead of the WHO in the field of health[11] that political analyses showed the spread of pro-market policy instruments during the contemporary period.[12] In their study of Ghana, India, Sri Lanka, and Zimbabwe in the late 1990s, Mills and colleagues demonstrated how reforms of health systems aligned with the liberal ideas of New Public Management (i.e., responsibility, accountability, performance) and its instruments (user fees, contracting, performance bonuses, hospital autonomy, privatization, good governance).[13] New Public Management can be regarded as "the Trojan horse of liberal rationality to conquer public action."[14]

In Africa, for example, although user fees have always existed, as we will demonstrate in this historical analysis, their large-scale deployment has been influenced and supported by the WHO, the World Bank, and the United States Agency for International Development (USAID) with the support of private consultancy firms.[15] The consequences have been catastrophic for the population, and 15 years after its dissemination, experts from UNICEF and the World Bank admit that it had been a mistake.[16] Similarly, large-scale deployment of the instrument of contractual approaches in hospitals[17] and the payment of performance bonuses to health facilities and staff was organized by the World Bank, WHO, the United States Agency for International Development, and dissemination entrepreneurs in Africa,

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often from some European NGOs and private consultancy firms.[18] Two decades later, World Bank experts explained that using these instruments was neither practical nor relevant.[19] Hospital reforms and their use of liberal-inspired instruments provide a third example. The search for autonomy in hospitals governance and funding are ideal liberal historical[20] and contemporary[21] ideas.

Yet, is the presence of these instruments concurrent with the rise of the Bretton Woods institution and the influence of international organizations after the decolonization of African countries? What did patients have to pay when they went to hospitals during the colonial period? Were performance bonuses granted to health staff? Did colonial doctors have a private practice of medicine? How did colonial institutions contribute to the deployment of these instruments? To answer these questions, one must critically explain the history of public policies and their instruments,[22] especially since contemporary liberal ideas are part of colonial heritage.[23] Thus, the historical aspect of these instruments is critical "to show [under what conditions] ... configurations ... gave rise to instruments that managed to last and maintain the belief in their effectiveness."[24] However, health historians in Senegal have understudied the history of health care financing instruments, in contrast to their colleagues in Europe[25] and, especially, France.[26]

Anthropological studies of the State in Africa, particularly in certain West African countries, have used the concept of "institutional lagging" to suggest that "organizational configurations found in the ex-colony today may still contain elements that were copied in colonial times."[27] Yet, this issue has yet to be analyzed about health care systems and financial policy instruments in Africa. For the financing of health care systems, it is necessary to verify the "sedimentation" hypothesis proposed: "Public bureaucracies in Africa can unite elements of an ancient colonial state with the very latest trends in administrative reform."[28] The instruments that are analyzed in this article are not the only ones implemented during the colonial period, such as military medicine or Indigenous medical aid—which was free for Native Africans but very limited in its means and distribution. Our analysis focuses on the instruments that feature a liberal approach.

In this article, we show that the institutional presence of these liberal financing policy instruments predates their contemporary promotion by international organizations.[29] Although they may differ from current norms, these instruments were effectively implemented during the French colonial period in Senegal.

The historical and institutional nature of policy instruments

Policy instruments are not only the effects of power struggles between economic, political, and social agents but also the result of autonomous institutional realities with their own internal logics. This essential aspect of policy instruments is illustrated in the proposed definition by Pierre Lascoumes and Patrick Le Galès[30]:

> A public policy instrument constitutes a device that is both technical and social, that organizes specific social relations between the state and those it

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> is addressed to, according to the representations and meanings it carries. It is a particular type of institution, a technical device with the generic purpose of carrying a concrete concept of the politics/society relationship and sustained by a concept of regulation.

The notion that a policy instrument is a "particular type of institution" is essential because it allows us to draw inspiration from institutionalist work in political science to understand better the historical development of public health care financing policy instruments in Senegal. In fact, policy instruments are historical realities that reoccur over time[31] even in African bureaucracies.[32]

At a deeper lever, we understand policy instruments as durable institutions that can reproduce over long periods in a path-dependent manner.[33] From this perspective, policy instruments can last over time when deeply entrenched in existing social and political institutions. This institutional embeddedness also applies to ideas that policy instruments feature. Social and political actors take these ideas for granted, as they can shape their behavior and reproduce over time.[34] The ideas that we focus on in this article belong to the liberal tradition, as they emphasize individualistic and pro-market principles. Since the 1970s, these liberal ideas have been recast as part of a liberal approach, which updates these ideas and turn them against more statist and redistributive policy ideas and instruments.[35]

Methodology and Context

This research uses a historical and institutionalist approach to analyze policy instruments covering the colonial period until the independence of Senegal (April 1960). Therefore, it is important to begin by briefly situating the context of this case study within the period of study before presenting the methodology employed.

When France colonized Senegal, it did not prioritize health, particularly for local populations.[36] In the nineteenth century, during pacification, the colonizer used hospitals as a "means of colonial penetration."[37] But in 1910, as Lahille states, "the medical service is a mystification." In the 1930s, doctors working in the bush were "an essential ally of colonization."[38] The French colonies had a budget that was funded by capitation (local taxes) and customs taxes. France's decision to give these colonies budget autonomy is already part of a liberal approach to public financing management, perhaps even as a first experiment. In fact, "France in 1900 was presented as the archetypal liberal country."[39] In the 1950s, many debates were organized around the dyad between liberalism and colonialism.[40] However, taxes were insufficient, and "the colonies only survived with loans contracted from the metropolis."[41] Thus, within a very limited budget, there were few health posts and hospitals and low rates of medical staff. The available hospitals and medical personnel were concentrated in a few cities. Although the supply of care has gradually increased since the 1930s, it has never been able to meet the needs of Senegalese.[42] Medical aid for Indigenous people in rural areas was and remains limited and underfunded (lack of staff, vehicles, medicines, etc.).

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In this study, we are specifically interested in Senegal and its hospitals because this country is where the presence and attendance of health facilities are the most prevalent in West Africa. From Senegal and the arrival of Faidherbe in 1854, the French conquest in West Africa was to be organized.[43] After Saint-Louis, Dakar became the capital of "French West Africa" in 1902. Referring to the reforms conceived just before the Second World War, Pearson explained that "Dakar was to be the heart of the project."[44]

The data analyzed in this article comes from multiple sources that have helped triangulate the information and support the historical analysis. First, we carried out a comprehensive study of the digitization of the *Annals of Colonial Hygiene and Medicine* published from 1899 to 1940 and the minutes of the *Colonial Council* from 1882 to 1936. Then, we studied documents found at archives of the hospitals of Dakar and Saint-Louis. The National Archives of Senegal are located in Dakar (H and HS series), and the archives of the health sector of the Institute of Tropical Medicine of the Army Health Service (IMTSSA) are in Toulon (France). The chronology of laws and regulations relating to the history of health in Senegal, 1822–2016,[45] made it possible to identify essential documents. Finally, we studied all historical academic writings on health in Senegal,[46] particularly those available in the library of Cheick Anta Diop University (Department of History). All the French-language quotes were translated by authors into English to facilitate readability.

Results

The results are presented chronologically for each of the four main policy instruments we found. From a heuristic perspective, we have selected the most illustrative facts to demonstrate these liberal-inspired policy instruments' historical and institutional presence and permanence.

User Fees and Responsibility of Patients

The colonial state organized its bureaucracy and produced official documents about user fees, thus contributing to their institutionalization. As early as 1840, a royal decision showed that a deduction was subtracted "*on the pay of officers and other attachés in the service of the Navy during their stay in the hospital.*" In 1852, as part of a clear institutionalization process, an order fixed the "*average price of the hospital day in favor of the indigent*" to organize reimbursements to the hospital by the Commune. For example, in 1868, the hospital day at Gorée Hospital was set at 9.55 francs. The administration reimbursed that sum, except for commercial sailors and individuals who were "*treated at their own expense.*"[47] The idea that people pay directly for hospital services without being taken care of by the administration is therefore a very old one. However, this remained a marginal practice in Saint-Louis (Senegal's capital) at the end of the nineteenth century.[48] Indeed, faced with the deplorable state of the hospice of Saint-Louis, "*paying patients hesitate to go to our hospital in fear of being malnourished there.*"[49] In 1892, the director of the civil hospital explained that as long as the fitting-out

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works were not completed, "*the hospital could receive only a dozen paying patients.*"[50]

The idea of rationing and efficiency, at the heart of the New Public Management, was therefore already well established and institutionalized by the end of the nineteenth century. In 1898, public assistance to the Colonies explained the process of payment in hospitals and the presence of payment by individuals: "In order not to make the metropolis bear all the expenses involved in the operation of this service, it is fixed each year for patients other than the military a price of the hospital day. In this way, part of the expenditure is reimbursed by the local budget and by individuals."[51] In 1900, the Minister of Colonies wished to start the study of an ambulance (health center) project of 12 to 15 beds where consultations and medicines would be free for the natives but asked that the admission of "all Europeans at rates appropriate to their situation should be organized."[52] Furthermore, if "indigents are visited free of charge … they do not receive medicines free of charge." Thus, the council implemented the policy that medicinal products must be distributed to them free of charge.[53]

Payroll deductions remained the norm for military personnel and hospitalized civil servants. For example, Mr Demba Sy, a teacher in Ziguinchor, suffered a deduction of 100 francs from his civil servant's salary (of 1500 francs) for staying 20 days at the civil hospital in 1914. The price of hospital days varied significantly throughout colonization but has always been organized according to social and racial categories of the time. For example, in 1914, the day's reimbursement rate was 12 francs for officers, 9 francs for noncommissioned officers, 6 francs for soldiers, and 3 francs for European children aged 5 to 12 and Indigenous.

The Regulation of August 12, 1912, confirmed the possibility of persons "treated at their own expense" and the fact that to be able to be treated, they must "make the provision in accordance with Article 222 in the hands of the accounting officer or the chief medical officer as the case may be." The principle of payment of a deposit at the entrance of all hospitalizations was in place. In Saint-Louis, an internal regulation of the civil hospital in 1909 stipulated the need to pay 15 days of treatment in advance.

Hospitals organized themselves to have rooms for paying patients. In 1919, the administration presented the project to create an Indigenous maternity unit in Dakar. It states that "this maternity ward will include paying rooms, where the price of the day will be five francs, intended to receive women who wish not to be treated as indigent, and rooms free of charge."[54] In 1934, the Colonial Hospital of Saint-Louis completed construction work on a "'small payroll" ward."[55]

The 1930 annual report of the central Indigenous hospital in Dakar provided an idea to scale-up people paying directly for health services. Thus, of the 84,696 days of hospitalization, 7.6% were paid by individuals. In his August 8, 1930, report, pharmacist Colonel Finelle of the Main Hospital in Dakar recalled that an instruction dated December 24, 1927, called for an increase in the purchase prices of medicines by 25%. In the 1935 Annual Report, we learned that "the disposals" of the sale of medicinal products amount to more than 1.1 million francs.

In 1939, the "expenditure borne by individuals" concerning the Principal Hospital and the two Ambulances was 573,118 francs or 28% of the revenue. At

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the Colonial Hospital of Saint-Louis, the total budget contributed by individuals at their expense is 22% of the total revenue of December 1939. Even in rural health facilities such as Kaolack, the head of Senegal's health service (Dr Vogel) notes in his 1939 tour report that "paying patients have allowed a recipe of 772,488 francs." At the Colonial Hospital of Saint-Louis in 1945, the higher one's category of hospitalization, the higher the percentage paid at one's own expense: 18% in first category, 10% in second category, 5% in third, and finally 0.15% for the fourth and fifth categories. The same social gradient was found in other hospitals in Senegal throughout the colonial period.

From 1945 to 1950, individuals paid at their own expense (PALF noted in the administrative documents), which accounted for 16% of the total hospital days and 24% of the full payment of treatment costs at the Main Hospital in Dakar. Between 1951 and 1955, the "miscellaneous disposals recovered" mainly concerned radiography and gynecological surgery. The situation is so complicated by the "multiplying of funds" that the Lieutenant-Colonel of Administration, manager of the hospital, recalled in 1955 his request to create a single fund. Moreover, "a large number of consultants do not pay on the spot, which leads to the sending of many reminder letters."

For Le Dantec Hospital in Dakar, the large council of the French West Africa (AOF) decided in 1953 (254/GC/53) to retain only two reimbursement rates—namely, the administrative rate (480 francs) and the "small payer" rate (160 francs). But the latter have never been applied. Therefore, offering the "Africans" the opportunity to pay had been considered, but those who came to Le Dantec did not have the means. In 1955, the cost of treating individuals at their own expense accounted for only 2.1% of the total revenue of Le Dantec Hospital. The payment of patients therefore had a different weight than that for the principal hospital in Dakar where, in 1955, individuals who paid at their own expense accounted for 12.6% of revenues. In northern Senegal, the status of administration of the colonial hospital of Saint-Louis in 1951 showed that PALF accounted for 1.6% of hospital days and 2.9% of the budget.

To better understand the issue of user fees, it is also interesting to look at the Federal Blood Transfusion Centre of the AOF, based in Dakar. Its director thus proposed in a letter of April 1951 to the Director General of the Health Service of the AOF to maintain the rates applied by the Pasteur Institute—6 francs per cubic centimeter of liquid plasma and 4 francs per cubic centimeter of red blood. It is expected that this blood was transferred not only to administration but also to the "private sector." The decree, which formalized this proposal in 1951 (3006/SP-AD), states that "these prices are increased by 25% for individuals," thus confirming the idea of user fees for selling blood with a profit margin. Examinations and analyses requested by hospital doctors for external consultations ("free practitioners") "must be paid by interested parties directly to the accountant." But doctors can get extra remuneration; the proceeds of this sale are divided into two parts: "50% for the benefit of the laboratory's managing budget; 50% for the benefit of the doctor in charge." Therefore, not only were the payment increased for individuals; the decree also gave entitlement to a rebate to the official doctor (a priori European, according to the organization chart). Finally, indemnities were paid to blood donors at a rate of 600 francs per

donation, in addition to a food ration, the content of which differed between Europeans and Africans.

Shortly before the decolonization of Senegal in 1960, technical groups focused on the role of hospitals in the health care system at the 10th World Health Assembly in 1957. There was a debate about fears of exponential increases of expenditure if one did not impose user fees on patients.[56] Therefore, the newly created international institutions began their influence on national decisions concerning user fees, which would be detrimental for decades to come, shown by its effect on contemporary history.[57]

Private Practice of Colonial Doctors

In 1876, in Saint-Louis, Mr. de Rochebrune (referred to as "health officer in charge of the stillborn") claimed his fees from the city for the findings of 38 stillborn babies. In 1925, Mr. Léon Demay, mutilated in war, complained in a letter to the Minister of Pensions that he could not assert his rights of free care to military doctors in Saint-Louis because they could "do clients—care to be given to traders, affluent natives, births." He even stated that "the military doctors here make clients so they can be held as civilian doctors."[58]

In a 1926 draft decree, there was an explicit reference to prohibiting staff from receiving "salaries and allowances other than those allocated to them by the texts in force," thus demonstrating a need for regulation. However, at the colonial council, the focus of the debates was on the lack of resources for health services. Discussions began on the need to "charge visits."[59] Mr. D'Oxoby explained that paid visits are already in place in Kébémer for 250 francs and Méhé for 80 francs. It considered "25 francs for the day visit and 50 francs for the night would be reasonable prices." Then Mr. Larrieu gave the example of a doctor from Kaolack who refused to travel during the night to Foundiougne for a complicated delivery "to treat a rich beginning of Sokhone." Larrieu specifies, "My aim, by insisting, is to point out to the doctors of the Indigenous Medical Assistance that their role is not to do only paying clients."

At the 1929 Colonial Council, Mr. Mabigué confirmed the existence of paid consultations, which would have had adverse consequences for the care of Indigenous people: "Considering that Dr. Charles of Ziguinchor, the main cause of this motion, is more concerned with his paying clientele than with the natives of the city. Medicines and dressing objects are exclusively reserved for its paying customers, although that clientele already obtains specialties from that doctor for consideration." Thus, it calls for "serious scrutiny" by the administration to "prevent the return of such errors."[60] The following year, he continued to denounce discriminatory medical practices by explaining that "pay rooms are only reserved for persons of white races to the absolute exclusion of natives of all conditions."[61] Then he persisted with the case of Dr. Charles de Ziguinchor, who did not accept that natives who had the means should have access. He also asked, and one imagines that it is necessary to read between the lines, "that any disposal of medicinal products or pharmaceutical products be the subject of a revenue order for the benefit of the local budget."[62]

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A report from an inspection of the Principal Hospital in Dakar in 1930 noted the challenges of regulating the private practice of doctors who were paid by the hospital. If the Order of 1926 confirmed the possibility of charging the analyses to individuals, the sums must be for "the benefit of the managing budget." However, the 1930 report stated that the Governor General agreed to a private practice within the hospital so that "several interventions would be paid for by the sick." The rapporteur seemed outraged by this practice because "it appears that the doctor is losing the rights of the hospital that pays him and is making him an unacceptable competition." Another 1930 report on the hospital's pharmacy services showed that management challenges also concern nurses: "Another, lesser cause of loss, but renewed every day, is due to the disappearance of vials containing drug prescriptions, with nurses sometimes reporting only half of the vials delivered."

Thus, Colonial Minister Louis Rollin sent a circular in 1935 "to the governors-general and governors of the Colonies with the intention of solving the problem of the exercise of clientele by medical civil and military officials."[63] Dr. Sasportas complained that this liberal practice was essential and made it possible to "*compensate the inadequacy of the balances allocated to them.*" He reported the fears of Dr Vital-Robert de Kaolack, who related the increase in competition with the arrival of foreign doctors, Syrians, Guadeloupeans, and French colonials resigning or retiring.

The year 1937 was the first year for which we found any information on private practice: "Decree relating to the exercise of paying clients for medical officials (No 591 of 5-3-1937)" and "Order No 1280 regulating the exercise of clientele remunerated by any military doctor, civil servant or contract doctor." This decree points to a clear form of institutionalization of user fees as a policy instrument.

A few years later, Dr Sasportas confirmed the private practice of some doctors: "I am aware that alongside those medical civil servants who work for the public and who form the majority, there are a few rare cases of colleagues living in large cities, making clients as in a French center."[64] Yet, they still received specific allowances from the government, which was "a very useful addition to the resources that customers can also provide."

Performance Bonuses for Mothers and Physicians

The archives show the long-standing presence of bonus payments for both patients (mothers) and health care professionals. In 1919, when the Colonial Council evoked the creation of an Indigenous maternity in Dakar, there was a need to plan the financing of bonuses for women who had given birth. The administrator asked to add to the budget "the payment to each child treated free of charge of a fee of twenty francs, a small premium, but sufficient to effectively rescue the mother and infant and to contribute practically to the publicity of the institution."[65]

In 1931, a report on the organization of Indigenous medical aid stated that a "slight premium is awarded to matrons for each child when, after three months, the mother and the child are in good health."[66] Furthermore, a premium was

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given to "mothers of five living children." In this document, Carde explained that he had planned this bonus in 1924. He added, "This practice is to be resumed and the bonus may be increased whenever the matron calls upon the competition or the control of the midwife or the doctor." In addition, the premium for mothers was described as "moral measures" to honor large families and in addition to an annual children's party, a competition with prize awarded to large families, "the most vigorous and best dressed infants, the owners of the most hygienic and well-kept boxes, etc."[67] In 1930, the total budget allocated to these bonuses in Senegal was 50,000 francs for both matrons and Indigenous women using maternity wards. In modern terms, the premium was intended for regulating supply and demand, which is clearly a liberal (pro-market) idea.

The 1933 annual report showed expenditure on "baby premiums" for 11,700 francs, without one understanding exactly what it is. This section also appeared in 1936 but without any indication of francs. In the 1939 annual report, we were told that "according to tradition" matrons who carried out childbirth "without pathological consequences owed to the birth attendant and especially without umbilical tetanus" received premiums. Would the latter be more for the birth attendants than matrons? In total in 1939, 2,405 francs were distributed in bonuses to 33 matrons, one of whom had completed 161 deliveries and "hit 644 Francs." Thus, it is understood that each childbirth was entitled to a bonus of four francs. Barthélemy described the operation of these payment bonuses without harmonization at the federation level.[68] In 1939, a doctor at the end of his tour of health facilities in Senegal evoked the interest in organizing yield bonuses for some "matrons selected from among those who practice in rural consultation centers regularly visit each week." These performance bonuses, which were clearly embedded in liberal (pro-market) ideas, would be awarded to them "every 3 or 6 months if the checks done by the doctors during their tour were satisfactory (information provided by the chefs, number of newborns aged 15 to 30 days presented each month with good umbilical healing and in good condition)."

Concerning health care professionals, Arthur Vernes and René Trautmann were surprised during their visit to the AOF in December 1938 when the state decided to prevent doctors from having income for their consultations (i.e., 15% user fees). "How could one think of hindering this important action [prestige of French thought] by ordering doctors to return to the Treasury the price of their consultations in this case, a sum of 50 francs average a user fee for them of 7.50 francs?" The two rapporteurs called for the abolition "without delay of such an absurd order," although they admitted that the administration paid the travel and salaries of these doctors. However, they stated that those sums were "derisory" without supporting data. They, therefore, called for this private practice "of tradition in the metropolis" to be promoted in "the interest of all: doctors, patients and the whole European and [I]ndigenous population."[69]

Bureaucracy was also in place for the payment of user fees to doctors. A circular (1004/SP-AD dated March 1, 1955) called for monthly statements to be sent for each colonial doctor. In March 1955, Colonel Coleno signed a monthly statement showing the fee amounts paid to doctors and the sums paid to the head of each health unit for paid home visits. For example, Dr Bovet from Kaolack

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received 4,000 francs in rebates for January and paid the health center 16,500 francs for his home visits. Some doctors received payments every month, but others received only a few. These nine doctors received 291,050 francs, or 4,000 francs per month per person (73 months of practice in total). In the case of the Hôpital Principal de Dakar, 13 doctors received kickbacks, including two pharmacists—all European military personnel. The sums involved (and the discrepancies) were sometimes substantial, as in the case of physician-commander Louis Brisbare, who received 88,800 francs for January 1955 alone, whereas physician-captain Michel Pannetier received 1,600 francs for the same month.

Conclusion

This study focused on the colonial period in Senegal and mirrors that of the contemporary history of health care financing in West Africa.[70] Once it became independent, Senegal decided to tackle the inequalities in the health care system that had been perpetuated by the colonial system. Thus, the first socioeconomic development plan (1960–1963) focused "on the equitable distribution of health care."[71] Yet, its implementation was significantly delayed because "preventive activities were victims of a lack of funding.[72]

The research findings confirm the path-dependent historical development and the autonomy of policy instruments as institutional realities.[73] At the same time, it testifies to "an incredible permanence throughout history"[74] of both policy instruments and the older liberal ideas embedded in them. This reality confirms the anthropological hypotheses of the analysis of the sedimentation of certain forms of state bureaucracy in Africa: "organizational configurations found in the ex-colony today may still contain elements that were copied in colonial times. In this sense, African public bureaucracies could be described as still only partly decolonized."[75] Yet, we must be cautious, as our study was not intended to show that liberal instruments predominate but rather that they existed and have endured. The study of their relative weight remains to be conducted.

The data allow us to advance the concept of instrument autonomy that we had proposed in our analysis of the choice of instruments during the COVID-19 pandemic in Senegal.[76] The study of the government's response to the COVID-19 pandemic shows that the state chose policy instruments from the past (Ebola) without adapting them or considering the lessons of the past.[77] The study also confirms the continuing ideational and institutional influence of international organizations such as the WHO, without norms necessarily being adapted to local contexts.

Two examples in North Africa show that it would be interesting to study the application of this autonomy of instruments on the scale of territories colonized by France. On one hand, the instrument of "additional cent," a tax added to the taxes of the people in Algeria at the beginning of the twentieth century,[78] was taken over in the 2000s by NGOs in Niger to find resources to finance the transport of the patients.[79] This latest case in Niger certainly suggests reinvention rather than sedimentation. However, the attempt at a health tax tested in

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the 1990s with the support of an USA consulting firm has not lasted.[80] On the other hand, in Algeria we know that colonial doctors had "the possibility of paying clients."[81] However, this care privatization is in full swing today in Algeria, where the private and public porosity is increasing, especially in hospitals[82] and across France.[83]

Evans and his colleagues[84] used a zombie metaphor to explain that during contemporary history, direct payment from users of health services, understood as an instrument of public policy, was constantly coming back despite its lack of relevance. The present study shows that despite this history dating back to at least to the nineteenth century in Senegal, as in France,[85] its legacy persists. Colonizers have always tried to make patients pay, but costs are experienced by patients unequally. It is impossible to compare this magnitude because the historical sources are administrative and colonial, thus representing a particular point of view. The decolonial analyses of public policies at the time remain rare, especially in contexts where some suggest that the formation of the state would be "the product of imported and imposed institutions (as New Public Management)."[86] Thus, there is a lack of empirical surveys to understand patients' point of view on user fees in colonial times despite excellent historical analyses of epidemics in Senegal.[87] However, "it is not possible to understand the citizen-state relationship in post-colonial states, without accounting for the colonial history of administration and bureaucracy."[88]

Moreover, although the terms of user fees have continued to this day, racial categories seem less present, but not absent, in the health sector in West Africa.[89] Yet, the social categories whose inequalities in the payment of care persist. The poorest still have the lowest access to health care in Senegal.[90] The challenges that the most vulnerable face is often insurmountable. Specifically, their right to free care through the recent community-based health insurance policies provided for by public policies,[91] as in neighboring Mali,[92] are not effective in increasing access to care. Moreover, although private practice was confirmed in the 1990s,[93] it remains implemented in current public hospitals even if only 0.2% of health care staff declared themselves employed by the private sector in 2019.[94] Private practice has developed and spread in Senegal,[95] like in France[96] and elsewhere in the world.[97] Although it is necessary to be cautious and "let us not fetish by African singularity,"[98] what we have described for Senegal could most certainly be analyzed in the same vein in many countries around the world where the diffusion of liberal ideas occurs.

Once the institutional permanence of these financing instruments has been brought to light, it would be useful to understand the dissemination processes and, above all, the actors (individual and organizational) at the origin of this consistency. It would be interesting to understand how groups of actors are more in favor of instrument constituents.[99] It would also be interesting to understand how instrumental coalitions[100] have evolved and acted throughout history to influence that continuity or even persistence, as has been shown for user fees in contemporary history.[101] It will be recalled, for example, that the French government tried to prevent the creation of the WHO, particularly its office in Africa, in order to avoid letting the disastrous health situation of the colonized countries be seen.[102] This is the same French government that, in 2023, is

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influencing Global Health Initiative such as the Pandemic Fund so that Senegal can sit on its board and obtain funding even though Senegal has not shown much leadership or interest in this issue. The goal would be to go beyond the classic and unheuristic North/South dichotomy[103] to uncover the power relations, the dissemination of ideas, and the strategies of actors in Senegal. This would advance the pursuit and development of these financing instruments,[104] which have been analyzed for the contemporary history of performance-based financing in Mali and Senegal, with the importance of entrepreneurs in disseminating these ideas.[105]

Finally, it would be necessary to test the hypothesis proposed by Baudot[106]: "Beyond political alternations and policy changes, the longevity of some techniques invites us to explore another hypothesis: an instrument would be all the more durable because it could—synchronically and diachronically—satisfy divergent rationalities, even potentially incompatible, and would be supported by as many groups as possible, which requires excellent flexibility." This hypothesis is consistent with the historical institutionalist focus on the role of ambiguity in policy stability and change, which is associated with the work of scholars such as Bruno Palier[107] and Kathleen Thelen.[108] Future institutionalist research on the sustainability and preproduction of policy instruments testing the above hypothesis could explore ambiguity as a potential ingredient for "coalition magnets"[109] that might help maintain and reinforce support for these instruments over long periods.

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