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Health Insurance and the challenges of public response to Pandemics in Burkina Faso: Exploring the role of the informal economy

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Abstract

Economic barriers remain the main challenge facing households regarding healthcare access in Burkina Faso. Universal health coverage is yet to be extended to the majority of the population, especially the most vulnerable. Furthermore, access to community based health insurance has been so far impeded by the financial challenges facing household to contribute. Yet, public health policy performances depend on the quantity and quality of health information. In case of epidemic outbreak, apart from mass testing, the standard sources of health information for decision-making are based on populations' demand for healthcare services. This paper explores the state of the economic determinants of this demand. The results of these analyses provide the basis for the evaluation of the impact of the economic situation of households on the government of Burkina Faso's response to the covid-19. The data used for the analysis come from two main sources. Firstly, a systematic documentary review of macro macroeconomic policy and social security regimes in the country has been conducted. Secondly, a survey of the economic living conditions of 503 households in

Ouagadougou is conducted. The analysis uses a conceptual lens drawn from classical sociological analysis of public problems, which provided the framework for the qualitative analysis. The paper argued that the dependence of public policy process on information constituted some constraints for government effective response to the pandemic to the extent that the macroeconomic context and the households' economic circumstances stand as barriers to households' access to health services - through which further information on the population could have been gained, in the absence of mass systematic testing. The results show that households have been resilient to the chock caused by the pandemic. From 2014 health policy measures started to reverse the trend in government's interventions in healthcare access that mitigated the negative impacts of several decades of privatization of healthcare services. Recent policy measures facilitated healthcare access for children aged less than five years and pregnant women, thus reducing households' health expenditures. Furthermore, the households in the informal sector suffered less from the restrictions due to the covid-19, as they benefited from the increase in domestic demand for goods and services in some of the branches of the economy.

Keywords: *health insurance; covid-19; Burkina Faso; public pandemic response; challenges*

1. Introduction

Economic barriers are increasingly becoming the main challenge facing households regarding healthcare access in Burkina Faso. Universal health coverage is yet to be extended to the majority of the population, especially the most vulnerable. Furthermore, access to community based health insurance has been so far impeded by the financial challenges facing household to contribute. Yet, public health policy performances depend on the quantity and quality of health information. In case of epidemic outbreak, apart from mass testing, the standard sources of health information for decision-making are based on populations' demand for healthcare services. This paper analyses the state of the economic determinants of this demand focusing on the small traders of the informal sector.

The informal sector constitutes the large part of many African economies that public policy must take it into account if it is to succeed. In fact, the topic of informal sector has been a scholarly interest since the end of the 1970s. It continues to be so in current debates on economic development in low-income countries. Discussing the concept of informality in the light of the COVID-19 pandemic in Ghana, Akuoko et al. [1] argued that neo-liberal approach to informality on the continent which has long considered it as an abnormality rather meant that the informal sector's contribution to the populations' resilience was largely neglected. Yet, in reality, many African countries show a different socioeconomic setup where informality takes the centre stage, to the extent that the effects of the pandemic in Africa are expected to take a specific pattern. In conceptualizing the concept of informality, the authors observed that "the theorization of the informal sector has gone from being labelled as 'hidden', 'black', 'second' to being recognized as a permanent and important aspect of urban lives globally" [1]. However, the neo-liberal approach to informality as a transitional abnormal phenomenon to be absorbed by the formal sector resulted in governments focusing on the illegality of informal sector rather than its capacity for development. Since the evidence has challenged such view, the authors call for approaching the informal sector as a relevant factor for understanding other social processes such as resilience to shocks, and pandemics in particular. The understanding of the causes and consequences of informality is however crucial given that the informal sector plays a dominant role in West African economies, particularly with regard to employment. Meagher [2] studied the link between crisis, informalisation and the urban informal sector in Sub-Saharan. Analysing the size of the informal economy in Sub-Saharan Africa, Xaba et al. [3] show that with 78 per cent is non-Agricultural Employment, 61 per cent in urban employment and 93 per cent employed in new jobs. Whereas in 1990, 21 per cent of SSA's 227 million labour force was working in the informal economy, by 1998 it was estimated to comprise 40-60 per cent of urban employment. During this period, while there was a decline or stagnation in the growth of formal employment, there was an increase in informal sector activities in the region. In some instances the informal economy plays a far more significant role in the country's economy than the formal economy, as reflected in the number of economically active people working in the informal economy; in addition, the informal economy is making an important contribution to the country's economic growth, as the GDP data reflects; and growth in the informal economy, while being more rapid in urban areas, is also evident in rural communities. Hussmanns [4] noted the informal economy plays an important role for employment creation, income generation and poverty reduction in many countries, especially developing and

transition countries. The IMF [5] notes that informal workers may be more vulnerable to negative shocks such as the COVID-19 pandemic, as they are likely to face greater income losses without the benefit of social protection. In their paper on self-Employment, wage employment and informality in a developing economy, Bennett and Rablen [6] observed that urban labour markets in developing economies exhibit considerable diversity, typically including significant segments of both voluntary and involuntary self-employment, as well as formal and informal wage employment. Onyebueke & Geyer [7] through a thorough review focusing on Nigeria shows how relevant it is to relate various processes in Africa with the informal economic realities of the continent. Meagher and Yunusa [8] engaged in discussion of the concept because of its centrality in socioeconomic analysis.

Surprisingly, this context has been largely ignored in many African governments' response to covid-19 pandemic. In the absence of mass screening, it is the population's health seeking behaviour that will be determinant in the public response to the pandemic. The health seeking behaviour is likely to be in disfavour of public formal health facilities because of the lack universal health coverage in countries, like Burkina Faso, thus not allowing public health authorities to diagnose the prevalence of the covid-19 virus among the population. Sociologists use the term "career" to make sense of this complex dynamic biographical and collective process. In its objective meaning, for Hughes [9], "a career consists of a series of status and clearly defined offices". Referring to work, Freidson defines the career-line of a worker as "the series of tasks or jobs performed over the course of a working life" [10]. When defined in subjective terms, the term career refers to "the moving perspective in which the person sees his life as whole and interprets the meaning of this various attributes, actions, and the things which happen to him" [9]. The term is applied both to things [10] and to human social and professional life [11] [12] [9]. In public policy analysis, some authors have found in the concept a handy shortcut for tracing the evolution of problems from their personal to their public status, and the consequences of such process on policy-making [13]. Knill and Tuson's [14] summary is to the point. For them, "a public policy can be defined as a course of action (or non-action) taken by a government or legislature with regard to a particular issue. Although this definition is very broad, it emphasizes two constitutive elements. First, public policies refer to actions of public actors (typically government), although societal actors might to some extent be involved or participate in public decision-making. Second, governmental actions are focused on a specific issue, implying that the scope of activities is restricted to addressing a certain aspect or problem" [14]. In other words,

public policy "is concerned with how issues and problems come to be defined and constructed and how they are placed on the political agenda" [15]. The attainment of public status of an issue is very often seen with optimism in relation to the modalities of support and the efficacy of the response the problem thus defined may receive. This explains why some interest groups put every effort to gain public definition of problems they are concerned with. Yet, the optimism that the public character of a problem conveys overshadows the complexity and uncertainty of the public policy process *per se*. According to Mills, the distinction between personal problems and public problems raises fundamental methodological questions regarding the appropriate level for their statement and resolutions. In fact, similar to the above line of thinking about the career of problems, Mills uses the term "troubles" to designate the individually experienced stage of problems. For him "*Troubles* occur within the character of the individual and within the range of his immediate relations with others; they have to do with his self and with those limited areas of social life of which he is directly and personally aware" [16]. With respect to the above definition of public policy, at this stage, the problem does not involve the government but the individual and his immediate environment (such as family, friends, and neighbors).

On contrast Mills refers to the term of "issue" to designate the collective, public stage of problems' career. According to him "Issues have to do with matters that transcend these local environments of the individual and the range of this inner life. They have to do with the organization of many such milieu into the institutions of an historical society as a whole…An issue is a public matter: some value cherished by publics is felt to be threatened" [16]. In reference to the definition of the concept of public policy stated above, issue corresponds to the stage of public definition of problems and the governmental involvement in the response to them. However, the fact that the public and its problems constitute a relatively autonomous level of reality raises important methodological issue that can constitute a challenge to public policy process, with the result of reducing the positive expectations that the evolution of a problem to public status usually conveys. Indeed, intelligence is considered as one of the main steps of public policy process. Through intelligence, public policy makers collect and process of all relevant knowledge and information that would enable them to identify and support selected alternatives for implementation. Access to information thus becomes a key challenge in public policy-making. The pandemic of covid-19 is a particular case of issue that is subject to public policy, and could face important challenges regarding the access to the relevant information on the population. The paper sets out to address the following questions: What is

the current health coverage opportunities offered to the population? What are the existing health insurance opportunities, and to what extent these opportunities are accessible to all citizens? What are the limitations of these existing opportunities and what are the implications for access in time of epidemic, such as that of the covid-19? What are the state of informal help regimes? How all of the above means for public response against the covid-19 pandemic in Burkina Faso?

These are important questions about which an understanding can inform appropriate measures for current and future pandemics in Burkina Faso and in Africa more generally. One reason why these are important questions is related to the relevance of economic determinants in explaining the demand for health services of the population supported by the literature. For example, Kremer and Miguel [17] have shown in their study about primary school enrollment in a deworming program in Western Kenya that the demand for health services were sensitive to price, with only 18% in cost-sharing school compared to 75% in schools which kept the free programme. Similarly, Cohen and Dupas [18] found similar results when studying the demand for new health products in rural Kenya. Subramanian and al. [19] showed relationship between inequality and health, while Swain [20] demonstrated that economic disadvantage affects the ability to access clinical care. Comparable findings are provided by Barreto [21], who has shown that inequality of health within a country relate to the distribution of accumulation of wealth within the society. Katikireddi [22] drawing conclusion on the economic factors contribution to health noted that “ensuring economic policy is cognizant of effects on health is likely to become increasingly necessary for public health in the future”. Tekabe [23] cross country study confirmed these findings; and for Deaton [24], income inequality is a health risk are as plausible for poor as for rich countries. Focusing on the covid-19 pandemic, Stojkoski and colleagues [25] have showed that there are socio-economic determinants that contribute to the resulting coronavirus pandemic; among other determinant is government expenditure and testing power of countries; that means that sensitivity of demand to price is waived, that could have hindered health service demand.

Another reason for undertaking this study is the lack of study on the topic at present. We did not find any scholarly published paper on the role of health insurance on the control of the pandemic whether individually or state response, regarding Africa; outside Africa only two papers are found, with one by Clay and colleagues [26] on broader issue in the past regarding the effects of medicaid implementation on pandemic influenza mortality, and how the expansion of insurance mitigate expansion of the disease among population. The other paper

Woolhandler and Himmelstein [27] concerns more directly COVID-19 and lack of the health insurance, particularly when many workers lose their jobs on the basis on which they accessed to health insurance. Both studies focus on the context of the United States. The aim of the present contribution is to explore how the context of health insurance coverage shapes pandemic control in an African context. We argue that economic constraints prevent demand for clinical services which would have provided complementary data on the prevalence of the pandemic among the population in the absence of systematic test of the population, and thus increasing the risk of exposure of other people in crowed promiscuous setting like markets. The paper is organized as follow. After this introductory section, methodological aspects are addressed. This is followed by the results section which covers macroeconomic determinants and household constraints regarding access to clinical care, before any diagnosis of covid-19 could be done. Finally, after the discussion section a conclusion is provided.

2. Methodology

Building on the state of the art regarding the economic determinants of health behaviour and its link with public policy, the study adopts a qualitative approach. Theoretically, Mills's conceptualization of personal troubles and public issues and their interdependences offered the guiding line for this research. Accordingly we agree with Mills that when personal troubles evolve to a public issue, "we may not hope to find its solution within the range of opportunities open to any one individual. The very structure of opportunities has collapsed. Both the correct statement of the problem and the range of possible solutions require us to consider the economic and political institutions of the society, and not merely the personal situation and character of a scatter of individuals" [16]. Individual households economic circumstances are examined and inferred to their chances of access to clinical services through which their health status regarding the coronavirus could be diagnosed and information fed into the health information system, that can inform policy action. Economic constraints of household appear therefore as a constraints, and challenges, for public response to the pandemic of covid-19, to the extent that economic constraints have the capacity to prevent households' demand for health services. The lack of demand reduces the information on the population that could be available to the government for proper policy decision-making.

To understand households' economic circumstances two methods were used for the data collection. The two methods are described as follow:

2.1. Systematic documentary review

This method is used to collect data on the existing macroeconomic policy and social security regimes. Regarding macroeconomic policy, focus is put on the evolution of the role of the state in social services provision in Burkina Faso. this involved what follows: a) inventory of macroeconomic policy from 1960 to 2021; b) inventory of social security regimes from 1960-202; c) analysis of the role of the state in social services financing; d) analysis of the role of citizens in social services financing. These data, which were analyzed using a reading grid, provided some insights on how vulnerable citizens are, in relation to access to some social services such as health services. This existing context also provided some understanding of the prevailing context of the covid-19 pandemic outbreak. In terms of analysis this situation is termed as a *process of detachment of the state* and *attachment of the populations* to the macroeconomic models, with the assumption that a strong attachment or dependence of the population to the model of the Market in healthcare provision would impede access to healthcare services, and therefore withdraw that population from the healthcare information system which would have provided some basis for evidence-based decision-making regarding the covid-19 pandemic.

2.2. Questionnaire survey

The questionnaire survey involved a random sample of 503 vulnerable households of traders operating within Ouagadougou, the capital city of Burkina Faso. The survey was carried out in November 2020. The data collection concerned 10 markets in 5 districts of the city of Ouagadougou which were closed by the government on March 20, 2020 as a response to the COVID-19 pandemic. These are the Yonko Yaar and Toukin Yaar markets in district 4, Nabi Yaar and Toles Yaar in district 5, Bendogo Yaar and Quatorze Yaar in district 10, Karpala Yaar in district 11 and the Marché du 15 in district 12. A total of 503 traders were surveyed: 69 in Yonko Yaar, 65 in Toukin Yaar, 68 respectively in Nabi Yaar and Toles Yaar, 67 in Bendogo Yaar, 66 in Quatorze Yaar, 49 in Karpala Yaar and 51 at the Marché du 15. In practice, 10 surveyors organized in pairs with the most experienced surveyor as team leader proceeded to collect data on these markets. Regarding the survey selection method, the surveyors first made contact with the market managers (Raag-Naaba). The surveyors then identified the participants with the help of market managers focusing on small traders with sheds who were more likely to be more affected by market closures. Among the 503

participants, 72.6% were females and 27.2% males, with an average age of 41 years. In terms of education, 53.5% were reported to be illiterate. Each household is made up of an average number of seven persons, with 95% being the respondent's children. The principal activity of 92.4% of the surveyed households is trade; 91.7% are reported to have not another secondary activity.

The analysis consisted in evaluating the current macroeconomic and personal economic circumstances of households and the possible impact of these circumstances on their demand for health services. The results of these analyses provided the bases for discussion about the policy challenges faced by the government of Burkina Faso in responding effectively to the covid-19.

3. Results

The results show that households have been resilient to the chock caused by the pandemic. From 2014 health policy measures started to reverse the trend in government's interventions in healthcare access that mitigated the negative impacts of several decades of privatization of healthcare services. Recent policy measures facilitated healthcare access for children aged less than five years and pregnant women, thus reducing households' health expenditures. Furthermore, the households in the informal sector suffered less from the restrictions due to the covid-19, as they benefited from the increase in domestic demand for goods and services in some of the branches of the economy.

3.1. The market for healthcare in Burkina Faso: From privatization to state involvement

Until the end of the 1980s, the Burkina Faso government's economic power ratio over its citizens was higher [28]. Indeed before 1990, it was almost the only provider of health care services. Besides, although in practice individuals bought some medicines from out of pocket, in principle, the law made this function primarily that of the state [29]. This is visible from the budget lines which shows larger share for transfer and drug expenses. However, these power chances started to weaken from particularly 1987, with the advent of a new state of exception, which overthrew the revolutionary regime (1983-1987). The government's economic power sources, which were largely made up of internal assets weakened. In fact, from 21 million USD in 1970, the total external debt of the country skyrocketed to 866 million USD in 1988 [28]. The country started also to trade with international financial institutions such the IMF

whose contribution to the external debt passed from zero to three million USD for the same dates. Moreover, aid was increasing from 1986 with a higher pic in 1988, one year after the advent of the new military regime. These revenues from debt and aid enabled the government to substitute its weakening internal revenue sources, and maintain its power ratio over its citizens. The problem is that the weakened economy of the country did not allow it to reimburse its debt, as expected by lenders. From the end of the 1970s, private lenders become dominant as source of capital to institutional financial institutions because of the economic crisis facing developed countries [28]. As a result, the government's dependence on international economic and political actors increased, and correlatively the latter's power ratios over it became higher. These actors took this advantage of their power chances to obtain from Burkina Faso economic reforms that weakened the country's power ratio over its citizens. The government was pressed to adopt the market as framework of conduct for economic and social services exchange, with the effect of discharging itself from its social function in favour of the private sector. For example, even the small 7% of the state's budget share of health expenditure dramatically fell to less than 4% between 1991 and 1995 [30].

As a result of the state's adoption of the Structural Adjustment Programme, there has been an increasing defunctionalisation (displacement) of the state in matter of health care provision and financing in Burkina Faso since 1991. In fact, private provision of health care has always existed in Burkina Faso. First practiced unofficially by French expatriates, it saw a booming since the country's adoption of free market in 1991, which resulted in the setting up of institutional framework for a private provision of health care services. The general deregulation measures, which followed the economic crises of 1972-1974, but which were blocked by the revolutionary regime (1983-87) in Burkina Faso, became generalized in the 1990s. Burkina Faso made its move to the market on 13th March 1991, opening a new area in the national health care system. In effect, Medical practice has been liberalized and the different areas of professional practice were later defined in the Public Health Code by the law no.23/94/ADP of 19 May 1994. The Hospital law no.034/98/AN/ of May 1998 organized the health system by defining the different categories of health services. The Decree no.398/PRES/PM/MS of 19 July 2005, complemented respectively by the inter-ministry and ministerial by-laws no.2006/MS/MCPEA/MFB of 16 June 2006, no.200-060/MS/CAB, defined the conditions of professional licensing, and of the opening and operation of private health care centres. With respect to traditional medicine, 'After a lethargy from 1960 to 1970, the end of 1970 saw the issuing of the Order no.70-68 bis/PRES/MSP/AS of December 1970

related to the Public Health Code and the rules for its application; this act tolerate Traditional Medicine' [31]; in 1994 then the law no.23/94/ADP on Public Health Code 'recognises Traditional medicine and Traditional Pharmacopeia as one of the components of the national health system' [31]. Health statistics shows that more than 80% of the population use traditional medicine; in 2010 it was estimated that there was over 30.000 traditional healers in Burkina Faso, with more than 600 healers in Ouagadougou, the capital of the country. In addition, according to Soubeiga [32] "Apart from their traditional activities of evangelisation, one of the common characteristics of Christian churches of different denominations established in Burkina Faso is that they appear more and more as places of care of illness". The marabous have been influencial since the pre-colonial period, as explorers mentioned it. In terms of its size, informal drug selling is also another market for health care provision in both rural and urban areas. There is not yet a specific fiscal regime for the sector of private provision of health services. Private provision of health services are under commercial fiscal regime. There not yet a specific fiscal status to the sector. There are no rationalized pricing and prescription systems; there is a lack of quality standard regarding facilities, equipment and personnel [32]. Policies, legislations, and the operation of public health services contributed to the development of private health care supply, particularly in urban area.

Therefore, a functional reconfiguration took place. As the market policy recommends, for the citizens to meet their health care needs, instead of subsidizing their access, the state has embraced from then on the function of negative regulator. Patients become consumers for both public and private health services. At the same time, the state becomes dependent on international financial actors. And as Elias cogently put it, the character of power chances is that it enables its owner "on the one hand, the control he can exert over his opponent, and, on the other hand, the control it gives him over the course of the game as such" [33]. As it will be seen later, international financial institutions, particularly the World Bank, has since using their leverage to shape the market for health care service in Burkina Faso. The weakening of the state's power ratio over its citizens is revealed through the process of withholding of public support to the latter and their later configuration with other sources of support – and hence of dependences. This power started to change from 2014. New policy measures facilitated healthcare access for children aged less than five years and pregnant women, thus reducing households' health expenditures. Furthermore, the households in the informal sector suffered less from the restrictions due to the covid-19, as they benefited from the increase in domestic demand for goods and services in some of the branches of the economy.

3.2. The limits of public involvement and the crisis of alternative solidarities

Referring to power, Elias suggested that "when one person (or group of persons) lacks something which another person or group has the power to withhold, the latter has a function for the former" [34]. What can be seen from the populations' side, is a defunctionalisation (or reconfiguration) of the state towards them on matter of health care, until 2014, through the withholding of the subsidies which were provided in so for their access to some of health care services. Indeed, in order for the private supply of health care services to exist there is at least two conditions. First, the State delegates all or part of its prerogatives on health care provision to a third party. In this case, the state pays this latter for the provision of the services to the population. Second is for the State to not only delegate all or part of its prerogatives on health care provision to a third party but also it makes patients responsible for the payment of the services they receive from the private provider. In this latter case, the public health care centres can continue free provision or ask for less or comparable payment. In Burkina Faso the State chose for the second alternative, before a new opposite trend starts in 2014.

In fact, health care has never been free for all and irrespective of the kind of individual health problems in the modern history of the country. The difference is that the responsibility of the individual patient for the payment of health care services has significantly increased since the 1990s. In fact, between 1970 and 1983, there was no major change in term of scope of the category of beneficiaries of the formal social security system. Instead, the changes were organizational. For instance Law n° 13/72 AN of 28/12/1972 on the code of social security created the National Social Security Fund (Caisse Nationale de Sécurité Sociale) which gather Family benefits (*Prestations Familiales*), Work accidents and Professional illnesses (*Accidents du Travail et Maladies Professionnelles*-AT & MP) Old age insurances (Assurances Vieillesse-AV)). At the date of 2001, only 11% of the population was covered by this mechanism, meaning that like most countries in Sub-Saharan Africa around, 90% of the informal sectors workers are excluded. Public social security arrangements cover the small population of employees of the formal sector. However the weakening of the state's economic power over its citizens did not result in an increase of the power of the individual unevenly. As the above analysis shows, the majority of the population cannot effort their health care on their own. They still need a support from a third party. New interdependencies have to be formed. In this context, due to the lack of adequate health care financing mechanism in order to pay for treatment during illness, the poor resort to various forms of informal means such as loans, dissolution of savings or the selling of essential resources [35]. Then, at first the state

sought to balance this discriminatory coverage by seeking to promote primary health. However, until the early 2000s, in practice, the tendency was rather for the state to discharge itself from the social protection of the population in the context of high external pressure for economic reform [36]. In the area of health, in Burkina Faso, like in most West African country, this was done through the implementation of the primary health program in the framework of the Bamako Initiative. The Bamako Initiative is the West African initiative design in the late 1980s to implement primary health care laid down in the late 1970s by the WHO. In the name of involving communities in their own health care and discharging the state from the burden of social expenses, the Bamako Initiative introduced user fees and cost-recovery mechanism through out-of-pocket payments and user fees alongside management responsibilities for the communities at existing health facilities [30]. Social changes in rural communities and the consequences of privatization resulted in the impoverishment of large sections of the population. Besides, the withdrawal of the state from the health sector resulted in poorer qualities of health services. As a result, not only primary health care providers were not accessible for all, but also the targeted financing mechanism still excluded many poor.

The community based health insurance (or *mutuelles de santé*) emerged at the beginning of the 1990s as the result of individual responses to the problem of access and quality of health care. These community health insurances are diverse and include community health insurance companies, help societies, insurance societies, specific prepayment schemes, mutual solidarity funds, professional mutual, solidarity banks and system of risk sharing. But beyond this diversity they all set to assist and help the poor and the vulnerable including access to adequate health care services. The community based health insurance covers low-income workers with informal labour relations. Membership fee is reported to be between 1000 and 2400 fcfa (between euro 1.50 and euro 3.00), and consists in the pooling of these funds to help reimburse the health benefits collectively. The main character of this form of solidarity is that usually it is reached only in small groups or among close relatives. At the village level, collective mobilisation becomes challenging because of the increase in conflicting polarities which are generally present in large groups. The community health insurance groups have a potential reach as the informal sector workers are around 90%. However in practice the mechanism covers much more less (about 1%). The number of Mutual Health Organizations (MHO) has significantly increased during the past decade. For instance, whereas in 1997 there were 6, in 2005 their number rose to 146 MHOs and cooperatives. Since 2000, the government has tried to support local community based health insurance with the aim to

extend nationally and help set a national network of mutual. Since that period International Labour Organization has been helping government to expand the community based system to the national level. In this connection, the decree no. 2008-736 of Feb 2009 established the Committee (Comité de Pilotage) to develop National Health Insurance System like Ghana's. In 2008, a permanent NHIS was adopted by Ministerial council, and in March 2009 the NHIS was officially approved; 2009 the *Comité de pilotage* was yet to design the benefit package for a Universal Health Insurance system. The Universal Health Insurance system (Assurance Maladie Universelle –AMU) relies on the community based health insurance for higher reach; full implementation is expected to be completed by 2015, while the system is stated to be launched in 2011. This is a generalising trend in the region, which Ouédraogo captured well when she said that "A promising approach of many governments in sub-Saharan Africa is the extension of mutual health insurance schemes to the national level. Through their integration in public social security arrangements, these national schemes can exploit the potential of MHIS and reach previously excluded population segments" [37].

The AMU is designed as a compulsory health insurance for the formal sector and as a voluntary health insurance for the informal sector; The formal sector will be covered by social security financing institutions such as the *Caisse Nationale de Securité Sociale* (CNSS), *Caisse Autonome de Retraite des Fonctionnaire* (CARFO), while the informal sector will be covered by the *mutuelles de santé*. It is believed that "The integration of mutual health insurance schemes (MHIS) into public social security arrangements is a new and innovative approach taken by many governments in Sub-Saharan Africa to include people of low-income within public social protection measures" [37]. The programme will use a single benefit package but different pricing measures (urban/rural, poor/rich). The system plan to use generic provided by state central drug agency (*Central d'Achat de Médicaments Génériques*). There are also private commercial insurances (main insurances including, SONAR, FONCIAS, UAB, GA, Colina Assurance…), but they covered a minority of privileged, being less than 1% of the population. The question of significant importance for the present purpose is that of how one can make sense of this dynamic of integration, which shows an apparent willingness from the part of the state to democratize social security protection so as to cover all the sections of the society. On further examination of the dynamic of the institutional design, there appears a striking matching of the level and pattern of integration of social security regime and the decrease in the pattern of interdependences between the governors and the governed. Since the end of the 1980s, there has been an increasing trend in the

individualization of health care expenses in Burkina Faso. Although in theory fees in public health centres are less than in private ones, the unavailability and the substandard nature of services, the long time required to receive services will play in favour of important development of private health care supply. The reconfiguration of the patient's function as user to consumer is complete as the above analysis shows. Citizens pay for their own health care through different models, with out of pocket still being the largest model of financing health care in Burkina Faso. New financial institutions have emerged to offer financial services to the populations in order to pay for their health care, at the same time the function of the state in that matter decreased.

3.3. **Fragile personal opportunities amid state crisis and disappearing community solidarities**

Like many citizens, the population concerned by the study interred the covid-19 pandemic period with almost no direct social support. The withdrawal of the state from social sectors, and particularly the health sector, continued to present. However, new policy measures facilitated healthcare access for children aged less than five years and pregnant women, thus reducing households' health expenditures. At the same time the private sector of health care has been expanding. Until the mid-1980s there was almost no private medical centre in Burkina Faso. There were only nineteen pharmacists and a few private nursing clinics. The number of private health centres increased from 58 in 1990 to 250 in 2000, and 380 in 2009; of the 380 centres in 2009, 54.6% are in Ouagadougou, 22.4% in Bobo-Dioulasso, the second biggest city of the country [33]. Since 2009, this number plateaued because between 2009 and 2014, there was a simple variation in the order of around 30, whereas this variation was 192 between 1990 and 2000, and 130 between 2000 and 2009. From 2009, the number of private health centres plateaued but still remain important, as in 2014 there were 407 private health centres. This figure was 544 in 2018 according to the latest health census. This is a perfect indicator of the relative disappearance of the state as a social support agent to its citizens. This privatization of individual troubles is reinforced by the lack of universal health insurance system, and the inability of many citizens to subscribe to the developing community and formal private insurance systems. Though flexible, the fact that community insurance systems require regular income source prevent many citizens in the informal sector, such as those concerned by the study, to subscribe. However the data did not support a significant loss of income during the covid-19 pandemic restrictions.

Of the 503 participants in the study, there were 72.6% females and 27.2% males, with an average age of 41 years. In terms of education, 53.5% were reported to be illiterate. Each household is made up of an average number of seven persons, with 95% being the respondent's children. The principal activity of 92.4% of the surveyed households is trade; 91.7% are reported to have not another secondary activity. When one consider the type of trade in which the participants are involved, one can see the precarious nature of these activities in the face of the multiple demands households are confronted to. To the question of the area in which they practice their trade, 22.1% said to be in the trade of seasoning 22.5% in clothing and 15.9% in fruit and vegetables; all together more about 70% have precarious activities. The evidence about such precariousness is that around 90% of the households do not have precautionary savings, 83% reported to receive no state direct support, and more that 90% do not receive support from a parent, while almost none of the participants receive a friend's support. The evidence shows that participants are left to their own. Nonetheless, 91.3% against 8.3% household reported to have access to health services, with an average household size of seven people.

3.4. Discussion and conclusion

Public policy is a function of intelligence [14], whether one adopt a positivist or a constructionist approach [15]. In the area of health, the availability of intelligence for public policy purpose is in turn a function of demand for health services whether for preventive or curative purposes as supported by recent empirical studies. Then, demand for these health services is a function of the economic circumstances of households [21] [18] [24] [22] [19] [20] [23]. The study predicted that intelligence constraints for government regarding policy making on the covid-19 based on the assumption that the economic circumstances of the surveyed households are likely to drive them away from the health apparatus through which knowledge about the prevalence of the pandemic among the population is gained. This withdrawal of household from the mechanisms of knowledge of the state would be supported by macroeconomic context of the country and the household individual economic circumstances. The evidence failed to support these assumptions. Small traders in Ouagadougou have been resilient to the covid-19 pandemic's shocks. It is still obvious that the state involvement remains weak. Like the general population of the country, the households have been freed by the public health system until very recently, through the structural adjustment measures that led to the privatization of health care provision in most of African countries [36]. As the state relinquishes from the social and particularly the health

sector, private agencies open for profit health care centres as to be become particularly in cities the dominant providers of health care services. At the same time, household have been proposed alternative community health insurance coverage which the precarious nature of households' income sources does not allow to subscribe amid disappearance of traditional solidarities. In sum, until very recently, one could support the statement that "the very structure of opportunities has collapsed"[16]. The state interventions in the healthcare sector witnessed some improvement from 2014. These findings challenge the handy shortcut that some authors have found in the concept of public issue to anticipate societal supportive outcome in relation to a give problem in society [13]. The optimism that the public character of a problem conveys overshadows, as has been shown, the complexity and uncertainty of the public policy process. Following Mills, the distinction between personal troubles and public issues raises fundamental methodological questions regarding the appropriate level for their statement and resolutions. In absence of mass systematic testing, the covic-19 pandemic is likely to continue challenging government measures as these latter lack a large part of the evidence-base for their formulation and implementation. The result of this process is the widening of health disparities among the population. In a country where most of the population are poor and lacks universal health insurance public response that is appropriate to pandemics is likely to succeed when control measures are not limited to those who attend health facilities. Social and economic processes mediate the population's attendance to health facilities in a way that a large part of it, mainly the elderly, is excluded from the health surveillance mechanisms. This excluded section of the population can sustain the pandemic for long time.

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