Workshop Democracy: Making Policy in Cote d'Ivoire

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ABSTRACT

Development experts would benefit from a better understanding of how policy is made in developing countries. In this article, I describe how health policy is made in Cote d’Ivoire, from the perspective of a Westerner embedded in the Ministry of Health for 10 months. I provide a narrative of how one health system reform—performance-based financing—moved from policy idea to enacted reform. I describe the origins of the reform in Cote d’Ivoire, how the government came to support the reform, and then the mechanics of
how the reform was enacted. I then present observations on how policymaking in Cote d’Ivoire differs from a Western democracy, including a discussion of the part played by local actors and Western organizations such as the World Bank. I conclude with recommendations for both Ivorian and Western technocrats on what practical steps they could take to achieve better reform outcomes.

I. INTRODUCTION

How is policy made in developing countries? Technocrats and academics alike would benefit from a better understanding of how the sausage is made in remote West African countries. The World Bank, USAID and the World Health Organization work with West African governments to produce better laws and regulations, but despite these long-running partnerships, people in Washington and Geneva do not always understand how bureaucrats in Lagos and Abidjan make important decisions about reforming their country’s laws and institutions. In this article, I describe policymaking in Cote d’Ivoire’s Ministry of Health from my vantage point as a special assistant to a high-ranking Ministry of Health official. I then present recommendations for both Ivorian and Western technocrats on how policymaking could be improved to achieve better reform outcomes.

A. Methods

From September 2013 to July 2014, as a Fulbright fellow, I worked as a special assistant in Cote d’Ivoire’s Ministry of Health, in the Department of Forecasting, Planning and Strategy (henceforth “Department of Strategy”). The Department of Strategy is one of the principal policymakers within the Ivorian Ministry of Health. During the ten months that I spent in Cote d’Ivoire, the Department of Strategy led a team of Ivorian and Western technocrats in their effort to enact a reform of the country’s health financing system.

This article is a qualitative study of the policymaking process in Cote d’Ivoire. In conducting this study, I relied on a mixture of academic research and participant observation. Participant observation is a research technique common to anthropology, and it has been expanded in recent years to explore behavior in other social sciences, including areas of political science such as

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1 Under the Fulbright-Clinton Fellowship program, U.S. citizens serve in professional placements in a foreign government ministry. As explained on the Fulbright website, “Fulbright-Clinton Fellows function in a ‘special assistant’ role for a senior level official.” I was placed in Cote d’Ivoire’s Ministère de la Santé et de la Lutte contre le Sida (MSLS) as a special assistant to the director of the Direction de la Prospective, de la Planification et des Strategies (DPPS).
lawmaking. Because of its deeper level of engagement, participant observation can be used to build a narrative full of rich material and insights. Many researchers are skeptical of narratives, and rightly so, as narratives are often used to simplify and politicize policymaking and to drive a specific political agenda. But narratives can also be complex and balanced; they can provide important context and understanding to the “hard data” of quantitative analysis. In the below article, I attempt to provide this sort of nuanced analysis.

But first, a brief overview of my experience in Cote d’Ivoire: during the ten months I spent in Cote d’Ivoire’s Ministry of Health (Ministry of Health), I was both an actor and an observer. From September 2013 to July 2014, I served as a special assistant to the director of the Department of Strategy, funded by a Fulbright public policy grant. I worked as a technocrat under the exclusive authority of the Ivorian Ministry of Health’s Department of Strategy and was thus an actor in the reforms described below. But despite the Ivorian government’s generosity in hosting me, I was clearly an outsider, there to observe and learn from what I was seeing. I compiled many pages of notes and read from a wide array of sources about policymaking and development, both generally and in West Africa. My observations come from a combination of these research methods.

The concern with participant observation is the “possibility of bias in objectivity” inherent in a study in which the observer is also an actor. I attempt to provide transparency by dividing this article into two distinct parts. Part I is descriptive, not normative: it narrates the policymaking process in Cote d’Ivoire without passing value judgments on this process. Part II is more openly subjective: it presents conclusions and analysis, with a focus on learning and opportunities for improvement.

B. Context

1. Political Context

For almost four decades, from its independence in 1960 until the turn of the millennium, Cote d’Ivoire was one of West Africa’s success stories. It enjoyed peace, stability and growth under President Felix Houphouet-Boigny, the father of the country’s independence, until his death in 1993. But stagnant growth in the 1980s and 90s created the conditions for political and social turmoil. In 1999, disaffected military officers staged a coup. Over the

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4 See Morris S. Schwartz & Charlotte Green Schwartz, Problems in Participant Observation, 60 AM. J. OF SOC. (1955); see also Agyepong, supra note 3.
12 years from 1999 to 2011, Cote d’Ivoire experienced a series of political and military crises. These crises eroded political stability, and the country’s once advanced institutions and infrastructure decayed.

In May 2011, Alassane Outtara emerged as the country’s president, and a relatively peaceful and stable climate was once again established. In the three years since, economic growth has boomed and the country’s infrastructure is undergoing extensive reconstruction. After a decade of stagnation, GDP grew by 9.8% in 2012, 8.7 in 2013 and was expected to grow by a further 8.5% in 2014. The government has pledged to devote 25% of the budget to infrastructure in the period 2012-15.

2. Regional Context

Despite its recent problems, Cote d’Ivoire remains one of the most influential countries in West Africa. It is the third most populous country in the region and the largest among Francophone countries. Cote d’Ivoire’s 2012 GDP of $24.68 billion makes it the third largest economy in the region, and it is the largest member of the West African Economic and Monetary Union, an eight-country monetary and customs union made up of Francophone West African countries.

3. Historical Context of Cote d’Ivoire’s Health System

After gaining its independence in 1960, Cote d’Ivoire adopted a system of free universal health care. Ambitious in concept, this policy was unworkable in practice in a country that was poor, lacking in administrative capacity, and highly dependent on foreign aid. Despite this progressive policy ideal, most of the population lacked access to formal health care services.

In the 1980s and 90s, Cote d’Ivoire embarked on a series of health reforms, none of which were ever fully implemented. In 1993, the government enacted a law allowing hospitals and clinics to charge user fees in an attempt to improve the fiscal balance. Soon after, the government

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6 Id.
7 International Monetary Fund, World Economic Outlook: Legacies, Clouds, Uncertainties 45 (Oct. 2014).
11 Id. at 15-16.
12 Décret 93-216 of Feb. 3, 1993 Portant Institution d’une Redevance Perçue auprès des Usagers des Etablissements Publics (Cote d’Ivoire); see also Data for Decision Making Project, Department of Population and Public Health, Harvard School of Public Health, Cote d’Ivoire
adopted the Primary Health Care (PHC) approach, under which many elements of the World Health Organization’s Bamako Initiative were adopted, including increased community participation and a reform of the pharmaceutical distribution system.13 The Ministry of Health also began to decentralize its administrative system, starting with the introduction of health districts in 1994. By 2001, the government had adopted a law intended to bring about significant institutional reforms: this new round of reforms transferred further powers to local authorities and established a system of universal health insurance.14 By adopting a universal health insurance law, the government was responding to a recent trend in global health circles: the World Bank and WHO believed that universal health insurance could increase access to care in poor countries and they encouraged similar reforms in many African countries.15 Unfortunately, this reform was never meaningfully implemented and there was little change in health outcomes.16

When the Ouattara government took office in Cote d’Ivoire in April 2011, the health system was in a state of disarray. Attempting to make good on a campaign promise, the Ouattara government’s first act in the health sphere was to adopt a system of free universal health care.17 Once again, government technocrats struggled to meaningfully implement this system due to the many fiscal constraints listed above. Almost immediately, it became clear that free universal health care was not a feasible policy. By December 2011, the government had already accumulated 20 billion CFA ($40 million) of unpaid debt to its hospitals and health facilities, and the President accepted that the system would have to be reformed.18 In January 2012, the government adopted a revised health policy known as “targeted non-payment.”19 Under the “targeted non-payment,” free health care would no longer be universal, but would instead be targeted at a few specific vulnerable populations. Free health care would be provided to pregnant

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13 MSLS, supra note 10, 16.
14 Loi 2001-636 of Oct. 9, 2001 (Cote d’Ivoire); see also Mohamed D. Kouyaté, Pour une Assurance Maladie Universelle en Côte d’Ivoire (2012).
19 Circulaire 0731, Ministère de la Santé et de la Lutte contre le SIDA/CAB of 27 Feb. 2012 (Cote d’Ivoire); Arrêté Interministériel 0047, Ministère de la Santé et de la Lutte contre le Sida/MEF/CAB of Mar. 21, 2012 (Cote d’Ivoire); Arrêté Interministériel 0048, Ministère de la Santé et de la Lutte contre le Sida/MEF/CAB of Mar 21., 2012 (Cote d’Ivoire). The “targeted non-payment” reform is referred to in Cote d’Ivoire as La gratuité ciblée.
women, children under five, confirmed malaria cases, and the first 48 hours of emergency medical treatment.20

But the targeted non-payment system suffered from many of the same flaws as universal non-payment. For one, the targeted population was simply too large. A 2013 study of the targeted non-payment reform found that the targeted population (malaria treatments, child deliveries, early life treatments and emergency treatment) made up 80% of patients in the observed region.21 Health facilities remained underfunded. Because of these financing problems, hospitals and clinics frequently lacked important medications and supplies.22 The targeted non-payment reform also created poor incentives for physicians and health workers: because physicians were not paid for services, there was no financial incentive to see patients. In some cases, physicians at public hospitals would tell patients that they could not be treated at the public hospital, but that they could treat them at a private hospital (in the informal market) later that afternoon.

It was in this context that several individuals within the Ministry of Health began a push to reform the country’s health financing system.

II: THE POLICYMAKING PROCESS IN COTE D’IVOIRE

A. Agenda Setting and Problem Identification

1. Origins of Cote d’Ivoire’s Interest in Performance-Based Financing (PBF)

Even before it was enacted, many within the Ministry of Health knew that the targeted non-payment policy was not feasible in Cote d’Ivoire. The Ministry of Health could not afford to fund all of the health care treatments that would be needed. In the month before the targeted non-payment policy was enacted, the Department of Strategy wrote an official Technical Note to the Minister of Health and the President explaining this problem and asking them to reconsider the policy or reduce the size of the targeted population.23 But despite these concerns, President Ouattara enacted the targeted non-payment policy in January 2012.

As the country’s health financing problems deepened, a handful of Ministry of Health officials began to push for a policy reform known as performance-based financing or PBF. Performance-based financing is a system in which “health providers are, at least partially, funded on the basis of their performance.”24 In other words, PBF attempts to introduce market

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20 Arrêté Interministériel Ministère de la Santé et de la Lutte contre le Sida/MEF/CAB 0047 du 21 Mars 2012 (Cote d’Ivoire).
21 Kouakou-Kouadio, supra note 18, 37.
22 Id. at 32-33.
23 See Id. at 32.
24 Bruno Meessen, Agnès Soucat & Claude Sekabaraga, Performance-Based Financing: Just a Donor Fad or a Catalyst towards Comprehensive Health-Care Reform?, BULLETIN OF THE
forces into the health care system by paying bonuses to doctors and nurses for providing certain treatments. Though these payments, PBF tries to correct market failures by incentivizing only those treatments that are underprovided, such as child vaccinations.\textsuperscript{25} For example, if the government wants to increase the number of hospital births or child vaccinations through PBF, it would pay bonuses to hospitals and clinics for each hospital birth or child vaccination that they perform. Bonuses are also paid to hospitals and clinics that achieve better evaluations on quality indicators ranging from whether the clinic maintains an adequate business plan to whether staff sterilize instruments and provide sufficient water and soap in the labor and delivery room. Finally, prices are liberalized, allowing hospital and clinics to determine their own prices for treatments and medications.

Governments across Africa have begun adopting the PBF reform in recent years. First came Rwanda, Africa’s star development case of the past decade. In Rwanda, the government partnered with civil society to introduce PBF in pilot districts in 2001, and a 2005 study found that the PBF pilot districts had achieved superior outcomes.\textsuperscript{26} Following this initial success, the reform was scaled up to the national level in Rwanda in 2005.\textsuperscript{27} Rwanda’s success has inspired a host of other countries to embrace this policy reform. Burundi and Sierra Leone have adopted PBF on a national level, pilot programs have been introduced in 14 other countries.\textsuperscript{28}

In Cote d’Ivoire, the Ministry of Health’s interest in PBF dates to 2010. At that time, the United Nations Population Fund (UNFPA) funded a PBF training mission to Rwanda for a handful of Ministry of Health officials, notably the director of the Department of Information, Planning and Evaluation (DIPE). Soon after this training, the director of the DIPE introduced the PBF concept to several members of the Department of Strategy. The deputy director of the Department of Strategy—formerly a physician at a large public hospital in Abidjan—took a particular interest in PBF, having experienced firsthand the difficulties in motivating workers and incentivizing high quality treatment.\textsuperscript{29} But despite this early surge of interest, there was little meaningful movement towards the PBF policy over the next

\begin{footnotesize}
\begin{itemize}
\item \textsuperscript{25} G. Fritsche and P. Vergeer, \textit{Performance-Based Financing Drill Down}, \textsc{World Bank}, available at \url{http://performancebasedfinancing.files.wordpress.com/2011/03/110210_pbf_drlldwn.pdf}.
\item \textsuperscript{26} Louis Rusa and Gyuri Fritsche, \textit{Rwanda: Performance-Based Financing in Health}, \textsc{Sourcebook on Emerging Good Practice in Managing for Development Results} 107-08 (2008) (citing Robert Soeters, Laurent Musango and Bruno Meesen, \textit{Comparison of Two Output Based Schemes in Butare and Cyangugu Provinces with Two Control Provinces in Rwanda}, \textsc{Global Partnership on Output- Based Aid (GPOBA)} (September 2005).
\item \textsuperscript{27} Id.
\item \textsuperscript{28} Results-Based Financing for Health, \textsc{Africa Health Forum 2013}, available at \url{http://siteresources.worldbank.org/INTAFRICA/Resources/AHF-results-based-financing.pdf}.
\item \textsuperscript{29} Interview with Dr. Samuel Ohouo, Health Economist, PEPFAR/USAID, in Abidjan, Cote d’Ivoire (Mar. 28, 2014).
\end{itemize}
\end{footnotesize}
two years. Ongoing civil conflict and political instability contributed to the delay. In spring 2012, the deputy director of the Department of Strategy attended a PBF training in Dakar, funded by UNFPA. He left the PBF training in Dakar convinced that PBF could improve Côte d’Ivoire’s health system.\(^{30}\)

2. Performance-Based Financing (PBF) Gains Momentum

Convincing senior officials was the crucial next step in the process. The deputy director of the Department of Strategy advocated the PBF policy to his director. The director encouraged him to pursue the PBF reform, and suggested that the Department of Strategy draft a National Strategy paper, along with a Technical Note to present to the Minister of Health. In December 2012, the deputy director gathered three other health officials—one from the Ministry of Health, one from the World Health Organization and one from the development contractor Abt Associates—for a small workgroup during which they drafted a preliminary National Strategy paper and a Technical Note.

In January 2013, the director of the Department of Strategy met with the Minister of Health and presented these documents to her. The Minister of Health was receptive to the idea of the PBF reform, but she expressed concerns over how the Ministry of Health would manage the political fallout of the reform.\(^{31}\) Free health care had been one of the President’s campaign promises, and she worried that he would be reluctant to go back to a fee-for-service (market-based) system in the run-up to the 2015 re-election campaign.\(^{32}\) Despite her reservations, the meeting ended on an encouraging note, with the Minister agreeing that the Department of Strategy should prepare a roadmap for the drafting and then enactment of the PBF reform.

It was at this point that the PBF reform hit a major roadblock. Having received UNFPA funding for its staff to attend a PBF training in Benin that April, the Department of Strategy was planning to hold a workshop in July 2013 at which stakeholders would write the first draft of the PBF National Strategy paper. These workshops are funded by international organizations, and, in this case, the World Bank was funding the workshop for drafting the National Strategy document. In early June, the World Bank informed the Department of Strategy that it had extra funding that would expire in July, and it asked if the Drafting Workshop could be pushed forward to late June so it could be funded with this money.\(^{33}\) Attempting to accommodate this request, the Department of Strategy made the preparations for a late June workshop, including formal invitations and initial approval from the Ministry of Health’s Executive Office. However, when the Minister was told about the June workshop, she expressed reservations, asking why it was taking place

\(^{30}\) Id.
\(^{31}\) Id.
\(^{32}\) Id.
\(^{33}\) Id.
on such a rushed timeframe. Worried that the Minister was no longer supportive of the PBF reform, the Executive Office’s deputy director cancelled the workshop and blocked further efforts to reschedule it. Attempts to negotiate this impasse were further complicated by a long-running dispute between the Executive Office’s deputy director and the director of the Department of Strategy. As a result, the PBF reform lost its inertia, with no real activity or progress occurring from June 2013 to November 2013.

The reform was jump-started in November. At a meeting between the World Bank and the Ministry of Health, a senior official World Bank official convinced the Minister to move forward with the PBF reform. For the Ministry of Health, the motivation was at least partly financial: the World Bank had offered $12 million in funding to finance a three-year PBF pilot project. Encouraged by this funding promise, the Minister of Health authorized the Department of Strategy to push the PBF reform forward at once.

B. Formulating the Policy Proposal

1. The Drafting Workshop

Upon receiving the news that the PBF reform would move forward, officials from the Department of Strategy sprang into action. The director of the Department of Strategy organized a series of meetings with international donors to inform them that the PBF reform now had the backing of the Minister. World Bank officials were enthusiastic and they promised funding for the policy workshops at which the reform would be adopted, as well as an outside consultant to help with the formulation of the policy.

In the Ministry of Health, reforms are enacted through a series of official workshops, funded by the international donors. Using World Bank funding, the Department of Strategy organized a workshop for the first week of December in Yamoussoukro. Over 60 participants attended the workshop, including representatives from the Ministry of Health, health facilities, and international donors. The first two days of the workshop were spent educating the participants on the background of the Ivorian health financing system and the basics of PBF. The final three days were spent largely in smaller workgroups, where teams were tasked with drafting the basic structure of the PBF reform. The groups worked to identify financial mechanisms for the PBF reform, sketch an institutional structure for the reform, and organize a timeline for the next steps of the reform. At week’s end, the participants had produced rough sketches of the basic structure of

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34 Id.
the reform, but these documents would still need to be organized and reconciled into a coherent National Strategy document.

2. The Finalization Workshop

The next big step in the PBF reform was to bring in an outside consultant for the Finalization Workshop. As promised, the World Bank hired the consultant, a Dutch doctor and well-renowned expert, who had consulted on PBF reforms in over a dozen African and Asian countries. The international expert arrived in January 2014 for a two-week visit, during which he would conduct a study and lead the PBF Finalization Workshop. During the first week of his trip, he visited a number of health facilities to collect material for his report on Cote d’Ivoire’s health financing system. At all levels of the health system, doctors and health staff expressed dissatisfaction with the current financing model. Because of the targeted non-payment system, hospitals and clinics were not receiving adequate funding for medications, equipment, or salary payments, yet they were not allowed to charge patients for most procedures, so they had no way to generate revenue to buy necessary medications or equipment. In one district hospital, multiple women had died over the previous year because the hospital did not have the medical kit necessary to perform a simple cesarean operation.37

The international expert was an energetic advocate of the PBF reform. In the week before the Finalization Workshop, he met with a number of health officials from government and international organizations in an effort to drum up support for the PBF reform. He outlined the flaws with the targeted non-payment system, explaining that it was a flawed system that provided no incentive for health staff to improve care. He explained how, by introducing a market incentive, the PBF reform would induce health workers to improve both the quality and quantity of care and lead to sweeping improvements of the health care system. Officials were receptive to these arguments and most expressed strong support for the PBF reform.

During the second week of his visit, the international expert led a workshop at which the group attempted to finalize the National Strategy. This workshop convened 20 participants, mostly from the Ministry of Health and international organizations.38 However, there was only one practicing physician at the workshop, and no other health staff, nor representatives from local NGOs.

The workshop produced lively debates about the principles of PBF and how feasible certain best practices would be in Cote d’Ivoire. Participants voted on priorities of the PBF reform, on which districts would be most

suitable for the pilot program and on which of the PBF “best practices” to adopt. The international expert encouraged debate during the workshop, but he argued forcefully for his list of PBF “best practices” and ultimately his position was adopted on every issue on which participants voted. Despite some officials’ frustration with the expert’s assertive style, the workshop ended with participants in broad agreement about the future of the PBF reform. Due to time constraints, the National Strategy could not be finalized at the workshop, but the international expert produced a report that contained all of the main points of agreement from the workshop. The Department of Strategy would integrate the material from this report into the final PBF National Strategy in the following weeks, with this document to be approved by stakeholders at a Ratification Workshop in early March and then by the Ministry of Health in the last week of March.

3. Revising the National Strategy

The ratification of the PBF National Strategy did not proceed as smoothly as planned. In the week after the Finalization Workshop, the PBF reform’s strongest champion, the Department of Strategy’s deputy director, was hired away by PEPFAR (the U.S. President’s Emergency Plan for AIDS Relief). His departure, in early March, took the rest of the Department of Strategy by surprise, and they were disappointed to discover that he had not made any revisions to the National Strategy in the five weeks since the Finalization Workshop. In his place, two inexperienced junior staff at the Department of Strategy were tasked with revising the National Strategy to integrate the material from the Finalization Workshop. Department of Strategy staff drafted a rough version of the National Strategy, drawing heavily from the international expert’s report. They then organized a handful of unofficial workshops at the Department of Strategy conference room at which participants from Abt Associates, UNICEF, and the Department of Strategy made final edits to the PBF National Strategy. At these workgroups, participants removed some of the more controversial, pro-market language from the international expert’s report. Officials still broadly supported the PBF reform, but some worried about the international expert’s “hyper neo-liberal” worldview, and they wanted to soften his language in order to make the National Strategy into a more politically acceptable document. The final draft of the document was written in a more diplomatic style, though it lacked many of the specific policy details from the expert’s original report. It was thought that the revised document would be more politically palatable and that specific policy details—such as the contractual relationship between hospitals and regulators—were better suited for the Procedural Manual that would be produced after the National Strategy had been ratified.

C. Legitimizing and Implementing the Policy

39 Rapport de Mission, supra note 37.
Now that a final version of the PBF National Strategy had been completed, the Department of Strategy hoped to see the reform approved by late spring 2014. The sooner the reform could be approved, the sooner the Ministry of Health and pilot districts could begin planning for the implementation of the pilot project, which was scheduled for January 2015. Instead, the process dragged on into October, leaving the Ministry of Health with little time to prepare for the reform’s implementation.

In order for the PBF reform to proceed, the National Strategy would have to be approved via a Ratification Workshop at which officials ironed out the final details of the policy and voted to ratify the document. In mid-April 2014, Department of Strategy officials believed that they were on the verge of ratifying the National Strategy. They sent a final draft to the Ministry of Health’s Executive Office for approval and began making preparations to hold the Ratification Workshop during the final week of April. The Department of Strategy expected the document to be quickly approved by the Executive Office, but the Minister seemed to be harboring second thoughts over the PBF reform, and several weeks passed without any further action. Once again, the process was hurt by the strained relationship between the director of the Department of Strategy and the deputy director of the Executive Office.

This delay caused concerns about the implementation timeframe. If enacted, the PBF pilot reform was scheduled to begin in January 2015. But as May ended, and the National Strategy document still had not been enacted, the Department of Strategy decided that it was necessary to begin planning the implementation of the PBF reform even though the National Strategy had not yet been approved. In June, the Department of Strategy received word that the Ministry of Health’s Executive Office had approved the request to hold a Ratification Workshop for the National Strategy. Despite this positive development, the Ratification Workshop did not take place for several months due to squabbles over funding and executive approval. The Ratification Workshop finally took place in the first week of October. It was funded by UNICEF and attended by over 60 individuals, representing the Ivorian government, the health sector, and international organizations. At the workshop, the Minister of Health gave the opening remarks and participants voted to ratify the PBF National Strategy. Participants were then organized into workgroup sessions at which they began drafting details of the implementation process.

At the time of this writing, several steps remained before the reform will be fully enacted and implemented. On the enactment side, the Minister of Health will now need to send the National Strategy to the President for his approval, and then the President will need to issue an Executive Decree, at which point the PBF reform would be legally enacted in the PBF pilot

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40 Termes de Référence, Atelier National de Validation de la Stratégie Nationale de Financement Basé sur la Performance (FBP) en Côte d’Ivoire (Sept. 2014) (on file with author).
districts. Because this reform is merely a pilot project, there is no need for the legislature to vote on it.

On the implementation side, the Ministry of Health will now draft a PBF Procedural Manual. Before it can go into effect, this document will need to run the same gauntlet of workshops as the PBF National Strategy. The Ministry of Health will also enact a number of regulatory and administrative changes necessary for the implementation of this reform. Finally, the Department of Strategy will conduct a baseline study of the pilot districts so that, after its implementation, the effects of the PBF reform can be properly evaluated. Because of the short timeline between the October ratification of the PBF National Strategy and the January 2015 start of the pilot project, there remain serious questions over whether these activities can be completed by the project’s start date.

III: DISCUSSION AND CONCLUSIONS

A. Observations of Health Policymaking in Cote d’Ivoire

“The presence of feedback mechanisms is very infrequent in policy making of developing countries…. Compared to developed countries, policies of developing countries are less responsive to the demands of the environment. Support from society as an input for decision making is also less significant in the developing country context.”

1. Centralized Decision-Making and the Lack of Local Input

Domestic constituencies—unions, politicians, local interest groups—were not involved in the PBF reform. Throughout the reform, decision-making was largely concentrated within a few individuals at the Ministry of Health with domestic interest groups largely excluded from the workshops and discussions. There are a handful of citizen-led interest groups in the health sector, but they exerted little influence on the state machinery. For example, there is a health worker union in Cote d’Ivoire, and it did at times engage with the Ministry of Health, but its influence was minimal. Ministry of Health policymakers seldom reached out to such groups, and their input was rarely solicited during the policymaking process. For the National Strategy Drafting Workshop in Yamoussoukro, a handful of doctors were invited, along with one member of the health sector employee union. But for the more critical Finalization Workshop only one practicing physician was present and he was not invited to the subsequent informal editing workshops at which the National Strategy was mainly drafted. Only after the National Strategy had been finalized did the Department of Strategy schedule a

42 Termes de Référence, supra note 36.
meeting with the health worker union to discuss the PBF reform, and this meeting was ultimately canceled because the director of the Department of Strategy had a conflicting appointment.

The PBF reform was not a grassroots effort, but rather stemmed from the “autonomous preferences” of government elites and international donors. Ministry of Health officials were “the most important actors in placing issues on an agenda for government action.” The reform was set in motion by a handful of Ministry of Health and foreign officials who decided to prioritize the issue. At no point during the policymaking process did health sector workers play a significant role in drafting or revising the National Strategy and few had even heard of the PBF reform. In fact, when a Ministry of Health team conducted a brief study in January 2014 at several health facilities near the capital, none of the personnel had ever heard of performance-based financing. For a reform that was intended to transform the medical profession in Cote d’Ivoire, the effective absence of physicians in the policymaking process showed a serious lack of citizen participation.

None of this is to say that citizens’ preferences were disregarded entirely. Populist political concerns loomed over the entire process, with officials continually worried that the President would not approve the reform because it conflicted with his campaign promise of free health care. Ministry officials worried that the President would not want to go back on a campaign promise in the year before the presidential election. But despite this concern with wider public opinion, the Ministry of Health never viewed organized domestic interest groups as important actors to be engaged in the policymaking process.

2. The Role of International Organizations

In contrast to citizen-led interest groups, who did not play a role in the PBF reform, international organizations were pivotal players. Large international organizations such as the World Bank and UNFPA greatly influenced the PBF reform; in many ways, these organizations supplanted the role played by unions, lobbyists and corporations in a developed country. They engaged in frequent dialogue with the government and, as funders for many programs, their opinions influenced the choices made by government policymakers.

Ivorian officials were the primary actors in the PBF reform, and many were quite enthusiastic about the PBF reform, but the World Bank, UNICEF and UNFPA were major players who shaped every stage of the policymaking process. During the agenda setting stage, UNFPA officials funded PBF trainings for Ministry of Health officials. Later, the World Bank used the

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43 Osman, supra note 41, 46.
44 Id.
45 Interview with Dr. Renée Bissouma, WHO, in Abidjan, Cote d’Ivoire (June 25, 2014).
46 Ohouo, supra note 29.
promise of funding to convince the Minister of Health to support the PBF reform. The World Bank then financed the National Strategy Drafting Workshop and provided a handpicked consultant and the funding for the Finalization Workshop.

Policy formulation was rarely seen as anything more than a formality. There was no real debate as to what type of financing system the Ministry of Health should adopt. The World Bank and UNFPA had decided to finance a PBF reform, not a reform of the health care financing and payment system in whatever form Ivorian policymakers constructed. The PBF reform would receive funding; alternatives were not considered since there was no international funding on offer for non-PBF health financing reforms.

The workshops at which the proposed policies were drafted and adopted were more like educational seminars than policymaking workshops. At the National Strategy Drafting Workshop, participants spent the first half of the workshop receiving lectures on PBF theory and best practices. Likewise, in the Finalization Workshop, the international expert spent large portions of the workshop lecturing to participants on the theory and best practices of PBF.

B. What Can Cote d’Ivoire Do to Improve this Process?

1. Increase Political Participation

Policymakers in the Ministry of Health should include more people—particularly Ivorians—in the policymaking process. As discussed above, Cote d’Ivoire does not have a well-established tradition of citizen-led advocacy. From the technocrat’s perspective, it is easy to see why more effort is not made to engage citizens: policymaking is a complex and tedious process, and few technocrats wish to add more steps or voices to the process. Nor is citizen advocacy something that can be easily generated by technocrats. For advocacy to be effective it should be organic, not a mandate imposed by government.

Nevertheless, there are a couple of practical actions that government officials could take to increase the level of local involvement in policymaking. One would simply be to share policymaking documents more widely. For example, upon finishing the final draft of the National Strategy, the Department of Strategy sent the document to ten individuals at the Ministry of Health and a couple of international organizations, but no one else. Circulating drafts of policy documents was not considered an important part of the policymaking process largely because, as one Ministry of Health director often said, “nobody ever reads them and nobody ever responds.” This

was not entirely true, as the Department of Strategy did occasionally receive comments from conscientious officials. Either way, it would not be a significant burden for Ministry of Health officials to attempt to circulate these documents more widely, particularly to impacted groups, such as doctors and nurses, or interested academics. By circulating policy documents more widely, the Ministry of Health would increase participation in the policymaking process, and such participation might stimulate the development of local think tanks and advocacy groups.

Encouraging the development of think tanks could also help to improve citizen participation. Think tanks can be a terrific avenue for “government consultation with citizens on policy issues”; indeed, a recent study on health reform in neighboring Ghana found that Ghanaian think tanks are “the main domestic policy entrepreneurs that facilitate setting the policy agenda.” There are currently only a handful of existing think tanks in Cote d’Ivoire and none that specialize in health care issues. Greater funding would help these institutions grow, but so would greater engagement from government. By inviting think tank staff to workshops and to contribute comments on policymaking documents, the Ministry of Health could spur the development of these institutions, increase public participation and develop consensus among key participants.

These are not unrealistic goals, even in West Africa. Having experienced policymaking in the Ivorian Ministry of Health, it was remarkable to read a study of Ghana’s National Health Insurance Act and to see what a large role local civil society played in the process. Ghana and Cote d’Ivoire have much in common as next-door neighbors and countries that have generally shared similar levels of development. Indeed, a description of Ghana’s policymaking in the early 1990s suggests that it shared many of Cote d’Ivoire’s current problems: a legacy of state elites who viewed policymaking as “an art of secrecy reserved for a few trusted citizens”; a lack of administrative capacity to engage public opinion; and decisions made on the basis of “intuition and experience” rather than “solid information.” In Ghana, local officials recognized that the problems with their reforms stemmed not from the policies themselves, but from “the lack of autonomous centers of power to curtail the overbearing influence of the state in policymaking.” Policymakers thus realized that “policymaking could produce better results if channels of interaction between the government and civil society organizations are kept open, and such organizations are encouraged to actively participate in the policy processes.” Ghana now has several policy think tanks that serve as “platforms for participating in the

49 See Agyenpond and Adjei, supra note 3.
50 Kpessa, supra note 48, 40.
51 Id. at 41.
52 Id.
policy process. By involving academics and concerned professionals in the policymaking process, Ministry of Health officials could encourage the development of similar institutions in Cote d’Ivoire.

2. Improve Policymaking Workshops

There are a number of ways in which policymaking workshops could be improved. As currently run, these workshops are often group writing sessions, where groups of 5-15 participants draft or edit a document while one person types up the edits on an overhead projector. Participants often spend long periods of time either debating economic theory or arguing about the semantics of a particular sentence. There is little discussion of practical or technical issues. And no outside research is brought into these discussions to improve the quality of the debate.

Workshops should spend less time on group writing of documents, and more time on technical details. Group drafting or editing of documents is extremely inefficient and it produces inferior writing. Documents end up with long, incomprehensible run-on sentences, probably because it is socially easier to add to a sentence than to delete someone else’s input. Participants also waste long stretches debating word choice and sentence structure, a poor use of limited human resources that would be better devoted to the technical details of implementation.

Workshops could be improved via better planning and preparation. Workshop tasks are often too open-ended. At the PBF National Strategy Drafting Workshop, participants were tasked with figuring out, from scratch, how to finance performance-based financing in Cote d’Ivoire. Another group was tasked with producing the entire institutional schema of the PBF reform. Neither of these tasks produced useful content. Workshop organizers should instead come up with more precise and practical objectives for participants. They could pre-select a choice of policy options and charge workgroups with deciding between them. Or, as a means to encourage additional research and precise thinking, they could task participants with researching and collecting necessary data.

Workshops should also be shortened. Many policymaking workshops last for 4 or 5 days, and this length of time is not at all justified by the minimal amount of useful content that they produce. At the National Strategy Drafting Workshop, almost half the week was spent on presentations about the theory of PBF. Few of the 60 participants paid close attention during these presentations. Likewise, these workshops waste a great deal of time holding opening and closing ceremonies featuring long-winded speeches from Ministry of Health officials. These ceremonies are unnecessary and should be removed from the agenda. There seems very little reason why

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53 Id. at 42.
54 See Shirley Kuiper, *Contemporary Business Report Writing* 156 (2009) (arguing that collaborative writing “tends to lead to extra work or inferior quality”).
workshops should be longer than one day, or perhaps two days in exceptional circumstances.

C. What Can Western Institutions Do to Improve this Process?

1. Less Reform, More Implementation

Western development institutions in Cote d’Ivoire would be more effective if they shifted resources from policy reform to policy implementation. Part of this problem is structural. For many staff at the World Bank and other development agencies, pushing through institutional reforms is the primary part of their job. A passed reform is a visible, tangible achievement that demonstrates a group’s contribution to the country’s development. Institutional reforms have thus become “a major line of business for most development agencies.”\textsuperscript{55} From 2000-2010, institutional reforms comprised more than 65 percent of all World Bank operations\textsuperscript{56} and accounted for more than $50 billion worth of World Bank projects over a recent five-year period.\textsuperscript{57}

Officials in developing countries like Cote d’Ivoire play along. They view these reforms as “signals to garner short-term support” from Western organizations.\textsuperscript{58} They know that if they pass these reforms, they will be rewarded with “access to new projects, money, and support.”\textsuperscript{59} But while these reforms “may produce new laws that make governments look better, these (laws) are seldom implemented and governments are not really better after the reforms.”\textsuperscript{60}

The PBF reform in Cote d’Ivoire provided a perfect example of these problems. There was a direct quid pro quo: if it passed the PBF reform, the Ministry of Health would receive $12 million from the World Bank, as well as significant funding from UNFPA and UNICEF. Within the Ivorian government, there were a handful of actors who were genuinely excited about the PBF reform, and nobody was greatly opposed to it. But senior Ministry of Health officials were never enthusiastic, and the reform was enacted largely because this was the reform that the World Bank, UNICEF and UNFPA wanted, and Cote d’Ivoire wanted these organizations’ money to fund its health care system.

Now the reform has been enacted, but how much effect will it have? Recent reforms, whether one looks at Cote d’Ivoire or abroad, offer little reason for optimism. In 2001, Cote d’Ivoire adopted a national health insurance law with funding from international organizations. This law was expected to “herald a fresh start in the field of health financing,” yet,

\textsuperscript{55} Matt Andrews, \textit{The Limits of Institutional Reform in Development} 7 (2013).
\textsuperscript{56} \textit{Id.}
\textsuperscript{57} \textit{Id.}
\textsuperscript{58} \textit{Id. at xi.}
\textsuperscript{59} \textit{Id. at 24.}
\textsuperscript{60} \textit{Id. at xiv.}
According to a recent government report, the past decade “has not witnessed any notable progress in achieving the objectives of (this law).”

Likewise, the National Plan for Health Development 2012-15 was funded by several international donors and adopted in 2012 with the goal of “providing an urgent and efficient response to the country’s health problems.” The National Plan outlines an ambitious list of health sector actions, but few of the planned activities have been undertaken. To provide one startling example, the Ministry of Health and World Health Organization held a meeting in spring 2014—18 months after the adoption of the Plan—to discuss why not a single aspect of the Plan’s monitoring and evaluation mechanisms had been performed.

Matt Andrews provides compelling evidence of the systematic failure to implement development reforms on a broader scale. Senegal, for instance, enacted 47 different World Bank institutional reforms between 1990 and 2010 at a cost of over $500 million, yet saw government effectiveness ratings fall during that period. Honduras has engaged in 59 World Bank institutional reform projects since 1988 at even greater cost; laws were changed, and the World Bank rated many of these reforms as successful; yet economic growth remained slow, and a recent coup “reflected the broad governance problems” in Honduras.

Western organizations further undermined implementation by poaching key staff from Cote d’Ivoire’s government under the guise of gaining local knowledge. During my time at the Department of Strategy, three of the DFPS’s six skilled technocrats were lured away by Western organizations, to the frustration of Ministry of Health officials. This left the remaining three skilled staff members with too many responsibilities and no ability to focus on long-term implementation. The health sector would have been better served had Western organizations used their funding on implementation initiatives that would keep institutional knowledge and skilled resources within Cote d’Ivoire’s government.

By prioritizing reform over implementation, the World Bank and other development organizations contribute to a narrative of poor governance and undermine the quality of governance. Instead of helping developing country governments to improve the implementation of laws, they encourage a cycle of never-ending reform. This focus on reform rather than implementation becomes itself an obstacle to good governance.

2. Balance Best Practices and Local Norms

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61 MSLS, supra note 10, 6.
64 Andrews, supra note 55, 15.
65 Id. at 24.
International organizations, local policy makers, and private consultants combine to enforce the presumption that the most advanced countries have already discovered the one best institutional blueprint for development and that its applicability transcends national cultures and circumstances. –Peter Evans, “Development as Institutional Change”

Côte d’Ivoire will emerge from the PBF reform process with a law that reflects current international “best practices” in health financing for a developing country. But it is unclear that these “best practices” have actually had positive effects elsewhere, and it less clear still whether they would be well suited to Côte d’Ivoire.

Western organizations make big promises about the potential for PBF in developing countries. According to a recent WHO bulletin, the PBF reform is not merely a hospital payment system, but rather a policy that “can catalyze comprehensive reforms and help address structural problems of public health services” and that “may contribute to profoundly transforming the public sectors of low-income countries (italics mine).” Yet the evidence for PBF as a contributor to improved health outcomes is mixed. A recent literature review of PBF evaluations showed “disparate findings,” with two studies showing moderate increases in quantity of care, another showing no change, and the fourth showing a significant decrease. Moreover, there is a high risk of bias in many of the PBF evaluations, since “intervention and control areas were not randomly allocated and the same people who implemented the programs also evaluated them.” Because of this weak methodology, and because of the general lack of studies, the review concluded that “no general conclusion can be drawn regarding the likely impact of performance-based financing in low- and middle-income countries.” This uncertainty was never communicated by Western organizations to Ivorian officials. In many ways, the role of the international PBF expert was closer to lobbyist than technical advisor. During his visit to Abidjan, the international expert presented a list of 11 PBF “best practices,” including practices such as “extending the PBF system beyond the health care sector.” The international expert was uncompromising about adapting his list of “best practices” into the Ivorian context. He played down the importance of current social norms and whether the “best practices” might contradict them, nor what difficulties this might pose for implementation. Ultimately, these best practices were never adjusted in any way to fit into the local context.

67 Meessen et al., supra note 24, 153.
69 Id.
70 Id.
71 See Aide Mémoire et Plan Stratégique PBF 2014-2016 en Côte d’Ivoire, supra note 37, 15.
The list of best practices came copy-and-pasted from the international expert’s training course on PBF, and it was then copy-and-pasted into Cote d’Ivoire’s National Strategy document.\(^{72}\)

The international expert may also have oversold the benefits of the PBF reform. He was unrealistic about PBF’s potential benefits to the Ivorian health system, and he undersold its shortcomings. He explained how PBF would increase access to care, improve quality, improve public sector regulation, stimulate public goods by changing population attitudes, and resolve negative externalities in the health sector. There was no mention of “mixed results” or “disparate findings” in previous PBF studies.\(^{73}\) Nor was there any discussion of claims that PBF had lead to a “gaming” of the system in other countries, in which hospitals non-reimbursed services were neglected in favor of reimbursed services.\(^{74}\) That is to say, doctors provided treatments for which they would be given a bonus payment over treatments for which there was no bonus payment. This effect has been observed in countries with far more advanced administrative institutions such as Rwanda, Brazil, and the UK; yet the international expert did not share these nuances in his role as technical advisor to the Ministry of Health.\(^{75}\)

Western institutions play a complex and delicate role here.\(^{76}\) On the one hand, they can play an important role in encouraging responsible policy against the populist policies favored by politicians. The status quo system of targeted non-payments is clearly a flawed, unaffordable policy, and the international PBF expert pushed hard to convince the government to reform this policy. On the other hand, there is reason for concern about rigid “best practice” prescriptions designed in Washington and not adapted to local practices or social norms.

3. Improve Technical Assistance

As a practical matter, Western institutions could improve Cote d’Ivoire’s health system by working to meld their technical expertise into the local context. Western organizations have useful expertise to offer, but it is far-fetched to believe that a technocrat living in Washington or Amsterdam and working in the World Bank’s West Africa office knows how best to reform Cote d’Ivoire’s health financing system. And it is unrealistic to expect


\(^{73}\) Fretheim et al., supra note 68, 558.


\(^{75}\) See Id.

\(^{76}\) See generally Steven Solter and Catherine Solter, Providing technical assistance to ministries of health: lessons learned over 30 years, 1:3 GLOBAL HEALTH: SCIENCE AND PRACTICE 302.
an international expert who flies in for two weeks to provide context-specific technical advice on the details of a reform.

Throughout the PBF reform, the most valuable role was played by organizations that provided basic “technical assistance.” Abt Associates and UNICEF frequently funded the workshops at which policy documents were written, and they supplied personnel to help draft these documents. These human resources were particularly useful as the Department of Strategy was understaffed during this period. In the weeks after the Department of Strategy’s deputy director’s departure for PEPFAR, the Department of Strategy lacked expertise, and Abt and UNICEF staff played a pivotal role in producing the final draft of the National Strategy. By hiring capable local staff and sending them out to plug holes within the Ivorian Ministry of Health, these organizations provided an important service in the development of Cote d’Ivoire’s institutions. It would be even more useful for such staff to play a role in the implementation of reforms, since this was a problem area for the Ministry of Health.

Westerners in the health sector rarely seemed interested in gaining in-depth knowledge about the local context. In most cases, Western organizations seemed to “value technical proficiency over country-specific expertise,” and “the vast majority (of development workers) arrive with little to no understanding of their locale of deployment.” For the Westerners in Cote d’Ivoire, their job was to manage Ivorians and make strategic decisions about budgeting and priorities; in-depth knowledge of the local context was not deemed necessary for this work.

International organizations should seek better methods of combining Western expertise and local knowledge. The best function for a Western organization in Cote d’Ivoire would be to train and deploy individuals who could combine expertise of Western health systems with an understanding of the Ivorian context and institutions. Such individuals were in short supply in Cote d’Ivoire. There were a significant number of Westerners working in the health sector in Cote d’Ivoire—more than two dozen would attend the monthly Executive Meeting at which larger strategy was discussed—but the Westerners did not participate in technical work. I attended several workshops during my tenure at the Ministry of Health, and the only other Westerner ever to attend a workshop during that time was the international PBF expert who flew in for two weeks to manage the Finalization Workshop.

4. Scrap the Workshop Model of Policymaking

Too much of policymaking in Cote d’Ivoire’s health sector is done via workshops that prioritize short-term concerns over long-term development goals. For Western institutions, the appeal of policymaking workshops is clear. Policymaking workshops are, in the words of an American World Bank

official, “a simple and expedient way of getting stakeholders together to
discuss and agree on a policy or implementation plan.” Such a quick and
clean process is useful for Western institutions attempting to push through a
policy reform. The donor organization provides money for a week’s worth of
lodging, a conference room, and meals for government and civil society
officials; these “stakeholders” emerge at the end of the week with the needed
policy reform document. It is a terrifically expedient way to produce policy
documents, obtain an acceptable level of stakeholder buy-in, and execute the
operations with minimum hassle or delay. It is also a poor way to make good
policy.

To start, its very expediency is a form of weakness. When participants
gather in these workshops, they discuss theory, but rarely facts or data. The
workshop model does not encourage outside research. It is a closed universe,
where a group of people will sit in a conference room for a week and pump
out a strategic plan without bringing in a single piece of outside data.
Participants make little effort to research on-the-ground problems or generate
detailed solutions. If a given fact is unknown, it is simply skipped over or
fudged so that the policy document can be finished on schedule.

These workshops encourage policymakers to focus on broad theory,
rather than technical details. Because technical details are often inaccessible
during a workshop meeting, participants spend the week arguing over theory
or semantics. The tedium of implementing the reform is continually pushed
off. In fact, these workshops encourage participants to defer concerns over
technical implementation, because the goal of the workshop is to produce the
necessary document within the scheduled timeframe, not to produce a
technically detailed document.

The workshop model produces bad governance habits. A common
refrain about workshops is that they allow participants to escape the
distractions of Abidjan and focus on a specific issue for a week. But this is
exactly the wrong attitude. Administration is a daily grind of managing the
dozens of issues that surface on a given project. A competent bureaucrat
should be able to multi-task, tending to multiple projects at a time. The
workshop model encourages the opposite: officials are asked to leave behind
the administration of their current programs while they draft the next
reform. This is a shortsighted approach from Western institutions. In their
haste to enact the next reform, Western institutions prioritize short-term
reform concerns over the long-term goal of building a better bureaucracy and
over the medium-term goal of effectively implementing the previous project.

Finally, the workshop model encourages a system of dependence upon
Western institutions in the policymaking process. Because the Ministry of

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78 Bissouma, supra note 45.
79 Imran Rasul and Daniel Rogger, Management of Bureaucrats and Public Service Delivery: Evidence from the Nigerian Civil Service, INTERNATIONAL GROWTH CENTRE 26-28 (June 2013) (arguing that “bureaucrats operate in a multi-tasking environment” in which attempts to reward them for one type of behavior can lead to dysfunctions in other aspects of the job).
Health is so accustomed to making policy at these workshops, policymaking is largely dependent on the whims (and funding) of Western institutions. Department of Strategy staff could not remember a single instance when the Ministry of Health had funded its own policymaking workshop. In fact, Department of Strategy officials often spent weeks waiting for funding to come through for a given workshop so that a document could be finalized. If the funding did not come through, the workshop would not take place.

Policymaking has thus become an exercise that is entirely dependent upon the support of Western organizations. This situation is convenient for these organizations, but not healthy for the development of well functioning local institutions. By increasing their focus on long-term issues of technical implementation and institution building, Western organizations would contribute to the development of a more effective health system in Cote d’Ivoire.

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80 Bissouma, supra note 45.