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Recourse to an Affordable Health Care Program for Sahel-Saharan African Countries in the Light of the Obamacare Plans.

Case of Study: Niger

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Dedication

I dedicate this dissertation

To my dear mother, **Wassilatou Abdoul Karim**

To my beloved father, **Adam Tamsoudima**.

To my lovely elder brothers **Sanou Adam Tamsoudima**

And **Issa Adam Tamsoudima**

To my adorable and generous uncle, **Dr. Mamadou Dagra**.

May God protect my dear brother, Sanou Adam Tamsoudima, in his military career

Big thanks for their great support and encouragement.

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Abstract

"Recourse to an Affordable health Care Program for Sahel-Saharan African Countries in the Light of the Obamacare Plans" is an important issue in the setting of third world countries. The New Affordable Health Care Act called Obamacare has been enacted into law in the United States of America in 2010 by President Barack Obama. It is intended to make health care insurance affordable mostly for poor populations through the contribution of wealthy people.

This research work focuses on ways to assess the feasibility and effectiveness of Obamacare plans in Niger, a Sahel-Saharan African Country. These twin research aims are met through an extensive study of relevant contemporary American and African civilizations and the implementation of practical research. The latter was carried out through a case study involving a number of Nigerien citizens.

This research work produced a number of key findings such as the sociocultural values that are behind the Obamacare Act. Basically, Obamacare Act calls for solidarity from the part of wealthy people to make health care insurance affordable to poor people. Therefore a primary statement would be that such a program would find fewer difficulties to be implemented in Sahel-Saharan African countries where solidarity still prevails. The purpose of this implementation is to improve the Nigerien health care system by providing the poor and vulnerable populations with an affordable health care insurance.

For the feasibility and effectiveness of Obamacare plans in Niger, this dissertation argues for a multi-pronged model of organizing multiple raising awareness programs and meetings to explain and convince all citizens about the importance of Affordable Health Care Insurance in Niger. In addition to this, there is the need for global support on the part of the government, private companies, donors as well as charities.

CONTENTS

List of Abbreviations

ACA: Patient Protection and Affordable Care Act

AFD: French Agency for Development

AIDS: Acquired Immunodeficiency Syndrome

AMO: Mandatory Health Insurance

CDSMT: Sector Expenditure Framework in Medium Term

CFA: African Financial Community Franc

CNS: Health National Accounts

CNSS: Social Security National Fund

CPN: Prenatal Consultation

DSBE: Basic Needs Satisfaction Degree.

EDSN: National Health and Demographic Surveys

EMTALA: Emergency Medical Treatment and Active Labor Act

FM: World Fund

FS: Health Center

GAR: Results Based Management

GDP: Gross Domestic Product

HIV: Human Immunodeficiency Virus

MICS: Multiple Indicator Cluster Survey

MSP: Ministry of Public Health

NGOs: Non-Governmental Organization

OMD: Millennium Goals for the Development

PDRH: Human Resources Development Plan

PDS: Health Development Plan

PDSD: District Health Development Plan

PEH: Hospital Facility Project

PTQ: Five Year Work Plan

QUIBB: Unified Questionnaire on Basic and Wellness Indicators

SAJ: Adolescent and Youth Health

SDRP: Accelerated Development and Poverty Reduction Strategy

SNIS: Health Information National System

US $: Dollar of the United States of America

WHO: World Health Organization

Lists of Figures and Tables

➢ List of Figures

➢ List of Tables

General Introduction

Education, Health, and Insecurity problems are scourges that characterize many sahel-saharan African countries. Basically, education and health are two main sectors which determine the development of any country. In Niger for example, health care services are hardly accessible to poor and vulnerable populations. This is a great issue since in Niger, almost 62% of the population lives under the poverty line. The country does not have enough resources to provide all the population with accessible health care services.

Consequently, universal health coverage is needed in Niger. In this sense, we chose to have recourse to an affordable health care insurance program in Niger in the light of the Obamacare program. In this sense, this research work aims to show the necessity for universal health care coverage first, and then evaluates the feasibility of Obamacare program in Niger. The main purpose is to find an adequate way of providing Nigerien populations with affordable health care insurance.

Before explaining what Obamacare system is, it seems necessary to evoke it in the context of contemporary American civilization by highlighting its main characteristics.

Undoubtedly, this period has been characterized by the election of 2008 and the rise of the first African American President, Barack Obama. He won the general election in part because of his message of change, a break with the recent past characterized by a great sense of individualism. The enactment of the New Affordable Care Act also called Obamacare, by President Barack Obama in 2010 is however a great change in the American health system.

Indeed, Obamacare is an American reform law that expands and improves access to care and curbs spending through regulations and taxes. The Affordable Care Act’s main focus is on providing more Americans –mostly the poorest individuals- with access to affordable health insurance.

The particularity of Obamacare program highlighted in this dissertation lies in its sociocultural aspects. The latter calls for more solidarity from wealthy people towards

poor individuals in the context of improving their health care access conditions. Therefore, we claim that President Barack Obama enacted a reform based on solidarity in an individualist society. However, if a reform based on solidarity is implemented in an individualist society, then why applying such a reform would not be feasible and even more effective in Sahel-Saharan African countries where solidarity still prevails?

Importantly, as a Universal Health Coverage, Obamacare implementation in Niger may help to reduce poverty. In this sense, the overall research aims to evaluate the feasibility of Obamacare Act in Niger and thereby find out the conditions and methods through which that Act would be more effective. In other words, the hypothesis is as follows: "Implementing the Obamacare plans in Niger may provide the indigent and vulnerable populations with an affordable health care insurance". Accordingly, the cause and effect relationships between health and poverty would be challenged.

Therefore, in evaluating the feasibility of Obamacare in Niger, two main issues are raised. The first issue is to find out if Nigerien social and cultural values would be in conformity with those of Obamacare program. This step is very important in the sense that the more this conformity exists, the fewer difficulties Niger will face in applying Obamacare program. As far as the second issue is concerned, it consists of finding out if Niger has the adequate and necessary financial means to implement the Obamacare program. Therefore, this research work is divided into three main chapters.

- ✓ The first chapter aims to find out if Nigerien sociocultural values would be in conformity with those of Obamacare program. To succeed in, this chapter draws a sociocultural approach to both Obamacare program and Nigerien society. In addition, this chapter gives some historical backgrounds of Obamacare program showing at the meantime its main facts.
- ✓ The second chapter presents the conditions of health care access and the issue of health insurance in Niger which show the need for an affordable health care insurance program in Niger. This chapter is intended to examine and find out if Niger has some existing financial means required to implement Obamacare program. The purpose of this task is to succeed in designing an adequate method of funding Obamacare program applicable in Niger.

- ✓ The third chapter offers a comprehensive practical issues ranging from the evaluation of the feasibility of Obamacare program in Niger, to the assessment of the conditions required to make it more effective.

The terms Obamacare and ACA will be used hereafter, that refer to the Patient Protection and Affordable Health Care.

Chapter One

A Sociocultural Approach to Obamacare Program and its Comparison to Nigerien Sociocultural Values

1.1. Introduction

The sociocultural values of any country highly influence its political strategies. In this sense, a political strategy or program would find too much trouble to be applied when it calls for unexciting sociocultural values. Based on these assumptions, we will dissect the Obamacare program mainly from a sociocultural approach. The aim of this analysis is to succeed in comparing Obamacare sociocultural values to those of Nigerien societies. Accordingly, the findings from this analysis will partly answer to the feasibility of the Obamacare program in Niger.

1.2. Presentation of Obamacare program

In 2008, the United States of America elected its first African American president, Barack Obama. He won the general election in part because of his message of change, a break with the recent past. That sort of change can be seen through his new Affordable Care Act of 2010 commonly called Obamacare. This section presents the historical background of Obamacare program, President Barack Obama as well as the different plans of the program.

1.2.1. Historical Background

In the 1940's,in the wake of World War II, European countries and Canada rebuilt their health care systems on a single-payer model. However, the United States continued its system of private health care insurance, which was largely paid by employers to cover the health care of employees. John Dingell[1], Sr. introduced a bill in Michigan to establish a national system of health care. When Dingell died in 1955, his son was elected to represent the same Michigan district in Congress. John Dingell, Jr. introduced the National Health Insurance Act, to provide universal health care in each session of Congress. In the Senate, Edward M. Kennedy[2] advocated for the first time the concept of universal health care. In 1965, Congress passed the law establishing

[1]John Dingell was an American politician who represented Michigan's 15th congressional district from 1933 to 1955. He was also a member of the Democratic Party.
[2]Edward M. Kennedy was the third longest-serving member of the United States in America history. He called healthcare "the cause of my life ". He succeeded in bringing quality and affordable health care for countless Americans.

Medicare – a single-payer insurance program for citizens over 65 which was funded through a federal payroll tax.

In 1986, the United States Congress passed the Emergency Medical Treatment and Active Labor Act (EMTALA). EMTALA requires hospitals and ambulance services to provide care to anyone needing emergency treatment regardless of citizenship, legal status or ability to pay. EMTALA applies to virtually all U.S. hospitals. As a result, many people who could not afford to see a doctor come to hospital emergency rooms for non-emergency care. Because EMTALA does not have a way of paying for this care, hospitals raised the rates charged to other patients to cover these costs.

On April, 2006, Massachusetts Governor Mitt Romney signed the state health legislation which provided for universal health coverage in that state.

During the 2008 elections, President Barack Obama had companied on healthcare reform, promising that negotiations would not be behind closed doors, but televised publically. He had also promised Planned Parenthood on July 17, 2007, that "Reproductive care" would be central to the coming health care bill. President Obama said:

> Well look, in my mind, reproductive care is essential care. It is basic care. So it is at the center and at the heart of the plan that I propose: essentially what we are doing is to say that we are going to set up a public plan that all persons, and all women, can access if they don't have health insurance. (Hamsher115)

As a candidate, Obama proposed what became the largest middle-class tax cut for health care in history. In the general election it was a cornerstone of his campaign. Obama developed this desire of a universal health care for all U.S. citizens. On March 2010 he succeeded in signing into law the Patient Protection and Affordable Care Act. At the signing, Obama noted that it was a law that "generations of Americans have fought for and marched for and hungered to see" (Hamsher 117). The major provisions of the New Act went into effect in January 1, 2014, although significant changes went into effect before that date and will continue in years to come.

1.2.2. President Barack Obama and his new Affordable Care Act

Few in 1897 would have predicted the Progressive Movement, the Forty-hour week, Women's Suffrage, the New Deal, the Civil Rights Movement, the successes of the second-wave feminism, or the Gay Rights Movement. Before 2008, nobody would have known that America will elect the first African American president. The year 2008 will certainly be remembered as the year when the United States elected the first African American president. The historical significance of the election of Illinois Senator Barack Obama as president of the United States was recognized literally by the entire world. Electing a person of African descent was a stunning reversal of history.

Barack Obama was born on August 4, 1961, in Honolulu, Hawaii. His mother Ann Durham was white. His father Barack Hussein Obama was a black. He was from Kenya a country in Africa. Barack Obama always wants to show people how to work together to bring about change. The audience was brought to its feet with the lines that rejected the partisan bickering and divisiveness that had been a feature of the past decades and that went against the spirit of e pluribus unum[1]. In this sense, President Barack Obama said "there is not a liberal America and a conservative America- There is the United States of America. There is not a black America and a white America and Latino America and Asian America- there's the United States of America"(Carl 3).

The speech immediately garnered much comment, most of it positive. Obama is characterized as a "transformative" president. He has introduced in America many policies to bring up change and transformation. Up to 2015, president Obama has expanded support by introducing many domestic policy initiatives such as the Lily Ledbetter Fair Pay Act for women and secretary of education Anne Duncan's Race. In 2010, Obama persuaded the congress to enact financial reform legislation, the Dodd Frank Wall Street reform and Consumer Protection Act, designed to prevent economic meltdowns.

However the Patient Protection and Affordable Care Act commonly referred to as Obamacare represents the most significant transformation of American political, social and cultural systems. President Obama, in many of his speeches praised the diversity of the United States and its tradition of individualism. Hence, from the

[1]E pluribus unum translates from Latin to English as follows: "e" meaning "from" or "out of"; "pluribus" being the ablative plural of the Latin for "more"; and "unum" meaning "one". Thus, "E pluribus unum" simply means "from many, one" or "out of many, one". It symbolizes the union of the thirteen independents colonies.

enactment of this law, he reminded Americans of another tradition, that of community and solidarity, based on the Biblical principle "I am my brother's keeper". We do observe a paradox between the sociocultural values of Obamacare Act and those of the contemporary individualist American society. That is to say, Obamacare program challenges the American social individualism. To understand this issue, we need to know more about that policy.

Figure 1.1*President Barack Obama is applauded after signing the Affordable Health Care for America Act during a ceremony with fellow Democrats in the East Room of the White House March 23, 2010 in Washington.*

1.2.3. Obamacare Facts

The Patient Protection and Affordable Care Act has two important provisions known as the "Individual Mandate" and the "Employer Mandate" (Betsy 27).

Through the individual mandate, the federal government, for the first time in history, required most Americans to purchase a particular product- in this case, health

insurance. Specifically, ACA requires nearly everyone to enroll in one-size-fits-all, which can be sold by private companies, regional insurers or nonprofit organizations. Alternatively, people can enroll in a plan provided by a large employer that can insure others.

When individuals file their taxes, they will be required to attach proof of their enrollment in a "qualified plan". Those who fail to enroll in a qualified plan will be subject to a financial penalty. However critics of the mandate contend that congress has no authority to force Americans to buy health insurance, or any product for that matter. As far as the individual mandate is concerned, there are penalties for not being insured. Starting in January 2014, anyone who is not enrolled in a "qualified" healthcare plan for at least ten months of the calendar year will be required to pay either a flat fee of $95 or 1% of their gross income. After 2014, the penalty becomes higher.

By 2016, people without insurance will have to pay either a flat fee of $695 or 2.5% of their gross income. The highest penalty as of 2016 will be the equivalent of $173 per month, and for most people it will be considerably less. Purchasing insurance would cost a great deal more, thus many people will undoubtedly opt to pay the fine instead. The IRS will be legally empowered to seize tax refunds as payment toward any unpaid penalty.

The following categories of people are exempted from the ACA's individual mandate:

- People who are already enrolled in government programs such as Medicare or Medicaid
- People who do not qualify for Medicaid but can prove financial hardship
- American Indians, who receive health insurance via a separate program.
- Prison inmates
- Members of the army services and their families
- Members of certain religious groups (Christian Scientists, who are uncomfortable with modern medicine, Scientologists, whose objections are more nebulous and Muslims, who may oppose the notion of insurance altogether).

- Young adults (under age 30) are not technically exempt from the individual mandate, but they can meet the qualified-plan requirement by purchasing a "catastrophic[1]" insurance policy.

Through the employer mandate, Obamacare Act stipulates that every business with 50 or more full-time equivalent workers- with "full-time" defined as 30 or more hours per week- must provide what the federal government considers to be adequate affordable insurance coverage for all of those workers. Any large business that fails to provide coverage that the government deems adequate will be required to pay a $2.000 annual penalty for each uncovered worker beyond 30 employers- if at least one worker takes advantage of a tax credit on the Obamacare insurance exchanges.

The implications of this employer mandate are obvious. Business owners now have an incentive to limit their "full-time equivalent" work forces to 49 people or fewer, and relying more on independent contractors.

However an International Franchise Association study predicts that because of the employer mandate and some of the law's provisions, the ACA will place as many as 3.2 million jobs at risk (Betsy 30).

Because Obamacare requires companies with 50+ workers to provide insurance that is "affordable" for those workers, employers will have to collect much personal information about each employer. For instance they need to know how much money each member of his or her household earns annually. This information will then be turned over to the IRS. The rationale for this practice rests on the fact that under the ACA employers are permitted to ask workers to contribute something toward the cost of their own healthcare, but the worker contribution cannot exceed 9.5% of household income. The latter refers to the total income of the worker, his/her spouse or domestic partner, and any resident children who are employed. If the employer contribution exceeds 9.5% of the employee's household income, the federal government considers the insurance policy "unaffordable", and the employee then goes to an insurance exchange to select a subsidized plan instead. The employer meanwhile gets hit with a $3.000 fine for failing to provide "affordable" insurance for the worker.

[1]The « Catastrophic plan » means that due to economic hardship, the person would not be required to have health insurance or pay a penalty for failing to do so. The plan is available to people under age 30, or people 30 and older who qualify for a hardship exemption.

The employer mandate has a particularly negative effect on low-wage and entry-level workers, because employers may deem the extra costs excessive when compared to whatever value the employees may bring to the business.

In addition to the individual and the employer mandates, Obamacare program includes the following "ten essential health benefits":

- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance-use-disorder services
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Pediatric services
- Preventative and wellness services and chronic disease management (Sally 57)

Finally, as far as the coverage options are concerned, health insurance sold through the Exchanges will be available at four levels: bronze, silver, gold, and platinum. These four "metal plans" will have actuarial values of 60%, 70%, 80% and 90% respectively. According to Sally's study, these metal plans will cover at least the ten "essential health benefits" as defined by the federal government, including dental and vision care for kids up to age 19 (60).

1.3. The Sociocultural Dimensions of Obamacare Program

To succeed in making a cultural analysis of President Osama's ACA is the main aim of this section. Basically, many Americans do not see the ACA in a good way since it calls for more non individualist values. We will analyze the social and cultural values hidden in Obamacare program, even though they challenge American individualism.

1.3.1. Sociocultural Aspects of Obamacare Program

In this research work, we have come to understand our methodology in terms of John Dewey's *The Public and Its Problems*. Dewey describes how different publics can take shape when the actions and interactions of private individuals affect distant people's

interests. For example, the high cost of health care affects most Americans, and tens of millions of people struggle to access affordable and timely services.

Naturally, we might expect a new public to form in favor of developing lower-cost community-based strategies to raise health care outcomes in the U.S. According to Dewey, however "a public is not simply the product of shared interests. Public must be unified by moral ideal and attachments, and the legitimacy of existing publics hinders new ones from gaining legitimacy" (184). Today the main publics served by U.S. health care are (1) working Americans with private health benefits, (2) Medicare recipients who treat their public insurance as private benefits, and (3) the specialist-heavy, acute-care physician workforce in whom Americans place their trust. We need to examine ongoing cooperative effort to reshape American health care reform institutions as well as the sociocultural aspects or values of Obamacare program.

David Craig in his noteworthy and timely book *Health Care as a Social Good* argues that "Americans think about health care the wrong way" (118). Some Americans claim that health care should be private – a private benefit provided by employers or a private choice made by consumers. Others argue that it should be public – a public right insured through a single-payer government health plan. The opinions of American citizens about the New Affordable Health Care Reform of president Obama go in these two different terms.

Conservatives tend to see that health care reform as a private good, while liberals tend to view it as a public good. What is lacking in both views is a sense of social solidarity. Rather than argue from first principles to defend his notion of solidarity, Craig discovers a record of social norms, public values, and a commitment to the shared humanity as Americans and persuasively argues that this "testifies to a hidden solidarity implicit in U.S. health care" (135).

However, Obamacare is neither a private good nor a public right, as these terms are understood publically. It is a social good, a benefit to all, something for which each individual shares some responsibility and to which all enjoy some rights. Supporters of the ACA charge Americans with a shared responsibility for making health care a common good. The ACA reform of President Obama works only if everyone is involved.

From this basis, Craig demonstrates fundamental flaws in a social contract vision of health care that presupposes the autonomous individual is the party executing the contract. This philosophical construction of the contract, for instance, hampers full

health benefits to the community. It problematically reduces community benefit to a *quid pro quo* exchange – One's tax-exempt status compensates for one's noncompensated care. Such a construction fundamentally misses the richer purpose ministries like Catholic health care aim to serve – understanding and doing what is truly beneficial for the health of the community.

Consequently, the contract model also marginalizes religious or nonprofit providers, diluting them from the full force of their mission. It forces them to divert focus away from trying to innovatively develop structures that incarnate their values in ways that meet the core needs of the community. Instead, in order to survive and be sustainable, contractual and economic values come to dominate operational ethos. The effect is a concept of health economy bereft of the idea of solidarity. In contrast to this, Craig illustrates that since humans are social by nature and flourish only through relationships, "the concept of the common good better captures the moral framework needed to actualize health care systems that meet true human needs through solidarity" (140).

Additionally, Craig states that contrary to political ideologies, "we humans are social individuals by nature. We are already both responsible and interdependent in providing for our own care and care for others" (141). In short, Craig calls the reform debate to start from a practical, lived reality and coherent moral vision rather than from political or economic principles. He peels back the rhetoric and states that in truth "as human beings, we need one another – to live, to grow, to be healthy and to be happy" (Craig 150). Craig reminds us of these social and moral values of humanity because he was able to rediscover the vast and strong expression of solidarity in Obamacare reform, which he finds necessary especially in political decisions.

Given American political culture and its exceptional emphasis on personal liberty, we do not see a single-payer plan as politically viable. President Obama showed that the emergence of a broader, more inclusive public – Great Community – would permit a more effective health care reform. Therefore, through the New Affordable Health Care Act, president Obama showed that health care works only if everyone is involved. This sentiment rings with the idea that Americans can form a new public, where, for example, the goal of securing better health and more affordable care for everyone takes hold as a commitment to social solidarity.

1.3.2. Obamacare as a Challenge to American Rugged Individualism

In any country, the national "culture" broadly influences some political actions such as medical practice. In post World War II America, the political right retained the vocabulary of individualism, which has political, ethical and cultural meanings.

Politically it stands for individual liberty, the notion that each individual should be free to live his own life as he sees fit. Ethically, it means valuing ourselves, taking pride in our achievement. Culturally, it means fostering reinforcing, and celebrating the elements of individualism. Basically, true individualism includes the belief that people are responsible for their own lives, actions, prosperity and happiness.

Moreover, individualism is a deliberate and peaceful sentiment which disposes each citizen to isolate himself from his fellows and draw apart with his family and friends. According to Tocqueville, "…individualism is abandoning the wider society to itself… sapping the virtues of public life… and finally being absorbed into pure egoism" (30).

America has been the land of individuals, and most Americans have thought of themselves as individualists. The political and economic manifestations of individualism are freedom and capitalism. This was to protect the life, liberty and property of each individual.

Because of the rugged individualism that defines America, President Obama has always seen the necessity for more solidarity in American society and said, "We have an obligation to put ourselves in our neighbor's shoes, and to see the common humanity in each other" (Carl 7).

America's individualism also includes the idea that the individual should possess the freedom to define himself as opposed to a government definition of his personality and liberty. It is a contradiction to a collective defining of worth and purpose that accommodates a stagnating philosophy of government oppression.

The social vision at the heart of Obamacare, for solidarity and mutual responsibility in healthcare system stands as a challenge to American individualism. Solidarity, this concept that we have concrete duties to others with whom we share solidarity (especially the poor and marginalized people) has never been a word with much cachet in American politics. It is not that Americans lack compassion for poor people; they appreciate the concept, but not so much the word itself. In America, the

concept of individualism prevails more, not only because of the importance of American mythos, but also presumably due to the fact that the concept of solidarity is primarily associated with Catholic social teaching; and the relationship between America and the Catholic Church has been complicated.

In fact, some Americans say that the government has no right to force people to pay for medical coverage. They cannot understand that everyone needed to participate in order to spread the risk of paying for those who fall ill. However, the real question is why so many Americans are so troubled by the idea of Universal Coverage. The only way to explain this resistance is to really understand that American political culture.

Firstly, there is the subterranean fear of socialism and socialized medicine, left over from the Cold World War, and never far from American politics. Mark Neumann, a Republican candidate from Wisconsin, responded to the Court's decision about Obamacare Act, in words and said "Barack Obama and his team are socialists in every respect of the word".

Secondly, there is the peculiar atomistic individualism of American political culture that sees itself as Christian but has been reluctant to create a social safety net that reflects those values. This individualism underlines the effective rhetoric used by Republicans and the Tea Party, which insist that health care reform will take away people's liberty and freedom. Some Americans said "Yes, in crisis, we can come together, but for the most part, we are not a country that cares about our brothers and sisters. Because of this individualism, Obamacare would find more difficulties to be perfect. In a nutshell, as individualism prevails in American society, the reality is that the wealthy people will never offer poor people the same quality of health care that they demand for themselves.

1.4. Effectiveness of Obamacare in USA

To be adopted in any other country, the Obamacare Act effectiveness in American society needs to be analyzed. To succeed in this task, we are going to evaluate the critics towards Obamacare Act first, and then explore the achievements over the five first years of it implementation (from 2010 to 2015).

1.4.1. Critics of Obamacare Program

In 2009 and 2010, it was widely assumed that consumers would show no real interest in signing up for coverage through the Affordable Care Act. Indeed, among some on the right, this was a foregone conclusion – Americans wouldn't trust "Obamacare". Besides, Republicans said that the ACA won't meet its enrollment goals.

Conservatives as they are concerned were absolutely convinced that private insurers would refuse to participate in the ACA's exchange marketplaces, repeating the prediction over and over again (a 2013 interview, New York Times).

Among Republicans, there was near certainty that 2014 -the first full year implementation- would be an abysmal year for the American job market.

After all, it seemed obvious to the right that "Obamacare" would crush job creation and push unemployment higher. The prediction was also that the ACA won't increase the insured rate because it will only help those who already have coverage.

John Boehner, a House speaker predicted that "Obamacare" would end coverage for more people that it would expand coverage to, "a net loss". Boehner said, "I actually do believe that to be the case" (a 2013 interview).

One of the projections that never sat well for Republicans, who sometimes pretend to care about the deficit, was that "Obamacare" would increase the nation's deficit by hundreds of billions of dollars in coming years.

1.4.2. The Achievements of Obamacare over its first five years

Anniversaries are a good time to pause, reflect, and take stock. When it comes to health care reform, objective observers are going to find it easy on the ACA's fifth anniversary to appreciate the law's triumphs. But it is a good time to take a moment to acknowledge those who told Americans exactly what to expect from the Affordable Care Act – and who got the story backwards.

Now that the Affordable Care Act has beaten back all judicial challenges, it is worth revisiting its vast success. A single-payer system would have been far preferable. But the present system is substantially better than nothing. As Jay Bookman pointed out in early May in the Atlanta Journal Constitution, none of the dire predictions of its critics have come true. There has been no jump in healthcare costs.

In fact, medical inflation has leveled off. The number of people who lost their insurance was no higher after the advent of Obamacare than it had been in previous

years. Obamacare program has not killed employment- rather employment is up. Let us consider the success of the ACA.

In summer of 2013, there were 42 million uninsured Americans. By February of 2015, that number had fallen to 25.8 million. That is nearly 17 million more Americans have health care than before Obamacare. The below graphic shows it.

Millions

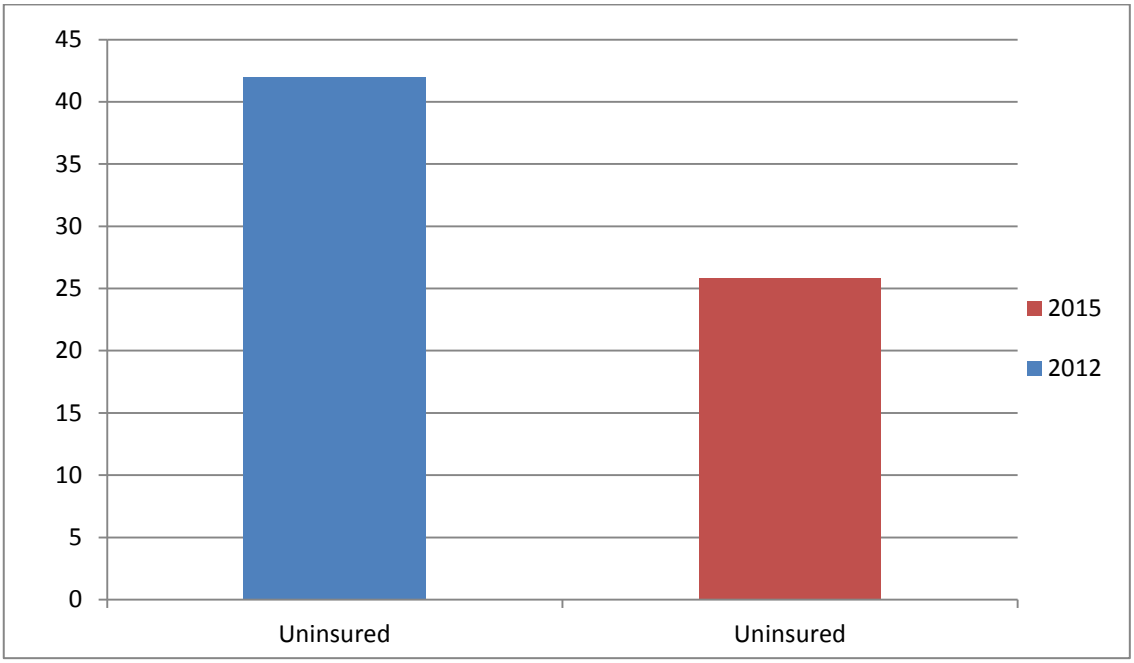

Figure 1.2 Report about the achievement of Obamacare Act in the Unites States of America. (a study of RAND Corp. Researchers, published by Paul Demko / May 6, 2015).

With regard to percentages, the country's uninsured rate was 17.1% in 2013, and it declined dramatically to 11.9% during the first quarter of 2015.People without health care are in a very uncertain situation – they could have a medical emergency anytime, and they have nothing to pay the hospital with. They also don't get preventive care because they don't pay to go see a doctor if they don't have to. Obamacare will save an estimated 24.000 lives a year (RAND Corp Study).

The International Business Times analyzed the implications of the law for racial equality and found out that all racial and ethnic groups showed gains in coverage, but the biggest improvement came among minority groups. The uninsured rate for Hispanics dropped by more than 12 percent, African American uninsured rates fell more than 9 percent and White uninsured rates fell more than 5 percent.

Women have been especially helped by Obamacare. They now pay the same premiums as men, which was not the case before. Even by early January, there had been a 5.5% decline in the number of uninsured women since 2013. As the International Business Times reports:

> "Up until last year, uninsured companies could- and often did – charge women different premiums than men for the same coverage. As of January 1, 2014, the ACA prohibits this gender discrimination. In part because of improved options and affordability, today's report outlines a significant 5.5 percentage point decline in the uninsured rate among women between the age of 18 and 64 since 2013" (30).

The National Bureau of Economic Research of USA compared children eligible for Medicaid during childhood to their non-eligible peers. It found that the Medicaid-eligible children were more likely to attend college, make greater contributions as adult taxpayers, and live longer than those without coverage (New York Times).

In a Nutshell, Obamacare which is covered by Medicaid expansion has the same effect, that of saving lives and enriching all Americans.

1.5. Practicability and Conformity of Obamacare Program with Nigerien Sociocultural Values.

The main aim of this chapter is to find out if Obamacare program would be in conformity with Nigerien sociocultural values. To draw this comparison, it is necessary to present the prevailing Nigerien Sociocultural values first.

1.5.1. The Prevailing Sociocultural Values in Niger

Niger is a country of about 18million inhabitants in 2014. It is divided into main ethnic groups which are the Hausa, Zarma-sonrai, Kanuri, Fulani, Tuareg with Toubou, Arabic and Gourmantché minorities. The population is 98% Muslim with a minority of Christians and animists. However, all ethnicities, cultures and religions live together in a form of social cohesion absolutely remarkable.

In Niger, each ethnic group has within it a way of expressing solidarity. One may take the example of the Fulani ethnic group. Fulani (also called Wadaabe) are nomadic peoples found in almost all African countries with a vast majority within the space of Sahel-Saharan Africa. The Fulani have a common practice called Habbanae (or attachment in Fulani).It is a tradition of the Wadaabe of Niger, recognized as the best cultural practice for a sustainable development in Niger. This is one among the cultural practices that contribute to improve population's quality of life and the integration of the cultural dimension in economic and social development.

The Fulani are largely dependent on cattle. When a breeder is experiencing hard times and loses his cattle, the practice of Habbanae requires the community members to lend him a cow about to calve for three years. This tradition is not simply a contract allowing the person to get out of a bad situation; it is also a way of consolidating the community by strengthening links between its members. In this practice of Habbanae we also read the voluntary determination of wealthy individuals to help the poor.

In Niger, beyond the ethnic groups, the entire community is also committed to express a form of solidarity and mutual aid. When a member of society must organize a wedding, birth or other social events, he invites all his relatives, friends and acquaintances. Take the example of an individual who is organizing the wedding of his daughter or son. All his relatives, friends and acquaintances will gladly make contributions of money or goods of all kinds, to help and show him their solidarity.

Thus, the strongest and most respectable individuals are those who succeed in gathering more people, and receive more gifts. To achieve this, then each person is obliged to be more caring towards others. Therefore, each individual is in danger of living in individualism.

However, during these social events, wastage of goods (food and money) is observed, whereas many people live in extreme poverty. Unfortunately, this solidarity is rarely expressed towards the sick people without incomes and whose healthcare quality highly depends on their financial means.

However, solidarity is not only based on human reason, but also on spiritual grounds. Individuals express great respect to their common union with God. As we have pointed out, the Nigerien community has 98% Muslims and a minority of Christians and animists. Islam and Christianity are religions that recommend more solidarity and help

towards the poor people. This is to say, in Niger, wealthy Muslims and Christians are always ready to help the neediest.

Moreover, solidarity is highly expressed in Niger to the extent that the government takes it into account to make more effective some of its policies such as the social protection mechanism (see chapter 2, section 2.4.3).Africans have a lot of cultural and social values that ensure and maintain social cohesion. This is a great wealth for Africa. Therefore Africans need to learn adapting their policies to their sociocultural values.

1.5.2. Would Obamacare be in Conformity with Nigerien Sociocultural Values?

At the very beginning of our research work, the issue about the practicality and conformity of Obamacare program with Nigerien sociocultural values seemed complex. In fact after analyzing the sociocultural dimensions of Obamacare reform first and those of the Nigerien society then we affirm that they present many similarities.

The goal is not to say that the Obamacare reform of the US President Barack Obama is of African nature. The aim is rather to show that Africa has some sociocultural values that may well contribute to its economic and social development. The different approaches show that indeed sociocultural values that characterize Obamacare reform are conform to those in many Sahel-Saharan African countries such. In this sense, Africans should raise the issue and wonder if President Barack Obama was able to adopt a reform that calls for great sense of solidarity in an individualistic society, then why African societies which still enjoy solidarity cannot?

Actually some African countries like Gabon adopted the reform of universal health coverage. Their reform was to take a 15% rate on employer's incomes, to provide health insurance to poor and vulnerable people. However, many of the Sahel-Saharan African countries do not enjoy such reforms.

1.6. Conclusion

In a nutshell, the first task in this research work was to succeed in drawing the sociocultural dimensions of both Obamacare program and Nigerien society. This

chapter was intended to draw a comparison between the two civilizations in order to see why sahel-saharan African countries are lagged behind in many domains such as that of health. The conformity of Obamacare sociocultural dimensions with those of Nigerien society answers partly to the feasibility of Obamacare program in Niger.

Chapter Two

Health Coverage Issue in Niger and the Need for Obamacare Program

2.1. Introduction

It is undeniable that education and health are the most sensitive areas for the development of a country. In other words, for a sustainable development in a country, social and political actions must be pointed towards these areas. However, Niger populations have little access to health care because of poverty and lack of efficient health policy. This chapter aims to find out if Niger has adequate financial means to implement the Obamacare program. Therefore, it presents the population's health status in Niger as well as the need for an affordable health care program like that of Obamacare.

2.2. Presentation of Niger and its Health Policy

For its geographical position and the lack of diversified natural resources, Niger faces several economic difficulties. For this reason, the health domain is much undeveloped. Consequently, the major part of the population is poor and can hardly get access to health care services.

2.2.1. Geographical, Historical and Socioeconomic Profiles of Niger

Sahel-Saharan country, Niger is bounded to the North by Algeria and Libya, to the East by Chad, to the South by Nigeria and Benin and to the West by Burkina Faso and Mali. In terms of surface area, Niger is one of the largest countries in West Africa with 1.267.000 km2. It is also a landlocked country with no outlet to the sea. The nearest port is located at almost 1.000 km. Its climate is tropical and is characterized by two main seasons. The Niger's population lives mainly on Agriculture, livestock, fishing and Crafts.

The history of the territory that became the current modern Niger is rich in events. It was marked by important migration and multiple intermixing of populations favored by its geographical position and the rapid expansion of Islam. The Republic of Niger gained its independence in 1960. The official language is French. Generally,

Niger is divided into seven regions - Agadez, Diffa, Tillabery, Tahoua, Maradi, Dosso, Zinder and an urban community which is the capital, Niamey.

With one of the highest rates of population's growth in the world, Niger has over 17 million inhabitants in 2012, while it was only 12 million in 2001. 80% of Niger population lives in rural areas. The average density is about 10 inhabitants / km2, with a large disparity between different regions of the country. The proportion of young people aged 10 to 24 years is 29.8% and that of women is 50.1% (2001 RGPH updated 2006).

The overall literacy rate is 20% with an enrollment rate in primary education of 56% for boys and 40% for girls. The Gross Domestic Product (GDP) was 1850 billion African Financial Community Franc (CFA) or (US $ 3.7 billion) in 2007, which equals to270 US $ per person per year (MPH- 2011-2015 PDS 21).

Moreover, the country faces recurrent exogenous shocks (floods, droughts, locust attacks, etc.) which affect food security of the population and weaken national economy which heavily dependents on agriculture. The weakness of the private sector and trade are also a hindrance to development. In addition, one of the main issues is the energy dependence of the country, especially vis-à-vis the Nigerian electricity.

Since the 80s, Niger is in an economic crisis due particularly to a trend reversal in the market for uranium, which is the main financial source of the Government. Despite all the difficulties, population growth is quite high and was estimated by the general population census of 2001, to 3.3% on average. This again is another challenge because that population growth requires extra essential services (water, housing, food, education, health), particularly for women and children. In terms of health, it was estimated in 1995 that there was one doctor for 35,317 inhabitants, whereas the World Health Organization (WHO) standards provide one doctor to 10,000 inhabitants. The rate of infant mortality and child mortality are 123% and 274% respectively (National Institute Statistics 465).

Figure 2.1 Geographical Map of Niger

2.2.2. Nigerien Health Policy: Strategies, Programs and Funding Mechanisms

The Ministry of Public Health (MPH) of Niger has defined in 2002, the strategic directions for health development within the first decade of 21st century (2002-2011). Niger then developed and implemented the 2005-2010 Health Development Plan (PDS) together with a Five-Year Work Plan (PTQ) for the same period. According to the National Institute of Statistics, "The plan's main objective was to reduce maternal and child mortality from existing potentials" (114). In order to consolidate the gains and avoid a break in the planning process, the MPH has undertaken the elaboration of a new PDS for the 2011-2015 period and a Framework of Medium Term Sectoral Expenditure (CDSMT), with all technical and financial partners involved in the health sector.

Through this new PDS, the overall objective that assigns the Niger is to contribute to the improvement of population's health for achieving the Millennium Goals for Development (OMD) related to health sector.

To meet this main objective, the specific objective set for the 2011-2015 PDS was to provide quality care and services to the population especially for vulnerable groups. To achieve this goal, eight strategic areas were laid out as follows:

- The extension of health coverage;
- The development of reproductive health services;
- Staffing of health facilities in competent and motivated human resources as required;
- Continuous supplying of health structures with medicines, vaccines, consumables, food and therapeutic inputs, reagents, blood and derivatives;
- Intensifying the fight against diseases that are the integrated monitoring object;
- strengthening governance and leadership at all levels of the health system;
- the development of sector funding mechanisms;
- promoting health research (MPH 2011-2015 PDS 23).

The 2011-2015 Health Development Plan represents the implementation plan for the national health policy for the previous five years. It is consistent with the Millennium Development Goals (MDGs), the Document of the Accelerated Development and Poverty Reduction Strategy (SDRP) from 2008 to 2012, the United Nations Framework Plan for Development Aid (UNDAF) and the strategic guidelines defined by the Ministry of health for 2002-2011.

The fact that Niger is a third world country does not promote adequate funding for the health sector. Niger has developed several political programs and different funding mechanisms to improve health care sector. However, the country still faces difficulties and lacks to provide adequate health coverage to populations.

The health funding system is confronted with the following major constraints:

- Chronic under-funding of the sector despite the allocation of efforts made in recent years: the Health National Accounts (CNS) estimate the total health care spending to 116.13 billion CFA francs in 2006, either 8965 FCFA or about 17 $

US per inhabitant. This level of expenditure represents half of that estimated by the macro economy and health commission Implemented by the WHO in 2001 (34 US $ per year and per inhabitant for essential health interventions);

- The virtual absence of social protection systems. 99% of the households health care spending is constituted of direct payments[1].The health care spending through the social security and the private health insurance system represents less than 3% of the total health care spending.
- A tendency to addiction vis-à-vis the outside: health care spending is dominated by public aid which has financed about one-third in 2005 and 2006 and 51% in 2007 according to the review of public expenditures; in parallel, internal resources contributed only up to 16% or 22% between 2005 and 2007 to the funding of the total health care spending.
- The underfunding of the sector is especially evident in the expenses of drugs / supplies, support for free health care and costs related to human resources (though, the wage bill ratio on health expenditure reaches the threshold of the convergence criteria, 35%);
- The free health care system introduced in Niger in 2006 covers the health care of children aged 0 to 5 years, the caesareans, family planning, prenatal consultations and gynecological cancers. Its implementation has significantly improved some health indicators and led to some important results (contraceptive prevalence rate which increases from 5% in 2006 to 16.5% in 2009, curative use rate increases from 18% in 2006 to 45% in 2009, and the caesarean rate from 0.47% in 2006 to 1.5% in 2009). However, the system faces major difficulties related to the inadequate funding and the delay repayment of the free health care costs[2].

Therefore, from 2006 to 2010, a total of 19.2 billion CFA was allocated by the State (84.26%) and the French Agency for the Development (AFD15.74%) under free health care. From 2006 to 2009, a repayment of 9.5 billion has been made with 7.1 billion (75%) by the State and 2.4 billion (25%) by the AFD. In addition to this repayment in

[1]At the hospital, the patient pays in cash money to get access to health care services or to afford to see a physician.

[2] Services freely provided by public health centers are billed to and paid by public treasury.

cash, the health sector received several donations in a kind (drugs, caesarean kits, CPN kit, contraceptives ...) from technical and financial partners; however as of May 31st, 2010, the total of unpaid bills amounted to 9.1 billion CFAF.

2.3. Effectiveness of Nigerien Health Policy

We cannot affirm that a policy is a total failure or a complete success. However Niger lacks adequate means to implement all the health policy plans it assigned. We will thus analyze the effectiveness of this health policy and the challenges it faces.

2.3.1. The Population's Health Status

Actually, the MPH of Niger analyzed the achievement carried out from the 2005-2010 PDS, because the 2011-2015 PDS is still being implementing.

Despite the political efforts made for years, the health situation remains precarious and is marked by the predominance of many epidemic and endemic communicable diseases (malaria, cholera, meningitis, HIV / AIDS, tuberculosis ...) and the emergence of non-communicable diseases (hypertension, diabetes, cancers, sickle cell disease and mental illness ....). Furthermore, the extreme vulnerability of the country results in the occurrence of quasi-regular emergency (food crises, natural disasters) to which the country is not always prepared. These multiple risk factors contributed to the spreading of diseases, especially among the most vulnerable (women and children).

This situation is aggravated by weak social protection of the population against the disease risk (3% of the population has a health coverage). This makes it difficult to accelerate progress towards achieving the health MDGs. We will evaluate progress with respect to the six main goals of the 2005-2010 PDS.

- Change with respect to the goal 1: extreme poverty and hunger alleviation. The nutritional problem of Nigerien children remains unsolved. It particularly degraded in 2005 and 2010 following the food crises in the country. Despite a saw tooth progress of the chronic malnutrition prevalence rate between 1990 and 2005, a substantial decrease is however observed from 2005 to 2009. Indeed, the

prevalence of malnutrition decreases from 50% in 2005 to 46.3% in 2009 and 48.1% in 2010 (National Institute of Statistics 115).

- Change with respect to the goal 2: Reducing mortality in children less than 5 years.

  From 318 per 100 000 children in 1992, the child mortality rate went to 198 in 2006. Among the contributing factors, we note that the malaria fatality rate went from 0.27% in 2005 to 0.13% in 2008; the immunization coverage against measles exceeded 80% since 2005; the malnourished recovery rate went from 29% in 2005 to 50.1% in 2008.

- Change with respect to the goal 3: Improving maternal health. The maternal mortality rate remains very high: 648 per 100 000 live births in 2006 but has changed very little (700 per 100 000 live births in 1990).
- Change with respect to the goal 4: Combating HIV / AIDS, malaria and other diseases. To effectively fight the Human Immunodeficiency Virus (HIV / AIDS), Malaria and Tuberculosis, Niger has set up specific national programs each of which having a strategic plan for combating. There is a stagnation of the overall HIV prevalence rate, which went from 0.87% in 2002 to 0.70% in 2006. The Tuberculosis incidence went from 168 per 100 000 inhabitants in 2005 to 180 per 100 000 inhabitants in 2008. The Malaria annual incidence went from 51.4 cases per 1000 inhabitants in 2000 to 146.2 cases per 1000 inhabitants in 2008.
- Change with respect to the goal 5: Ensuring environmental sustainability. Populations are still suffering from inadequate water and sanitation promotes which cause diarrheal diseases, ARI, malaria and proliferation of some diseases vectors (trachoma etc...). Community-based interventions for child survival strategy remain insufficient (1.5% of national coverage).
- Change with respect to the goal 6: Implementing a global partnership for the development. The adoption of the 2011-2015 Health Development Plan and the CDMT will be followed by the signing of a Country Compact engaging both the Government and its partners for the financing and implementation of the new Plan. This goal addresses the key issue of essential medicines. The availability of medicines and medical supplies, including ARVs, has been improved in

recent years, the state budget for the purchase of medicines, reagents and consumables went from 624 million in 2005 to 1.2 billion CFAF in 2008.

2.3.2. Health and Poverty

Niger is considered as a third world country according to the new poverty profile based on the "Basic Needs Satisfaction Degree" (DSBE) and the results of the investigation QUIBB (Unified Questionnaire of Essential Welfare Indicators) conducted in 2005. The poverty affects 62% of Niger's population with a higher incidence in rural areas (66%) than urban areas (52%). Moreover, "in 2005, more than nine out of ten are considered as vulnerable to poverty" (MPH-QUIBB 45).

It is recognized that poverty leads to poor health status by limiting access and use of services: the poor spend individually, on average to health, 1439 FCFA or 2.3% of their income, against 8018FCFA for wealthier people, or 3.6% of their income.

It is also true that a poor health status contributes to poverty through direct payment of health care cost by the patient, increasing all vulnerability: because of lack of social protection, the households provide most of the direct payments (97 % of spending).

It is clear that the high level of morbidity is a barrier to productivity and economic growth. According to the World Health Organization investigation in Niger, it is widely recognized that health and nutritional weak conditions associated with high fertility are key factors of poverty (20).

This close link of cause and effect between health and poverty should lead policymakers to make it a major priority for socio-economic development with a particular focus on the health of poor people. The capacity of the health sector to meet the needs of the poor people, ensure their participation in the concept, plan and monitor the health services and its accountability in relation to social objectives should be the major challenges. Therefore, one of the priorities of the Accelerated Development and Poverty Reduction Strategy (SDRP) is the equitable access to basic social services. The

2005-2010 PDS as well as the 2011-2015 PDS that followed are the response of the health sector to the 2008-2012 SDRP which was part of the MDGs[1] by 2015.

Figure 2.2A picture of people consuming inadequate water in Niger, illustrating the cause and effect relationship between health and poverty.

2.4. The Issue of Health Care Insurance in Niger

The concept of health insurance is almost nonexistent in Niger health policy. There is no specific health insurance policy. However, some plans have been implemented to assist vulnerable populations. The main plan is to free health care for children aged 0-5 years. The private sector of health insurance remains undeveloped.

[1] MDGs are the Millennium Development Goals that Niger is planning to achieve in order to reduce poverty and improve the health and education sectors.

2.4.1. Mutual Fund and Private Health Insurance

Facing difficulties of health care access, people have started to organize themselves by setting up mutual health insurance.

Mutuality is a form of voluntary association of persons to guard against disease risks. Mutual funds result from the pre-payment by the members in a recovery framework costs. Disease risk metallization through mutual fund and other types of health insurance system has a very timid development. Covered benefits are usually curative, simple deliveries, hospitalizations and laboratory tests. There are about thirty health mutual funds in Niger which consists of 514 members in 2010, including 441 contributors. However, none of these mutual funds are subsidized.

As far as private health insurance is concerned, it is not sufficiently developed. It is still limited to few wealthy individuals who subscribe for themselves and bilateral and multilateral agencies for their staff. The regime of access to health care by private health insurance schemes amounted 1.45% in 2008 and 1.53% in 2009 of the national health expenditure according to the Health National Accounts CNS.

The political will of the Nigerien authorities was clearly formulated in 2002-2007 Poverty Reduction Strategy which plans to develop a discussion on alternative health financing especially through the development of mutual funds and insurances and strengthen the existing partnership between populations, local authorities, civil society, government and development partners. The 2011-2015 PDS actually makes it also one of its priority actions through its seven axes related to health financing.

In general the Nigerien population is divided into five major groups in relation to disease risk protection (MPH-2012 IV):

- The first group is composed of officials, military and security forces.
- The second group is made up of private sector employees affiliated to the national social security fund. The latter provides the employees and their families with affordable health care. Each regional health fund is consisted of some community health centers where different tariffs are offered. Good tariffs are offered to patients who are affiliated to the fund.

- The third group is made up of public sector employees where each company has a form of internal health insurance. Employees benefit from a health support that covers 80% of their health care costs. Generally, these companies have their own clinics and patients turn first to those health centers.
- The fourth group is made up of some insured people affiliated to commercial insurance companies. This group is composed of Non Governmental Organizations, embassies, companies and corporations workers. This mechanism works by a system of repayment.
- The fifth group is made up of the countryside and modern informal sector whose exact composition and income are little known. This group does not benefit from a form of disease protection. Members of this group receive health care according to their financial capacities rather than according to their requirements.

2.4.2. Health Social Fund

From the early years of the Independence of Niger, the care financial support, the hospitalization and medical evacuation of poor people was regulated by Decrees 62-127 / MS and 64-004 MS of January 28th, 1964. Indeed, the decree 62-127 provides support of healthcare costs for some populations in hospitals. Subsequently, Decree 62-004 has made specific provisions for the indigents. Under the provisions of Article 1 of that Decree, the municipalities and local authorities are obliged to provide with support for costs related to hospitalization and evacuation of people in a state of indigence. According to this text, public health centers must treat people in a state of indigence by municipalities and local authorities and ask for the payment of the corresponding tariffs for institutions that issued the corresponding certificate of indigence.

However, the lack of financial resources (mobilization) prevents municipalities and other local authorities to fulfill their obligations. Since no payment is made for the provided care, the operation of this system is totally obstructed and health centers are unable to ensure the continued financial support of the indigents.

Health Social Fund is a social institution whose task was to provide financial support and care for poor and vulnerable people. Its creation follows the movement of the 2002-013 Act on the decentralization which entrusts the social action responsibility to municipalities.

It aimed to increase financial access of indigents to health services.

For the implementation of this Social Fund, the Ministry of Public Health initiated the decree 00145 / MSP / SG / DEP / DERP of April 16th, 2012, on the creation of a Technical Committee to discuss the creation of a social fund for health in Niger.

2.4.3. Free Health Care for Children aged 0-5 Years

In Niger, the introduction of free health care for a certain segment of the population was involved in a very seamy socioeconomic context. Indeed 63% of the population lives below the poverty line on less than a dollar per day. This situation has significantly affected the health status of the population. According to QUIBB survey, "more than 29% of the population is declared not to have access to health care because of their poverty" (iv). Moreover, the analysis of some health indicators revealed a high rate of maternal mortality (648 per 100 000 live births); the child mortality rate is about 198% in 2006 (MICS 3) and a low use of health services to curative less than 21%.

In 2005, in order to enhance the above-mentioned indicators and the MDGs achievement, free health care centered on the care of children aged 0-5 years, pregnant women, cesarean and gynecological cancers and the PF was introduced. To this end, several regulations have been adopted.

The strategy of free care for vulnerable populations, which started since 2005 has had as result the significant reduction of maternal mortality rate (554 per 100 000 live births) and infant (130.5%) and improvement of several other health indicators. Thus, from 2006 to 2010, a total of 19.2 billion CFA was allocated by the state (84.26%) and AFD (15.74%) under free health care. From 2006 to 2009, a repayment of 9.5 billion was conducted including 7.1 billion by the state or 75% and 2.4 billion by AFD or 25%. In addition to this repayment in cash, health care structures have received several donations in kind (Medicines, caesarean kits, CPN kit, contraceptives ...) from technical and financial partners. However, from 2006 to 2011, an outstanding of approximately 16 billion CFAF still remains to be recovered.

Today this strategy is facing difficulties. They include: inadequate funding, the delay in the transmission of support documents of health centers to the Ministry of Public Health and this latter to the Ministry of Finance. There is a permanent tension of treasury that

public finances of Niger face for over 20 years. In addition, the lack of monitoring of commitments in the expenditure circuit both at the Ministry of health and the Ministry of Finance prevails.

2.4.4. Social Protection

The Nigerien government main concern is to contribute to the well-being of the population through the social and cultural development of individuals, groups and communities. Meanwhile, the government encourages the affirmation and recognition of the true roles of women in society and the preservation of child's physical, moral and mental health.

In Niger, according to the Ministry of Population and Social Reforms, there are two different mechanisms for social protection, "the modern system" and "the traditional system" (28).

The modern system comprises two main forms of social protection:

- Collective protection structures are assured in particular by the state and its dismemberments (NGOs, associations and other partners);
- Individual protection structures whose access to services is related to the affiliation to its structures, including the Social Security National Fund (CNSS), the insurance companies, mutual credit etc ...

As far as the traditional system is concerned, it is based on cultural values such as solidarity and mutual aid. Considered as an expression of mutual responsibility between several people or social groups, solidarity has always been a widespread feeling in Nigerien traditional societies.

In this sense, Nigerien populations have developed since the dawn of time, some forms of social organizations to sacralize the solidarity within the community, to sustain and face adversity from where it may come. Different forms of solidarity occur in a more or less spontaneous way and ensure, whenever necessary, the safety of vulnerable social groups.

The Government of Niger, through the Ministry of Population and Social Reforms organized the *'Study Days on social protection in Niger'* which main objective was to

make an inventory on social protection in Niger and identify the needs of populations in matter of social protection.

However, a number of observations were noted concerning the social protection system dysfunction in Niger, including:

- The overwhelming majority of poor and rural populations are excluded from the buckets and institutions of modern social protection;
- The very complex and sometimes inadequate administrative machinery, does not allow legally protected people to benefit from the performances;
- Despite the social coverage by the said formal system, public officers, some social groups including women, children and disabled people have difficulties to get access to health care benefits.
- It is not without interest to raise also the relationship that exists between the exercising or effective enjoyment of rights by some insured and the level of education. Generally, those who are educated are far more likely to enjoy the benefits of this system;
- The current regulations in matter of social coverage are mainly based on the idea that man, as head of the household, is entirely responsible of the family. But increasingly, there are employee couples and spouses, who can be in community property regime, involved one and the other in child maintenance.

To overcome these deficiencies related to social protection and ensure better social protection for the populations, the Ministry of Population and Social Reforms developed a national social protection policy in Niger. This policy serves as reference framework for the government and all other partners for interventions in the field.

2.5. The Need for an Affordable Health Care Program such as Obamacare in Niger

The plans established in the Obamacare system cannot all meet the realities of Nigerien society. In this sense, we need to analyze the important aspects of Obamacare system to be considered and which can effectively be implemented in Niger with regard to Niger’s financial capacity.

2.5.1. Important Aspects of Obamacare Program Adoptable in Niger

The feasibility of a particular design of the Affordable Health Care of President Barack Obama will be based on ethical, behavioral and sociocultural dimensions. Obamacare is a community health insurance system that is more likely to operate in countries where ethnic or geographic groups show strong social cohesion. In Niger, the National Solidarity sentiment is strongly developed within the population. That is to say, Obamacare system would be more effective in some of Sahel-Saharan African countries such as Niger. However, an affordable health care Act may better suit a country with a high number of people employed in the formal sector of the economy. In Niger, the informal sector of the economy filled the largest number of employees. That is why we will analyze the suitable important aspects of Obamacare system to consider.

As discussed in the previous section, only 3% of Niger population has health care insurance. In addition to this, 63% of Niger's population lives below the poverty line. Consequently, most people do not have access to health care services. The Government of Niger has no means to ensure the health of all people, especially the poor people who get access to health care only when they have the means. From this point of view, Niger needs a community health insurance like the Obamacare program.

In Obamacare program, there are two important aspects to be taken into account which are the “individual mandate” and the “employer mandate" (see chapter one, section 1.2.3).

Concerning the” individual mandate”, all individuals who do not have health insurance should join Obamacare initiative. In Niger, people who do not have health insurance are numerous and represent the indigent, women and children. Individual mandate is the answer to this scourge. According to Obamacare program, private companies are allowed to sell this health insurance. The purchase of insurance by the individual is done through a tax payment. The important aspect of this plan is that any person who does not buy health insurance will be penalized. Therefore, rather than being penalized, the individual will prefer better to buy the insurance. This is not a way to force the individual to buy insurance but rather a mechanism to ensure that everyone is insured.

In the first chapter, the eligible people to join Obamacare system are defined. In Niger, we suggest that all people with no health insurance become eligible. Therefore all eligible people must register themselves and accede to the system, and pay the tax corresponding to the coverage. Authorities in charge of the implementation of this affordable care system should consider the price of the new insurance so that the poorest person could be able to afford one.

The second important aspect is the "employer mandate". This plan requires any employer, with 50 or more employees, to ensure its employees. This is to say, employees are asked to contribute and help the indigent to afford health insurance through tax payment. As for the individual mandate, any employer who refuses to pay his taxes will be penalized through a surcharge. Obamacare defined the different steps a penalized person will undergo. In the case of Niger, we suggest that the penalty imposed on the employer be proportional to the budget of the company.

2.5.2. A Method of Funding Obamacare Program in Niger

The Obamacare program is financially feasible to the extent which leaders and decision makers would accept this program. However, any country wishing to implement Obamacare program needs to take the following aspects into consideration.

- The current and future economic situation (PIB per inhabitant);
- The capacity of the economic structured sector that can be imposed or contribute in the form of a health insurance system for employees;
- The effectiveness of the current health system and the current level of household health spending, part of which may be used to finance the health insurance;
- The financial capacity also depends on the organizational and operational capacity of the country to collect, consolidate and spend funds effectively;
- The Ministries of Finance and of Health must work together in order to evaluate the government capacity and commitment to finance an affordable health insurance;
- Economists, actuaries and accountants can provide information on this issue from the analysis of different scenarios relating to the financial capacity of the country and to the insurance design.

Because of the low levels of public spending on health in low-income countries, such as Niger, it is not surprising that a significant proportion of health spending is paid by the wealthiest. The wealthy people pay the income tax rates or higher property taxes. In low-income countries, the amount of health taxes needs to be reduced for the indigents. The Niger may solicit funds from foreign donors to subsidize poor populations' premiums. Niger must also go through the implementation of a mandatory health care insurance (AMO) so that rich people cannot withdraw from risks' pooling. Finally, Niger needs to make a reallocation between the various pooled funds; for example, the richest neighborhoods should pay for the most disadvantaged neighborhoods. Thereby, there is hope that an affordable health insurance exits in Niger.

2.6. Conclusion

Niger is a third world country, with nearly 62% of the population living below the poverty line. It hardly has a health insurance policy. There is only a free health care system for children aged 0-5 years. Moreover, the state is in the incapacity to make the repayment or payment of the bills that derive from this system. Consequently the bills pile up and cause the malfunction of health institutions and poor quality of care. Therefore Niger is in a serious need of an affordable health insurance system based on the community national solidarity that exists in Niger. The wealthy people are going to help the indigents to have a better health. This contribution would help the government to better enhance its financial capacity to adopt such a system. This chapter encourages us to conduct a practical study of the feasibility of Obamacare program in Niger. Therefore the third chapter is developed for this purpose.

Chapter Three

The Feasibility of Obamacare Program in Niger

3.1. Introduction

Generally speaking, education and health sectors are the basis of the development of any country. Because of the predominance of poverty, the Nigerien government is not able to provide all citizens –mostly the poor populations- with affordable health care. The case of Niger is very serious in terms of health coverage since only 3% of the population has affordable health care. Consequently the major part of the population lives in danger.

To overcome this scourge, we aim to refer to the New Affordable Health Care Reform of President Barack Obama commonly known as Obamacare. The purpose of this chapter is to evaluate the feasibility of Obamacare plans in Niger in order to provide poor and vulnerable populations with affordable health care. The target populations that we survey are the Nigerien citizens among who are wealthy and poor people. Therefore, we dealt with employers, employees and unemployed people. However, 25 Nigeriens are involved in this case study. The questionnaire is distributed among them from their home and work place. So after having shown the necessity to have recourse to Obamacare in Niger in section 1, we are going to demonstrate the existence of solidarity in Niger, as to show its conformity with Obamacare sociocultural values in section 2; and finally in section 3 we will show the extent to which Nigerien citizens –who are the main actors- would welcome the Obamacare plans in Niger.

3.2. The Information Gathering Process

In the first instance, it is important for us to show that Niger government did not succeed in providing populations with affordable health care. This implicates the necessity to have resort to universal health coverage such as Obamacare system. To do so, information about the target group should be gathered. In this task we have chosen to use questionnaire because it is more efficient to gather information on a large scale. The questionnaire is divided into three main sections. It revealed some information about the participants that tell either the person is wealthy or poor.

- **Section 1:Health coverage issue in Niger**

The firsts section consists of three questions in which we attempt to establish an overview of the difficulties of access to health care services mainly for poor people and

the necessity of a universal health coverage that will not discriminate poor populations. The first question is designed to know about the participants' financial situation which determines their access to health care services. This is to say, the poorer you are, the less is your chance to get access to health care services.

- **Section 2: The prevalence of a sustainable sense of solidarity in Niger**

This section focuses especially on the existence of solidarity in Nigerien society. The objective in here is to know if Nigeriens do believe in that sense of solidarity. The section comprises two questions. The first question indicates the concrete existence of solidarity in Nigerien society. The second question tries to raise a kind of consciousness among the populations about the important domain in which solidarity should be expressed. Again, the questions are intended to show the conformity of Obamacare sociocultural values to those of Nigerien society.

- **Section3: The idea of an Affordable Health Care such as Obamacare in Niger.**

This section is intended to evaluate the feasibility of Obamacare plans in Niger. It is very important to know that participants are asked about that reform in an indirect way. Since the rate of illiteracy is considerable in Niger, we do not expect all the participants to have already been taught about Obamacare. Therefore, asking directly the participants about that reform would not facilitate the information gathering process, and would rather intimidate them. We wanted them to feel free and express themselves. For this purpose, we designed the seven questions of this section in an indirect way. The main idea we provide here is the one that involve wealthy people for the benefit of poor populations in matter of health care.

As mentioned in the second chapter, the main aspects related to Obamacare program are the Individual Mandate and the Employer Mandate. These two facts indicate the tax and penalty payments. The first two questions are asked to introduce Obamacare to the participants and to examine their different opinions. The third question is an open one, which leaves space for participants to express themselves. The purpose of this question is to make sure that we are not enforcing the intended results on the participants' answers. Indeed we are curious to know their different opinions about the way wealthy people should act. The two following questions are designed to know participants'

opinions about the way Obamacare system determines wealthy people involvement. The last two questions as they are concerned open the discussion around the involvement of poor people in Obamacare program.

- **Participants**

In fact, participants are wealthy and poor people, from urban and rural communities, with different cultures, belonging to different ethnic groups. We choose to work on such diversity because the aim of Obamacare Act is to provide people with affordable health care without discrimination. Twenty five people are involved in this case study and they are all Niger citizens.

3.3. Data Analysis

As mentioned above, the designed questionnaire is divided into three main sections and consists of twelve questions. Through the following figures and tables, we are going to analyze the different answers.

Q1. In relation to disease risk protection, which of these five groups do you belong to?

A- The first group is composed of officials, military and security forces.

B- The second group is made up of private sector employees affiliated to the national social security fund. The latter provides the employees and their families with affordable health care. Each regional health fund is consisted of some community health centers where different tariffs are offered. Good tariffs are offered to patients who are affiliated to the fund.

C- The third group is made up of public sector employees where each company has a form of internal health insurance. Employees benefit from a health support that covers 80% of their health care costs. Generally, these companies have their own clinics and patients turn first to those health centers.

D- The fourth group is made up of some insured people affiliated to commercial insurance companies. This group is composed of Non-Governmental Organizations, embassies, companies and corporations workers. This mechanism works by a system of repayment.

E- The fifth group is made up of the countryside and modern informal sector whose exact composition and income are little known. This group does not benefit from a form of disease protection. Members of this group receive health care according to their financial capacities rather than according to their requirements.

	Poor	Normal situation	Less wealthy		Wealthy
Group	E	A	B	C	D
Number	7	13	3	1	1
Percentage	28%	52%	12%	4%	4%
			16%		

Table 3.1 Results of Q1 (Section 1)

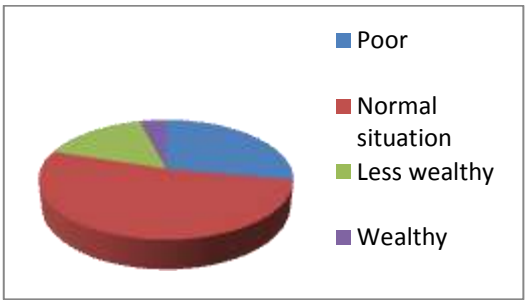

Figure 3.1 Results of Q1 (Section1)

The participants' honesty in answering this question has been of great importance for the coming questions. From the above table and figure, the major part of the participants does not enjoy a satisfactory financial situation. This is borne out by the fact that over eighty percent (52%+28%) of the participants affirms it. Poor people are those who live under the poverty line, with less than 1US $ per day.

Those in normal situation, as they are concerned are only able to satisfy their very basic needs. It would be difficult, if not impossible for them to satisfy some other financial needs out of the basic ones. They cannot afford to buy a health insurance. However they are still counted among people who need to join universal health coverage. The participants who represent the remaining twenty percent (20%) have access to health insurance. That is a good starting point in this evaluation since the financial situation and other diverse characteristics of the participants reflect that of the whole country.

Q2. Do you have a health insurance?

As the below diagram shows, the majority of the participants (60%) do not have a health insurance neither a disease risk protection. This situation can be obviously expected according to the results of the previous question.

However, 40% of the participants are partly insured. Few of them said that they have a medical support from Niger government. This medical support covers 80% of their health care costs. Others affirm that they bought their health insurance in insurance

companies. This 40% belong to the groups B, C and D of the first question, and is obviously the category of wealthy people.

	Number	Percentage
Yes	0	0%
No	15	60%
Partly insured	10	40%

Table 3.2 Results of Q2 (Section 1)

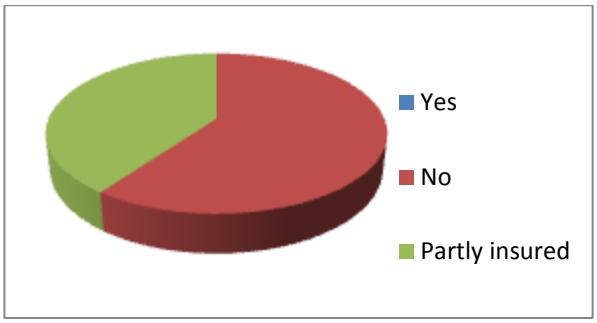

Figure 3.2 Results of Q2 (Section1)

Q3. For how long do you remain insured?

According to the previous question, only 40% of the participants is partly insured. However, the duration of their health insurance varies. Those belonging to the group B affirm that they are insured until they retire, and are often government workers. Participants belonging to the groups C and D most often work in the private sector. However, they have the choice to join an insurance company or not.

Q4. Is Nigerien society a caring one?

	Number	Percentage
Yes	22	88%
No	0	0%
To some extent	3	12%

Table 3.3 Results of Q4 (Section 2)

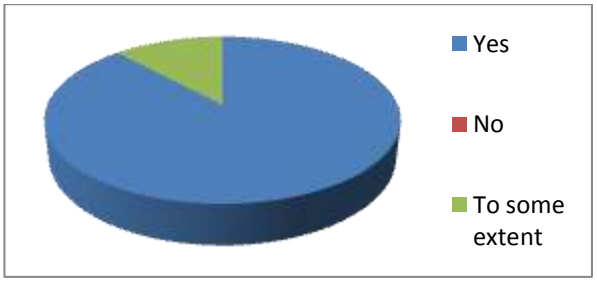

Figure 3.3 Results of Q4 (Section2)

According to the above results, 88% of the participants approves the prevalence of solidarity in Nigerien society. Some of them affirm that the value of solidarity does absolutely exits in Niger, and that is why most people do not mind the lack of health insurance. They occasionally receive some help and charity from wealthy people who maybe their relatives or friends. In Niger, people do care about each other. Populations still live in mutual aid. The concept of individualism does not exist.

From the above table 3.3, none of the participants disapprove this fact. However, 12% affirms that even if solidarity exists in Niger, it is not openly expressed towards health care needs. They sustain that the most important sector in which solidarity should be expressed is that of health and education; unfortunately, this is not the case.

Q5. We observe the expression of solidarity and mutual aid in Nigerien society especially in case of marriage, baptism or death. People are always willing to help the person in charge of the ceremony. Is it possible to consider this solidarity towards the poor and vulnerable people healthcare?

To this question, all the participants answer affirmatively. As many of them have already noted it when answering the previous question, since the country counts many poor people, the most important sector in which solidarity and mutual aid should be expressed is that of health, to help the most vulnerable. They affirmed that it is not impossible to do so, but it would be very difficult. According to one participant, considering solidarity towards poor people healthcare issue would be a blessing for the country.

Q6. Do you think that every citizen - either employed or unemployed- deserves to afford a health insurance?

All participants answered positively this question without any hesitation. It is more than a right for each citizen either wealthy or poor, to have a health insurance. They raise the issue of equality between citizens. Some participants even pretend that the Government should create all the conditions to allow of all social classes to get access to health care services. Participants show that in this 21st century, health care should not be a prestigious good. The health status of the population is very important in that all what people can realize and achieve in their societies depend on their health status. Thus, unhealthy country cannot progress towards development. They also suggest that all unemployed citizens should be medically supported by the Government, because they all deserve and need to be insured. In a nutshell, all participants think that every citizen deserves to afford a health insurance.

Q7. Do you think the issue of health insurance should be a shared responsibility?

To begin with, this question is intended to introduce Obamacare as universal health coverage to the participants, in an indirect way. From the different comments on the previous question, it is obvious that the present question is of great importance. As the below table and figure show, 80% of the participants approves the idea of health care as a shared responsibility. 12% does not think so. However, 8% choose not to answer. The participants who do not share this opinion put the entire responsibility on the government. The latter should help all citizens -mostly rural women, children and poor people- to have health insurance. The major part of the participants however supports the idea that even if the government should be the main actor in that perspective, it should not be the only part being concerned. According to some of them, it would be too naive on the part of the population to believe that the government can provide all citizens with health insurance. Indeed, private companies, national and international donors should help the government in this task. Others categorically think that it is all employers and employees who beneficiate from the government investments responsibility to help the government in making health care insurance affordable to poor and vulnerable populations. One participant among the 80% suggests that the responsibility should be shared between the employer and the employee. This opinion reflects the principles of Obamacare reform.

	Number	Percentage
Yes	20	80%
No	3	12%
No answer	2	8%

Table 3.4 Results of Q7 (Section 3)

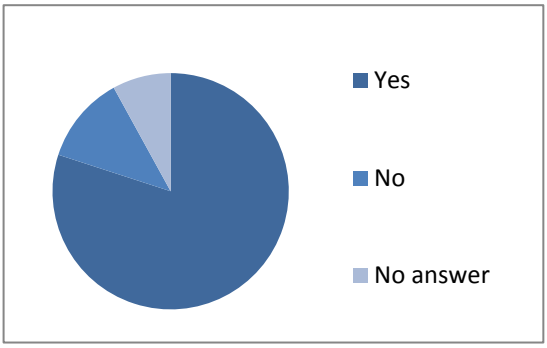

Figure 3.4 Results of Q7 (Section 3)

Q8. If wealthy individuals can or should contribute to provide the poor people with affordable health care, then how to proceed?

This question is asked on purpose, in order to hear participants' different opinions, ideas and suggestions about the question. We avoided imposing the idea of taxation on participants' opinions, because things that are imposed are most often perceived negatively.

As we have expected, participants suggested many different and important methods. Five main propositions are analyzed here. 36% of the participants proposed to collect money from wealthy people. 24% of them wanted the government to open a special fund to collect money from wealthy people of the country and the international donors and charities on behalf of poop people. They also add that a special institution should be organized to manage the fund and work on the issue. One participant -representing 4%- reminds us with the advantage of being in a Muslim country. She states that being caring towards the poor people especially in terms of healthcare is in conformity with Islamic values and recommendations. After all, giving Zakat is the third pillar of Islam (which consists of five pillars). It requires every wealthy Muslim to offer, yearly, a defined percentage of his/her wealth to the poor, in order to reduce poverty. She says that since Niger is a largely Islamic country -98% of Muslims - then the Zakat should be collected for the issue. She obviously shares the same opinion with the 36% of participants. In this sense, she suggests the use of religious arguments to convince wealthy people to join.

24% thinks that the most important method of organization is to impose taxation on the income of wealthy people. In addition, every employer should be responsible for his/her employees' health insurance.

Finally, the remaining 12% insisted on the idea that all these methods would be difficult or even impossible to be adopted without a prior raising awareness. Therefore, campaigns and programs should be organized to raise awareness and motivate wealthy people to contribute in a way or another to the poor health security.

Q9. Can taxes be levied on the incomes of wealthy people to provide affordable health care to poor people?

As we can see in the below table and figure, over 88% of the participants approve the idea. According to these participants, the government should sustain and encourage this method through a reform or law enactment.

	Number	Percentage
Yes	22	88%
No	3	12%

Table 3.5 Results of Q9 (Section 3)

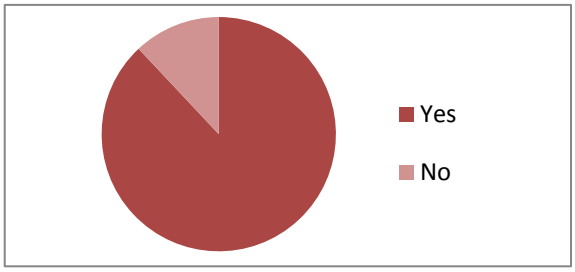

Figure3.5 Results of Q9 (Section 3)

However, the remaining 12% does not share the idea. This group of participants thinks that no wealthy person should be obliged to pay such a tax. The tax can be levied only with the consent of the person without any pressure.

Q10. Should the wealthy individual be penalized through a surcharge if he/she refuses to pay such taxes?

	Number	Percentage
Yes	15	60%
No	4	16%
Other suggestions	6	24%

Table 3.6 Results of Q10 (Section 3)

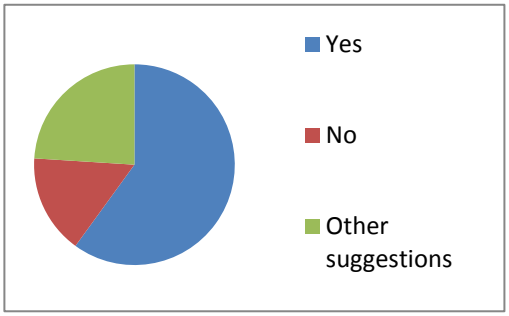

Figure3.6 Results of Q10 (Section 3)

The vast majority of the participants (60%) positively welcome the concept of penalty. By means of surcharge, wealthy people will be obliged to pay their primary taxes. Moreover the concept of penalty would make the initiative more sustainable. 16% however thinks that no one should be obliged to pay a tax or surcharge. According to these participants, the wealthy people should be free to join or not.

The remaining 24% presents many other suggestions. According to one among them, in Niger wealthy people are those who make laws and reforms. Thus, it would be impossible to convince them to join through pressure; the concept of taxation and penalty would rather be effective through raising awareness on the part of the wealthy people.

Q11. If the Government offers affordable health care insurance thanks to the contribution of wealthy people, should the poor people be obliged to buy insurance?

	Number	Percentage
Yes	17	68%
No	8	32%

Table 3.7 Results of Q11 (Section 3)

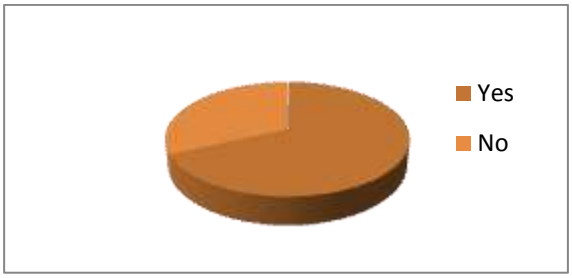

Figure 3.7 Results of Q11 (Section 3)

From the above table and figure, we can see that 68% approves the idea. According to this group of participants, if wealthy people accept to contribute, then the poor people should at their turn make the effort to join too. It should be an obligation for every individual to hold a health insurance.

Other participants (32%) however do not think poor people should be obliged to buy insurance. According to them, a person is totally free to afford insurance or not. They think that the fact that some individuals may not have the means to buy it is an issue to take into consideration.

Q12. To incite the poor people to buy insurance for their own security, should they be penalized whenever they refuse to join the program?

	Number	Percentage
Yes	10	40%
No	11	44%
Other suggestions	4	16%

Table 3.8 Results of Q8 (Section 5)

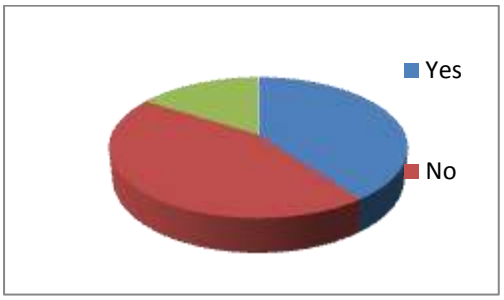

Figure 3.8 Results of Q8 (Section 5)

This time, only 10 participants (40%) share the idea of penalty. According to them, as we may oblige the wealthy to contribute, we should act similarly towards the poor. If wealthy people and the government accept to make the effort to make health insurance affordable, then poor people should manage to buy it. However, 44% of the participants does not approve the idea. According to them, it might not be true that all poor people have the required means to buy insurance. Moreover, they think that health insurance is not an emergency good to own. The remaining 16% chooses not to answer.

3.4. Summary of the Findings

Relying on our findings and understanding of the context, we are now in a position to interpret the overall results to assess the feasibility of Obamacare program in Niger. As it was mentioned in the earlier chapters, our main interest is to find out if the Nigerien sociocultural values and realities would efficiently welcome Obamacare plans. We also give great importance to the method through which Obamacare plans can be financially managed and implemented in Niger. Thus, this third chapter finally answers the issue of feasibility of Obamacare reform in Niger. In this sense, the findings and analysis of the questionnaire are interpreted in three main sections. The results show firstly that Nigeriens are suffering from the lack of universal health coverage. Secondly, there is the prevalence of a sustainable sense of solidarity in Niger. Finally, an affordable health care program such as that of Obamacare would be welcome in Niger.

Firstly, the way we designed the questionnaire shows that was necessary for the participants to precise their financial situation. This is an important point because in Niger health care system is based on direct payment, and health care insurance is not affordable for poor people. That is to say, the quality of health care a person receives depends on his/her financial capacity. According to the data collected, the majority of the participants are in unfavorable situation. As we mentioned it earlier, the situation of these participants represents that of the whole country. Thus, through these participants, we can deduce the feasibility of Obamacare reform in the whole county. Naturally, all those who do not enjoy a favorable financial situation do not have health insurance. No institution is in charge of them. Only children aged 0-5 and sometimes women do benefit from free care. Moreover, populations are suffering from the cause and effect relationship between health and poverty.

Due to the system of direct payment, a poor person is obliged to impoverish himself again to pay the health care costs. This situation gives space for poverty. Understanding that issue, however guides us to say that fighting for affordable health care is also fighting against poverty. On the other hand, fighting against poverty helps to create conditions for good health.

Indeed few participants do have health insurance. This latter generally expires by the end of the work contract or at the owner retires. Those enjoying good financial situation however are free to buy insurance whenever they feel the need of it. Unfortunately many of these wealthy people do not consider the necessity of owning insurance because they do not really know its importance. One participant stated that holding health insurance should not be a necessity since it is just like preparing oneself for a situation that did not yet happen. This section proves again all what have been said in the second chapter. Indeed, in Niger, health care is not accessible to all the population. Poor and vulnerable people, who represent 62% of the population, are the main victims of the poverty. Therefore, for a sustainable development, it is an emergency to reconsider the issue of affordable health care in Niger. This is a necessity since nothing great can be accomplished if the population's health is bad. All the results gathered in the first section of the questionnaire proved the strong and emergent need for affordable health care in Niger. At the end of the first chapter, after a critical sociocultural exploration, we concluded that Obamacare is a good and suitable example of affordable health care plans for Niger.

In the first chapter, we also explored the prevailing sociocultural values of Niger. Solidarity is part of these values. However, we needed to explore this solidarity in Nigeriens real life situation. The purpose was not only to know exactly if populations still believe in that sense of solidarity, but also to know if the latter can be directed towards health care. This time, Obamacare reform was introduced to the participants in an indirect way. Solidarity is part of society's daily life in Niger. The prevalence of that value is mainly due to historical and religious reasons.

In Niger, people from different ethnic groups and cultures live together on the basis of a great sense of solidarity. Generally in Africa, the strongest individuals and people are those who are attached and linked to others. This is to say, the more a person expresses and shows a sense of individualism, the more he/she stays apart from the society. Other people with whom he/she may be living at their turn would not care of him/her. This is somehow a way of punishing that individualist person in one hand, and

in the other, to show him that in fact a human being is made to live with others, and that individualistic behaviors are not part of African realities.

Solidarity within health care system as a characteristic of Obamacare system is perceived by Nigerien as a blessing for the whole country. In other words, Nigerien populations really wish solidarity to be taken into consideration in health system. This leads to affirm that Obamacare system has many chances to be welcome in Niger.

When dealing with a large scale of people for social, economical or political issues, good communication is fundamental and very necessary. Therefore, it was necessary for us to explain at least the main characteristics of Obamacare plans. Indeed, individual and employer mandates are the two main principles of Obamacare system that we could not afford to ignore. The main features of these principles are the tax and penalty payments both by the employee (who is supposed to be poor) and the employer (who is supposed to be wealthy). Before we introduce these principles to the participants, some of them suggested levying taxes on the incomes of wealthy people as a method of expressing solidarity within health system. Nigeriens, precisely some wealthy people approved to be taxed on the behalf of poor and vulnerable people health care. They then suggested going through raising awareness about the importance of the issue. Many Nigeriens find the system of penalty payment acceptable. Those who did not approve that idea thought wealthy people would feel oppressed. In the way we dealt with them, we can say that this negativity is due to a misunderstanding that can be overcome throughout raising awareness.

A group of participants chose not to answer, not because they are indifferent to the issue but rather because they do not believe that the government would succeed in adopting it as a reform. A participant said “it is not possible to have such a reform since wealthy people who are supposed to be the main actors are in fact those who make laws and reforms”. This is not totally false, since in Niger the major part of wealthy people belong to the informal sector and are most often uneducated or illiterate people. They need to understand and be convinced that their money will not go in the pocket of the decision makers in charge of the fund. They are not wrong since the phenomena of corruption and funds misappropriation are current in the country.

However, it is a scourge that can be overcome through education and raising awareness. The individual mandate as it is concerned raised many polemics because Nigeriens think poor people do not have the means to subjugate to the program. Firstly, they accepted that any citizen whether poor or not should hold health insurance.

Secondly, they assumed that if wealthy people would make the effort to contribute and make health care affordable, then the poor people at their turn should be obliged to buy their health insurance. Few people accept the concept of penalizing poor people who do not join the system. In fact, there are many people in Niger who do not even have the means to feed themselves, and penalties could be a debt that they could never be able to pay. However, this category or poor people need to be educated and taught about the importance of health insurance. They should be aware that bad health status is the only enemy of a human being, and that everything starts with a good health.

We end up saying that, to be away from disease risks is to be away from poverty. Naturally, it will be difficult to convince people to join an affordable health care program at the right beginning. However latter on, no one will choose to stay uninsured. In a nutshell, Nigeriens approve the characteristics of Obamacare program. Before offering recommendations on the effectiveness of Obamacare program in Niger, it seems necessary to present the limitations of the study.

3.5. Limitations of the Study

Dealing with the feasibility of an American reform in Niger is a complex issue. Indeed the participants do have no idea about Obamacare system, and whenever they are told about its origin, they are intimidated. They think we are going too far, and that African realities are totally different and far away from those of Americans. Indeed, they think so, simply because they do not know about the richness of social and cultural values we still have in Africa. The U.S President, Barack Obama simply proved this truth through his New Affordable Health Care Act called Obamacare.

The contact with the participants was not easy at all when we visited a private insurance company for the first time. Explaining the Obamacare program for both employees and employers was a great deal. Some participants even asked us if really we do find President Barack Obama as a model for African leaders. The major difficulty that we found was that many people can hardly see their role in our research project.

Whenever we spoke about health insurance, they automatically said that it is not their professional domain. In this way, they totally ignore that it is the concern of any citizens.

In contrast to some countries like Togo and Algeria in which we experienced research work, where academic researches and scientific researchers are given great consideration, in Niger people are intimidated by research questions. Many abnormal attitudes were observed and a sense of mistrust prevailed. This can be understood because of social insecurities and political instabilities.

However, we also met people who appreciated the research topic. They welcome and offered us many important documents and sources on the issue of health care insurance in Niger. They also provided us with many pieces of advices on the way to handle the research topic. The main point is that, we are not trying to copy the personality of President Barack Obama but rather his idea and plans established within his New Affordable Health Care Act.

Moreover, in Niger, it is important for a researcher to be firstly convinced about the research topic he/she chooses to work on and be very motivated in order not to be discouraged by people's attitudes.

3.6. Recommendations

Having finished the research work process that we undertook in three main chapters, we will use the outcome data and the overall findings to provide with some recommendations. The discussion centers around two main recommendations which are about:

- How to make Obamacare program more effective in Niger?
- The methods of materializing Obamacare program in Niger.

It is obvious that Nigerien health sector needs to be improved. For a sustainable development, poverty should stop causing health problems. Indeed the Nigerien government on its own cannot succeed in providing all citizens mostly the poor people with affordable health care. Solidarity and mutual aid are required towards each other.

In this sense, the long of this research work, we not only suggested Obamacare reform as a possible solution to this scourge but also we tried to evaluate its feasibility in Nigerien societies. The findings show that indeed, Obamacare is feasible in Niger. The main issue then is to make it more effective. Since populations are the main actors,

it is very important to conduct some programs that raise people's awareness on the issue.

We think that this should be the first step to begin with. Populations need to be taught about their different roles. Indeed, social reasons as well as religious motives can be used to convince more people to join the initiative. Moreover, all the achievements should be recorded, shown and exposed to those involved –mostly to wealthy. Employers are not the only category of people that should be considered as wealthy people, but also all other donors and national and international charities. Authorities should at their turn arrange an institution that would be in charge of this fund. The latter should be used for the issue without any misappropriation.

Finally, we suggest that implementing Obamacare system is not only the concern of public sector but also that of private sector. Indeed, it is not easy for Nigerien authorities to implement such a program mainly because of the problems at political management level.

Nevertheless, academic and scientific researches need to be conducted on a given issue before implementing it as e political reform. Furthermore, many political decision makers should be qualified in their domain. Individuals who are specialized in the appropriate domains are not much solicited because they may not belong to the political party holding the political power. In this sense, we need also the nongovernmental organizations to be involved. Obamacare plans are an initiative that nongovernmental organizations can be able to materialize.

The achievements resulting from that would be a wide and strong introduction and presentation of Obamacare program to the government. This is why, academic and scientific researchers who want their discovery and creativity to be materialized should not wait for the action of the government. They should take the initiative to create or join nongovernmental organizations. Only then we can make sure that good initiatives or ideas such as Obamacare would not remain unexploited.

3.7. Conclusion

This chapter as a project on its own has been concerned with the feasibility of Obamacare system in Nigerien society. So to sum up, it is important to emphasize the main principles of Obamacare system taken into consideration when designing the research questionnaire. (1) The first step has been to incite population to express the

need of Universal health coverage in Niger; (2) The second was to test the prevalence of Solidarity in Niger. The final step has been to analyze people's opinion about the employer mandate first and then the individual mandate. In the last section, we tried to put all the results and findings together to come up with a reliable answer about the feasibility of Obamacare system in Niger.

From our conclusion on these findings, we can say that implementing Obamacare system in Niger appears to be feasible. In this sense, a special attention should be put on how to materialize it and make it more effective in Niger. These responsibilities are addressed to people who are specialized in the field, from or outside the country, in order to get solutions, new ideas and improvements. In this perspective, we do suggest that it is even an emergency for all the actors who are the poor people, charities, donators, nongovernmental managers, political leaders to be taught about the possibility for universal health coverage in Niger. The idea of universal health coverage is not much discussed in Niger. However, a single committee has been recently created to discuss the issue and conduct required researches on the notion of universal health coverage.

GENERAL CONCLUSION

In a nutshell, replicating the Obamacare plans in Niger –a Sahel Saharan African country- appears to be feasible. To make it effective, we need to make the entire community aware about what Obamacare actually represents and means.

We have come to show the conformity of sociocultural values of Obamacare with those of Nigerien society. Basically, solidarity as the main characteristic of Obamacare system is also a prevailing value in Nigerien societies. Therefore the reform is more likely to be welcomed in Niger.

Moreover, we presented the conditions of health care access to populations in Niger. Most Nigeriens can hardly have access to health care services. This is partly due to the nonexistence of a health insurance policy in Niger, where only 3% of the population has access to affordable health care insurance. It is also due to the fact that all individuals who do not have health insurance have access to health care services only through direct payment. The latter refers to the payment of health care costs in cash money.

Nevertheless, the majority of the population is poor, and do not necessarily have cash money when encountering health problems. This is to say in Niger, poor people, who represent nearly 62% of the population are obliged to impoverish themselves through indebtedness or by sailing their properties (house, land, cattle, etc…) to pay their health care costs. Those who cannot find money simply will not get access to health care, unless if a relative or a charity helps them.

Consequently, health problems cause poverty, and vice versa. Unfortunately, poverty at its turn causes health problems because indigent are confronted to hygiene problems, malnutrition, and lack of drinking water which are source of many diseases. Therefore, understanding this cause and effect relationship between health and poverty is vitally important in understanding the fight for affordable health care insurance and the fight against poverty in Niger. From this perspective, it is necessary for the latter to implement a program of affordable health care insurance similar to that of Obamacare. Indeed, the latter needs the wealthy to contribute for indigent health care access. Thus, since not only the government will be in charge of the funding, then it can be said that Niger has the financial means to implement the Obamacare Program.

To materialize Obamacare plans, the Ministry of Public Health and the Ministry of Finance in Niger should work hand in hand together in addition to the taxes and penalties levied on the incomes of wealthy people. However, in case the government would/could not adopt such a reform, then non-governmental organizations should be involved. Private companies too, can deal with the issue, not only to make their own business, but also to help poor populations. The majority of the participants believe in the feasibility of Obamacare plans in Niger.

Additionally, raising awareness about the programs is extremely important in making sure that all citizens learn and know about the characteristics and principles of Obamacare Act. To be more effective, social as well as religious motifs should be used to convince more people to join these campaigns.

All in all, Obamacare program appears to be feasible in Niger, a Sahel-Saharan African country. Furthermore, implementing Obamacare plans is a good and reliable solution to the issue of health insurance in Niger. Through Obamacare program, almost all the indigent people will have access to affordable health care insurance. Consequently, the poverty will be reduced in the country. The latter can then head towards the development.

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Questionnaire designed for the feasibility of Obamacare Program in Niger.

Name: …….

Profession ……Sector:……...

Nationality: ……..……..

P.S: All personal information are to be kept secret, hence feel free in your answers.

Section 1: Health coverage issue in Niger

Q.1: In relation to disease risk protection, which of these five groups do you belong to?

A- The first group is composed of officials, military and security forces.

B- The second group is made up of private sector employees affiliated to the national social security fund. The latter provides the employees and their families with affordable health care. Each regional health fund is consisted of some community health centers where different tariffs are offered. Good tariffs are offered to patients who are affiliated to the fund.

C- The third group is made up of public sector employees where each company has a form of internal health insurance. Employees benefit from a health support that covers 80% of their health care costs. Generally, these companies have their own clinics and patients turn first to those health centers.

D- The fourth group is made up of some insured people affiliated to commercial insurance companies. This group is composed of Non Governmental Organizations, embassies, companies and corporations workers. This mechanism works by a system of repayment.

E- The fifth group is made up of the countryside and modern informal sector whose exact composition and income are little known. This group does not benefit from a form of disease protection. Members of this group receive health care according to their financial capacities rather than according to their requirements.

Q.2: Do you have a health insurance?

Q.3: For how long do you remain insured?

Section 2: The prevalence of a sustainable sense of solidarity in Niger

Q.4: Is Nigerien society a caring society?

Q5: We observe the expression of solidarity and mutual aid in Nigerien society especially in case of marriage, baptism or death. People are always willing to help the person in charge of the ceremony. Is it possible to consider this solidarity towards the poor and vulnerable people healthcare? Section 3: The idea of an Affordable Health Care such as Obamacare in Niger**.**

Section 3: The idea of an Affordable Health Care such as Obamacare in Niger.

Q6. Do you think that every citizen - either employed or unemployed- deserves to afford a health insurance?

Q7. Do you think the issue of health insurance should be a shared responsibility?

Q.8: If wealthy individuals can or should contribute to provide the poor people with affordable health care, then how to proceed in?

Q.9: Can taxes be levied on the incomes of wealthy people to provide affordable health care to poor people?

Q.10: Should the wealthy individual be penalized through a surcharge if he/she refuses to pay such taxes?

Q.11: If the Government offers affordable health care insurance thanks to the contribution of wealthy people, should the poor people be obliged to buy insurance?

Q.12: To incite the poor people to buy insurance for their own security, should they be penalized whenever they refuse to join the program?

Logo of the Patient Protection and Affordable Health Care Act enacted by the U.S. President Barack Obama in 2010 commonly known as Obamacare.