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Do Community-based Health Insurance Schemes Improve Poor People's Access to Health Care? Evidence From Rural Senegal

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Summary. — Community-based health insurance is an emerging and promising concept, which addresses health care challenges faced in particular by the rural poor. The aim of this paper is to analyse whether rural Senegal members of a health insurance scheme are actually better-off than nonmembers. The results show that in poor environments, insurance programs can work: Members of *les mutuelles de santé* (mutual health organizations) have a higher probability of using hospitalization services than nonmembers and pay substantially less when they need care. Furthermore, the analysis revealed that while the schemes achieved to attract poor people, the poorest of the poor remained excluded.
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Key words — risk sharing, health insurance, access to health care, Senegal

1. INTRODUCTION

Health security is increasingly being recognized as integral to any poverty reduction strategy. While the objective of poverty reduction remains of central concern, there has been a shift of focus away from poverty reduction *per se* to social risk management. Such is the case because of the growing appreciation of the role that risk plays in the lives of the poor (Holzmann & Jorgensen, 2000). Of all the risks facing poor households, health risks probably pose the greatest threat to their lives and livelihoods. A health shock leads to direct expenditures for medicine, transport and treatment but also to indirect costs related to a reduction in labor supply and productivity (Asfaw, 2003). Given the strong link between health and income at low income levels, a health shock usually affects the poor the most (CMH, 2001; Morrisson, 2002).

The states in most developing countries have not been able to fulfill health care needs of their poor population. Shrinking budgetary support for health care services, inefficiency in public health provision, an unacceptable low quality of public health services, and the resultant imposition of user charges are reflective of the state's inability to meet health care needs of the poor (World Bank, 1993). [1] In the last decade, the "health care crisis" led to the emergence of many community-based health insurance schemes (CBHI) in different regions of developing countries, particularly in sub-Saharan Africa (Preker, 2004; Wiesmann & Jütting, 2001). The decentralization process unleashed in these countries to empower lower layers of government and the local community further fueled their emergence (Atim, 1998; Musau, 1999). The success of community-based microcredit schemes may have also contributed to the emergence of community-based health initiatives designed to improve the access through risk and resource sharing (Dror & Jacquier, 1999). Elsewhere, particularly in regions of Asia and Latin America, community-based health initiatives have come about independently and

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as part of income protection measures or to fill the void created by missing institutions. [2]

Neither the state nor the market is effective in providing health insurance to low-income people in rural and informal sectors. The formal providers are often at an informational disadvantage and face high transaction costs. On both these counts health insurance schemes rooted in local organizations potentially score better than alternate health insurance arrangements. [3] In rural and informal sectors where supply of health services is expected to be weak, both financing and provision aspects need to be tackled simultaneously. [4] Indeed, most of the CBHI schemes have either been initiated by the health providers i.e., missionary hospitals, or tend to be set around the providers themselves (Atim, 1998; Musau, 1999). Thus, the potential benefit of these schemes is seen not just in terms of mobilization of resources but also in the improvement and organization of health care services.

Whereas the CBHI concept is theoretically appealing, its merits still have to be proven in practice. In the literature, this question is controversially debated: Proponents argue that CBHI schemes are a potential instrument of protection from the impoverishing effects of health expenditures for low-income populations. It is argued that CBHI schemes are effective in reaching a large number of poor people who would otherwise have no financial protection against the cost of illness (Dror & Jacquier, 1999). Other available studies however, are less optimistic. Community structures may not necessarily reflect the views of the wider population, critical decisions may not take into account the interest of the poorest, and they may be excluded from decision-making (Gilson *et al.*, 2000). It is furthermore argued that the risk pool is often too small, that adverse selection problems arise, that the schemes are heavily dependent on subsidies, that financial and managerial difficulties arise, and that the overall sustainability seems not to be assured (Atim, 1998; Bennett, Creese, & Monash, 1998; Criel, 1998).

The existing studies on CBHI schemes face the important limitation that most of them are not based on household data and/or rely solely on qualitative methods of investigation. In addition, they mainly look at the impact of the schemes on the provider or the insurance scheme, largely neglecting the effects on the members.

Against this background, the objective of this paper is to analyze the impact of community financing on the access to health care using data from a household survey in rural Senegal. We chose the case of Thiès region in Senegal for the following reasons:

—a relatively long, 10-year experience with community-based health insurance schemes,

—the Thiès area is characterized by a high incidence of poverty, malnutrition and bad health conditions, while the health care supply is tailored only to a small percentage of the population,

—an innovative institutional setting. There exists a contract between a nonprofit health care provider, a Catholic-run hospital, and the mutuals, which allows them to receive health care at a lower rate.

To answer our question we use a logit/log-linear model to analyze the impact of membership on health care utilization and financial protection.

The outline of the paper is as follows: Section 2 elaborates the conceptual framework of the study and highlights the dynamic interactions between the supply and demand effects after the introduction of a health insurance scheme. Section 3 describes the case study, research design and methodology. The results of the estimations are discussed in Section 4. Section 5 concludes the paper.

2. SUPPLY AND DEMAND EFFECTS OF HEALTH INSURANCE

Health insurance schemes are supposed to reduce unforeseeable or unaffordable health care costs through calculable and regularly paid premiums. In contrast to the history of social health insurance in most developed countries, where health insurance schemes were first introduced for formal sector employees in urban areas, recently emerging health insurance schemes have taken the form of local initiatives of a rather small size that are often community-based with voluntary membership. [5] They have either been initiated by health facilities, member-based organizations, local communities or cooperatives and can be owned and run by any of these organizations (Atim, 1998; Criel, 1998). There are several possible ways to classify these schemes, according to: Kind of benefits provided, degree of risk pooling, circumstances of their creation, fund ownership and management and the distinction whether the schemes focus on coverage for high-cost, lowfrequency events or on low-cost, high-fre-

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