

**Community-Based Health Insurance Schemes
in Sub-Saharan Africa:
Which Factors Really Influence Enrolment?**

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ABSTRACT

Health micro-insurance systems have experienced a fast development for some fifteen years in sub-Saharan Africa as a means of improving the access of the poor to healthcare services. The present article focuses mainly on community-based health insurance (CBHI) systems, as they currently constitute one of the most developed forms of health micro-insurance.

However, it must be acknowledged that the enrolment rates remain particularly weak and coverage of the target population only rarely reaches 10%. Several authors have already observed this fact and undertaken research on the factors which influence enrolment. Nevertheless, the methodologies used, size of the samples, characteristics of the surveyed individuals, inclusion or not of non-members in the surveys, geographical areas etc. vary a lot from one author to the other. This is why this article aims at synthesizing the empirical studies carried out to date and to identify major concurring results beyond methodological differences. We finally come out with two factors which seem to play a major role and six others which seem to have a significant influence on enrolment, while surveys do not confirm the role of various other variables.

We conclude with some lessons regarding the roles of the promoters and supporting NGOs in the establishment of CBHI schemes.

Key-words: health services, health insurance, poverty, non-profit organisation

Introduction

A significant part of sub-Saharan populations currently live in extreme poverty and suffer serious health problems. Whereas health care was previously subsidized to a large extent by the state, they have been based, since the Bamako Initiative (1987), on the financial contribution of users, according to a rationale of cost recovery. The withdrawal of the public sector from the financing of health care systems has had important consequences for the populations, in particular those working in the informal sector. Moreover, the private insurance markets being insufficiently developed or inaccessible, many individuals have no access to a protection against disease risk. These groups, being deprived of any form of social protection, are financially unable to benefit from good-quality health care services.

In an attempt to provide an answer to these difficulties, health micro-insurance systems have been emerging for some fifteen years in sub-Saharan Africa. Their main goal being to improve the access of economically deprived populations to health care, they can constitute a relevant alternative for those who do not benefit from any form of social protection. This is why they raise today a lively interest on the part of many actors, both public and private. These health micro-insurance systems are relatively recent, but they are continuously gaining ground. Their number indeed seems to be ever growing; an inventory carried out by the "Concertation" (2004), a platform bringing together the actors supporting the development of community-based health insurance schemes in Africa, listed in 2003 some 622 organizations in eleven countries of Western and Central Africa.¹ However, many of these initiatives do not go beyond the experimental stage and are faced with numerous obstacles to their development.²

Among the problems encountered by health micro-insurance systems, the question of enrolment appears as a central element. Despite the development and upsurge of community-based health insurance (CBHI) schemes, the number of beneficiaries remains particularly low. In any case, one has to acknowledge that the enrolment and coverage rates currently remain very low; they only rarely reach 10% of the target populations.³ Several surveys have explored the reasons accounting for this low participation, but the methodologies used and the contexts within which they were carried out made it difficult to compare results. The present article thus aims to provide a state of the art of the researches carried out in this area with a view to identifying the elements known with greatest certainty as regards the factors influencing the decision to enrol in CBHI schemes.

In section 1, we will briefly describe the context of emergence and the characteristics of health micro-insurance systems and CBHI schemes in sub-Saharan Africa. In section 2, we will address the question of enrolment from a theoretical point of view, and we will then outline the researches which are relevant for our synthesis. In subsequent sections, we will analyze the different factors influencing the decision to enrol that have been identified by the surveys. In order to do so, we will successively deal with the factors linked to households, those linked to health services providers and those linked to CBHI schemes themselves.

¹ It has to be noted, however, that the lack of available data and documentation makes it impossible to establish an exhaustive inventory. No update of this inventory has been carried out since 2003, and it appears that these figures are now outdated, due to the development of the movement in Western Africa.

² By way of example, only 366 health micro-insurance schemes, out of the 622 listed by the Concertation, seemed to be really functional (La Concertation, 2004).

³ De Allegri et al., 2006a; Waelkens and Criel, 2004.

1. The emergence of community-based health insurance schemes

During the colonial period, health care in sub-Saharan Africa was generally provided free of charge. After they gained their independence, most emerging states, due to the epidemiological context of the time, chose to favour "vertical" programmes, focussing on the fight against major plagues but failing, to a large extent, to take into account the economic dimension. These governments encountered growing problems in matters of financing, accessibility and equity of health care; in this context, the Declaration of Alma Ata recommended, in 1978, a fundamental reform of health systems and designed a strategy to achieve the goal of primary health care for all. This strategy was applied in different ways in the different countries, but none of them had sufficient financial means to ensure equity in terms of access to health care services deemed essential. The Bamako Initiative, in 1987, emerged in this context of inequality, poor quality of health care and deterioration of health facilities. It privileged community funding of health care, in the framework of a cost recovery strategy in public health facilities.

This rationale proves today to be very costly in terms of consequences for the most deprived, who are often financially unable to have recourse to health facilities. Governments only provide an insufficient answer hereto: social welfare provision only concerns workers in the formal sector and public agents, i.e. some 10% of the population in Western Africa.⁴ Similarly, private insurance companies remain scarce and unaffordable for most people. And finally, even though communities, faced with difficulties, organize solidarity-based and informal forms of mutual help, these solutions often remain insufficient to overcome the problems of health care financing.⁵ Consequently, in a context of democratization and emergence of the civil society, various systems of community-based financing of health care services have emerged in sub-Saharan Africa, with a view to improving access to good quality health care and social welfare services for larger segments of the population.

Various terms can be used to describe these new initiatives. The notion of "health micro-insurance", which refers to a large variety of systems, was put forward by the STEP programme of the ILO; it reflects the low level of the premiums paid by the members as well as the proximity between the latter and the organization.⁶ The term "micro" also refers to the low level of social organization in the framework of which the activity is carried out.⁷

CBHI schemes constitute one of the most fully-fledged and developed forms among these initiatives in sub-Saharan Africa.⁸ The STEP programme of the ILO defines the community-based health insurance scheme as "*a non-profit association, based on the principles of solidarity and mutual help among the physical persons who enrol in the organization on a free and voluntary basis*".⁹ Thanks to member premiums, which are not linked to individual risks, and to its principle of participative democracy, the mutual health organization primarily aims to ensure the payment or reimbursement of all or part of the costs of health care,

⁴ BIT-STEP, 2000.

⁵ Fonteneau, 2000.

⁶ Fonteneau, 2003.

⁷ However, this term is sometimes criticized by some CBHI schemes' promoters because they consider it not to reflect to a sufficient extent the participative, non-profit and solidarity-based characters of these associations (Develtere et al., 2004).

⁸ BIT/STEP, 2000; Fonteneau, 2000.

⁹ BIT/STEP, 2000, p. 25.

according to the contracts negotiated with the providers. Although nine health micro-insurance initiatives out of ten define themselves as CBHI schemes,¹⁰ their mechanisms and principles can, in practice, differ widely.¹¹

2. The question of enrolment: theoretical approach and empirical surveys

Among the various challenges that CBHI schemes have to face, the question of enrolment currently appears as crucial. Indeed, despite the continuous growth of the CBHI schemes movement in sub-Saharan Africa, the percentage of people covered only rarely reaches much more than 1%.¹² The coverage rates observed everywhere remain relatively low, sometimes jeopardizing the organization's sustainability itself.¹³ The enthusiasm generally raised among the target populations by CBHI schemes at their inception contrasts with subsequent actual results: enrolment rates generally lower than predicted, high non-renewal rate and problems in the collection of premiums.¹⁴

Enrolling in a CBHI scheme implies in fact a double process: first, a will to insure oneself against health hazards, and secondly, a will to become member of an organization. The target populations thus have to accept the principles of pooling of risks and resources. Enrolment also implies some degree of commitment towards the mission of the CBHI scheme. In order to become a member of a CBHI scheme, one must not only pay membership fees, but also be up-to-date on the payment of one's premiums. The commitment and participation of the member in the life of the organization can also be part of the conditions for enrolling.

In theory, a series of indicators can be used to assess the enrolment dynamics: the gross growth rate, which allows to assess the evolution of the number of enrolees and beneficiaries; the renewal rate, which is the proportion of enrolees renewing their enrolment; the coverage rate, which refers to the proportion of individuals who become members among the population initially targeted; the internal and external growth, which allow to assess the evolution in terms of new members in previously covered (internal growth) or new areas (external growth); the premium collection rate, which can reveal a non-renewal of membership. When studying the factors influencing the decision to enrol in a CBHI scheme, first enrolment should also be distinguished from enrolment renewal.¹⁵

The question of enrolment can also be analyzed from the point of view of individuals' willingness to pay for a health micro-insurance system. Such an approach does not assess the decision to enrol as the previously mentioned indicators do, but it nevertheless allows to assess the maximum amount of money that an individual is willing to spend on such a product. The willingness to pay for a CBHI scheme thus constitutes an indicator of the utility of such an organization for individuals or their degree of (actual or expected) satisfaction.¹⁶

In practice, empirical studies analyzing the participation in CBHI schemes almost always face the problem of lack of available data within organizations.¹⁷ Indeed, very few organizations

¹⁰ La Concertation, 2004.

¹¹ Fonteneau, 2003.

¹² Waelkens and Criel, 2004; Fonteneau, 2003.

¹³ De Allegri et al., 2006a; De Allegri et al., 2006b; De Allegri et al., 2005; Musango et al., 2004; Criel et al., 2002; Tine, 2000.

¹⁴ De Allegri et al., 2006a; Fonteneau, 2003.

¹⁵ Fonteneau, 2006 and 2003.

¹⁶ Dong et al., 2003.

¹⁷ Fonteneau, 2006; Fonteneau, 2003; Dubois, 2002; Atim, 2000.

have data on members' profiles and the various registers are often incomplete. Although the various abovementioned indicators are necessary to analyse the question of enrolment, they are thus difficult to calculate. Besides, the studies analysing exclusively the question of enrolment remain scarce, even though their number has been increasing in recent years.¹⁸

In such a context of "statistical poverty", it seemed all the more interesting and necessary to attempt to provide a state of the art of empirical knowledge relating to the factors influencing the decision to enrol in CBHI schemes in sub-Saharan Africa. In order to do so, we based our analysis on 15 empirical studies carried out in Western Africa¹⁹ or in Eastern and Central Africa²⁰. Moreover, three comparative researches were also taken into account.²¹

A table summarizing the main parameters of these surveys is provided in appendix. One should keep in mind the fact that some analyses focused specifically on the question of enrolment in CBHI schemes, whereas others analyzed this subject among other questions. These studies belong to various academic disciplines, such as economics, sociology and public health.

Another divergence among these empirical studies lies in the methodology used. Some studies are based on a quantitative approach.²² Others privileged qualitative analyses²³ by relying on "focus groups" and/or semi-structured individual interviews. The number of CBHI schemes taken into account as well as the way in which the interviewed individuals were selected also vary, sometimes widely. And finally, the CBHI schemes surveyed also differ - in terms of "membership", benefit package on offer, external support, etc.

3. Household-related factors influencing the decision to enrol

In this section, we analyze the factors influencing the decision to enrol which are linked to the characteristics of individuals and to the socioeconomic characteristics of households.

3.1. Individual characteristics

Individuals' age, sex, ethnicity, religion, education and occupation are all characteristics that can potentially affect the decision to enrol or not in a CBHI scheme.

Age and sex

Most studies concur on the fact that enrolment does not seem to be linked to gender.²⁴ However, the study carried out by Dong et al. (2003) in Burkina Faso indicates that men are willing to pay more than women for a CBHI scheme. This could be linked to the fact that women have on average lower education and income levels and higher nuptiality rates than men.

¹⁸ De Allegri et al., 2006a; Fonteneau, 2006; De Allegri et al., 2005.

¹⁹ De Allegri et al., 2006a; De Allegri et al., 2006b; De Allegri et al., 2005; Jütting, 2005; Criel and Waelkens, 2003; Dong et al., 2003; Fonteneau, 2003; Dubois, 2002; Criel et al., 2002; Tine, 2000.

²⁰ Basaza et al., 2008; Schneider, 2005; Musango et al., 2004; Criel, 1998.

²¹ Fonteneau, 2006; Waelkens and Criel, 2004; Atim, 2000.

²² De Allegri et al., 2006b; Jütting, 2005; Musango et al., 2004; Dong et al., 2003; Dubois, 2002.

²³ Basaza et al., 2008; De Allegri et al., 2006a; De Allegri et al., 2005; Schneider, 2005; Criel and Waelkens, 2003; Fonteneau, 2003; Dubois, 2002; Criel et al., 2002; Atim, 2000; Criel, 1998.

²⁴ De Allegri et al., 2006b; Jütting, 2005; Musango et al., 2004; Dubois, 2002.

Results regarding the influence of age are contradictory. Dubois (2002) notes a high proportion of people over 60 among enrollees. Other studies indicate that age does not seem to have any influence, no age group being under- or over-represented among enrollees.²⁵ Finally, Criel (1998) notes that older people are more often excluded from the community, both economically and socially, and thus find it more difficult to participate in the CBHI scheme. Similarly, Dong et al. (2003) note that older people would be willing to pay less than younger people for a mutual health insurance.

Education level

Empirical data also reveal that education influences the participation in a mutual health insurance: a higher education level favours enrolment.²⁶ The hypothesis put forward by Dubois (2002) is that individuals having benefited from a formal education would be more attentive to health hazards, would display greater openness towards innovation and would be better able to understand the benefits of mutualist system.

The study carried out by Jütting (2005) in Senegal indicates that the higher the education level, the greater the probability to enrol in a CBHI scheme, and this remains true independently of the way in which this level is measured – be it in years of schooling or in terms of capacity to read and write. In the population covered by this research, for example, some 80% of individuals with a secondary school degree and 90% of individuals with a university degree were members of a CBHI scheme. Household heads with a minimum level of formal education were more likely to participate than those who had not received any formal education. Similarly, people able to read and write were more likely to enrol in a CBHI scheme than illiterate people (respectively 70% and 55% of these two groups enrol).

Ethnicity

Two empirical studies observe higher enrolment rates in CBHI schemes among some ethnic groups.²⁷ A research carried out in Burkina Faso by De Allegri et al. (2006b) reveals a positive association between enrolment in a CBHI scheme and Bwaba ethnicity (the majority of CBHI schemes' members are Bwaba in spite of this ethnic group being a minority in the targeted region); the authors mention a greater openness of the Bwaba towards innovation, inter alia in matters of health, and the fact that the Bwaba hold a risk perception regarding disease that differs from that of other ethnic groups.

Similarly, according to Jütting's (2005) study in Senegal, the Wolof ethnic group has an enrolment rate in CBHI schemes (90%) which is markedly higher than that of other ethnic groups, such as the Serer (68%) and Fula (35%). Just like the Bwaba in Burkina Faso, the Wolof would generally display greater openness towards innovation. Another possible explanation lies in the fact that, on average, the Wolof would have a higher standard of living than other ethnic groups (their average expenditures are twice as high as those of the Serer, for example). There is also a logical reason for the low enrolment rate of the Fula: these nomadic populations would be less likely to enrol in a CBHI scheme as it is difficult for them to avail themselves of the contractually agreed services, which are available only in specific areas.

²⁵ De Allegri et al., 2006b; Jütting, 2005.

²⁶ De Allegri et al., 2006b; Jütting, 2005; Dong et al., 2003; Dubois, 2002.

²⁷ De Allegri et al., 2006b; Jütting, 2005.

Religion

Although most of the selected studies do not envisage religion as a factor possibly influencing enrolment, it could also have an influence on the decision of households to enrol in a CBHI scheme.²⁸ For example, according to the survey carried out by Jütting (2005) in the Thiès region, in Senegal, Christians tend to enrol in health insurance systems proportionally more than Muslims do (80% vs. 50%). The standard of living does not seem to account for this difference, since Muslims have, on average, a higher standard of living than Christians. But this higher enrolment rate among Christians could be accounted for by the significant support provided by the diocese to the CBHI scheme surveyed. Indeed, it appears that the promotion of the CBHI scheme's activities was more intense in the villages where the Catholic Church was present and active. The Muslim population seems less motivated to enrol than the Christian population, but it is also less informed. Differences in awareness could thus *in fine* also account for these very different enrolment rates.

Cultural beliefs

The potential influence of cultural beliefs on enrolment in a CBHI scheme is little studied in the various empirical studies. The one carried out by De Allegri et al. (2006a) mentions the fact that the individuals interviewed (enrolees and non-enrolees) were reluctant to admit that some beliefs likely to discourage would-be enrolees could account for the low levels of enrolment. Practically all these persons nevertheless recognized that the fact of saving (or contributing money in advance) for health involved a risk of "attracting" disease, although they did not consider themselves to be concerned by such beliefs and systematically attributed them to other people. According to Jütting (2005), this conception of saving for health, frequently mentioned in Senegal, constitutes a real obstacle to enrolment in an insurance system.

Occupation of the household head

Strictly speaking, the household head's occupation does not seem to influence the decision to enrol or not in a CBHI scheme²⁹, with the exception of the case of the Fula who, as we have already mentioned, have low enrolment rates due to their nomadic way of life³⁰.

3.2. Socio-economic characteristics of households

We analyze here the contributory capacity of households, their size, their marital status, the average health status of the household's members, the social cohesion within the target group of the CBHI scheme and the experience of the community in terms of involvement in associations.

Households' financial capacity

Households' income level appears as an essential parameter of enrolment. Indeed, empirical data indicate that a low contributory capacity of households constitutes a major obstacle to enrolment in a CBHI scheme.³¹ The lack of financial resources is often the first reason mentioned, both by enrolees and by non-enrolees, to account for the low enrolment rate in a

²⁸ Jütting, 2005; Dong et al., 2003.

²⁹ De Allegri et al., 2005; Musango et al., 2004.

³⁰ Jütting, 2005.

³¹ Basaza et al., 2008; De Allegri et al., 2006a; De Allegri et al., 2005; Jütting, 2005; Criel and Waelkens, 2003; Fonteneau, 2003; Criel et al., 2002; Tine, 2000; Criel, 1998.

CBHI scheme.³² Several studies indeed indicate that the socio-economic level of enrolees is higher than that of non-enrolees.³³ Although people usually consider the individual premiums to be fair or "affordable" (especially in comparison to the costs incurred in case of non-enrolment), many are not able to pay the premiums for all the members of the household.³⁴

Jütting (2005) assesses the standard of living of households by taking into account three distinct indicators: households' income, their yearly expenditures and the perception that they have of their own wealth in comparison to other villagers. The three indicators allow to determine that the poorest households are markedly less represented among CBHI schemes' members than better-off households. The study also reveals that member households have better equipped houses and more goods and tools than non-member households. However, a study carried out by Criel (1998) indicates that not only the poorest households, but also the richest ones in the community are over-represented among non-members. For the second group, two types of explanation can probably be put forward. The richest households are likely to have fewer apprehensions regarding their future capacity to pay for health care expenses without being enrolled in a CBHI scheme. They could also fear to become fully involved in a system in which other, less well-off members find it difficult to pay their premiums regularly.

Household size

Regarding household size, the results of empirical works are somehow contradictory. According to Dubois (2002), household size would not have any significant influence. Although large households have a higher enrolment rate³⁵, this would be linked primarily to the highest income level of these households; small households indeed have, on average, a lower contributory capacity³⁶. Conversely, other studies indicate that large households find it more difficult to take part in a health risk-sharing system³⁷. Although these families are not considered as belonging to the poorest families within the community, they are generally unable to pay for the premiums of all the household's members.³⁸

Marital status

No study found an association between the marital status and enrolment in a CBHI scheme. Dubois (2002) also underlines that, among enrolees, the proportions of monogamous and polygamous households are relatively similar and close to national statistics. However, Dong et al. (2003) indicate that married men's willingness to pay for a CBHI scheme is higher than that of non-married men.

Average health status of the household's members

Two studies indicate that the average health status of household's members does not influence the decision to enrol.³⁹ For example, in the Kabutare district, in Rwanda, the morbidity of member households does not differ significantly from that of non-member households

³² Basaza et al., 2008; De Allegri et al., 2006a; Jütting, 2005; Waelkens and Criel, 2004; Criel et al., 2002; Criel, 1998.

³³ De Allegri et al., 2006b; Jütting, 2005; Musango et al., 2004; Dubois, 2002.

³⁴ De Allegri et al., 2006a; De Allegri et al., 2006b; De Allegri et al., 2005; Criel & Waelkens, 2003.

³⁵ Musango et al., 2004; Dubois, 2002.

³⁶ Dubois, 2002.

³⁷ Basaza et al., 2008; Criel and Waelkens, 2003; Fonteneau, 2003; Criel et al., 2002.

³⁸ Criel and Waelkens, 2003.

³⁹ De Allegri et al., 2006b; Musango et al., 2004.

(respectively 43% and 38%). Similarly, the proportion of individuals who declare to have suffered from a serious affection is similar among enrolees (85%) and non-enrolees (84%) (Musango et al., 2004). Conversely, the study carried out on the Zabré CBHI scheme, in Burkina Faso, shows that the health status of enrolees is globally better than that of non-enrolees (Dubois, 2002).

Use of curative care and perceptions of health

According to Dubois (2002), CBHI schemes' members care more about health than non-members. Another study carried out in Burkina Faso indicates that the members of a CBHI scheme have a more negative perception of traditional care than non-enrolees; enrolees often consider the care delivered by traditional healers to be mediocre or inadequate (De Allegri et al., 2006b). However, the previous use of health care services does not seem to influence the decision to enrol: the use of curative care is globally similar among members and non-members.⁴⁰ Jütting (2005) notes for examples that, in the Thiès region, the first-line facility is the local health centre for 90% of individuals, and that enrolees and non-enrolees do not differ in this regard. As regards preventive care, the study carried out by Jütting and Tine (2000) indicates that enrolees make a more frequent use than non-enrolees of techniques such as water purification or mosquito nets. However, these differences would be linked primarily to the higher income level of enrolees.

Cohesion of the target group

Divergences appear among authors regarding the impact of the target group's cohesion on the decision to enrol in a CBHI scheme. According to some authors, an atmosphere of trust and solidarity within the community does not seem to influence the decision to enrol or not in a CBHI scheme.⁴¹ For example, in the Thiès CBHI scheme, in Senegal, enrolees and non-enrolees rate in a similar way the degree of trust and solidarity within their village (Jütting, 2005). Similarly, the values of solidarity and mutual help seem to be similar among members of the Zabré CBHI scheme and non-members (Dubois, 2002). Atim (2000), on the contrary, indicates that, among the voluntary, CBHI schemes covered by its study, only two CBHI schemes, whose target group was small and particularly united, managed to achieve a high coverage rate (over 50%).

Studies do not concur either on the role played by community leaders. According to Dubois (2002), the participation of community leaders positively influences the decision to enrol: 41% of CBHI schemes' members declared to have enrolled on advice of an influent individual. However, in the Thiès CBHI scheme, only a very small percentage of members declared to have enrolled because of the participation of the leader (Jütting, 2005).

Previous involvement in associations

The existence of informal risk-sharing associations seems to favour the setting up of a CBHI scheme.⁴² However, the rationale behind traditional mutual help institutions being different, it could also generate misunderstandings and disappointments among enrolees (Jütting, 2005). In this regard, Criel and Waelkens nevertheless note that both enrolees and non-enrolees clearly distinguish the characteristics specific to CBHI schemes from those of traditional mutual help systems (Criel & Waelkens, 2003 ; Criel et al., 2002). As for De Allegri et al.

⁴⁰ De Allegri et al., 2006b; Jütting, 2005.

⁴¹ Jütting, 2005; Dubois, 2002; Jütting and Tine, 2000.

⁴² De Allegri et al., 2006b; Jütting, 2005; Dubois, 2002.

(2006b), they observe that setting up a CBHI is easier in communities already used to sharing risks. However, as they find the same proportion of individual involved in another formal or informal risk-sharing system among members and non-members, the influence of this factor on the decision to enrol remains questionable.

According to Dubois (2002), however, CBHI schemes' members are more involved in associations within the community than non-members. The positive influence of individuals' previous involvement in associations could be accounted for by the greater tendency of members to get involved in a system of community sharing; by the imitation effect of individuals already participating in an association; by increased awareness about the CBHI scheme within pre-existing systems; and by the fact that enrolment in the CBHI scheme is made almost compulsory in order not to lose the money invested in one of the founding organizations.

However, as we will see later (see section 6), previous negative experiences can tamper with populations' trust and constitute an obstacle to enrolment in a CBHI scheme.⁴³

4. Factors influencing the decision to enrol linked to health care service providers

The role played by health care service providers in the decision to enrol in CBHI schemes can be analyzed from four different points of view: the quality of health care services; populations' trust in the competence of health care service providers; the geographical proximity of in-network health centres⁴⁴; and the way in which the health centres are chosen.

4.1. Quality of health care

The quality of health care can also be analyzed from two points of view: first, it can constitute a necessary condition for the success of CBHI schemes; secondly, CBHI schemes can contribute to the improvement of the quality of health care services provided in the in-network health facilities.⁴⁵

The "objective" quality of health care or the more subjective perception of this quality by populations can motivate individuals to enrol or deter them from enrolling in a health risk-sharing system. Enrolment would however be more influenced by the perception that the users have of the quality of the benefit package.⁴⁶ But empirical studies precisely show that populations are generally unsatisfied about the quality of health care, in particular in public health facilities.⁴⁷ The main criteria used to evaluate the quality of the health care services on offer are linked to patients' reception (availability of the health care providers, waiting time, respect and consideration displayed by the caregivers), the prescription and availability of drugs as well as the rapidity of the treatment's results.⁴⁸ Whereas some studies underline the fact that the main criticisms made by enrolees relate to the poor quality of the drugs

⁴³ Basaza et al., 2008; Schneider, 2005; Criel and Waelkens, 2003; Criel et al., 2002; Dubois, 2002.

⁴⁴ By "in-network" health centres/healthcare service providers, we refer to health centres/healthcare service providers that have signed an agreement with a CBHI scheme.

⁴⁵ Waelkens and Criel, 2004; Atim, 2000.

⁴⁶ Waelkens and Criel, 2004.

⁴⁷ Schneider, 2005; Waelkens and Criel, 2004; Fonteneau, 2003; Criel, 2002; Criel, 1998.

⁴⁸ Waelkens and Criel, 2004; Criel and Waelkens, 2003; Fonteneau, 2003; Criel et al., 2002; Atim, 2000.

prescribed⁴⁹ and to product shortage⁵⁰, other studies note that the dissatisfaction of beneficiaries is rather linked to the over-prescription of drugs and to the fact that the way in which health care providers treat patients varies according to socioeconomic status.⁵¹ Finally, some members complain about not receiving as good a treatment as non-members.⁵² According to them, this difference in treatment between members and non-members is linked to the fact that health care providers lose some advantages because of the existence of the new actor that the CBHI scheme constitutes (which makes it more difficult to impose additional payment, in money or in kind, upon patients). Some members also declare that they will not renew their membership if the quality of health care in the in-network health centres does not improve.⁵³ Thus, poor quality of the services provided does indeed appear as a crucial factor for non-enrolment and an important reason for non-renewal of membership in a CBHI scheme.

Many beneficiaries recognize that, despite all their shortcomings, CBHI schemes often contribute to reinforcing and facilitating access to health centres, inter alia in terms of rapidity and frequency of the visits to the health centres.⁵⁴ Some schemes would even manage to achieve results in terms of improvement of the quality of the health care services on offer. Indeed, beneficiaries sometimes observe that they receive a better treatment in in-network health centres after enrolling in the CBHI scheme.⁵⁵ Moreover, CBHI schemes can set up their own health services in order to guarantee a good quality of services.⁵⁶ Waelkens and Criel (2004) nevertheless underline that such examples remain too infrequent to claim that an improvement in the quality of health care can be achieved through the setting up of a CBHI scheme.

CBHI schemes are not yet important enough to really influence the behaviour of health care providers.⁵⁷ First, many enrolees (and non-enrolees) are not sufficiently aware of the role of counter-power to health care providers that CBHI schemes could play. Secondly, health care providers, who are not used to holding a dialogue with populations, are not sufficiently prepared to establish this type of relations with users.⁵⁸ Besides, some resistance on the part of health care providers has sometimes been observed when CBHI systems are being implemented.⁵⁹ Although the incentive capacity of CBHI scheme is not disputed, improving the quality of health care thus requires a change of behaviour on the part of health professionals.

4.2. Trust in the competence of health care providers

Beside the dissatisfaction of users regarding the way in which caregivers treat patients, empirical researches underline the mistrust of populations towards the competence of health care providers.⁶⁰ According to the study carried out by Schneider (2005), both enrolees and

⁴⁹ Criel et al., 2002.

⁵⁰ Basaza et al., 2008; Criel and Waelkens, 2003.

⁵¹ De Allegri et al., 2006a; De Allegri et al., 2005; Schneider, 2005; Criel, 2002.

⁵² Criel et al., 2002; Criel, 1998.

⁵³ Criel et al., 2002.

⁵⁴ Schneider, 2005; Criel and Waelkens, 2003.

⁵⁵ Fonteneau, 2003; Atim, 2000.

⁵⁶ Atim, 2000.

⁵⁷ Criel et al., 2002.

⁵⁸ Waelkens and Criel, 2004.

⁵⁹ Waelkens and Criel, 2004; Fonteneau, 2003; Criel et al., 2002.

⁶⁰ Schneider, 2005; Criel et al., 2002.

non-enrolees complain about technical incompetence on the part of health care providers. Some beneficiaries also blame providers for not respecting their agreements with the CBHI system. The study suggests that communities' scepticism towards health care providers tampers with their trust in the insurance scheme and thus negatively affects enrolment.⁶¹

According to Waelkens and Criel (2003), caregivers' competence is too often associated with the sole prescription of drugs. If those prove inefficient, caregivers are often accused of being incompetent. Criel et al. (2002) however indicate that this competence is also perceived on the basis of the caregiver's experience, capacity to make a diagnosis and communication with the patient. Confidence in a caregiver is thus based primarily on the caregiver's professional experience and capacity to listen and provide information to the patient.

4.3. Geographical distance

The results of the analyzed studies diverge regarding the influence of the distance to the in-network health centres. According to some studies, a large distance constitutes a significant obstacle to enrolment, and even a reason for non-renewal of membership.⁶² Other studies indicate that the distance between the enrolees and the health centre does not constitute a hindrance to the development of CBHI schemes.⁶³ Researches carried out in a CBHI scheme in Burkina Faso even indicate that enrolment rates would be higher in the communities that are the farthest away from the health centre.⁶⁴ This result, which might seem surprising at first sight, could be accounted for by the intense awareness-raising campaigns carried out among the populations living in the farthest areas, and by the fact that transportation costs are covered by the insurance schemes. Finally, some beneficiaries consider that another problem linked to geographical distance could be the fact that the advantages of the CBHI scheme are not clearly visible for people living too far away from the in-network health centre.⁶⁵

Criel (1998) reports that the team responsible for the hospitalization insurance scheme of Bwamanda in the Democratic Republic of the Congo had noted that the indirect costs (transportation, food, accommodation for the family, etc.) of care were higher for the individuals living the farthest away from the district hospital. These individuals also had less frequently recourse to the hospital. On the basis of this observation, a system of differential fees, based on the distance between the health centre and the hospital was implemented: the greater the distance between the health centre and the hospital was, the lower the admission fee was. However, the implementation of this system did not influence the frequency with which the members living the farthest away had recourse to the hospital, which seems to indicate that large distances remain an important obstacle to enrolment in the CBHI scheme.

4.4. Way in which health facilities are chosen

De Allegri et al. (2005) mention the dissatisfaction of enrolees with being assigned a health centre that they have not chosen. According to beneficiaries, this decision would discourage some households from enrolling in the CBHI scheme because of the quality of the health care offered and of the relations with health care providers. Some individuals would e.g. prefer to go to a health centre that is farther away but where they have better relations with the

⁶¹ Schneider, 2005.

⁶² Fonteneau, 2003; Dong et al., 2003; Dubois, 2002; Criel, 1998.

⁶³ De Allegri et al., 2006a.

⁶⁴ De Allegri et al., 2006b.

⁶⁵ De Allegri et al., 2006a.

caregivers. The choice of the in-network health centre by the communities themselves would positively influence enrolment; the difficulty in this case lies in the scarcity of health facilities in rural areas.⁶⁶

5. Factors specific to the CBHI schemes

Regarding the question of enrolment, the community-based health insurance scheme itself can be analyzed from three points of view: first, enrolment procedures and conditions and the benefit package on offer; secondly, communities' trust in the scheme; and finally, the way in which the insurance scheme designs and implements awareness-raising and information campaigns among the target populations.

5.1. Enrolment procedures and conditions and benefit package on offer

Enrolment fees and premiums

As mentioned above, the enrolment fees and premiums⁶⁷ are generally deemed to be acceptable by individuals, despite the fact that many of them lack financial resources.⁶⁸ The patient's financial participation would not be impugned, primarily because of the small amount of money that it represents. However, according to Criel (1998), users seem not to understand very well the reason why this system was implemented.

Premium payment frequency

The periodicity of the payment of premiums seems to influence the decision to enrol. Indeed, it appears that the obligation to pay the enrolment fee and/or the yearly membership premiums in one payment constitutes an important obstacle, in particular for large families.⁶⁹ Households express for example a will to be allowed to spread the payments of enrolment fees and membership premiums.⁷⁰ The period of the year when enrolment fees and/or membership premiums are collected can also favour enrolment or, on the contrary, constitute an obstacle, according to whether it takes into account or not the seasonal fluctuations of income.⁷¹ However, collecting fees during the harvest period, which seems more appropriate in some contexts, does not guarantee individuals' capacity to pay the due amount.⁷²

Enrolment of the entire household or of individuals

The obligation to enrol the entire household seems to constitute a real obstacle⁷³; this is all the more true that enrolees do not grasp the link between this obligation and the necessity, for the CBHI scheme, to counter "adverse selection" (which occurs if the household heads only enrol the most vulnerable members of their family: this obviously unbalances the insurance system).⁷⁴ It can be observed that only some members of the household are generally enrolled in the CBHI scheme, which suggests that enrolment of the whole family is perceived as

⁶⁶ Fonteneau, 2003.

⁶⁷ In some CBHI schemes, individuals or households must pay enrolment fees in order to be registered as members.

⁶⁸ De Allegri et al., 2006a; De Allegri et al., 2005; Criel and Waelkens, 2003.

⁶⁹ De Allegri et al., 2006a; De Allegri et al., 2005; Criel, 1998.

⁷⁰ De Allegri et al., 2005; Criel, 2002; Criel, 1998.

⁷¹ De Allegri et al., 2005; Atim, 2000; Criel, 1998.

⁷² Criel and Waelkens, 2003; Criel et al., 2002.

⁷³ De Allegri et al., 2006a.

⁷⁴ Criel and Waelkens, 2003; Criel et al., 2002.

financially unreasonable. Besides, enrolees complain about individual flat-rate premiums⁷⁵ and appreciate the application of differential premiums for adults and children⁷⁶; this is perceived as a culturally appropriate means of counteracting the tendency to privilege adults in the allocation of the – often limited – resources for health care⁷⁷.

The definition of the household used in CBHI schemes, although it is socially acceptable, would not adequately reflect day-to-day family decision-making processes and would not sufficiently take into account the context of polygamy and households' changing make-up⁷⁸. Regarding this topic, a study carried out by De Allegri et al. (2005) in Burkina Faso mentions the criticism made by enrolees about the definition of "household" which is used by the CBHI scheme. Similarly, regarding the PRIMA project in Guinea, Waelkens and Criel (2003) underline the fact that the definition of "the family" is not accurate enough.

Benefit package

The benefit package offered by CBHI schemes seems to be globally appreciated by members.⁷⁹ However, it seems that both enrolees and non-enrolees have a relatively limited knowledge of the services offered by the health insurance scheme, although they know that some services are excluded because of the low level of premiums and the small number of enrolees.⁸⁰ Some express a desire to see the benefit package become more extensive with time.⁸¹ The fact of including a new service in the health insurance scheme's benefit package would positively influence enrolment. For example, during the first three years after its inception, the Wer Werlé CBHI scheme in Thiès did not cover the costs of childbirth, despite the populations' requests. The insurance scheme's managers feared to have to increase excessively the level of premiums. This obstacle could finally be overcome by slightly modifying the reimbursement rate in order to maintain the adequacy between the premiums and the services on offer. Introducing the coverage of costs linked to childbirth in the benefit package positively influenced enrolment.⁸²

Conversely, not covering some services would constitute an obstacle to the enrolment of some individuals.⁸³ According to Basaza et al. (2008), the fact that the Ishaka CBHI scheme, in Uganda, does not cover chronic diseases and ambulance transportation appears as one of the reasons accounting for the low enrolment rates. And the exclusion of a service would negatively influence enrolment.⁸⁴

Internal rules

Finally, the rigidity of some rules established by the CBHI scheme would also have a negative influence on enrolment. For example, the two health micro-insurance schemes studied by Basaza et al. (2008) in Uganda require that 60% of the target group or 100 villagers enrol before the members can start benefiting from the scheme. This rule constitutes a measure

⁷⁵ Criel, 1998.

⁷⁶ De Allegri et al., 2005.

⁷⁷ De Allegri et al., 2006b.

⁷⁸ De Allegri et al., 2005; Criel, 2002.

⁷⁹ De Allegri et al., 2005; Fonteneau, 2003.

⁸⁰ De Allegri et al., 2005.

⁸¹ De Allegri et al., 2005; Criel, 1998.

⁸² Fonteneau, 2003.

⁸³ Basaza et al., 2008; Fonteneau, 2003; Criel, 1998.

⁸⁴ Fonteneau, 2003.

against adverse selection, but it is perceived by the communities as being too rigid and inadequate.

5.2. Trust in the CBHI scheme

Trust in the CBHI scheme also influences the decision to enrol or not.⁸⁵ Waelkens and Criel (2004) distinguish between two dimensions of populations' trust in health insurance schemes: first, trust in the management of the scheme, which is dependent upon the competence and integrity of the scheme's managers; and secondly, trust in the scheme's capacity to achieve the announced goals.

The study carried out by De Allegri et al. (2006a) indicates that enrollees themselves establish a link between the decision to enrol and the trust they have in the scheme's management. The documents received when enrolling, the support provided by an external organization, the collective character of the scheme and the enrolment of other community members all constitute elements contributing to the reinforcement of populations' trust in the CBHI scheme.

Target populations frequently adopt a cautious attitude when a CBHI scheme is being set up; they often choose to observe before enrolling.⁸⁶ This behaviour could be accounted for primarily by the fact that they have previously experienced the negative consequences of dishonest management in other saving or credit schemes, co-operatives, informal associations, etc. However, if this type of suspicion can account for belated enrolment in a health insurance scheme, it does not appear, for some, as a major reason for not enrolling.⁸⁷ Other studies, though, indicate that doubts about the honesty of the insurance scheme's managers or previous experiences of embezzlement would indeed negatively influence enrolment.⁸⁸

Various studies also indicate that the integrity and competence of the scheme's managers, as regards both administrative and organizational aspects, are not questioned by members.⁸⁹ However, a major criticism made to the organization can then be linked to the fact that it does not comply with its commitments and does not achieve its goals. Such disappointments mainly relate to the quality of health care and the advocacy in favour members in the relations with health care providers.⁹⁰ Obviously, this also erodes populations' trust.

5.3. Information and understanding

Whereas some studies underline the fact that both members and non-members have a very good understanding of the mutualist principles,⁹¹ others indicate that populations have a very poor knowledge of the CBHI scheme.⁹² In this latter case, information would not be efficiently transmitted due to the fact that awareness-raising campaigns are unattractive or ill-adapted to illiterate populations.

⁸⁵ De Allegri, 2006a; Schneider, 2005; Waelkens and Criel, 2004.

⁸⁶ Schneider, 2005; Criel and Waelkens, 2003; Criel et al., 2002.

⁸⁷ Criel and Waelkens, 2003; Criel et al., 2002.

⁸⁸ Basaza et al., 2008; De Allegri et al., 2006a; Schneider, 2005.

⁸⁹ Criel and Waelkens, 2003; Dubois, 2002; Criel et al., 2002.

⁹⁰ Criel and Waelkens, 2003; Criel et al., 2002.

⁹¹ Waelkens and Criel, 2003; Criel et al., 2002.

⁹² Basaza et al., 2008; De Allegri et al., 2006a; Schneider, 2005.

The impact of information and awareness-raising campaigns is primarily envisaged in terms of trust. Logically enough, according to De Allegri et al. (2006a), a low degree of knowledge would contribute to the reinforcement of populations' scepticism towards CBHI schemes and would negatively influence enrolment. Conversely, an efficient information campaign would contribute to the building of communities' trust in the insurance scheme's promoters and managers.⁹³ Along the same lines, the study carried out by Basaza et al. (2008) indicates that members have a better understanding of the mutualist principles than non-members do. As for the study carried out by Jütting (2005) in Senegal, it indicates that 15% of the population purely and simply ignores the existence of CBHI schemes in the Thiès region, due to a lack of information within some segments of the community.

However, it also happens, as was the case for the MUCAS in Guinea, that both non-enrolees and enrolees have a good understanding of the operation, advantages and disadvantages of the mutualist system (Criel & Waelkens, 2003 ; Criel et al., 2002). This could be linked to the extent and quality of the information and awareness-raising campaigns carried out before the setting up of the CBHI scheme. It has to be noted, though, that no study really describes the information methods implemented to promote the CBHI scheme and raise the awareness of communities.

6. Summary of findings

In order to summarize the abovementioned results, we classify here the different factors influencing the decision to enrol identified by the empirical studies in four categories: major factors, i.e. factors upon which many studies concur; factors upon which a more limited number of studies concur; factors upon which studies diverge; and finally, factors that have been found not to influence the decision to enrol.

As indicated in table 1 here after, many of the various studies analyzed concur in identifying two major factors influencing the decision to enrol. Firstly, it appears that populations' low level of income limits their contributory capacity and negatively influences the decision to enrol. In other words, the lack of financial resources remains the first reason cited by households as the explanation for not enrolling in a CBHI scheme (this holds true in all the regions covered by the selected studies). Although this might seem strange and at first sight contradictory, the target populations consider the enrolment fee and/or membership premiums to be fair and affordable. However, this contradiction is only apparent, as most studies asked the target populations to what extent they deemed the level of the membership premiums to be fair or acceptable considering the services to which the scheme's members are entitled. On these precise questions, both enrolees and non-enrolees generally recognize that the level of the fees is not too high, in particular in comparison to the prices that they know would be imposed upon them by health care providers outside the mutualist framework. But actually paying for these fees for all the household members, or even for some of them only, nevertheless often remains impossible.

Secondly, the decision to enrol is also significantly influenced by the factors linked to the health care services and to the relations with health care providers:

- When the quality of health care is poor (in terms of caregivers' helpfulness and friendliness to the patients, prescription and availability of drugs, efficiency and rapidity of the treatment), this negatively influences enrolment.

⁹³ Waelkens and Criel, 2004.

- Populations' scepticism regarding the competence of the caregivers reinforces the patients' mistrust towards the caregivers and has a similar effect on enrolment. Moreover, doubts as to the organization's capability to improve the quality of health care also contributes to deterring individuals from enrolling. The reasons accounting for the lack of trust in the health insurance scheme can also relate to previous negative experiences or to doubts regarding the integrity of the insurance scheme's managers.

Other factors, although they are not observed as frequently in the selected studies, also seem to influence significantly the decision to enrol. Regarding the factors relating to CBHI schemes, three main elements stand out. First, the obligation to pay the yearly premiums in one payment tends to deter households from enrolling. Conversely, the fact of taking into account the seasonal fluctuations in income increases enrolment rates. Secondly, it very often happens that only some members of the household actually enrol; this seems to indicate that the global and compulsory enrolment of the entire family is considered as financially unreasonable. It also appears that households generally prefer individual premiums, with a differential rate for children and adults. CBHI schemes displaying more flexibility in the collection and periodicity of payments of premiums and regarding enrolment conditions and procedures tend to register higher enrolment rates. The third factor significantly influencing the decision to enrol is the contents of the benefit package. The target populations are generally satisfied with the benefit package, which is generally defined in agreement with them, on the basis of the amount that they are willing to pay. But if the inclusion of a new service in the benefit package can attract new members, the exclusion of a service can conversely lead to some members not renewing their membership.

The decision to enrol can also be linked to more individual characteristics. Some studies concur on the influence of education – a high education level guaranteeing greater openness towards the innovation that the health insurance scheme represents and a better understanding of the mutualist system and its advantages. Similarly, ethnicity and religion can also influence the decision to enrol. But these factors might in fact be secondary; they might be linked to more influential factors, such as the income level or the religious orientation of the health insurance scheme's founder organizations.

Besides, the number of empirical studies analyzing information campaigns, and thus the level of understanding within communities, seems surprisingly small. The direct influence of information and awareness-raising campaigns has practically not been analyzed. We will come back to this subject in the following section.

As for the other factors, either they are subject to disagreement between the studies, or no influence could be brought to light. Consequently, we do not consider them as factors influencing the decision to enrol, but other, more thorough studies might be useful.

**Table 1 - Summary of findings:
Factors influencing the decision to enrol in a CBHI scheme**

Major factors (many concurring studies)

- Financial capacity of the target populations (9 studies: Burkina Faso – Guinea – Uganda – Democratic Republic of the Congo - Rwanda – Senegal)
- Quality of health care (8 studies: Burkina Faso – Guinea – Uganda – Democratic Republic of the Congo - Rwanda - Senegal)

Significant factors (concurring studies, but lower number of studies)

- Periodicity of the payment of membership premiums (5 studies)
- Enrolment procedures and conditions (5 studies)
- Trust in CBHI schemes (4 studies)
- Information and awareness-raising (4 studies)
- Education level (4 studies)
- Benefit package (3 studies)

Slightly significant factors (concurring studies, but very low number of studies)

- Trust in the caregivers' competence (2 studies)
- Cultural beliefs (2 studies)
- Ethnicity (2 studies)
- Religion (2 studies)

Factors upon which studies diverge

- Age
- Household size
- Health status of the household's members
- Perception of health
- Cohesion of the target group
- Enrolment of community leaders
- Previous involvement in associations
- Geographical distance
- Way in which the in-network health facilities are chosen

Factors not influencing enrolment

- Gender
 - Occupation
 - Marital status
 - Use of curative care
-

7. Enrolment as envisaged by CBHI schemes' promoters

Before concluding, we would like to compare the results that we have just summarized with those of a survey carried out by J. Failon (2008) in Benin. She did not interview households but the managers of nearly all the organizations promoting and supporting health micro-insurance schemes in the country. The survey, which included 12 organizations, focused on the obstacles to enrolment identified by the managers interviewed.⁹⁴ Globally, this survey confirmed, to a large extent, the abovementioned results, but it seems useful to highlight some elements which appear as complementary to the abovementioned results.

Field staff confirm that a low income level constitutes the main obstacle to enrolment in health micro-insurance schemes. Promoters note in particular that the poorest households remain excluded from health micro-insurance schemes. The cotton crisis (cotton is one of the main crops in Benin⁹⁵), which affects a large part of the population in the informal sector, is often cited as an explanation for non-enrolment or decreasing enrolment rates. Each health micro-insurance organization, when faced with communities' financial difficulties, has its own strategies: using a period for collecting contributions more in line with the time when farmers have cash inflows; promoting diversification of financial resources; coupling the health insurance scheme with a micro-credit institution,...

Some promoters, though, have a mixed opinion regarding the importance attributed by literature to the question of health care quality. The perception of health care quality by populations would vary widely, in particular between urban-area users and rural-area users, or according to the education level. Moreover, several examples seem to indicate that some health insurance schemes are able to negotiate with health care providers in order to obtain higher quality health care.⁹⁶

A problem that is specific to Benin but is likely to occur elsewhere is linked to the monopolistic situation of the CAME (*Centrale d'Achat en Médicaments Essentiels*⁹⁷, or "central purchasing agency for essential drugs"), which often leads to essential drugs being out of stock. Besides, the monopoly of the CAME is often cited by health care providers as an explanation for the lack of generic drugs in health centres and to justify the sale of illicit products, not covered by the health insurance schemes, to the patients.

Besides, the fact that CBHI schemes represent nowadays a cultural and social innovation implies, according to the interviewees, that a long-term information and communication work

⁹⁴ This survey (carried out in November 2007) is based on interviews with various actors active in the field of CBHI schemes in Benin: the various promoters of CBHI schemes, several managers of mutualist organizations, organizations supporting the development of CBHI schemes, financial backers and agencies for technical cooperation, and public authorities in charge of the field of health micro-insurance (Ministry of Health, Ministry of Labour and Public Services).

⁹⁵ In Benin, it is estimated that cotton represents some 80% of export income and 18% of GDP.

⁹⁶ This is for example the case of the Sérarou CBHI scheme, one of the schemes set up by the CIDR (*Centre International de Développement et de Recherche*, or "International Centre for Development and Research") in the Borgou department, which is now part of the *Réseau Alliance Santé* ("Health Alliance Network"). The Sérarou health insurance scheme's members, who were not satisfied with the team of caregivers of the in-network health centre, managed to have this team replaced, thus demonstrating that well-organized health micro-insurance systems are able to express their claims and to exert a significant pressure on health care providers.

⁹⁷ The CAME is a non-profit organization buying and supplying generic drugs which are essential for public health centres, non-profit organizations, the private sector and wholesalers.

is necessary in order to promote these schemes. As a matter of fact, whether the difficulty to conceive the health risk is linked or not to a defined conception of misfortune, the usefulness of a health insurance is not obvious for the communities and thus requires specific awareness-raising actions. Whereas some studies note that a high level of information among the target populations does not necessarily generate higher enrolment rates, the promoters of CBHI schemes in Benin insist particularly on these ongoing awareness-raising actions and their potential effects. The promoters also insist on the importance of the ongoing nature of awareness-raising activities, which have to be envisaged in the long run, until the "reflex" is acquired.

Finally, some promoters insist on the importance of identifying influential people, groups and opinion formers and involving community leaders in the setting up of CBHI schemes, in order to avoid that local authorities, resenting their being "left out", start spreading disinformation. Besides, the fact of relying onto pre-existing organizations and of involving them in the setting up of a CBHI scheme would constitute a necessary condition for the system's success. For other promoters, though, there is a real risk of the mutualist organization being hijacked by specific groups. The issue would then be to balance these two types of risk in order to ensure the best possible integration of the CBHI scheme among local associations.⁹⁸

Conclusion

Among the challenges that CBHI schemes are currently facing, the issue of enrolment currently appears as crucial. Indeed, even though the mutualist movement keeps developing in sub-Saharan Africa, enrolment rates remain relatively low, sometimes jeopardizing the sustainability of these organizations. Since the early 2000s, several surveys have aimed to better grasp the reasons accounting for the weak participation of populations. But these works have appeared to be very different in terms of their approaches, and have produced sometimes contradictory results; we have thus attempted to provide a comparative summary of these works, likely to highlight the most significant factors influencing the decision to enrol as well as the factors that appear to be of less or no significance in this regard.

However, beside the factors taken into account in these surveys amongst households, it seems to us that other elements would deserve attention. For example, the ways in which members are involved in the organization as well as the ways in which CBHI schemes are controlled by their members or by external entities could also influence enrolment rates. Moreover, CBHI organizations could also be affected by the competition with other, informal mutual help mechanisms, and even, in some specific contexts, in particular in urban areas, by the competition among CBHI schemes. Finally, these organizations being often created at the initiative of external stakeholders, the credibility of these external stakeholders in the eyes of the communities would also deserve to be studied more thoroughly.

⁹⁸ By way of example, the non-profit organization, SOLIDEV (*Solidarité et Développement*, or "Solidarity and development"), which promotes CBHI schemes in the Atacora department in Benin, insists on this involvement of leaders, in particular small farmers' organizations, and on the necessity to have a good knowledge of the environment. The managers of ADMAB (*Association pour le Développement d'une Mutualité Agricole au Bénin*, or "Association for the development of an agricultural CBHI scheme in Benin"), another organization providing support to CBHI schemes in several Beninese departments, consider the involvement of village heads to be necessary in order to strengthen the community's trust in the health insurance scheme and to generate some kind of social conformism. Another NGO, Louvain Développement, recruits community leaders into the initiative committees of the CBHI schemes. Finally, PISAF's (*Projet Intégré de Santé Familiale*, or "Integrated family health project") managers gradually involve the mayors in the setting up of CBHI schemes.

Moreover, it has to be underlined that the analysis of the factors influencing the decision to enrol only constitutes one approach among others to examine this complex issue. Indeed, the various studies analyzed here mainly focus on local issues. The relations between CBHI schemes and their more global environment, such as the national or regional political context, the role of NGOs promoting these schemes, or the public health system, at the national level, are taken into account only to a very limited extent. All these dimensions would also deserve to be analyzed more thoroughly.

Along the same lines, questions relating to the ways in which the field of health micro-insurance is regulated should be explored more thoroughly. A first step would be to analyze all the mechanisms and institutions providing the framework within which CBHI schemes develop. A process aiming to set up, at the UEMOA level, a regulatory framework for community-based health micro-insurance schemes is being mentioned with increasing frequency, which currently questions the role of public authorities with respect to these organizations. As Vermer et al. (2007) underline, this calls for a broader reflection on governments' responsibilities in matters of regulation, control, financing of and support to this sector in sub-Saharan Africa.

Similarly, studying the types of agreement between the CBHI schemes and the health centres constitutes another way of analyzing this sector; as a matter of fact, the types of agreement influence both the relations between the two partners and the improvement of health care quality. Finally, the combination of CBHI companies with other actors, such as micro-finance institutions, could also be analyzed thoroughly in terms of possible reinforcement of mutualist organizations.

References

Atim, C., 2000, *Contribution financière des mutuelles de santé au financement, à la fourniture et à l'accès aux soins de santé : Synthèse de travaux de recherche menés dans neuf pays d'Afrique de l'Ouest et du Centre*, STEP, Bureau International du Travail, Genève.

Basaza, R., Criel, B., Van der Stuyft, P., 2008, "Community health insurance in Uganda: Why does enrolment remain low? A view from beneath", *Health Policy*, vol. 87, no 2, 172-184.

Bennet, S., Gotsadze, G., 2003, "Le renforcement des capacités et la consolidation des conditions de mise en œuvre au niveau communautaire", in DROR, D., PREKER, A. (sous la direction de), 2003, *Réassurance sociale. Stabiliser les micro-assurances santé dans les pays pauvres*, Editions ESKA, Washington DC, pp.225-244.

BIT/STEP, 2000, *Micro-assurance santé. Guide d'introduction aux mutuelles de santé en Afrique*, Organisation internationale du Travail, Genève.

Concertation, 2004, *Inventaire des mutuelles de santé en Afrique. Synthèse des travaux de recherche dans 11 pays*, La Concertation entre les acteurs de développement des mutuelles de santé en Afrique, Dakar (En ligne)

<http://www.concertation.org>

Criel, B., Waelkens, M.-P., 2003, "Declining subscriptions to the Maliando Mutual Health Organisation in Guinea-Conakry (West Africa): what is wrong?", *Social Science Medicine*, 57 (7), 1205-1219.

Criel, B., Barry, A., Von Roenne, F., 2002, *Le projet PRIMA en Guinée Conakry. Une expérience d'organisation de mutuelles de santé en Afrique rurale*, Bruxelles, Medicus Mundi Belgique.

Criel, B., 1998, *District-based health insurance in sub-Saharan Africa, Part II : Case-studies*, Studies in Health Services Organisation & Policy, Anvers.

De Allegri, M., Sanon, M., Sauerborn, R., 2006a, "« To enrol or not enrol? »: A qualitative investigation of demand for health insurance in rural West Africa", *Social Science Medicine*, 62 (6), 1520-1527.

De Allegri, M., Kouyanté, B., Becker, H., Gbangou, A., Pokhrel, S., Sanon, M., Sauerborn, R., 2006b, "Understanding enrolment in community health insurance in sub-Saharan Africa: a population-based case-control study in rural Burkina Faso", *Bulletin World Health Organisation*, 84 (11), 852-858.

De Allegri, M., Sanon, M., Bridges, J., Sauerborn, R., 2006, "Understanding consumers' preferences and decision to enrol in CBHI in rural West Africa", *Health Policy*, 76 (1), 58-71.

Defourny, J., Failon, J. & Sarambe, I., 2008, "Les approches de l'économie sociale et solidaire face aux mutuelles de santé en Afrique", Centre d'Economie Sociale, Université de Liège

Dong, H., Kouyate, B., Snow, R., Mugisha, F., Sauerborn, R., 2003, "Gender's effect on willingness-to-pay for community-based insurance in Burkina Faso", *Health Policy*, 64 (2), 153-162.

Dubois, F., 2002, *Les déterminants de la participation aux mutuelles de santé : Etude appliquée à la mutuelle Leeré Laafi Bolem de Zabré*, Mémoire de fin d'études, Université de Liège, DES en Gestion du Développement.

Failon, J., 2007, *Approche socio-anthropologique de la micro-assurance santé. Etude de deux systèmes au Bénin*, Institut des Sciences Humaines et Sociales, Université de Liège.

Fonteneau, B., 2006, "Déterminants d'adhésion aux mutuelles de santé : proposition de grille d'analyse et résultats de quelques recherches", Communication lors du séminaire du GRAP-OSC "Le croisement des regards : déterminants d'adhésion aux mutuelles de santé", Liège, 6 octobre 2006.

Fonteneau, B., 2003, *Les défis des politiques de micro-assurance santé en Afrique de l'Ouest. Cadre politique, environnement institutionnel, fonctionnement et viabilité*, Hoger Instituut voor de Arbeid, Leuven.

Jütting, J., Tine, J., 2001, L'impact des mutuelles de santé en milieu rural africain. Une analyse empirique dans la région de Thiès au Sénégal, STEP Working Papers.

Jütting, J., 2005, *Health insurance for the poor in developing countries*, Aldershot: Ashgate.

Musango, L., Martiny, P., Porignon, D., Dujardin, B., 2004, "Le profil des membres et des non membres des mutuelles de santé du Rwanda : le cas du district sanitaire de Kabutare", *Cahier de santé*, vol. 14, n° 2, pp. 93-99.

Nyssens, M., Vermer, M.-C., Wélé, P., 2007, "La régulation des mutuelles de santé au Bénin", GRAP/OSC, Louvain-la-Neuve.

Schneider, P., 2005, "Trust in micro-health insurance: an exploratory study in Rwanda", *Social Science & Medicine*, 61 (7), 1430-1438.

Waelkens, M.-P., Criel, B., 2004, *Les mutuelles de santé en Afrique subsaharienne. Etat des lieux et réflexions sur un agenda de recherche*, HNP Discussion Paper, Banque Mondiale, Washington DC.

