PROVIDING SERVICES TO NON-CONTRIBUTING MEMBERS

HOW COMMUNITY-BASED HEALTH INSURANCE COPED WITH THE IMPLEMENTATION FAILURES OF THE FEE EXEMPTION POLICY IN THE DEPARTMENT OF KAOLACK, SENEGAL

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In 2013, two major social programs were launched in Senegal:

- **UHC program** = **CMU**
- ‘Conditional’ **cash transfer program** = **PNBSF**

**Targeting** of the ‘most vulnerable’ and ‘poorest’ households:

- Mixed methods
- **300,000 households** targeted through 4 rounds (“generations”)

**Progressive enrolment** of the targeted households in CBHI (*mutuelles de santé*):

- **Fully subsidized** by the State
  - Contribution + adhesion fees + co-payment compensation
    = 9,000 FCFA [13.72 EUR or 15.17 USD]
- **Free healthcare services**:
  - Consultation and drugs in public facilities
  - Drugs from accredited pharmacies
Aim

Analysis of:

• the enrolment process of ‘poor’ and ‘vulnerable’ households and the implementation of this strategy at the local level

• its consequences on the functioning of the mutuelles and on the uptake of health services for beneficiaries

Methods

Socio-anthropological fieldwork:
- 12 weeks between 2016 and 2018 (+ 3 weeks in 2019)
- Semi-structured interviews with policy makers, mutuelles’ leaders, public providers and beneficiaries
- Analysis of the literature and the available quantitative data
Specificities of the department of Kaolack

- **A long history** of CBHI development:
  - First CBHI in the 1990s
  - Many partners and projects (ILO, Abt/USAID, Enabel, SolSoc)
  - A support network called “Oyofal Paj”

- **Pilot-department** for the DECAM project (Décentralisation de l’Assurance Maladie > CMU)
  
  “As we were part of the pilot-stage, compared to the other department, we have benefited from a strong financing”
  
  [CBHI Leader, December 2, 2017]

- **Strong leadership**
  
  ➢ **Limited external validity**
How the CBHI network coped with the payment delays

**Progressive enrolment** of beneficiaries in the department of Kaolack…

- 1st generation in the end of 2014 (pilot)
- 2nd generation in July 2017

… despite the fact that **subsidies are paid afterwards** (the following year)

“The [CMU] Agency gave us the lists of these beneficiaries, but they have not subsidised us yet. So, as usual, we say ‘let’s make the first move’. […]

The Regional Union is well organized, to the point that they have around 150 millions FCFA [228,674 EUR or 252,846 USD] in their guarantee funds that can help us pre-finance things”

[CBHI Leader, September 14, 2017]

- The CBHI regional union **acted as a guarantee fund** and **loaned** money to the local schemes in order to be able to pay the providers.
- When they receive the State’s subsidies, CBHI **reimburse** the regional union
Consequences on users…

- Effective provision of free healthcare services to the enrolled households (Kaolack, 2014-2017)

- Despite some temporary suspension of the program in a few mutuelles:

  “Two months ago, my grandchild was sick, she had fever […] but at that time, they had stop the mutuelle. There was no money left, no subvention. We needed to wait for money to be sent. Now, they started again.
  - How long did they stop?
  - Just a month”

  [BSF Beneficiary, 1st Generation, September 18, 2017]

However, some beneficiaries complained about tough reception and services at the CBHI office:

  “Sometimes, I was embarrassed to go to the mutuelle because they told me ‘You’re sick all the time, you’re sick all the time’. And I responded that it is not my fault. I was pregnant at that time”

  [BSF Beneficiary, 1st Generation, September 20, 2017]

These stigmatizing attitudes can be explained by:
- The financial pressure applied on CBHIs due to delays of subsidies payment
- The unfounded belief that 100% free healthcare services automatically lead to overconsumption
- The negative perception about the targeting process and inclusion mistakes

  “Actually, the BSF beneficiaries don’t consume much. […] It’s because the BSF subsidies has not arrived yet that there are all these screams. The problem is that the mutuelle is suffering and it uses the money from contributing members [to pay for the care of BSF]”

  [CBHI leader, February 27, 2018]
By the end of 2017, the 3rd generation of beneficiaries (out of 4) was enrolled in *mutuelles*

- BUT the number of CBHI “normal” members stayed about the same (and only part of them are effectively contributing)

- non-contributing members ≥ contributing members

- AND the last payment of subsidies dates back to the beginning of 2017 (> 2 years of delay)

- According to the Departmental Union, the State owes **more than 2 billions FCFA** [3,050,000 EUR or 3,371,500 USD] to the CBHIs in Kaolack

- Most CBHIs **suspended** their services to BSF beneficiaries in 2019…

  so as to be able to **keep on providing services for contributing members**
Conclusion

Failure of most “equity funds” and “exemptions policies” to provide free healthcare services for the poorest in West Africa

> Need to look at the implementation stage of these strategies (Ridde & Jacob, 2013; Olivier de Sardan & Ridde, 2014)

- The experience of Kaolack is of particular interest, because of the role that the CBHI network played to countervail State’s delays in payment and to maintain services for the poorest… for a while!

- Ideas and perceptions of ‘street-level workers’ (Lipsky 1980) also influence the implementation (Béland & Ridde, 2014)

- Mutuelles often put forwards that their organisations rest on values of solidarity. However, solidarity encompasses different meanings:
  - mutual solidarity between contributing members (the healthy and the sick)
  - the solidarity towards the poorest (which, in this case, is ‘imposed’ by the State and jeopardizes the functioning of the entire system)

- CBHIs are increasingly (financially) dependent and (strategically) driven on/by the State (Boidin, 2015)

  Community-based, autonomous organization vs. public service provider?