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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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Introduction : *Couverture Maladie Universelle* and the subsidization of the contribution for the poorest

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

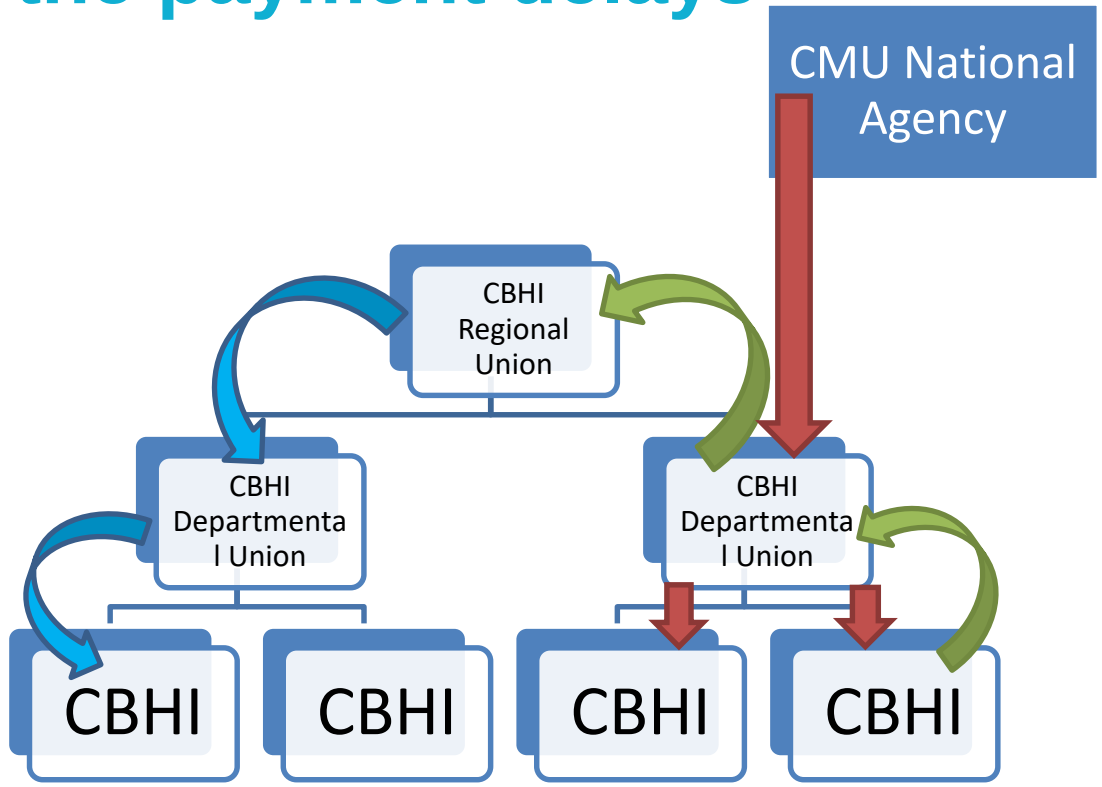
Progressive enrolment of beneficiaries in the department of Kaolack…

- 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]

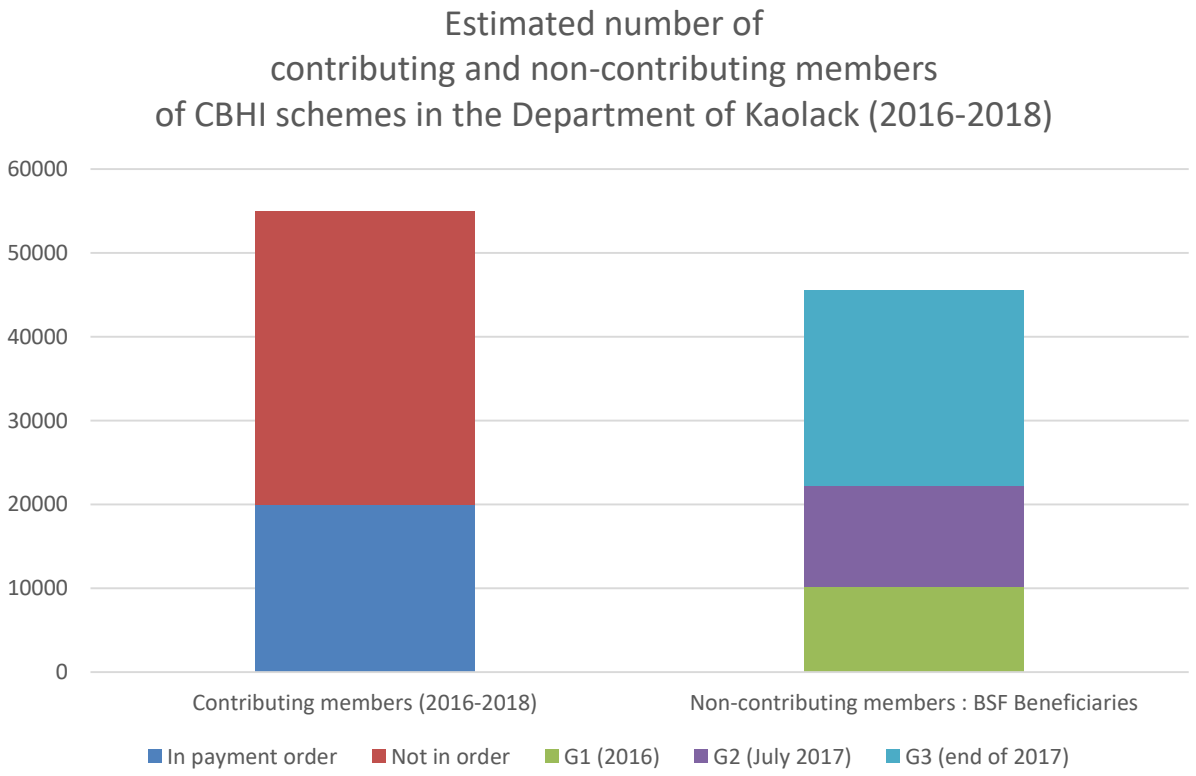
These stigmatizing attitudes can be explained by :

- 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]

Amplification of implementation failures (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

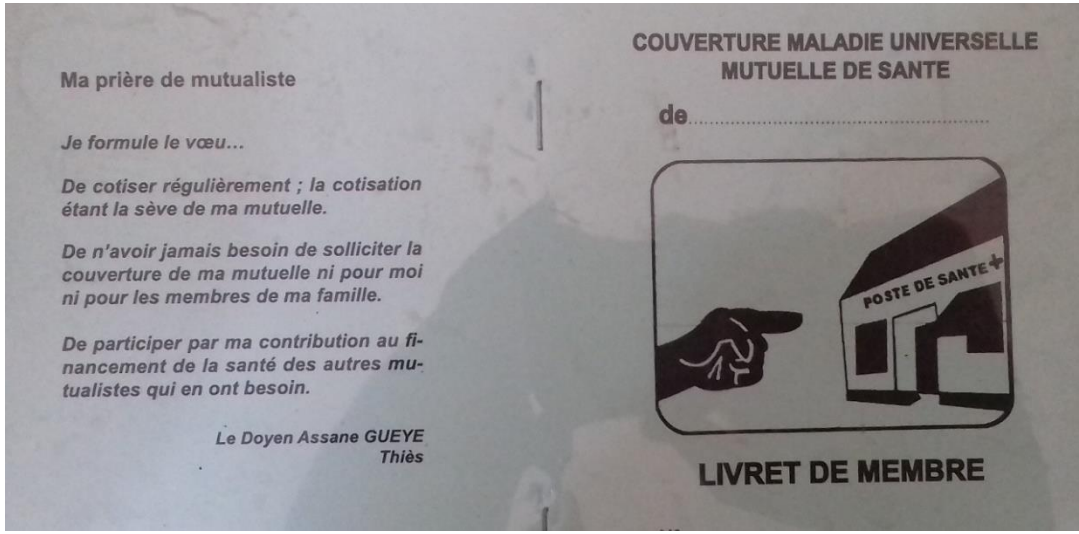
Failure of most “equity funds” and “exemptions policies” to provide free healthcare services for the poorest in West Africa

> 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?