Social Science & Medicine 107 (2014) 78–88

Contents lists available at ScienceDirect

Social Science & Medicine

journal homepage: www.elsevier.com/locate/socscimed

Why do people drop out of community-based health insurance? Findings from an exploratory household survey in Senegal

Philipa Mladovsky

LSE Health, London School of Economics and Political Science, London, UK

ARTICLE INFO

Article history:
Received 5 June 2013
Received in revised form
31 January 2014
Accepted 11 February 2014
Available online 12 February 2014

Keywords:
Senegal
Community-based health insurance
Participation
Insurance coverage
Drop-out
Cross-sectional survey

ABSTRACT

Although a high level of drop-out from community-based health insurance (CBHI) is frequently reported, it has rarely been analysed in depth. This study explores whether never having actively participated in CBHI is a determinant of drop-out. A conceptual framework of passive and active community participation in CBHI is developed to inform quantitative data analysis. Fieldwork comprising a household survey was conducted in Senegal in 2009. Levels of active participation among 382 members and ex-members of CBHI across three case study schemes are compared using logistic regression. Results suggest that, controlling for a range of socioeconomic variables, the more active the mode of participation in the CBHI scheme, the stronger the statistically significant positive correlation with remaining enrolled. Training is the most highly correlated, followed by voting, participating in a general assembly, awareness raising/information dissemination and informal discussions/spontaneously helping. Possible intermediary outcomes of active participation such as perceived trustworthiness of the scheme management/president; accountability and being informed of mechanisms of controlling abuse/fraud are also significantly positively correlated with remaining in the scheme. Perception of poor quality of health services is identified as the most important determinant of drop-out. Financial factors do not seem to determine drop-out. The results suggest that schemes may be able to reduce drop-out and increase quality of care by creating more opportunities for more active participation. Caution is needed though, since if CBHI schemes uncritically fund and promote participation activities, individuals who are already more empowered or who already have higher levels of social capital may be more likely to access these resources, thereby indirectly further increasing social inequalities in health coverage.

© 2014 Elsevier Ltd. All rights reserved.

1. Introduction

Community-based health insurance (CBHI) aims to provide financial protection from the cost of seeking health care through voluntary prepayment by community members; typically it is not-for-profit and community owned and controlled (Atim, 1998; Hsiao, 2001). The Senegalese government elected in 2012 views CBHI as a key mechanism for achieving universal coverage (Ministère de la Santé, 2012), a policy initiated by the previous government (Ministère de la Santé, 2004). Senegal has witnessed a rapid increase in the number of CBHI schemes, reaching around 139 between 1997 and 2004 (Hygea, 2004). Yet as in most low- and middle-income countries (LMIC), overall population coverage remains low, with 4% or less of the Senegalese population enrolled in CBHI (Soors et al., 2010). Another problem for CBHI schemes is retaining enrolees; it is estimated that in Senegal in 2004, 47% of people who had ever enrolled in CBHI had ceased paying the premium and therefore lost access to the benefits of CBHI (Hygea, 2004). In order to explore why people drop-out of CBHI schemes, this paper develops a conceptual framework of community participation in CBHI and draws on data collected in a household survey on the relationship between CBHI membership, active community participation and social capital.

2. Background

2.1. Drop-out from CBHI

While drop-out from CBHI is frequently reported as a problem it has rarely been analysed in depth (De Allegri et al., 2009). Two exceptions come from West Africa. One is a quantitative study of a CBHI scheme in Burkina Faso which had been operational for three years and had a drop-out rate of 30.9–45.7% (Dong et al., 2009). The

E-mail address: p.mladovsky@lse.ac.uk.

http://dx.doi.org/10.1016/j.socscimed.2014.02.008
0277-9536/© 2014 Elsevier Ltd. All rights reserved.

study focuses entirely on demographic, economic and health-related indicators and finds that female household head, increased age, lower education, fewer illness episodes, fewer children or elderly in a household, poor health care quality, less seeking care, higher household expenditure and shorter distance to the contracted health facility were correlated with increased drop-out. The other paper is a qualitative study from Guinea-Conakry (Criel and Waelkens, 2003) where CBHI population coverage fell from 8% of the target population to about 6% in the following year. The main reasons for non-enrolment and drop-out were poor quality of care and reported inability to pay the premium. Understanding of the concept of insurance, information flow, mistrust of institutionalised associative movements, confidence in the management of CBHI and integration of CBHI with existing systems of mutual aid were found not to be underlying causes, possibly because CBHI promoters discussed the scheme with community members from the start (Criel and Waelkens, 2003). However, as with the Burkina Faso study, the Guinea-Conakry study was conducted only two years after the commencement of the scheme. This makes it difficult to assess the longer-term determinants of drop-out and the sustainability of the participatory dynamic of the scheme.

2.2. Community participation in CBHI

Community participation, ownership and control in scheme design and management are in principle key defining features of CBHI (Atim, 1998; Hsiao, 2001; Soors et al., 2010). Smallness of CBHI schemes has been seen as a drawback in terms of risk pooling, but an advantage in terms of community focus (Davies and Carrin, 2001). As CBHI was rolled out in LMIC, policymakers and researchers hoped that the community-oriented approach would promote a set of important benefits: trust in CBHI management, solidarity and acceptance of cross-subsidisation, the flow of information, the quality of health services; and reduced fraud, moral hazard and adverse selection (Davies and Carrin, 2001; Hsiao, 2001; Pauly, 2004; Pauly et al., 2006; Zweifel, 2004). Implicit in this view was the idea that CBHI would benefit from existing social capital (Mladovsky and Mossialos, 2008), defined as "the information, trust and norms of reciprocity inhering in one's social network" (Woolcock, 1998, p. 153). It was hypothesised that the community-oriented dynamic would in turn promote high levels of enrolment in CBHI. However, this hypothesis has hardly been studied and the various possible modes of community participation in CBHI have never been rigorously conceptualised in the form of an overarching theoretical framework.

In contrast, community participation has been extensively conceptualised and analysed in the broader literature on health (Morgan, 2001; Rifkin, 1986, 2009; Zakus and Lysack, 1998). Rifkin (1986), points to three main approaches to community participation in health programmes: medical; health services; and community development. The latter approach defines participation as "community members being actively involved in decisions about how to improve [health]", where health is seen as a "human condition which is a result of social, economic and political development" (Rifkin, 1986, p. 241). Key factors are "people's perceptions of health and their motivation to change health care" as well as the importance of communities "learning how to decide the ways in which change can best be achieved" (Rifkin, 1986, p. 241). This approach seems to best match the goals of CBHI as described by policymakers and researchers and is the definition adopted in this study. Rifkin further distinguishes between different modes of community participation. The most passive mode is participating in benefits of the programme: in CBHI this accords with becoming a member of the scheme by paying the premium. More active modes in ascending order of range and depth of participation are: activities, management, monitoring and evaluating, and planning (Table 1) (Rifkin, 1986).

It is not clear whether low CBHI enrolment in sub-Saharan Africa could be linked to a lack of active participation, as there is little evidence on this topic. The few studies on community participation in CBHI present contradictory results. Two qualitative studies (De Allegri et al., 2006; Ridde et al., 2010) compare the views of members of CBHI to non-members and find that although levels of active community participation in CBHI were generally low, people did not point to this as a reason for not enrolling. In contrast, two other qualitative studies (Atim, 1999; Basaza et al., 2007) compare schemes in which the level of active community participation was high with schemes with low active participation and suggest that higher active participation may be one of the factors accounting for higher levels of enrolment. A further qualitative study (Schneider, 2005) suggests that active participation may have positively influenced enrolment by building trust, transparency, solidarity and honesty.

Table 1
Mode, definition and examples of community participation in CBHI in Sub-Saharan Africa.

Mode of participation (in ascending order ranging from passive to active)	Definition	Examples of active community participation in CBHI in sub-Saharan Africa
1. Benefits	Passive: community members are recipients of services	Enrolment/paying the premium
2. Activities	Active: community members contribute to health programmes but do not participate in the choice of what activities are to be undertaken or how they will be carried out	Disseminating information, attending meetings and general assemblies, voting in elections, receiving training
3. Management	Active: those involved in activities have some managerial responsibilities. They make decisions about how these activities are to be run, but do not decide which activities are undertaken	Managing the day-to-day operation of the scheme (e.g. enrolling members, collecting premiums, managing finances, holding meetings and general assemblies)
4. Monitoring and evaluating	Active: community members are involved in measuring objectives and in monitoring activities, but not involved in developing programme objectives	Collecting information, reporting and reviewing
5. Planning	Active: community members (usually key individuals such as leaders and teachers) decide what programmes they wish to undertake and ask health staff, agencies and/or government to provide the expertise and/or resources to enable the activities to be pursued	Identifying the need for the scheme; deciding on the scheme design and objectives (e.g. benefits package, premium price, mode of collection, target population); leading the scheme (e.g. contracting providers, hiring and training staff, setting the agenda for general assemblies, attracting funding, research and technical assistance); coordinating CBHI on a regional level; developing CBHI policy.

Source: Adapted from (Rifkin, 1986) and literature on community participation in CBHI in Sub-Saharan Africa

Download English Version:

https://daneshyari.com/en/article/7335524

Download Persian Version:

https://daneshyari.com/article/7335524

Daneshyari.com