

The Role of Health Insurance in Poverty Reduction: Empirical Evidence from Senegal

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Outline

- 1) Poverty, equity and (health) insurance
- 2) Conceptual framework
- 3) Case study Senegal
- 4) Empirical analysis
- 5) Policy challenges

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Why is health a crucial issue for development and poverty reduction?

- High and often “hidden costs” of illness for the poor
- Widely exclusion of the poor from access to public health service
- Interesting institutional innovations world wide in coping with health risks

1) Poverty, equity and (health) insurance

- The overall development context
 - MDG’s attached importance to health
 - World Bank’s Report on Equity
 - Emerging issue: Risk/vulnerability and social protection
- Recent innovations in health care financing
- Can health insurance contribute to poverty reduction?

2) Conceptual framework

- Literature addressing « impact »
 - “Early” studies: looking at health systems, sustainability of schemes etc.
 - Today: greater focus on impact for members
- Three important areas
 - Who participates?
 - Direct impact on access to health care and financial protection
 - Indirect impact on labour productivity, health outcomes, income and well-being

3) Case study Senegal

Data source: WHO survey in 2002

1. HH level

- More than 3600 HHs (with nearly 28, 000 members) were interviewed.

2. Individual level

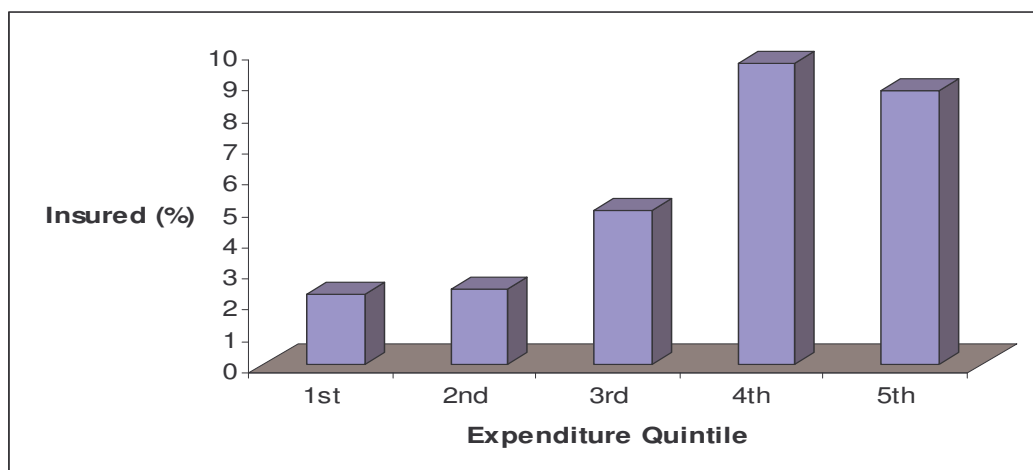
- More than 3200 individuals were randomly selected and interviewed.

4) Empirical analysis

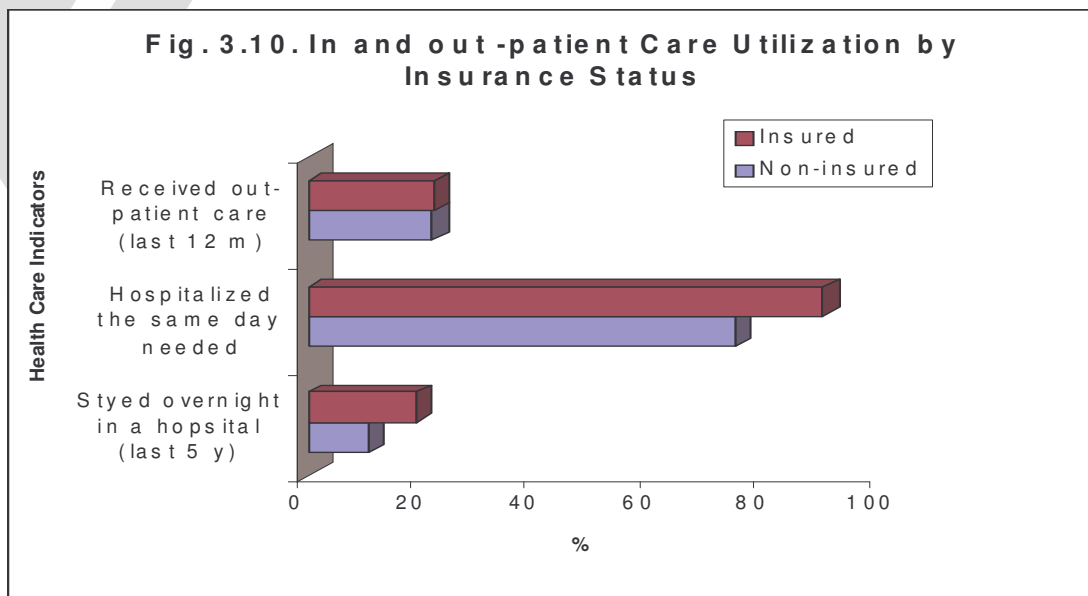
- Methodology: descriptive analysis; logistic regression models – test for endogeneity if “insurance” variable significant
- Determinants of membership
- Health care utilization (maternal, child, out and in-patient services)
- Financial protection (OOP, catastrophic health spending)
- Household strategies to deal with health shocks

Determinants of Health Insurance Membership

- Coverage 5.41% (by any type of health insurance)
- The average contribution in voluntary plan US\$3/year/person
- Most important: income, education, urban

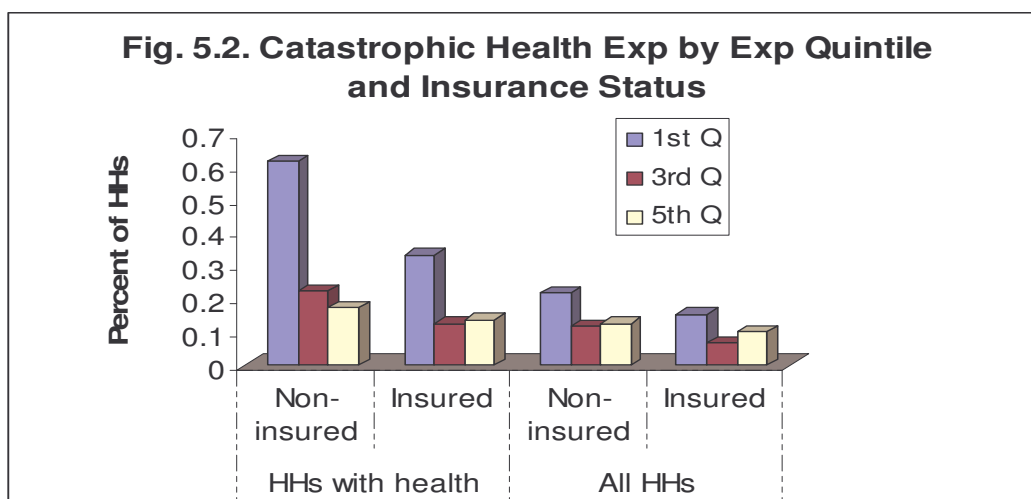


Utilization of Health Services



Catastrophic Health Spending (distribution)

- In both the conditional and unconditional analysis insured HHs were less likely to face catastrophic exp from OOP.
- This was true irrespective of their income and where they live.

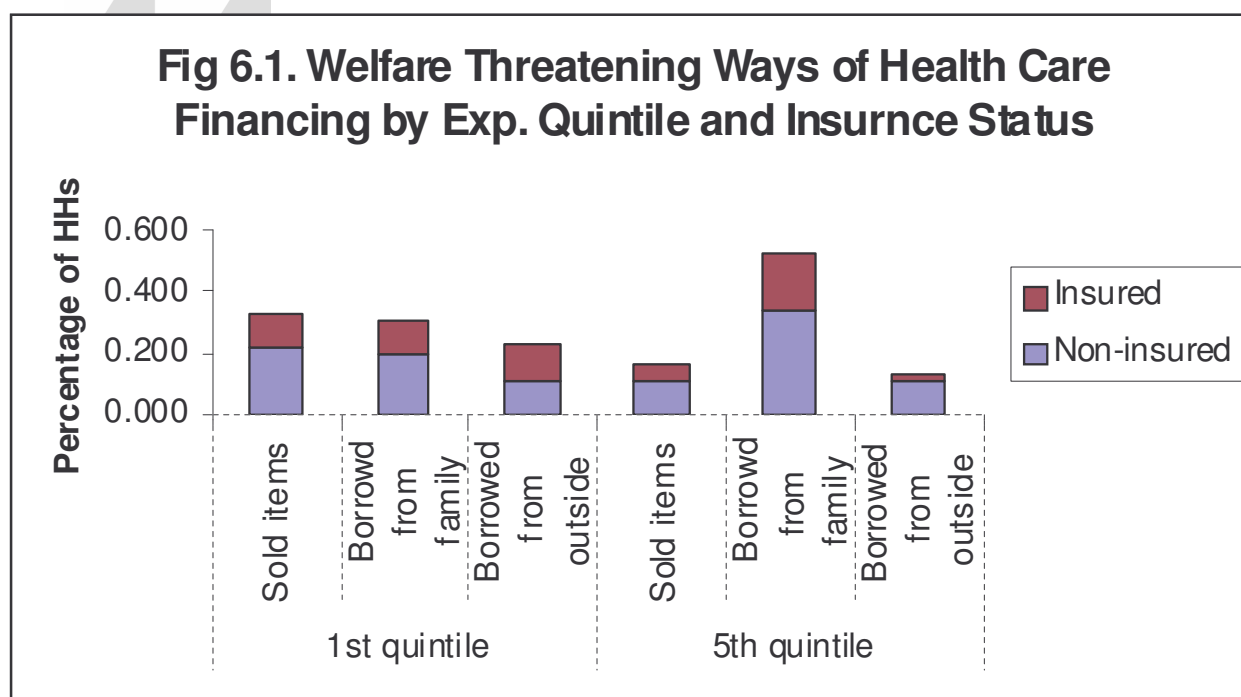


Determinants of Catastrophic Health Expenditure

Variable	Unconditional		Conditional	
	Coefficients	Marginal effects	Coefficients	Marginal effects
Setting	-0.544***	-0.00005	-0.569***	-0.0701
First quintile (reference)				
Second quintile	-2.403***	-0.00014	-2.442***	-0.1764
Third quintile	-4.780***	-0.00026	-4.854***	-0.3059
Fourth quintile	-6.122***	-0.00028	-6.221***	-0.3918
Fifth quintile	-8.111***	-0.00044	-8.216	-0.5768
Insured	-0.724*	-0.00005	-0.736*	-0.0698
Ln out-of-pocket health expenditure	1.927***	0.00018	1.968***	0.2356
Ln family size	0.925***	0.00008	0.940***	0.1125
Constant	-16.155***		-16.502***	
No of observations	2544		1370.000	
Pseudo R2	0.581		0.442	

***, **, * significant at one, five and ten percent level, respectively

Health Care Financing Strategy



Summary of Findings

- Participation: the chronic poor excluded
- Access to health care improved
- Financial protection: modest improvement
- Negative long term impact of health shock reduced

5) Policy Challenges

Deepening poverty reduction impact requires:

- Broader coverage, e.g. smart subsidies
- Capacity development
- Promoting institutional innovations (e.g. community financing schemes, PPP's, etc.)
- Linking up with PRSPs and decentralization
- Donor support