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Reconciling the Senegalese Population with Their Healthcare System: Strategies to Mitigate Healthcare Renunciation

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Senegal is undergoing significant structural changes in its population due to declining fertility and mortality rates. This demographic transition is leading to an increase in the age dependency ratio, i.e. the ratio between the working-age population and the dependent population (young and elderly), which increases the country's growth and investment potential (Sall, 2013). To harness fully the demographic dividend for sustained economic growth, it is imperative to implement policies aimed at enhancing employment opportunities and increasing worker productivity. Central to this objective is the enhancement of workforce health.

Over the past ten years, Senegal has invested considerable resources to improve the health of its population. In 2013, the government launched its national health insurance programme called Universal Health Coverage (UHC) to cover 75% of the population by 2017. UHC implements a free care programmes for children under the age of five, pregnant women who need a caesarean section due to their health condition (or the foetus), and people aged 60 and over (known as *Plan Sésame*).

Recently, in 2022 and 2023, the country has made new investments to improve health services. This has resulted in the construction of four new level 2 hospitals – facilities that provide services in general medicine and surgery, obstetrics, emergency care, and specialised medical, surgical, or psychiatric care. These hospitals will primarily serve isolated populations in the Kaffrine, Kédougou, and Sédhiou regions.

These investments are not necessarily a guarantee of rapid improvement in health indicators. The outcomes depend on the convergence between health services and citizens' needs. The efficacy of governmental efforts hinges upon their utilisation by the population in need of health care.

Several factors, whether objective or subjective, can discourage citizens from seeking healthcare and consulting

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health professionals in the event of illness or accident. These behaviours can contribute to a deterioration in the health status of those affected, increase long-term healthcare costs, and hinder productivity gains. It is difficult to understand and explain why people renounce healthcare when they are ill. This *policy brief* presents original data that contributes to a better understanding of the extent and motivations of this phenomenon in Senegal. It also suggests possible solutions to reduce this problem.

Two decision-making processes for healthcare renunciation

Healthcare renunciation can occur through voluntary choice or as because of access barriers

We define healthcare renunciation as the scenario wherein an individual necessitates healthcare, possesses the right to avail themselves of the services provided, yet deliberately opts against exercising that right. This concept remains relatively ambiguous in the existing literature, with a few notable exceptions. Notably, Després et al. (2011) emphasise that "*from a scientific standpoint, healthcare renunciation, still inadequately explored, seeks to identify unmet healthcare needs that would be justified by the health status*". Poirot-Mazères (2021) approaches renunciation through the lens of the "*autonomist model*" and views it as an outcome of "*individual considerations*". He defines it as a personal choice, which may stem from various motivations: "*Renunciation entails a conscious decision not to pursue care, marked by recognised refusal, hesitancy, or resignation*".

There are two overarching categories of reasons for healthcare renunciation, each entailing distinct decision-making processes (Valmy et al., 2016; Després et al., 2011):

- ***Renunciation-barrier*** occurs when an individual refrains from seeking healthcare due to perceived, whether accurate or not, inaccessibility. Factors contributing to this barrier include economic hardships faced by patients, the complexity of the healthcare system, regulations dictating access to healthcare, and insufficient transportation options.

- ***Renunciation-refusal*** denotes the scenario where an individual chooses an alternative approach to address their health concern. Factors contributing to renunciation-refusal encompass a lack of trust in the public healthcare system, feelings of shame and guilt experienced by certain patients in the presence of healthcare professionals, and cultural norms that prompt them to seek alternative forms of medication or care practices.

These factors may intersect or stem from shared causes such as poverty or low levels of education within the affected populations (Bodenmann et al., 2014).

Findings from a quantitative survey

To gain deeper insights into the phenomenon's scope and underlying motivations, we conducted a quantitative survey spanning 2019-2020, encompassing 2,170 households across three regions of Senegal: Tambacounda, Diourbel, and Thiès. The primary objective of this survey was to document spatial discrepancies in healthcare access and assess the efficacy of the UHC programme. A key component of the survey involved identifying individuals who had recently renounced to necessary healthcare and documenting the primary reasons for this renunciation, as depicted in Figure 1.

Figure 1.A illustrates the magnitude of the phenomenon. Among individuals who reported experiencing illness or injury within the 30 days preceding the survey, 41.2% of them refrained from seeking healthcare or visiting any healthcare facility. This renunciation rate, surpassing 40%, holds significant importance. By comparison, in 2008, only 15.4% of the French population aged 18 and above reported renouncing healthcare due to financial constraints within the previous twelve months (Després et al., 2011).

Figure 1.B presents the distribution of the main reasons cited by individuals who renounce to healthcare. Predominantly, preferences for self-medication (41% of respondents) and the high cost of care (39.4%) emerge as the two most prevalent reasons. The notable prevalence of self-medication is closely linked to the demographic influence of the religious city of Touba within the sample. Both Touba and Dakar host street vendors selling medications. Additionally, it is noteworthy that 14.7% of respondents, or nearly one in seven, underscore the perception that professional health services are unnecessary.

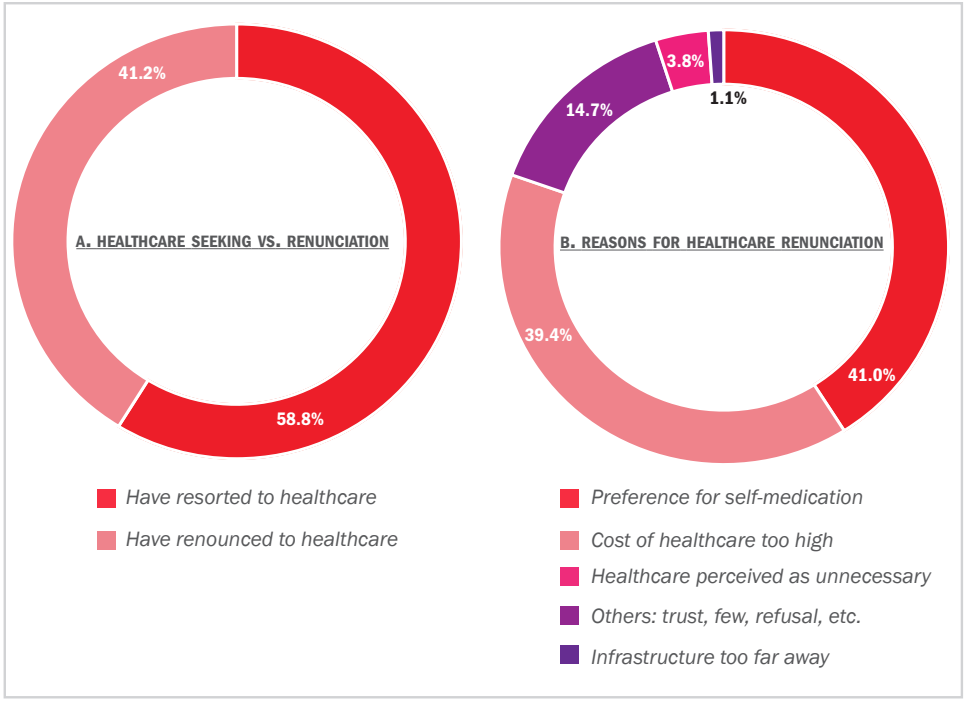

Figure 1: Healthcare renunciation in three Senegalese regions

Therefore, healthcare renunciation emerges as a notable phenomenon in Senegal, largely driven by the adoption of alternative self-medication practices or financial limitations. It makes sense to attribute the scale of this phenomenon to the inadequate development and accessibility of UHC programme in remote regions of the country, or its failure to reach the most vulnerable population segments. What is the current reality?

The survey findings reveal that among individuals covered by the health insurance system, 28.7% of them reported renouncing healthcare when needed. In contrast, among individuals not covered by health insurance, the renunciation rate surged to 42.6% of respondents. Furthermore, the survey allows for an examination of whether individuals benefiting from free programmes, such as children aged 0 to 5 or elderly individuals, exhibit different behaviours. Among them, 100 individuals experienced illness in the past 30 days and 69 sought professional healthcare facilities, while 31 opted to renounce to healthcare. These figures provoke contemplation and reflection.

Individual Determinants of Healthcare Renunciation

A substantial proportion of individuals experiencing serious illness choose to renounce to healthcare

A multivariate statistical analysis aids in identifying the determinants of the probability of an individual renouncing to healthcare when facing illness or after an accident. Potential factors considered in this analysis encompass age, gender, income or educational attainment, place of residence, health insurance coverage, and the nature of the illness or injury experienced by the individual. From this analysis, we can draw several conclusions:

- **Age:** Individuals over 60 are more likely to renounce to healthcare, whereas mothers or guardians of children under five have the lowest probabilities.
- **Gender:** Women are more likely to seek healthcare compared to men.
- **Income and Education:** Individuals with higher income or education levels are more likely to seek healthcare than those with lower levels.
- **Place of Residence:** Renunciation rates are higher in rural areas compared to urban areas.
- **Health Insurance:** Individuals with a health insurance plan are more likely to seek healthcare than those without insurance.
- **Morbidities:** Surprisingly, individuals with chronic, degenerative, and metabolic diseases are more likely to renounce to healthcare than those suffering from other illnesses.

From observations to recommendations

The relatively high proportion of individuals who renounce to healthcare underscores the inaccessibility of the public healthcare system for a significant segment of the population. Greater reliance on self-medication and access costs are the most cited reasons to renounce to healthcare (8 out of 10 individuals). These two reasons

often appear inseparable. Indeed, the high cost of healthcare - consultations, examinations, and medications - compels poorer individuals, those with less education, or those isolated in rural areas to resort to self-medication, perceived as the only accessible alternative. According to the Senegalese proverb, "*the child who cannot suckle from his mother's breast will be forced to suckle from his grandmother's*". Thus, self-medication becomes the default choice par excellence. The absence of regulation in informal medicine further promotes self-medication and portrays it as a legal alternative, particularly in the eyes of users with lower levels of education.

In principle, we anticipate the establishment or enlargement of the UHC scheme to reduce the incidence of healthcare renunciation. This conjecture is particularly plausible given that the excessive cost of healthcare emerges as the predominant cause of renunciation in 39.4% of the respondents surveyed. This finding lends weight to the importance and validity of implementing the UHC programme and the intention to expand it gradually to encompass all strata of the population. However, in practice, the elevated rates of renunciation observed among beneficiaries of health coverage indicate that merely extending health insurance does not automatically ensure access to quality healthcare tailored to the needs of the populace.

Several reasons explain this observation. Firstly, the content of the packages offered by insurance schemes in general, and those responsible for UHC in particular, only sometimes aligns with the demands of the insured. For example, consider the role of morbidity in the decision to renounce healthcare: the survey shows that individuals with chronic, metabolic, and degenerative diseases are more likely to renounce healthcare than those with other illnesses. This is detrimental since these often-severe diseases are more prevalent among the elderly, and therefore, affect insured individuals benefiting from free programmes (*Plan Sésame*) implemented since 2006.

Secondly, the survey also reveals that medication expenses following consultations are prohibitive. People and households spend the most on medication purchases in their healthcare expenditure. This is especially significant with prescribed medications for the elderly, which are specialised drugs rarely available at healthcare facilities and mainly dispensed by private pharmacies. Patients anticipate the high cost of prescribed medications, leading them to avoid seeking care at public healthcare facilities.

Thirdly, the survey also reveals that a negative perception of the quality and utility of healthcare leads to renunciation. Recall that 14.7% of respondents state they renounced healthcare primarily because they deemed it unnecessary. This perception of the uselessness of healthcare may stem from several possible and non-exclusive causes:

- **A negative perception of service quality**: this includes the inefficiency of therapeutic protocols, the imbalance between expected benefits and their costs (consultations, examinations, and medications), sometimes-unfriendly behaviour of healthcare providers, unwelcoming atmosphere, non-respect of the confidentiality of medical results, etc.

- **Trivialisation of illness or its temporary nature**: while understandable in the case of minor illnesses (common cold or seasonal flu), this attitude seems unjustifiable when dealing with chronic, metabolic, and degenerative diseases.

- **Causal attribution of illness to external events**: this leads to the belief that addressing ailments falls more within the domain of traditional medicine than modern medicine. Such cultural norms likely contribute to perpetuating the use of traditional practices.

Reducing healthcare renunciation requires a combination of measures

In light of these observations, we can formulate several policy and programmatic recommendations to stimulate healthcare demand and enhance the effectiveness of public investments in the healthcare system:

- **Enhance healthcare provision by improving the content of packages offered through UHC programmes**; ensuring essential medications are readily available at public facilities, and enhancing the quality of healthcare services (including practitioner training, patient reception, and confidentiality protocols).

- **Conduct awareness and communication campaigns** highlighting (i) the significance of healthcare, especially in managing chronic and degenerative conditions such as cancer, kidney diseases, and heart conditions, (ii) the importance of timely treatment for illnesses, and (iii) the risks associated with self-medication and the use of street medications.

- **Regulate** traditional healthcare practices and street vendors selling medications.

- Regarding system governance, **expedite the decentralisation of healthcare provision**, particularly for specialised care; decentralise the management of UHC programme through mutual health organisations at an appropriate geographical level and professionalise services. The consolidation of communal mutual health organisation into departmental and regional unions may facilitate this process, enabling them to enrol a larger number of individuals.

The existing knowledge on healthcare demand and the underlying causes of renunciation prompts us to advocate for further scientific research on the decision-making process that leads to renunciation. This entails enhancing our understanding of the specific determinants of renunciation barriers and renunciation-refusal across different levels of care (along the healthcare pyramid), as well as assessing the impact of various reforms, policies, or programmatic initiatives mentioned earlier.

We can conduct pilot experiments in priority regions or healthcare domains, followed by thorough evaluations before considering potential scaling up.

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