Schweizerische Eidgenossenschaft
Confédération suisse
Confederazione Svizzera
Confederaziun svizra

Federal Department of Foreign Affairs EDA
Swiss Agency for Development and Cooperation
Department of Global Cooperation
Division Global Programme Health

Better social protection, more sustainable financing – What can private health insurance contribute?

Savings and Credit Forum: Sustainable health financing through inclusive health insurance, 10 June 2021

Alexander Schulze, Head, Division Global Programme Health, Swiss Agency for Development & Cooperation

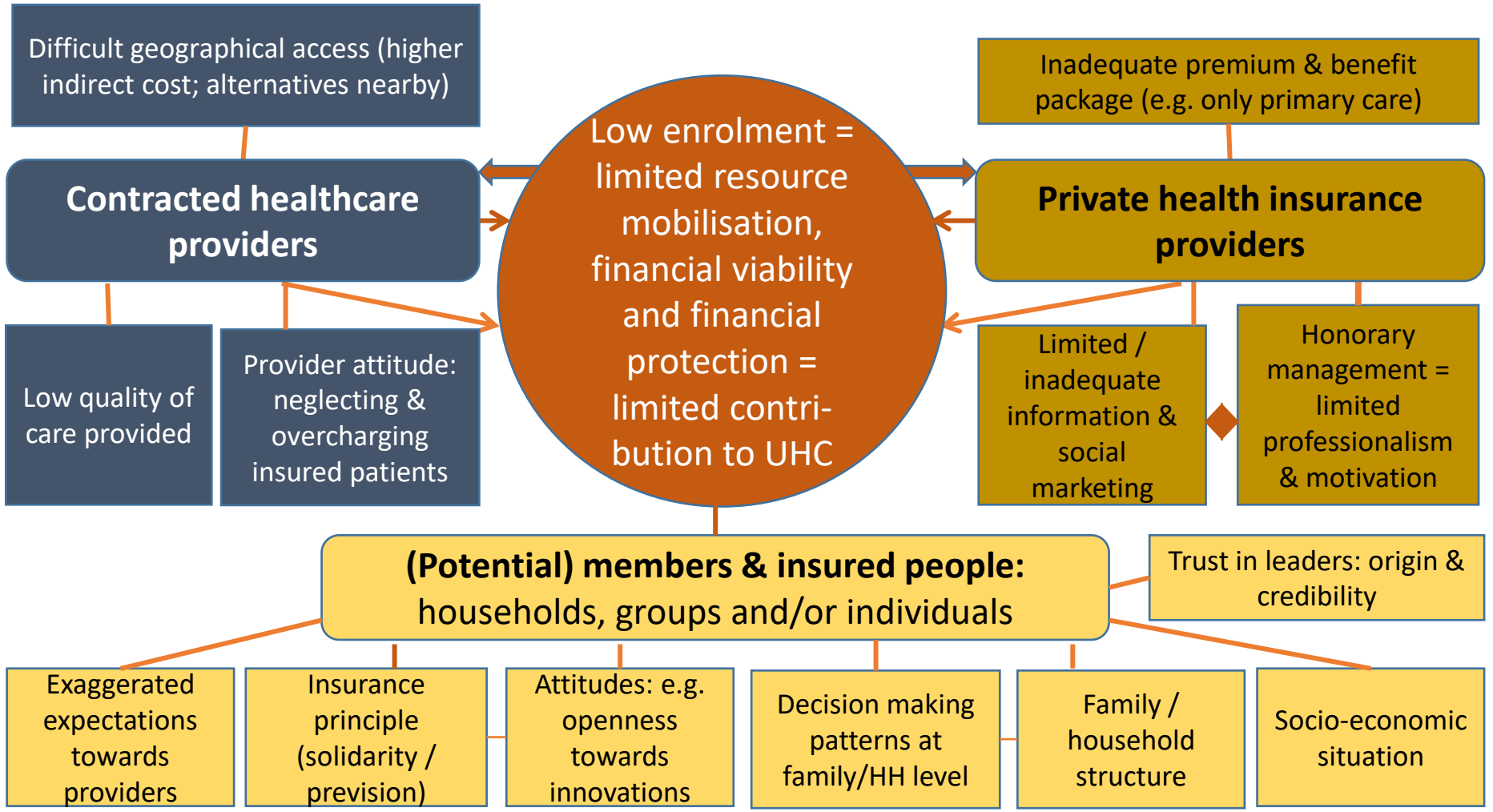
The overall context – the case for private health insurance

- Health financing in lower-income setting still largely dependent on out-of pocket payments (OOP)
- Social health protection mechanisms such as insurance promoted to increase domestic resources for health financing and reduce OOP
- Public system coverage largely limited to formal employees and the (very) poor
- Substantial parts of the population without coverage (e.g. non-poor informal sector / rural near-poor populations in Cambodia: 3.2 million people) 
- Potential market for private for profit or non-profit **voluntary** health insurance

Social Health Protection mechanisms

Social health protection / health financing mechanism	Steering mode	Source of financing	Targeted / covered population groups	Country examples
Formal mechanisms				
National Social Health Insurance (Bismarck model)	Hierarchy	Contributions of employers and employees	Employees in public and formal private sector	Germany, France, Belgium, Costa Rica
National Public Health Services (Beveridge model)	Hierarchy	Taxes, development aid	Entire population or disadvantaged populations	*Social cash transfer* in Brazil and Zambia, *National Health Service* in GB
Provident funds	Hierarchy	Individual / household	Employees in public and formal private sector	Anglophone African countries
Medical saving accounts	Market	Individual / household	A priori open to all	South Africa
Private commercial health and life insurance	Market	Individual / household	A priori open to all	Chile, Switzerland, Kenya, Egypt
NGOs etc.	Solidarity	Member fees, development aid	Disadvantaged populations	Worldwide
Mutual health organisations, cooperatives	Solidarity	Member fees, development aid. State, decentral	Employees in informal sector, rural populations	Ghana, Rwanda, Tanzania, francophone West Africa; Asia: India, Thailand, Vietnam
Informal mechanisms				
Saving & credit groups (tontine)	Solidarity	Member fees	Members	Francophone Africa: tontine
Family, kin, neighbours	Solidarity	Income, assets	Family, kin members	Worldwide

The challenge – low enrolment rates of voluntary private health insurance



Evidence for more informed policy and practice – main research gaps

Three main research gaps in comparative analysis of insured and non-insured households:

1. No systematic analysis of socio-cultural characteristics
   - Selection of factors not guided by hypothesis
   - Factors not always quantified (e.g. attitudes)
2. Household / family structures and decision making patterns not considered
3. Significant factors not related to each other.

Research questions

- **Which factors influence** (either foster or constrain) **enrolment in a voluntary health insurance scheme**?
  - Socio-economic status?
  - Local socio-political context?
  - Socio-cultural characteristics and attitudes?
  - Household and family structure?
  - Decision making patterns?
- **How do they relate to each other**?
- In how far do the respective combinations reflect **different life style patterns**?

Key finding 1: **Weak influence of socioeconomic status on enrolment**

Based on Principal Component Analysis (39 items):

Location	No of insured people out of total population	Lower socio-economic tercile	Middle socio-economic tercile	Higher socio-economic tercile
Location 1	14.8%	56.7%	38.2%	5.1%
Location 2	7.4%	10.2%	28.5%	61.4%

Indicator	p-value (0.05)	Confidence Interval (95% CI)	Odd Ratio (OR)
Households of the lower socioeconomic tercile slightly more likely to be member of the health insurance scheme than those of the middle socioeconomic tercile, yet result not significant	C: 0.654 K: 0.963 Both: 0.669	C: .56-2.5 K: .273-3.44 Both: .63-2.02	C: 1.18 K: .97 Both: 1.13
Households of the higher socioeconomic tercile (twice) more likely to be member of the health insurance scheme than those of the middle socioeconomic tercile, yet result not significant	C: 0.277 K: 0.321 Both: 0.295	C: .54-8.11 K: .68-3.14 Both: .77-2.28	C: 2.11 K: 1.46 Both: 1.33

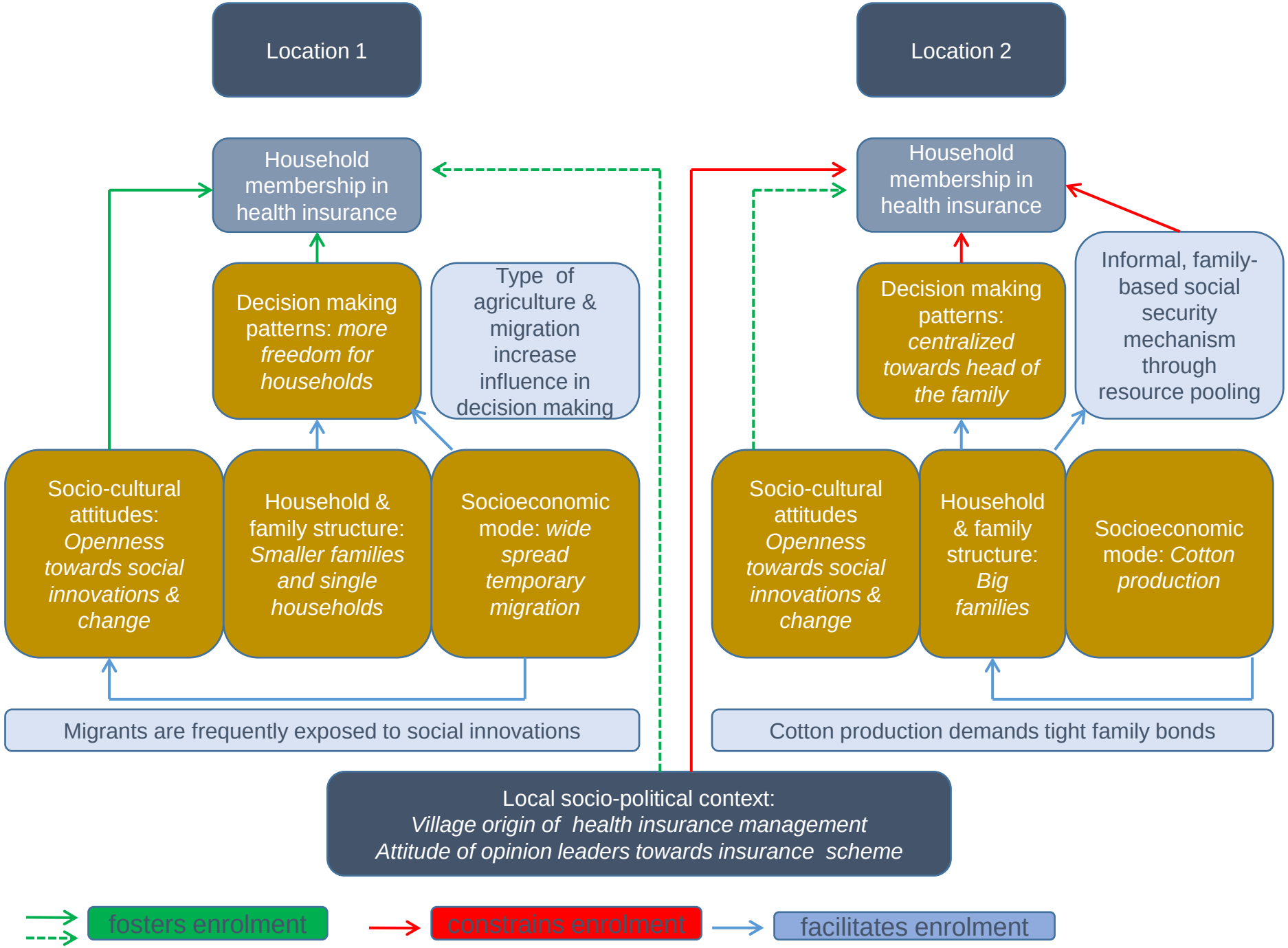
Key finding 2: **Family size and decision making patterns matter**

Quantitative data:

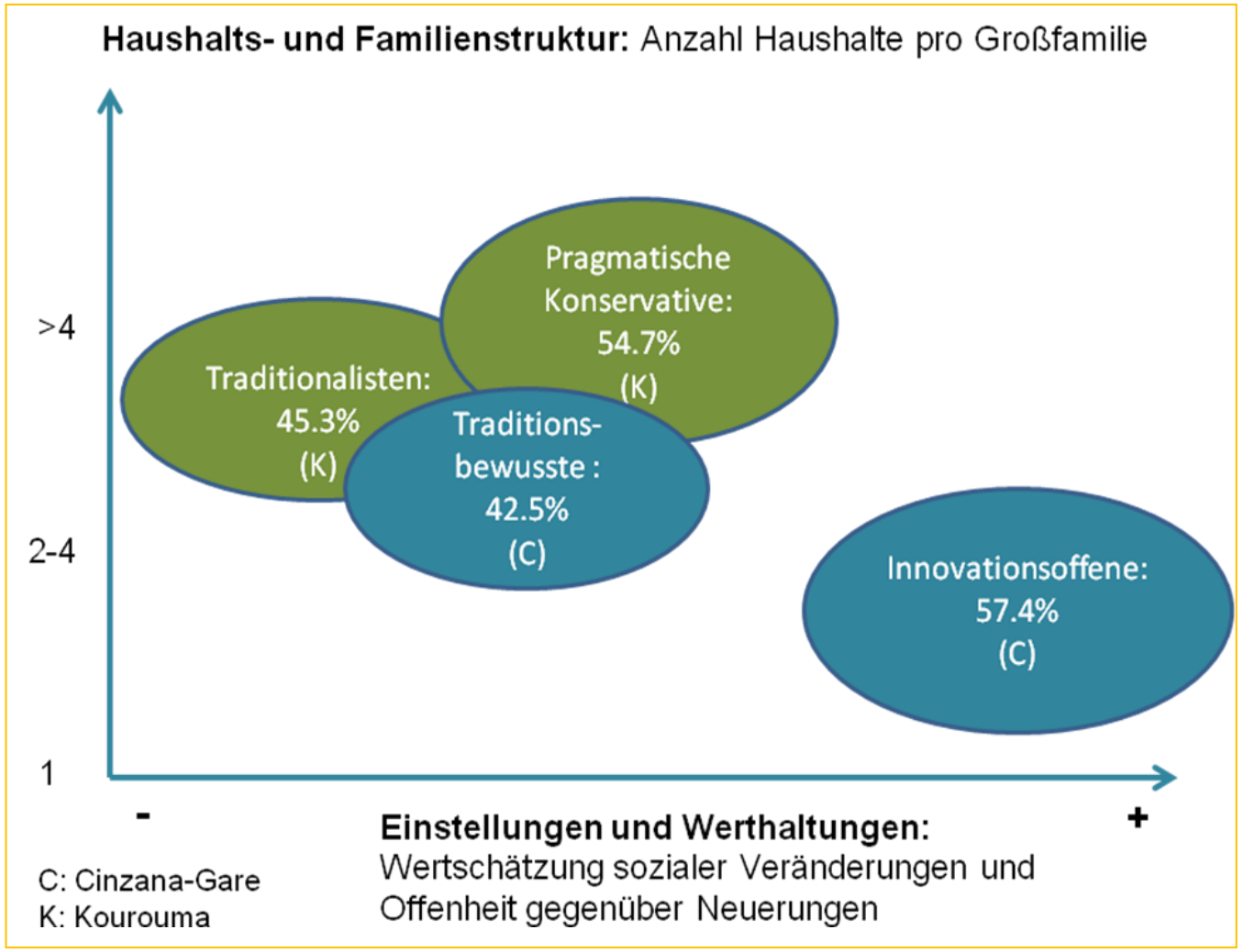
- More single households in location 1 where membership rates are higher
- 60% single households in the main village with the highest enrolment rate (31.5%)
- In contrast, location 2 characterized by big families

Qualitative data:

- Single households and those of smaller families have more decision making power, also due to wide spread temporary migration
- Centralized decision making in big families.


Location 1
Location 2
Household membership in health insurance
Household membership in health insurance
Decision making patterns: *more freedom for households*
Type of agriculture & migration increase influence in decision making
Decision making patterns: *centralized towards head of the family*
Informal, family-based social security mechanism through resource pooling
Socio-cultural attitudes: *Openness towards social innovations & change*
Household & family structure: *Smaller families and single households*
Socioeconomic mode: *wide spread temporary migration*
Socio-cultural attitudes *Openness towards social innovations & change*
Household & family structure: *Big families*
Socioeconomic mode: *Cotton production*
Migrants are frequently exposed to social innovations
Cotton production demands tight family bonds
Local socio-political context:
Village origin of health insurance management
Attitude of opinion leaders towards insurance scheme
fosters enrolment
constrains enrolment
facilitates enrolment

Social differentiation in rural Mali – a household typology



Favourable lifestyle patterns towards enrolment

- Before considering enrolment, some „sequenced preconditions“ must be given for households / individuals:
  - trust in health insurance provider and management
  - certain decision making power of household heads (and their wives) which are structured by socio-economic modes
  - Non-availability of alternative social security mechanisms
- If this is given, then come into play:
  - Attitudes and guiding values favoring social innovations

Conclusion and considerations for private inclusive health insurance

- Get a solid understanding of the target population/customers and their social differentiation beyond socio-economic status

- On this basis, define
  - Primary target customers
  - Tailored benefit package according to potential demand

- Select quality healthcare providers and establish solid relationship with them

Many thanks for your attention!

Social differentiation in rural Mali – a household typology (2)

Locality / Group	Group 1	Group 2: *In location 1, more likely to be insured (p-value: 0.02, OR:1.8)*
Location 1	***Hesitant conservatives***: 42.5% - monogamous - high importance of values such as respect, honesty or trust - appreciate traditional organizations - do not state positive social changes	***Innovation adopters***: 57.4% - appreciate new formal organizations - state positive social changes - health important value - from smaller families - polygamous
Location 2	***Traditionalists***: 45.3% - polygamous - children not enrolled in school - high importance of values such as respect, honesty or trust - appreciate new formal organizations	***Pragmatic conservatives***: 54.7% - monogamous - children in school - do not state positive social changes - from big families