

This Policy Brief is the result of discussions taking place at the VIIth UNAIDS and World Bank Economics Reference Group meeting. Representatives from each agency as well as prominent economists and researchers met to discuss the linkages between social protection, social health insurance and HIV and AIDS.

More information, including presentations made, can be found on the ERG Secretariat's website: <http://www.heard.org.za/research/economics-reference-group/seventh-meeting>

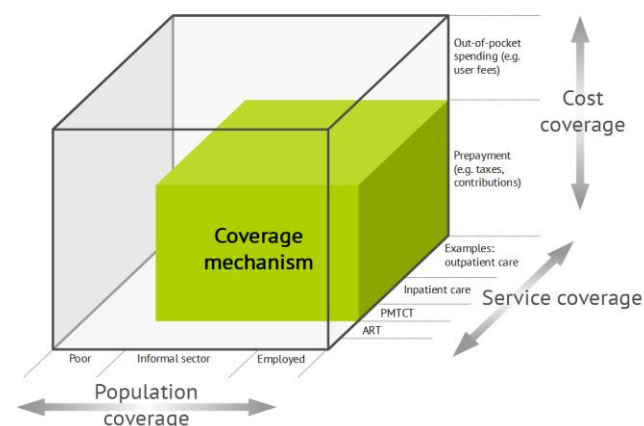
Summary

- Explicit insurance does not offer a panacea for HIV and AIDS service coverage.
- Where an insurance-based health system is already in place, it can be expanded to include HIV and AIDS services.
- Introducing SHI is complicated and will take time to cover all people. The process should not be rushed and existing mechanisms should continue. This means that some people will continue to be inadequately covered - they should not be forgotten.
- Political commitment indispensable for inclusion of HIV services in any coverage mechanism. A political-economy lens will be useful to adopt.
- Financial feasibility is key. External funding may be necessary at the start and then gradually be replaced with government funds. Not all people will be able to contribute to the scheme. Subsidies will play a central role.

Background on Insurance-based health systems

There are three elements to a healthcare system (Figure 1). Population coverage describes how many people are covered. Service coverage describes the health services offered under the benefit package, and includes service quality. Full service will cover all aspects of prevention, care and rehabilitation required by the population. Cost coverage reflects both how much of the insurance premium covers major health issues and how equitably distributed costs are.

Figure 1



Taxed-based financing systems involve the provision of health services at no charge at the point of use to citizens and is funded by government taxes. Population coverage is therefore high.

Explicit insurance is financed by contributions (premiums) by individual members who subscribe

to various levels of health care coverage. Social health insurance and 'private health insurance' are distinct forms of this kind of insurance model.

Countries generally have a mixture of several types of health schemes at any one time. Where provisions for the poor continue to be insufficient, or when accessing healthcare requires user-fees and high indirect-costs, then OOP will continue to be a key means of financing healthcare.

In many resource-poor countries, healthcare is financed by households, which are often left vulnerable to catastrophic healthcare costs. SHI schemes aim to increase the provision of formal health services and reduce these costly out-of-pocket expenditures (OOP). The pooling of resources into one large basket allows for diversification of risk and acts as pre-payment for future use of health care. The pre-payment mechanism is an effective way to also increase coverage of, and access to, health services. Insured households are less likely to experience disastrous healthcare costs that lead to increased household financial instability.¹

SHI and HIV and AIDS services

Universal coverage is the ideal goal of any public healthcare system. In HIV-endemic countries, health systems need to provide and finance both preventative and curative services. These services pose a real challenge in terms of cost. A benefit package that includes HIV and AIDS-related services will be expensive. Donors to date have filled the resource-envelope by providing assistance for treatment and prevention specifically for HIV and AIDS. As a consequence, funding silos have been created, encouraging a vertical approach to health financing. There is a need to move from 'AIDS exceptionalism' to 'health exceptionalism' and explore alternative models of health care financing, such as SHI, that can include HIV and AIDS health services.

Can HIV and AIDS services be insured?

¹ Scheil-Adlung, Jütting, Xu et al. 2005

Generally, most HIV and AIDS services regarded as 'private goods' are insurable. In this case, the net benefit of being insured for the financial costs of a potential future HIV-related health risks accrues to the insured person. Insurance protects the individual agent from individual or idiosyncratic risk, and it thus becomes in their interest to protect themselves. This includes PMTCT, hospitalisation and treatment of opportunistic infections and ARV treatment.

Public goods are not regarded as insurable. This is where the net-benefit accrues to the public and is therefore seen as part of wider health promotion. Non-insurable HIV and AIDS services include mass HIV awareness campaigns, HIV testing and distribution of condoms. These costs must be borne by public finances.

The potential for adverse selection is a concern. Those who know they are HIV positive (or recognise they are at high risk of becoming so) subscribe to an insurance package specifically to receive AIDS treatment. This increases costs and thereby insurance premiums for all.

What does the evidence say?

Doetinchem, Lamontagne and Greener's review² of health insurance schemes in a selection of countries, finds "no HIV-specific variables that have led countries to include HIV-related services within the coverage of a health insurance or to keep it separate through public provision". Countries that do provide HIV-related services either have strong health systems already or are seeking to improve it.

In a multi-country study of SHI programmes, Bitran³ shows that if insurance already exists and covers a significant share of the population, then HIV and AIDS services should be incorporated. This is provided that enough financial resources are available to make it feasible. In cases of low insurance coverage, expecting providers to cover HIV and AIDS services into the benefit package immediately will be premature.

² Doetinchem, Lamontagne and Greener (2010)

³ Bitran, Ricardo

Other evidence points to a role for external funding to play in the provision of HIV and AIDS services within a social health insurance scheme. Lange provides an example of the Dutch-funded Health Insurance Fund (HIF) in Nigeria and Tanzania that covers basic health care, including treatment of HIV and AIDS, tuberculosis and malaria. Insurance premiums were subsidised, although members made co-payments. Local health maintenance organisations are responsible for financial management and for the quality of care. Preliminary results find that long-term donor money acted as long-term collateral which reduced the risk for private investors. This attracted external investments which vastly increased the availability of money for healthcare. In this way, the HIF scheme increased the demand for, and supply of, healthcare.

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Conclusion

Explicit insurance does not offer a panacea for HIV-service coverage. There is nothing specific to health insurance that makes it particularly unique to boost efforts to expand population and financial coverage of HIV and AIDS services.

Where an insurance-based health system is already in place, it makes sense to expand it and to build HIV and AIDS services into it - whether in the cost, service or population coverage dimension, or in all three. This will be more cost-effective than creating separate HIV and AIDS services that require continuation of vertically funded HIV and AIDS programmes. In this way, donors can streamline funding and adopt a 'horizontal' approach to HIV and AIDS funded that is part of the main health system.

Availability of financial resources is key. Countries with currently low health insurance coverage should not wait for the sector to develop first before governments attempt to expand services. Rolling out an insurance-based health scheme will depend critically on public subsidies for it. Donor assistance may initially be required to support the expansion of HIV and AIDS services. While domestic capacity to implement and manage a national health insurance scheme is critical, many developing countries lack good systems to implement compulsory contributions.