

Linking Global Financing Mechanisms to Social Health Insurance Schemes: towards Sustainable Financing of National Responses to HIV/AIDS

Background

Many national health systems in developing countries are as yet unable to provide their populations with appropriate health care. Moreover, the majority of the population in developing countries is not adequately protected against the financial risks of illness. If people fall ill, they have to pay very often for costly treatments themselves. The bulk of the costs are in most settings met by individual out-of-pocket payments. When people succumb to ill-health, these payments are a major cause of impoverishment and thus exacerbate social inequality. In that way HIV/AIDS is also a great risk for impoverishment. According to estimates by the World Health Organisation (WHO), 100 million people every year are driven into absolute poverty by catastrophic health expenditures (WHO, World Health Survey, 2005).

HIV/AIDS, ART and Health Financing Mechanisms

In many developing countries, antiretroviral therapy (ART) is still available to far too few patients. Of the approximately 6.5 million people worldwide who need antiretroviral therapy, so far only just over 1 million have access to it (WHO/UNAIDS report on 3by5 and beyond, March 2006).

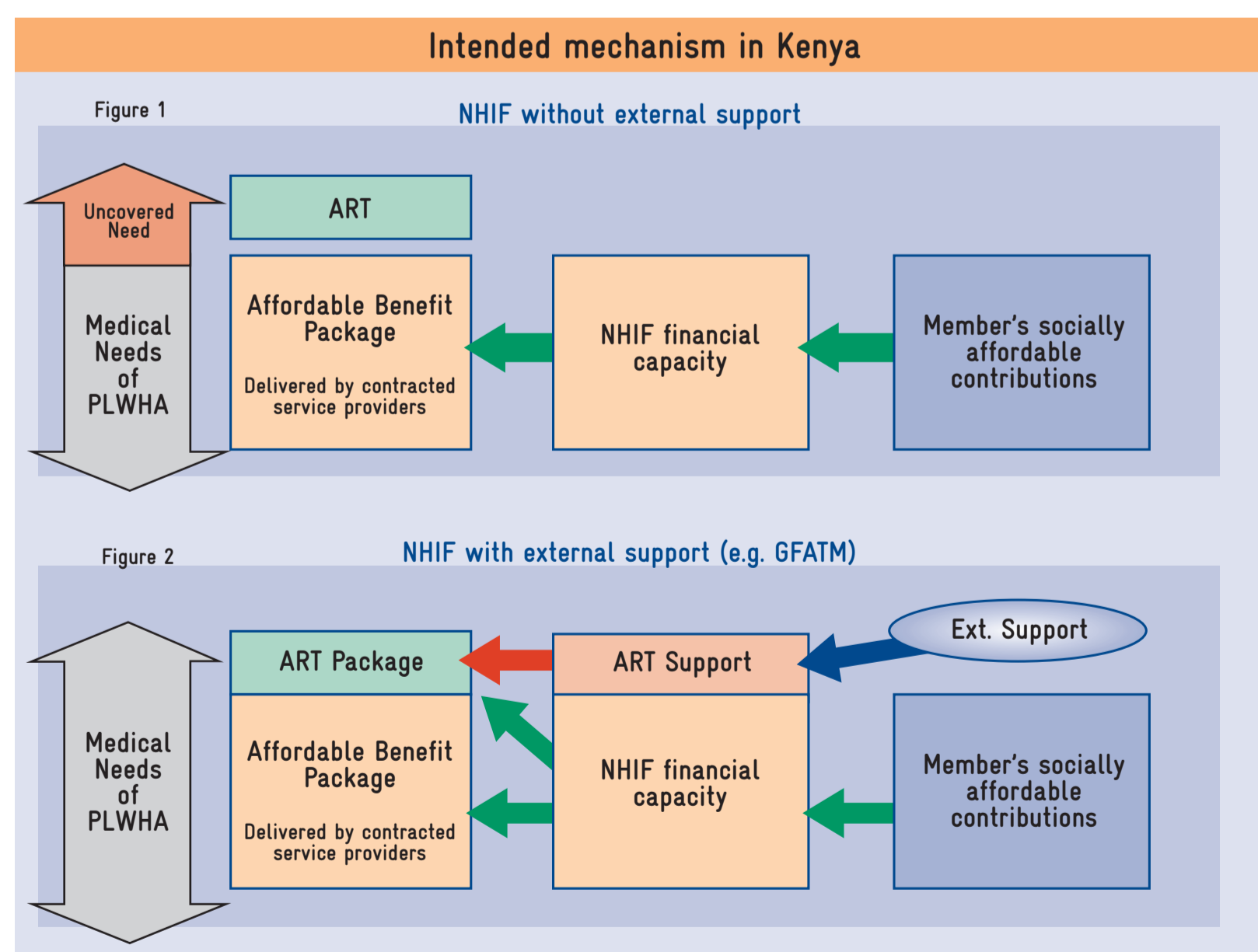
The HIV/AIDS related burden of disease has forced a growing number of developing countries to explore sustainable health financing mechanisms such as social health insurance or community based health insurance schemes in order to install fair and sustainably delivered healthcare services. However, cross-subsidisation fails to raise sufficient funds for a desired comprehensive service package for the whole population, neither on a local nor on a national scale. At the same time, funding for national responses to the AIDS-epidemic is increasingly available on a global scale (Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria (GFATM) etc).

Substantial gains in efficiency and sustainability of global AIDS financing can be achieved by funding community based and/or national social health insurance schemes. Two different models of such a linkage, that are in the process of being co-implemented by the German Technical Cooperation (GTZ) in Kenya and Rwanda, are used to illustrate and discuss this hypothesis.

Strategies in Kenya and Rwanda

In both countries it is planned to employ GFATM funds to enable the financial sustainability of the insurance schemes and at the same time to secure a more cost intensive treatment of HIV and AIDS patients. The great challenge for all current schemes is that the higher the premium fee, the less people are able to pay it.

In Kenya it is intended that GFATM funding is made available for a national social health insurance (that is in the final stage of the political process of legislation). The amount of the GFATM funds will be calculated from the number of registered clients that are in need of treatment. As at present, GFATM money is used to procure ARV drugs and laboratory equipment and reagents which allows for free access to drugs and reduced cost sharing for laboratory tests in a separate vertical programme. The existing National Hospital Insurance Fund (NHIF) covers already cost for treatment of opportunistic infections (from national contributions) if a member is admitted in hospital. However, ART is mainly done on outpatient basis and there are still serious cost implications for doctor consultations, routine laboratory investigations in the health facility apart from costs for transport and waiting which presently have to be covered out-of-pocket. Until the law for the Social Health Insurance is passed it is envisaged to include ART in the benefit package of the NHIF. The costs for the addition to the benefit package would be covered by contributions from the GFATM and not through higher membership premiums.



To this end, the international contribution is not covering individual risks but topping up the budget of the health insurance for covering services.

Social and community-based health insurance systems can help to overcome financial barriers to accessing health services. As a sustainable means of establishing fair and solidarity-based financing mechanisms, they can contribute to the reduction of health-related poverty. They protect people from devastating medical expenditures and loss of income in the event of ill health, and raise demand for health services. Hence social and community-based health insurance systems can contribute in eradicating poverty and reaching the Millennium Development Goals (MDGs).

In Rwanda a distinctive system of community-based health insurances is in place. In total more than 350 community-based insurance schemes have been providing coverage to some 43% of the population. In order to increase the number of covered people and thus to enlarge the risk-pool, it was intended to use funding from the GFATM to pay the premiums of the very poor, orphans, vulnerable groups and PLWHA. For PLWHA a higher premium is contributed, approximately triple the normal contribution. The funds were also intended to be used for training of health personnel, assurance of drug provision and provision of electricity to health centres so as to improve the quality of the services provided. Further the services were thought to be extended to public health interventions like prevention, e.g. provision of information and condoms as well as the inclusion of voluntary testing and counselling (VCT) facilities.

Key advantages

We deduce that employing existing health insurance structures for global AIDS-financing either community-based or national has some key advantages.

A) Equity in access

- > Global solidarity can supplement national risk-pooling
- > Improved financial accessibility to health care
- > Ex-post payment for service providers as implementation incentive: money follows service (demand side subsidies) and not vice versa (as compared to pre-financed programs)
- > Expanded basic benefit package from one horizontal programme

B) Synergies in administration

- > Possible efficiency gains for global finances through usage of existing administration health insurance infrastructure, procurement and M&E systems

C) Quality in services

- > Incentives for quality improvements through competition and different reimbursement rates for different quality levels

Conclusions

Social justice can only be brought about in the health sector by making comprehensive and sustainable improvements to the whole health care system and its financing structures. In the endeavour to establish universal access to all health services, including antiretroviral therapy, a priority is to find financing solutions for the poorest of the poor.

Global finance mechanisms and health insurance schemes can complement each other in very effective and sustainable ways. In the light of growing international efforts to ensure donor harmonisation and aid effectiveness (Paris Declaration), donor countries should work closely on coordinated approaches to health system development in partner countries. International funding from sources like the GFATM or the MAP should be used to strengthen existing or emerging health financing mechanisms, and horizontally integrated into these. As reinsurance schemes or funds for social and community-based health insurance schemes, especially in countries with low income levels, these are promising approaches. These approaches need to be strengthened and elaborated, timing and application mechanisms reviewed. Further research and good practices are needed to broaden experience.

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