

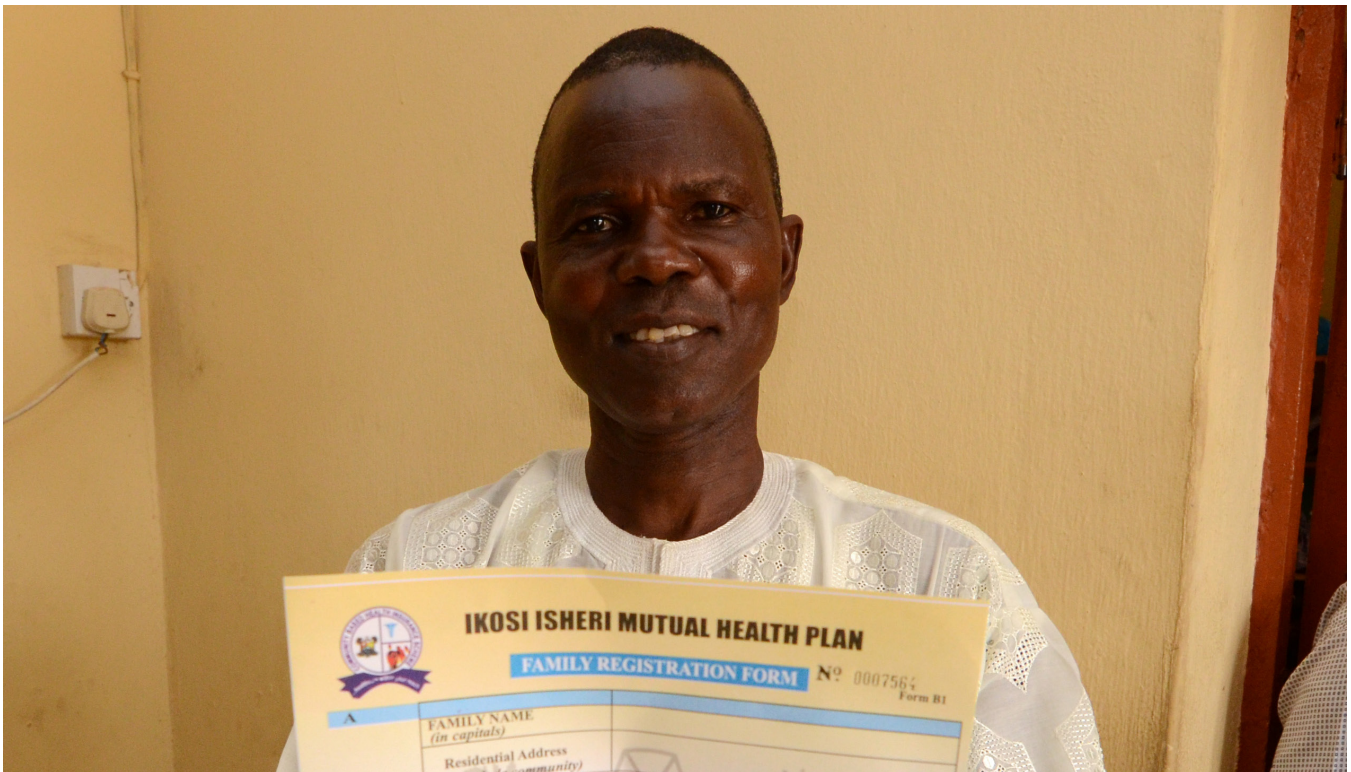


**USAID**  
FROM THE AMERICAN PEOPLE



**PEPFAR**  
U.S. President's Emergency Plan for AIDS Relief

# Expanding Private Health Insurance Coverage for HIV and AIDS in Sub-Saharan Africa



**BRIEF**



Strengthening Health Outcomes  
*through the Private Sector*

**Summary:** This policy brief reviews examples of private health insurance that provide coverage for HIV treatment and prevention in several sub-Saharan African countries. It identifies factors that facilitate or hinder efforts to expand private insurance coverage of HIV treatment, and presents recommendations for policymakers and insurance companies.

---

**Acknowledgments**

The authors thank Thierry van Bastelaer, Sara Sulzbach, Agnes Gatome-Munyua, Ayodeji Ajiboye, Sean Callahan, and Caroline Quijada for their help in finalizing this brief. The authors also acknowledge these insurance companies for the information they provided for this brief: Total Health Trust, Redcare HMO, Health Partners Limited, Managed Healthcare Limited, ExpatCare Health, Clearline HMO, Health Care International, East African Underwriters, Case Medicare, IAA, African Air Rescue, AON, Cooperative Insurance Company, Pioneer Insurance, APA Insurance, Heritage CFC Insurance, Jubilee Insurance, Pacis Insurance, Madison, Mercantile, Resolution, and British American Insurance.

**Keywords:** AIDS, HIV, health insurance, policy, private sector assessment, private sector health, universal coverage

**Recommended Citation:** Talib, Aisha and Laurel Hatt. 2013. *Expanding Private Health Insurance Coverage for HIV and AIDS in Sub-Saharan Africa*. Brief. Bethesda, MD: Strengthening Health Outcomes through the Private Sector Project, Abt Associates

**Cover photo:** Doug Trapp

**Project Description:** The Strengthening Health Outcomes through the Private Sector (SHOPS) project is USAID's flagship initiative in private sector health. SHOPS focuses on increasing availability, improving quality, and expanding coverage of essential health products and services in family planning and reproductive health, maternal and child health, HIV and AIDS, and other health areas through the private sector. Abt Associates leads the SHOPS team, which includes five partners: Banyan Global, Jhpiego, Marie Stopes International, Monitor Group, and O'Hanlon Health Consulting.

**Disclaimer:** The views expressed in this material do not necessarily reflect the views of USAID or the United States government.

**Cooperative Agreement:** GPO-A-00-09-00007-00

**Download:** To download a copy of this publication, go to the resource center at [www.shopsproject.org](http://www.shopsproject.org).

## Expanding Private Health Insurance Coverage for HIV and AIDS in Sub-Saharan Africa

Despite substantial growth in donor funding for HIV treatment since 2003, and the rapid scale-up of antiretroviral therapy (ART) to 3.9 million patients by the end of 2009, the majority of sub-Saharan African countries have yet to achieve universal coverage of HIV prevention and treatment. Policymakers in national governments and donor organizations are looking for ways to sustain and scale up treatment, testing, and prevention programs in an era when aid budgets are flat or declining. Public health systems also face increasing human resource and logistics constraints, as the number of people on treatment increases. As a result, both national governments and donor organizations have begun to explore the potential contribution of private health care providers in their countries. A scan of the region shows that in Zambia, for example, an estimated 54 percent of total health expenditure for HIV and AIDS is spent in private facilities (Table 1).

**Table 1: Percent of Total Health Expenditures for HIV and AIDS that are Spent at a Facility or on a Program (%)**

Country	Public Facilities	Private Facilities	Community Health Workers*	General Health Administration and Insurance	Providers of Public Health Programs**	Others
Tanzania	36	17	5	2	40	0
Kenya	37	20	21	7	12	3
Malawi	83	17	0	0	0	0
Namibia	50	6	2	2	37	2
Zambia	40	54	0	0	0	6

\* In Namibia, this column shows dispensing chemists.

\*\* This item comprises both government and private administration and provision of public health programs such as health promotion and protection programs.

Private sector actors who contribute to HIV and AIDS efforts include formally trained and licensed private providers, insurance companies financing health care, private corporations offering HIV and AIDS services, pharmaceutical companies, and distributors (Abt Associates, 2012). Yet many barriers remain to engage the private sector in providing HIV and AIDS prevention, treatment, and care services. One critical barrier is that,

without adequate financing mechanisms such as insurance, people living with HIV are usually unable to afford treatment at private facilities. Even those who manage to pay out of pocket for services at private facilities run the risk of going into debt and not being able to continue treatment. HIV treatment has historically been excluded from health insurance plans (both public and private) in developing countries, as it is deemed too costly. However, a few studies have examined health insurance coverage for HIV treatment and prevention in sub-Saharan Africa to explore changes in the past decade, since ART costs have fallen. This brief includes examples of private health insurance coverage for HIV treatment and prevention from six countries (Kenya, Malawi, Namibia, Nigeria, Tanzania, and Uganda), and identifies factors that facilitate or undermine efforts to expand benefits for HIV treatment.

## METHODS

The information presented in this brief is based on several sources: a review of published and gray literature; semi-structured interviews conducted with insurance companies in Kenya, Uganda, and Nigeria from May 2011 to June 2012; and private health sector assessments conducted in Namibia and Malawi. Nearly all of the published literature on this topic focuses on South Africa. However, that country's relatively highly developed private sector and insurance markets are not representative of the challenges faced in the rest of the region, so South Africa was excluded from this report.

Insurers were purposely selected and identified using a snowballing technique. Eleven out of eighteen insurance companies contacted in Kenya, four out of six in Uganda, and six out of six health maintenance organizations (HMOs) in Nigeria responded to requests for information.<sup>1</sup> Private health sector assessments were conducted by the Strengthening Health Outcomes through the Private Sector (SHOPS) project from March to April 2010 in Namibia and in May 2011 in Malawi.

## FINDINGS

### Private Insurance Coverage of HIV and AIDS

There is scant published literature examining the extent to which private insurance plans include HIV treatment and testing benefits in sub-Saharan Africa. Private voluntary health insurance in sub-Saharan Africa rarely covers more than 2 percent of the population (World Health Organization, 2012). Private insurance plans are often aimed at formal sector workers and are usually provided as an employment benefit. One exception is in Nigeria where the government is contracting with private HMOs in its national health insurance plan (see box).

---

<sup>1</sup> East African Underwriters, Case Medicare, International Air Ambulance (IAA), AON Ltd, Total Healthcare Trust, ExpatCare Health, Redcare HMO, Health Partners Ltd., Managed Health Ltd., Healthcare International, Pioneer Insurance, APA Insurance, UAP Kenya, Pacis Insurance, Jubilee Insurance, Heritage Insurance, Madison Insurance, Resolution Insurance, Corporate Insurance Company, African Air Rescue (AAR), and British American Insurance.

## Nigerian National Health Insurance Scheme (Plan)

In Nigeria, the national health insurance system works with private health maintenance organizations (HMOs). This mechanism has helped sustain and expand the private insurance market. Initially, eight prominent pre-existing HMOs were accredited by the national health insurance system, and by May 2012 there were 62. Five insurance companies and three insurance brokers have also been accredited and registered (Nigerian National Health Insurance Scheme, 2012). However, while voluntary counseling and testing is included in the primary care package, antiretroviral (ARV) treatment for HIV patients is currently excluded. The government provides free ARVs in its clinics, and in 2006 signed the first agreements to allow selected private sector providers to receive government-funded ARVs for free, as long as they do not charge patients for these drugs. The private clinics can charge for tests and physician services (Feeley, 2007).

The majority of people living with HIV seek treatment from overstretched public providers. Less than 7 percent of total health expenditures for HIV and AIDS are managed by private firms or private insurance (Table 2) (Tanzania Department of Policy and Planning, 2012; Kenya Ministry of Medical Services and Ministry of Public Health and Sanitation, 2011; De, 2009; Government of Namibia, 2010).

**Table 2. Percent of Total Health Expenditures for HIV and AIDS, by Financing Agent (%)**

Country	Public (MOH, other Ministries, National AIDS Programs, NHIF)	NGOs and Donors	Household Out-of-Pocket	Private Firms and Private Insurance	Others
Tanzania	26.0	56.0	17.2	0.9	0.0
Kenya	27.3	47.3	19.2	6.1	10.0
Malawi	72.0	20.0	5.0	3.0	0.0
Namibia	70.2	26.5	2.5	0.7*	0.0
Zambia	28.0	56.0	14.0	2.0	0.0

\*This number refers to private financing agents.

Note: MOH = Ministry of Health, NHIF = National Health Insurance Fund

All eleven of the insurance firms surveyed in Kenya stated that HIV and AIDS are covered as a chronic condition, subject to a monetary limit based on the insurance package purchased (see Table 3). These firms stated that they changed their policies to include optional HIV and AIDS treatment coverage between the years 2000 and 2003 (Andaro, 2012; Kinyanjui, 2012; Miriti, 2011; Mwigu, 2011; Ndungu, 2012; Waiyaki, 2012). The coverage limit varies by insurance provider. Four of the insurers interviewed in Kenya (Jubilee, Madison, Pacis, and Pioneer) stated that they conducted actuarial analyses to calculate premiums that cover HIV benefits. In Uganda, the four insurance companies surveyed all provide coverage for HIV and AIDS (Katusiime, 2011; Kigonya, 2012; Kirraga, 2011; Korukundo, 2011). One insurance company mentioned that it was approached by a provider who requested to be included as part of its network of providers. The insurance company negotiated the cost of treatment packages with the provider and came to an agreed-upon price. The insurance company then added the provider to their network, based on the perceived quality of care. Of the six HMOs interviewed in Nigeria, only one provided an optional HIV and AIDS benefit that clients could request for an additional premium. The HMOs that did not include a benefit for HIV and AIDS cited the cost of treatment as their major concern.



Jessica Scranton

**Table 3. Overview of HIV Benefits at Select Private Insurers In Nigeria, Uganda, and Kenya**

Country	Number of clients	Number of service providers	Cover VCT	Cover OI	Cover ART
<b>Nigeria</b>					
Total Health Trust (THT)	250,000	1,850	✓	✓	
Clearline HMO	260,000	2,000	✓	✓	
ExpatCare HMO	130,000	3,500	✓	✓	
Health Care International	400,000	2,000	✓	✓	
<b>Uganda</b>					
East African UnderWriters	30,000	100	✓	✓	✓
Case Medicare	5,000	80	✓	✓	✓
IAA	40,000	102	✓	✓	✓
African Air Rescue	50,000	120	✓	✓	✓
AON	30,000	95			
<b>Kenya</b>					
Pioneer	60,000	200		✓	✓
APA Insurance	64,000	200		✓	✓
Jubilee Insurance	160,000	200		✓	✓
UAP Kenya	100,000	400	✓	✓	✓
Cooperative Insurance Company	550	376	✓	✓	✓
	150,000	376	✓	✓	✓
	5,288	94	✓	✓	✓
British American Insurance	50,000	300		✓	✓
Heritage/CFC Insurance	25,000	300	✓ <i>Only for wellness checks</i>	✓	✓
Madison Insurance	30,000	300	✓	✓	✓

Country	Number of clients	Number of service providers	Cover VCT	Cover OI	Cover ART
<b>Kenya (continued)</b>					
Mercantile	n/a	n/a – patients choose doctors of their choice		✓ Only for IP cases	✓ Only offer ARVs on IP basis and none given after discharge
Pacis	6,570	100		✓	✓ ART for 1 month after discharge and OP from a group fund
Resolution	55,000	400		✓	✓

Note: Information was collected between May 2011 and March 2013.

IP = inpatient, OI = opportunistic infection, OP = outpatient, VCT = voluntary counseling and testing

### Factors Facilitating Private Health Insurance Coverage of HIV and AIDS Services

From interviews with 21 companies in Nigeria, Uganda, and Kenya, and from SHOPS project work in Malawi (SHOPS Project, 2012a) and Namibia, the major factors that influenced a company's decision to expand coverage to include HIV were the national policy, risk analysis, external investment, and social health insurance schemes.

#### *National Policy Encourages Benefit Expansion*

The Kenyan constitution prohibits discrimination on the basis of health status. While the constitution does not explicitly mention HIV, insurance companies did not want to appear discriminatory toward people with the virus. In 2006, the government passed the National AIDS Control Act, which explicitly states:

#### **National AIDS Control Act (Kenya), Section 19**

Every health institution, whether public or private, and every health management organization or medical insurance provider shall facilitate access to healthcare services to persons with HIV without discrimination on the basis of HIV status (Kenya Ministry of Health, 2006).



The act prohibits insurance companies from requiring an HIV test prior to offering health insurance. Although it does not specifically require insurance companies to offer a package that includes treatment for HIV, the act has incentivized companies to show compliance with the spirit of the law by offering coverage for treatment, according to those interviewed. Since companies cannot screen out people living with HIV, the companies reported that it is arguably in their interest, from an actuarial point of view, to manage the disease at an early stage and avert later treatment costs for opportunistic diseases and inpatient care. No similar national legislation was mentioned by insurers in Malawi, Namibia, Nigeria, or Uganda.<sup>2</sup>

### *Risk Analysis Favors Coverage of HIV and AIDS*

All of the insurance companies surveyed in Kenya and Uganda mentioned that, as the cost of treatment has fallen, the perception of risk associated with covering people living with HIV has decreased. Insurers mentioned that actuarial analysis indicates that other conditions, such as cancer, are far costlier to insurance companies than ART. One study in South Africa found that when the cost of highly active ART was reduced by 40 percent, it was more cost-effective to treat patients at all CD4 thresholds than to not treat them at all (Badri, 2005).

ExpatCare Health International Ltd, the only Nigerian HMO surveyed that offered any HIV benefits, added an optional HIV and AIDS management and routine annual HIV testing benefit to their benefit package in 2008. ExpatCare Health managers noted that only a small percentage of clients were HIV positive and were already seeking treatment for opportunistic infections. Given the low prevalence of HIV-positive clientele and the low perceived risk and cost, ExpatCare Health deemed it economically favorable to offer the additional benefit.

Providing the optional coverage also benefits ExpatCare Health because this makes transparent any risk involved when enrolling new clients. The benefit can be purchased for an additional premium (usually 10 percent). It covers laboratory tests, opportunistic infections, and antiretroviral (ARV) treatment at any designated HIV management and treatment center in their network, with no financial limit for the covered benefits.

Likewise, risk analysis also favors coverage for male circumcision to lower HIV transmission. In Namibia, the SHOPS project worked with the Male Circumcision Task force in the Ministry of Health and Social Services and the Namibian Medical Association of Medical Funds (NAMAF) to conduct an actuarial analysis of covering male circumcision as a preventive benefit with local anesthesia. The analysis demonstrated that it was less expensive for private insurance companies to cover male circumcision as a preventive benefit if the use of general anesthesia and in-patient surgery were eliminated. The proposed reimbursement rate for providers was approved by NAMAF in 2011 and was included in the 2012 NAMAF rates recommended for all private insurance providers in the country. Currently, nine out of ten health insurance plans in Namibia cover male circumcision

---

<sup>2</sup> None of the insurance regulation laws in these countries make mention of HIV and AIDS. Nigeria's 2003 National AIDS Policy prohibits revoking insurance based on a change in HIV status. Malawi's 2003 National HIV and AIDS Policy says that "the HIV serostatus of an employee shall not affect his or her eligibility for any occupational insurance or other benefit plans provided for employees by an employer" (p. 23).

as an HIV preventive benefit at the NAMA rate. Namibia is now the first country in the world to uniformly finance the provision of male circumcision through the private insurance sector (O'Hanlon, 2010).

#### *Partnerships between Insurers and Investors Facilitate Coverage*

External financial support has also facilitated private insurers' coverage of HIV benefits. Donors have supported insurers by subsidizing ARVs and by providing financial backing to reinsurance plans. Likewise, private equity investors have also supported insurers by providing the financial backing and actuarial analysis skills that small insurers need. For example, the Global Fund has accredited a clinic run by Case Medicare Insurance in Uganda, authorizing it to receive free ARV drugs from the Global Fund. Case Medicare's insurance plan provides coverage for ARVs at this clinic.

*Namibia is the first country in the world to uniformly finance the provision of male circumcision through the private insurance sector.*

The private equity firm LeapFrog Investments has a fund of \$135 million which it invests in microinsurance companies primarily in seven target countries: Ghana, India, Indonesia, Kenya, Nigeria, the Philippines, and South Africa. Since 2011, LeapFrog has invested \$14 million in a microinsurance group called Apollo that operates in Kenya, Tanzania, and Uganda. Apollo was one of the first health insurance companies in Kenya to expand its insurance package to include HIV and AIDS coverage. LeapFrog's sister organization, LeapFrog Labs, provides grant capital to companies, performs research on best practices, and provides other forms of technical assistance. Leapfrog Labs assisted Apollo with an actuarial analysis of its benefit packages and related premiums to make coverage of HIV more financially viable.

#### *Social Health Insurance Strengthens the Private Insurance Market*

Social health insurance plans are a form of mandatory government health coverage funded through payroll taxes. In developing countries, governments often start by covering government employees and other formal sector workers through social health insurance. Plan members may be given a choice of private insurers. With access to large numbers of government workers, private insurers are guaranteed a large client base that includes a large risk pool of both sick and healthy individuals, which further reduces the risk of covering high-cost treatments like ART. All of the insurers surveyed benefited from contracts with governments through a social insurance plan.

## Jubilee Insurance, Kenya

Jubilee Insurance was founded in Kenya in 1937 and has a presence in Burundi, Mauritius, Tanzania, and Uganda. In early 2004, Jubilee Insurance expanded its medical insurance coverage. The company's benefits now include medical coverage options for pre-existing, chronic conditions and HIV and AIDS. The HIV and AIDS coverage includes ART, CD4 counts, inpatient and outpatient treatment, opportunistic infections, and viral load monitoring. The annual inpatient coverage limit for chronic conditions, which includes HIV and AIDS, starts at a standard 300,000 Ksh and ranges higher, based on the needs of the individual or employers; there is no sub-limit on outpatient care for HIV and AIDS, which is covered up to the full outpatient limit. While individual clients have a one-year waiting period to access the HIV and AIDS benefits including ART, small- and medium-size organizations and corporate clients have no waiting period, and the benefit commences at the policy start date. An estimated 70 to 80 percent of corporate clients (employer-based groups) buy the optional HIV and AIDS coverage. An actuarial analysis using the average cost of treatment and prevalence rate is used to calculate the premium. The major factor that influenced the company's decision to expand coverage was market-driven, given the prevalence of HIV and AIDS in Kenya and the decision by Jubilee to offer non-discriminatory insurance solutions. The National AIDS Control Act also prohibits discrimination against people with HIV seeking health insurance.

Despite the decline in the cost of ART treatment, the price of treatment regimens can exceed the coverage limit depending on when and where treatment is sought. Delayed diagnosis, with the ensuing opportunistic diseases and HIV complications, pushes up the cost significantly. High-end facilities favored by some clientele also tend to attract higher costs. Members who cannot cover the cost of treatment themselves and therefore must discontinue treatment serve as a particularly acute challenge for insurance providers. To address this challenge, Jubilee holds education sessions inviting medical specialists to advise members on how to achieve the most cost-effective treatment to maximize their insurance benefits and improve health outcomes.

Jubilee noted that, due to heightened awareness about HIV and AIDS and testing campaigns, people living with HIV are diagnosed earlier, which contributes to lower treatment costs for those who proactively manage their conditions. In contrast, other chronic conditions, such as cancer, which are covered by insurance often remain undiagnosed or are diagnosed late, leading in some cases to higher long-term treatment costs, compared with HIV and AIDS. Thus, the gains made in AIDS awareness and testing have positively impacted the actuarial costs of treating HIV and AIDS (Karori, 2012).

### **Factors that Hinder Private Health Insurance Coverage of HIV and AIDS Services**

Interviews with private insurers in Kenya, Malawi, Nigeria, and Uganda revealed numerous factors that hinder the development of private coverage for HIV services. The major ones were concerns about provider-induced demand, the cost of treatment, and national referral policies that discourage new financing mechanisms.

### *Concerns about Provider-Induced Demand for HIV Services*

Insurance companies and health care providers face different incentives for prescribing treatment. Insurers want to minimize claims to maximize profits, while providers want to maximize revenue by offering as many reimbursed services as possible (Ly, 2013). Providers may prescribe unnecessary lab tests or more expensive medications to increase the reimbursement they can claim, or they may falsely bill for non-covered services. While these concerns apply to more health care services than just HIV care, the broad range of conditions (such as opportunistic infections) associated with HIV infection may make it difficult for insurers to identify overprovision of care. Moreover, treatment regimens vary by patient, making unnecessary tests or services hard to identify.

### *Perception that HIV is Too Costly to Insure*

In Nigeria, unlike Kenya and Uganda, only one of the HMOs interviewed—ExpatCare Health—provides an optional HIV and AIDS benefit that clients can purchase for an additional fee. Interviews with other HMOs in Nigeria revealed that they are unlikely to increase coverage to include HIV treatment for fear that it will increase the cost of premiums and drive away clients. The general perception among Nigerian insurers is that expanding coverage to include HIV and AIDS as a benefit would not be financially advantageous. This perception that HIV treatment is more expensive than treatment for other chronic or serious conditions is not supported by actuarial data, but many insurers have not conducted the necessary actuarial analysis, and no actuarial analysis has been done by the Nigerian HMOs surveyed. Kenyan insurers chose to expand coverage based on actuarial analysis conducted 10 years ago, when ARV drugs were significantly more expensive.

*The perception that HIV treatment is more expensive than treatment for other chronic or serious conditions is not supported by actuarial data.*

### *National Referral Guidelines that Discourage New Financing Mechanisms*

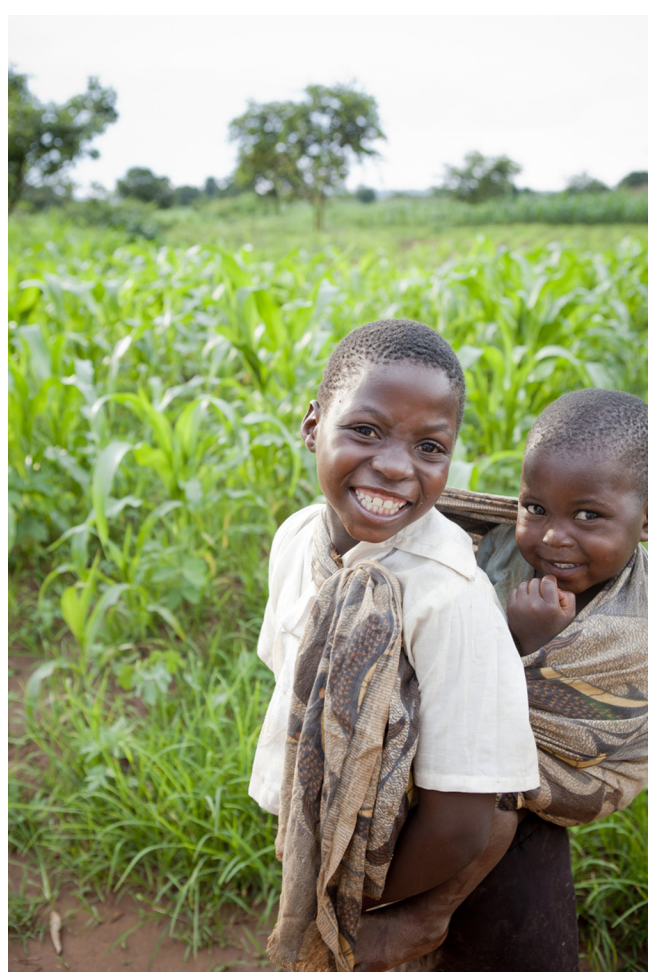
In Nigeria, the National Health Insurance Plan guidelines suggest that HMOs refer clients to public providers who provide ARV treatment free of cost (Ly, 2007). Only where special agreements exist with providers is the cost of drugs either covered by the insurance company or reimbursed by the employer. Thus, Nigerian HMOs continue to refer clients to government-run clinics providing ART treatment following NHIS guidelines; they face no incentive to expand their benefits.

## Madison Insurance, Kenya

Madison Insurance in Kenya has been operational since 1974 and has provided medical insurance since 1998. The company has more than 27,000 beneficiaries. In 2004, Madison amended its standard benefit package to include voluntary counseling, voluntary testing, and treatment for HIV and AIDS. There is no limit on outpatient benefits, and inpatient benefits have a limit of 300,000 Ksh. The decision to include voluntary counseling and testing and ART was made in part based on the observation that competing firms were amending their benefits package to include treatment for HIV and AIDS.

As of December 2011, Madison had 600 clients who were confirmed to have HIV. There are prearranged clinics for ART, and patients receive calls to remind them of upcoming and missed appointments. All hospital admissions are preauthorized and monitored. Patients see a doctor in a hospital to determine the severity of the case and the treatment needed. The doctor then refers the patient to a government- or mission-funded hospital such as the Coptic Mission Hospital or the Women's Hospitals for subsidized treatment.

At both the Mission Hospital and the Women's Hospitals, Madison negotiated a package of services at a price that was agreeable to both parties based on an internal cost analysis at the hospitals. In addition to price, Madison was equally concerned with the quality of care provided at the hospitals they included in their network of ART providers. One interviewee stated, "Higher quality care means that clients go back to the hospital less frequently, which reduces the cost of treatment and improves health outcomes."



Jessica Scranton

## CONCLUSIONS AND RECOMMENDATIONS

The past decade has brought about remarkable treatment advances for people with HIV, as well as lower costs, reduction in stigma, and increased life expectancy. Several insurers interviewed in Kenya and Uganda were able to expand coverage for HIV even a decade ago when ARV costs were much higher. Cost-based arguments are even stronger today. These key factors should positively influence private health insurance providers across Africa to reevaluate their coverage limits. This section highlights key conclusions and recommendations for policymakers and insurers.

*Lower costs should positively influence private health insurance providers across Africa to reevaluate their coverage limits.*

1. **National policy plays a crucial role incentivizing insurance companies to expand coverage for HIV and AIDS.** In Kenya, the constitution and the National AIDS Control Act on non-discrimination toward people living with HIV positively influenced insurers to expand coverage for HIV and AIDS. In contrast, Nigeria's national health insurance policy, which requires insurers to refer clients to public sector providers, deters insurers from forming partnerships with private providers and bearing any part of the cost themselves. Government policies are essential for setting up the best incentives to promote sustainable health financing mechanisms to cover the cost of treatment.
2. **Risk analysis favors HIV and AIDS coverage.** Insurers should perform an actuarial analysis to compare the cost of treating later opportunistic infections with the cost of starting patients on ART as soon as they are diagnosed. Male circumcision and other prevention services that can reduce the risk of transmission should be included in the actuarial analysis. Insurers should also review the actual level of uptake for treatment of opportunistic infections to predict the likely uptake of ART benefits, and determine the range of financially viable benefit packages. ART can be included as a standard benefit with or without a specified limit, or offered as a standalone, optional HIV and AIDS benefit package for a fee. Since benefit education helps to improve health outcomes and limit coverage overruns, insurers should hold member education sessions to advise clients on where to seek the most cost-effective treatment to maximize their insurance benefits and improve health outcomes.
3. **Perceived financial viability encourages insurers to expand benefits.** Development partners and private equity firms can play an important role in providing the financial backing necessary for insurers to expand their benefit package.
4. **Government partnerships with private insurers can educate the public on benefits of health insurance.** Insurers should establish a partnership with the Ministry of Health and the national health insurance plan (if one exists) to educate the general public about health insurance. With greater awareness of insurance

products, people living with HIV will be more likely to seek insurance, and insurers will recognize an unmet demand.

Understanding the incentives of insurers and providers to engage with one another to create effective partnerships is critical to expanding health insurance for people living with HIV. These findings are relevant to all countries seeking to develop sustainable financing to increase access and reduce the cost of treatment for HIV and AIDS.



Jessica Scranton

## REFERENCES

Abt Associates. 2012. *Strengthening the Health Sector by Engaging the Private Sector: Promising HIV/AIDS Partnerships*. Policy Brief. Bethesda, MD: Health Systems 20/20 Project and Strengthening Health Outcomes through the Private Sector Project, Abt Associates.

Andaro, Kenneth (Assistant Manager, British American Insurance). Interview. February 9, 2012.

Badri, M., S. Cleary, G. Maartens, J. Pitt, L. G. Bekker, C. Orrell, and R. Wood. 2006. "When to Initiate HAART in Sub-Saharan Africa? A South African Cost-Effectiveness Study." *Antiviral Therapy*, 11.

Beauliere, A., A. Le Maux, C. Trehin, and F. Perez. 2010. "Access to Antiretroviral Treatment in Developing Countries," *Revue d'Epidemiologie et de Santé Publique*, 58: 171–179.

Bureau for Economic Research. 2003. *The Economic Impact of HIV/AIDS on Business in South Africa*. Cape Town: Stellenbosch.

Connelly, R. P. 2006. "Treatment for HIV/AIDS at South Africa's Largest Employers: Myth and Reality." *South African Medical Journal*, 96(2): 128–133.

De, S. W. 2009. *What Happens to HIV/AIDS Funds at the Country Level? A Comparative Analysis of Before and After the Donor Influx in Kenya, Malawi, Rwanda, Tanzania and Zambia*. Bethesda, MD: Health Systems 20/20 Project, Abt Associates.

Feeley, F., A. S. Preker, and C. Ly. 2007. *On a Path to Social Health Insurance? A Look at Selected Anglophone African Countries*. Washington, DC: World Bank.

Government of Namibia, Health Systems 20/20 Project, World Health Organization, and UNAIDS. 2010. *Namibia Health Resource Tracking: 2007/08 & 2008/09*. Bethesda, MD: Health Systems 20/20 Project, Abt Associates.

Karori, Catherine. Interview. March 28, 2012.

Katusiime, Harriet (East African Underwriters). Interview. July 20, 2011.

Kenya Ministry of Health. 2006. *National AIDS Control Act*.

Kenya Ministry of Medical Services and Ministry of Public Health and Sanitation. 2011. *Kenya National Health Accounts 2009/10*. Bethesda, MD: Health Systems 20/20 Project, Abt Associates.



Kigonya, Fred (AON, Uganda). Interview. February 10, 2012.

Kinyanjui, Njeri (Marketing, Pioneer Assurance). Interview. May 24, 2012.

Kirraga, Dithan (Uganda Health Initiatives for the Private Sector). Interview. July 26, 2011.

Korukundo, Sheila (Case Medicare Uganda). Interview. March 28, 2011.

Ly, C., Y. Dukhan, F. G. Feeley, A. S. Preker, and C. Atim. 2013. "Big-Bang' Reforms in Anglophone Africa," Chapter 8 in *Scaling Up Affordable Health Insurance: Staying the Course*. Washington, DC: The World Bank.

Miriti, Kioni (Claims Manager, Resolution Health East Africa). Interview. August 9, 2011.

Mwiga, Florence (Claims and Case Management, Heritage Health Manager). 2011. Interview. July 27, 2011.

Ndungu, Patrick (Senior Manager, Madison Insurance). Interview. February 16, 2012.

Nigerian National Health Insurance Scheme. 2012. "Formal Sector." Accessed July 17, 2012, [http://www.nhis.gov.ng/index.php?option=com\\_content&view=article&id=54&Itemid=70](http://www.nhis.gov.ng/index.php?option=com_content&view=article&id=54&Itemid=70)bid.

O'Hanlon, B. 2010. *Namibia Private Sector Assessment*. Bethesda, MD: Strengthening Health Outcomes through the Private Sector Project, Abt Associates.

O. P., I. de Beer, M. E. Lindner, M. van Vugt, P. Schellekens, and T. F. Rinke de Wit. 2009. "Innovation in Namibia: Preserving Private Health Insurance and HIV/AIDS Treatment." *Health Affairs*, 28, No. 6, 1799–1806.

SHOPS Project. 2012a. *Malawi Private Health Sector Assessment Brief*. Bethesda, MD: Strengthening Health Outcomes through the Private Sector Project, Abt Associates.

———. 2012b. *ART Modeling Study*. Bethesda, MD: Strengthening Health Outcomes through the Private Sector Project, Abt Associates.

Tanzania Department of Policy and Planning. 2012. *Tanzania National Health Accounts Year 2010 with Sub-Accounts for HIV and AIDS, Malaria, Reproductive, and Child Health*. Dar es Salaam, Tanzania: Department of Policy and Planning, Ministry of Health and Social Welfare.

Vincent, H. 2012. *Protecting the Bottom Line: Five Corporate Models to Lower Costs and Increase Access to Health Care for Formal Sector Workers in Africa*. Bethesda, MD: Strengthening Health Outcomes through the Private Sector Project, Abt Associates.

Waiyaki, Catherine (Operations Manager, Pacis Insurance). Interview. May 24, 2012.

World Health Organization. 2012. *World Health Report*. Geneva: World Health Organization Press.



**BRIEF**

Expanding Private Health Insurance Coverage for HIV and AIDS in Sub-Saharan Africa

For more information about the SHOPS project, visit: [www.shopsproject.org](http://www.shopsproject.org)



Abt Associates Inc.  
4550 Montgomery Avenue, Suite 800 North  
Bethesda, MD 20814 USA  
Telephone: 301.347.5000 • Fax: 301.913.6019  
[www.abtassociates.com](http://www.abtassociates.com)