



NHIF IN KENYA

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POLICY BRIEF #5: FINANCING OF AIDS TREATMENT COSTS THROUGH A NATIONAL HEALTH INSURANCE FUND IN KENYA¹

Produced by: Oxford Policy Management (OPM) - APW with UNAIDS 2016/637467



The potential of health insurance for AIDS treatment

Although many components of the global HIV response might be thought of as public goods (for example behaviour change communication, mass media or human rights advocacy), others are private goods (in particular anti-retroviral therapy or ART) that are

suitable for inclusion within existing health insurance packages, although it is typically not included in low and middle-income countries. This brief describes a proposal to include ART within a proposed extension of the Kenyan National Health Insurance Fund (NHIF).

The costs of lifelong HIV treatment

High treatment coverage of ART in Kenya has greatly improved the life expectancy of people living with HIV. People who become infected with HIV now can expect to survive for several decades. From the perspective of health financing, this means that each HIV infection causes a spending need that extends over the same several decades.

Estimates made for the Kenya HIV investment case show that the healthcare costs generated by one person contracting HIV rise to about US\$500 annually within 10 years following an HIV infection, remain at about this level for over a decade, and decline only slowly afterwards². When expressed as a net present value, the costs of one HIV infection in 2014 are estimated at US\$12,000 when a discount rate of 3 percent is applied, of which about US\$9,500 results from treatment costs.³

¹ Adapted from a discussion note prepared as part of the investment case, "Financing of HIV Treatment Costs through a National Health Insurance Fund in Kenya", Markus Haacker and Charles Birungi

² Increased attrition from mortality are the dominant cause of the eventual decline in the projected costs.

³ Based on preliminary cost estimates

⁴ Lievens, Murray-Zmijewski and Humphrey, 2012, Sustainable Financing for AIDS in Kenya (Oxford: Oxford Policy Management).

Expanding the NHIF

Kenya's NHIF currently covers about 20 per cent of the population⁴ employed in both the formal and informal sectors, and covers its members for a package of services that has recently been revised to include chronic conditions and non-communicable diseases, but does not include ART treatment for AIDS. Ongoing reforms aim to increase the membership (contributors, not counting dependents) of the NHIF to about 5 million by 2020, and 12 million by 2030, at which stage the NHIF would cover more than 60 per cent of the population. These reforms are part of a pathway towards ensuring universal health coverage for all sectors of society. One key question is whether

the NHIF could cover the costs of AIDS treatment for its contributors.

HIV currently accounts for a large proportion of the costs of public health services. The Health Sector Strategic and Investment Plan projects that HIV will absorb 20 per cent of disease-specific spending in 2013-17⁵, and AIDS was expected to account for around 30 per cent of deaths. While the burden of disease attributable to HIV is projected to decrease in coming years, this is largely due to the increased availability of treatment, so that the number of people receiving treatment (and its costs) is actually set to increase.

Potential risks for the NHIF

The main challenge with funding AIDS treatment through the NHIF is how to set affordable premiums that cover the treatment costs of those members who contract HIV, while also funding the treatment of people already living with HIV. Setting premiums too high could jeopardise the expansion of the NHIF's coverage for other conditions.

Broadly speaking, there are two ways that HIV/AIDS treatment could be covered under an insurance system like the NHIF: a pay-as-you-go system or a capitalised system. See Box 1.

PAY-AS-YOU-GO SYSTEM

Current contributions (from all insured) finance the current costs for everybody accessing treatment. As access to treatment increases over time, premium costs will also increase to cover this.

Annual premium in 2014 (two beneficiaries per member): US\$25

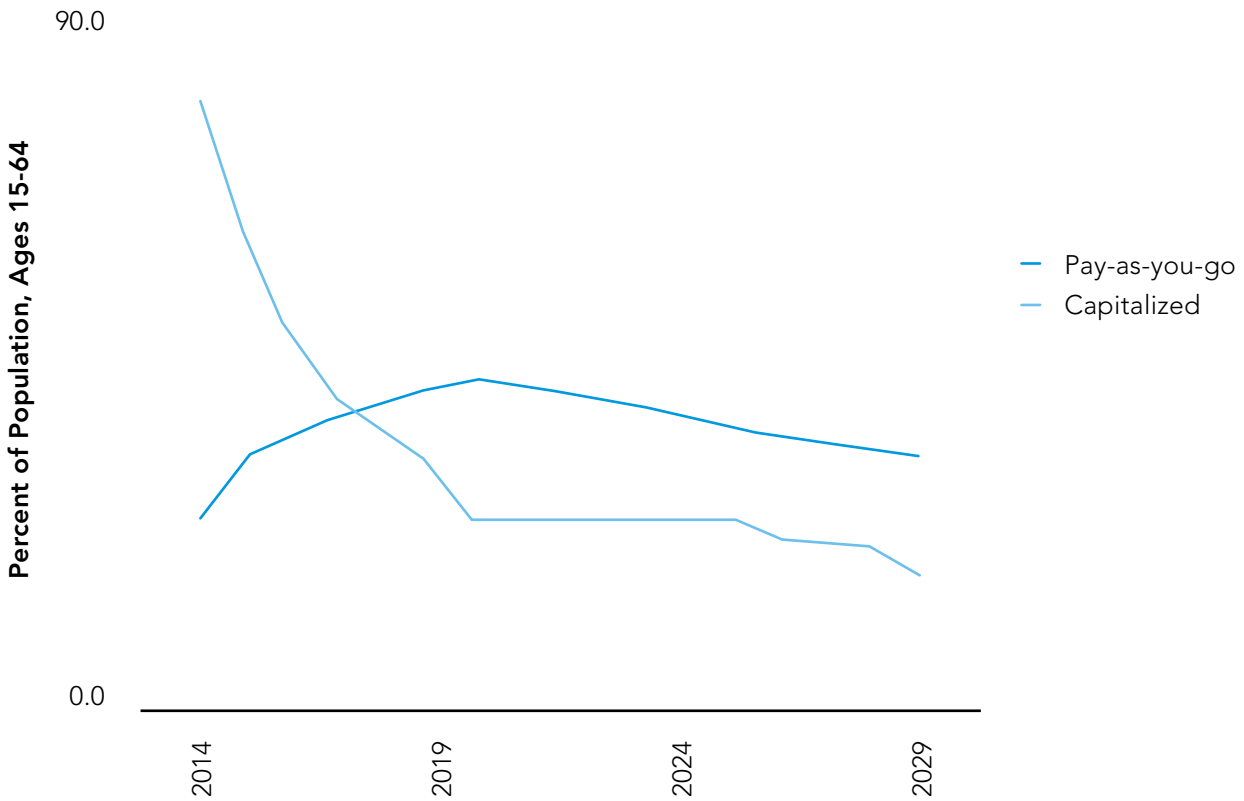
Annual premium in 2020 (two beneficiaries per member): US\$44

CAPITALISED SYSTEM

Current contributions cover the risk of contracting HIV in a given year. The HIV infection risk will decrease over the coming years, so premiums will also decrease. This system cannot cover the costs of treatment for people already living with HIV.

Annual premium in 2014 (two beneficiaries per member): US\$78

Annual premium in 2020 (two beneficiaries per member): US\$25



Source: Author's calculations, based on Kenya 2014 HIV/AIDS estimates (NACC,2014) and "Goals" report (Stover,2014)

Advantages and disadvantages of a capitalised insurance system

A capitalised insurance system is the most attractive option for several reasons. First, the cost of the premium will decrease rather than increase over time as the rate of HIV infection drops nationally. This means insurance premiums are directly linked to the success of HIV prevention programs – an attractive feature politically. Second, NHIF members would only be paying a premium that reflects their own collective risk of contracting HIV. In the pay-as-you-go system, a large part of their premium subsidises other people receiving treatment from previous infection.

There is one main disadvantage to a capitalised system: the treatment costs of people already living with HIV are not covered and would need to be financed from other sources, as would any fast-track expansion of treatment coverage in either a capitalised or a pay-as-you-go system. Using the existing financial reserves of the National Hospital Insurance Fund (the precursor to the NHIF) would be unfeasible. The lifetime costs of services to people already living with HIV are estimated at US\$16.3bn, equivalent to 32 percent of GDP. If the NHIF covered 60 percent of the population, it would need to take on a liability of 19 percent of GDP – about 20 times the NHIF's current revenue.

How could we cover the treatment costs of people already living with HIV?

Kenya requires a gradual transition to a funded health insurance that includes AIDS treatment services. Given the liabilities discussed, policy options to achieve this include:

1. **Direct external support** in the form of subsidies to the NHIF paid by international partners
2. **A government-issued bond (i.e. domestic borrowing)**, the proceeds of which would be used to fund the AIDS-related liability taken on by the NHIF. This would allow the government to spread the costs of meeting the liability over a period of time.
3. **Using the proposed Kenyan health trust fund** as seed financing for a more comprehensive health insurance. This proposed trust fund (possibly subsidised from external support) would initially channel funds to the national HIV response. However, with a projected gradual decline in the costs of this relative to GDP, in parallel with a transition to a NHIF and Kenya taking over the responsibility for funding treatment, the trust fund could eventually be used to cover the liability of treating people currently living with HIV.



HIV ERG

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