

A Unique Low-cost Private Health Insurance Program in Namibia: Protection from Health Shocks Including HIV/AIDS

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Introduction

Africa today is bearing an extraordinarily large health burden as the epidemics of HIV/AIDS, tuberculosis, malaria and the opportunistic infections associated with some of these diseases put increasing demands on the healthcare sector. Health risk is one of the severest risks confronting poor households. Apart from the personal suffering it brings, illness can cripple a poor household's income earning capacity. Sick individuals can no longer contribute to household income. On top of that, households must allocate resources to provide care within the family and cover the expenses of treatment. More than 150 million people globally suffer financial catastrophe every year due to out-of-pocket health expenditures. The surge of HIV/AIDS-related illnesses and deaths only exacerbates this problem. In the absence of access to free and good quality public care or health insurance, households are forced to resort to alternative coping strategies. However, for low-income households the depletion of savings, assets, or human capital may lead to a further eroding of their already poor asset base. For example, children might have to decrease their time in school and start working for income, care for their ill household member or take over domestic chores. In such circumstances, the benefits of health insurance schemes that include HIV/AIDS treatment are potentially large.

Currently, our knowledge is limited with respect to the impacts of private health insurance on health care utilization, health status and financial risk protection. In this article, we initiate a policy discussion around the potential role of private insurance to buffer health shocks, especially in the face of HIV/AIDS. We present a case study of Namibia where the Dutch organization PharmAccess has initiated a pilot program introducing the concept of low-cost private voluntary health insurance products.

The state of health and the health sector in Namibia

Namibia is a lower-middle income country with a GNP per capita of US\$6,960 (the African average is US\$2,074). However, this number conceals the enormous differences in wealth within the population. In fact, Namibia has one of the highest levels of inequality in the world. The richest 10 percent of the population receive 65 percent of the country's total income, while approximately 35 percent of the population lives below the poverty line of US\$ 1 a day.

The Namibian population suffers from three major communicable diseases; HIV/AIDS, tuberculosis and malaria. These three diseases are the first, second and third major causes of deaths in hospitals, respectively (WHO 2004). HIV/AIDS prevalence rates increased from 4.2% in 1992 to 19.9% in 2005. There was a substantial drop in life expectancy due to the HIV/AIDS epidemic from 60 to 52 for males and from 63 to 55 for females between 1991 2004 (WHO, WHOSIS, 2006). Currently, approximately half of the 45,000 individuals in need of antiretroviral therapy (ART) are receiving treatment. In a few years, the total number of individuals in need of ART could be well above 200,000 as infected people increasingly develop AIDS. This will put a tremendous strain on the health sector.

Over the past two decades, there has been considerable improvement in the public health care sector. After independence from South Africa in 1991, the Namibian health system was very fragmented. Most health facilities were concentrated in the urban areas and segregated along racial lines. Since then, a strong political commitment to upgrade the primary health care system has made health services more responsive to the needs of the population, albeit at a slow pace (WHO Country Cooperation Strategy, Republic of Namibia 2004-2007).

As health is one of the government's priorities, Namibia is now among the top tier of African countries with respect to health expenditures. Over the period 1993 to 2000, 11 percent of government spending was earmarked for health (WHO 2004). The country has one of the highest total expenditures on health as percentage of GDP - 6.8 percent - nearly 70 percent of which are government expenditures (WHO, 2006). Not only is government health spending high in relative terms, but out-of-pocket expenditures as a proportion of private health expenditures are 18 percent; the second lowest among African countries, surpassed only by South Africa. These figures, however, camouflage the large inequities in access to health care services between rural and urban dwellers, and between the rich and the poor. Although in principal public health care is freely available, in practice the public sector suffers from long waiting times, absenteeism among health workers and other ails.

The Namibian health insurance industry is relatively well developed and primarily organized into medical aid funds that are either open or closed. Closed funds limit membership to employees in a particular firm or industry: the closed government health fund PSEMAS is the largest such scheme, insuring 43 percent of all insured individuals. On average employers pay 38 percent of the premium, although for PSEMAS the employers contribution is just below 20 percent.

In the Greater Windhoek Area, over thirty percent of individuals are enrolled in a medical aid fund. Enrollment is equally likely for men and for women. Nevertheless, enrollment levels are substantially higher for male-headed household members (37 percent) compared to female-headed household members (22 percent). In addition, there are large discrepancies in coverage across socio-economic categories. Only five percent of individuals in the poorest consumption quintile are enrolled in medical aid schemes, while 70 percent of individuals in the richest quintile have medical aid benefits. Medical aid enrollment shows a similar pattern across education levels. In addition to income and education differences in insurance enrollment, there is also a differentiation by industry of employment. Those most likely to be insured are individuals whose head of household works in government or defense. The least insured industries are manufacturing, retail/accommodation and construction. Not surprisingly, the employed are more likely to be insured than the unemployed.

The economic consequences of health shocks

Based on a dataset collected in Greater Windhoek in 2006, we estimate the mitigating effects of private health insurance on the relationship between health shocks and economic outcomes. Overall, we find no evidence that health shocks have severe economic consequences for households that are enrolled in a medical aid fund. In contrast, households without health insurance suffer from large medical expenditures after the death, hospitalization or problematic weight loss of an adult household member, despite the free access to public care. Although gifts and support from others help them to overcome part of the financial burden, findings suggest that they need to resort to additional coping strategies, such as selling assets, decreasing non-food consumption or taking up loans.

Perhaps surprisingly, the results do not show substantial effects related to HIV-infection. As most HIV-positive individuals do not yet suffer from physical symptoms, weight-loss can be taken as a proxy for a more advanced state of AIDS. Weight loss is not only associated with high costs for medical treatment but also with substantially lower labor productivity and earned income. Remittances from others are significant but not sufficient to compensate for all consequences of the health shock, as the higher use of credit among affected households suggests.

This finding is particularly worrisome in view of the high HIV prevalence in Namibia. Our survey, which also includes medical testing for HIV-infection, shows that individuals who are most likely to be infected are also the ones least likely to have health insurance. As an increasing number of infected people without insurance develop AIDS over time, households' coping abilities, their social support networks and the public health system will come under increasing pressure.

A potential way forward

In an attempt to address some of Namibia's health care challenges, a pilot project initiated by the Dutch organization PharmAccess in 2004 sought to provide low-cost private health insurance for low-income workers, including HIV/AIDS treatment and care, using private sector insurance companies. With these new products, output-based contracts were developed between insurers and health care providers to guarantee easily accessible and high quality care. Health providers would be carefully monitored to ensure that quality standards were maintained. Payment of providers on a per-capita basis instead of a fee-for-service basis would help keep the schemes financially viable. The concept behind the so-called Okambilimbili program was based on the idea that the private sector has under-utilized resources that can play a significant role in scaling-up health care services. Employing the private sector also provides the ability to enforce strict quality standards using output-based contracts where regulatory control is weak. Moreover, financing health through insurance would be efficient because it provides predictable revenue streams and encourages investment in the health sector. In addition, using private resources (household contributions and employer contributions) frees up public funds which can be used for the poorest of the poor who cannot afford insurance and therefore cannot use anything but public health care. Finally, providing health care for the low-income but economically active population has strong economic benefits, enabling an increase in participant and employer payments of the insurance premiums, thereby increasing the sustainability of health financing.

Because private insurance companies in Namibia are interested in establishing their own low-cost health insurance programs, the key feature of the Okambilimbili program became the establishment of a risk equalization fund (REF) for HIV-related expenditures. In this fund, the privately insured groups contribute monthly premiums to a risk pool with a defined set of HIV/AIDS treatment benefits. Thus, the insurance industry can share the risk related to the high HIV-prevalence in Namibia in order to keep their low-cost products financially sustainable.

The emphasis of Okambilimbili is on selling insurance through employers, rather than to individual workers. Many employers currently face substantial costs due to health-related absenteeism and productivity loss among their workers. Indeed, there is a substantial demand from employers for the new low-cost insurance schemes. Of the twenty-five companies that were approached by PharmAccess to take part in the Okambilimbili project, twenty-four were keen to participate in the new products. Employers are required to contribute at least a 50 percent employer subsidy of the premiums, thereby keeping the products affordable to their mostly low- and middle-income employees. At present, over 40,000 people are benefiting from the new insurance products.

In conclusion, despite the relatively well-functioning health care system in Namibia, uninsured households run considerable economic risks from health shocks. Although medical expenses are low on average, acute illnesses and injuries represent a large financial burden for low-income households. This provides substantial scope for risk-pooling through insurance. However, the lower quintiles are least likely to be insured, due mostly to the high premiums of traditional insurance schemes, making them unaffordable for the poor. Since 2004, the Okambilimbili pilot project has introduced new low-cost, thus affordable, private health insurance schemes in Namibia. Two of the defining characteristics of the new schemes are that they include full coverage of HIV/AIDS treatment and care, and that they pool HIV-related risk to ensure financial viability of the schemes. The expectation is that these programs will 1) allow for better basic health care for low-income workers and their families; 2) protect individuals against health shocks including those related to HIV/AIDS and the potentially negative mitigating behaviors associated with shocks; 3) relieve some of the burden on the public health sector; and 4) improve productivity of workers (as a result of better health) and in the long-run, the economic growth of the country. Evaluations of the program are currently ongoing to quantify the impact of the insurance schemes.

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