

Including HIV in public and private sector insurance policies and products

Introduction

The right to health is a fundamental human right. Article 25(1) of the Universal Declaration of Human Rights (1948) affirms that “Everyone has the right to a standard of living adequate for the health of himself and of his family, including food, clothing, housing and medical care and necessary social services.”

Goal 3 of the Sustainable Development Goals (SDGs)¹ aims to “Ensure healthy lives and promote well-being for all at all ages”. Target 3.3 of the Goal is to by 2030 “... end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases.”

On 8 June 2016, the UN General Assembly adopted the *Political Declaration on HIV and AIDS: On the Fast-Track to Accelerate the Fight against HIV and to End the AIDS Epidemic by 2030*.² Paragraph 60(e) provides that all 193 member States are committed to “Work towards achieving universal health coverage that comprises equitable and universal access to quality health-care services, including sexual and reproductive health, and social protection.”

“Members should ensure that workers living with HIV and their dependants benefit from full access to health care, whether this is provided under public health, social security systems or private insurance or other schemes...”
Paragraph 18 of the ILO HIV and AIDS Recommendation, 2010 (No. 200)

UNAIDS developed a new strategy for the period 2016-2021.³ It enhances the fast track approach of 2014 to achieve the treatment target of 90-90-90 by 2020⁴: “90% of all people living with HIV will know their HIV status, 90% of all people with diagnosed HIV infection will receive sustained anti-retroviral therapy (ART); and 90% of all people receiving antiretroviral therapy will have viral suppression.”

AIDS will not end without expanding the coverage of social protection to people living with and affected by HIV. This realization is captured in UNAIDS’s new Strategy, the SDGs and the Political Declaration of 2016:

- “75 per cent of people, at risk of and affected by HIV, who are in need, to benefit from HIV-sensitive social protection.” (*Target 10 of the UNAIDS strategy*);
- “Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all.” (*Target 3.8 of the SDG 3*);
- “Strengthen the capacity of domestic financial institutions to encourage and expand access to ...insurance ... services for all.” (*Target 8.10 of the SDG 8*); and
- “Adopt policies, especially ... social protection policies, and progressively achieve greater equality.” (*Target 10.4 of the SDG 10*).

“Members should, in accordance with national circumstances, establish as quickly as possible and maintain their social protection floors comprising basic social security guarantees. The guarantees should ensure at a minimum that, over the life cycle, all in need have access to essential health care and to basic income security which together secure effective access to goods and services defined as necessary at the national level.”
Paragraph 4 of the ILO Social Protection Floors Recommendation, 2012 (No. 202)

¹ Adopted 25 September 2015 and available at: <http://www.un.org/sustainabledevelopment/sustainable-development-goals/>

² United Nations General Assembly, *Political Declaration on HIV and AIDS: On the Fast-Track to Accelerate the Fight against HIV and to End the AIDS Epidemic by 2030*, Resolution 70/266 (adopted 8 June 2016) A/RES/70/266.

³ UNAIDS, *UNAIDS 2016-2021 Strategy: On the Fast-Track to end AIDS*, 2015. Available at: http://www.unaids.org/sites/default/files/media_asset/20151027_UNAIDS_PCB37_15-18_EN_rev1.pdf

⁴ UNAIDS, *90-90-90: An ambitious treatment target to help end the AIDS epidemic*, Geneva, 2014, at p. 1. Available at: http://www.unaids.org/sites/default/files/media_asset/90-90-90_en_0.pdf

The need for affordable medical insurance coverage for PLHIV

According to UNAIDS, an estimated 36.7 million people were living with HIV (PLHIV) globally at the end of 2015 and 17 million PLHIV were accessing antiretroviral therapy (ART). Only 46 per cent of all PLHIV who needed were able to access ART.⁵ Even when ART is provided for free by governments, often in partnership with donors/international organizations, PLHIV need affordable medical insurance to cover other essential costs, including the cost for treatment of opportunistic infections and out of pocket expenses related to treatment.

HIV-related illnesses continue to be disproportionately excluded from public and private sector insurance policies and schemes. PLHIV are often denied insurance coverage because of their pre-existing condition or are covered at a higher cost.

Insurers perceive covering PLHIV to be a risky business and costly for them. However, this is not the case anymore. Thanks to ART, often provided for free by governments, PLHIV are living a healthy, productive and longer life. In 2014, there were 4.2 million people aged 50 and older living with HIV and it is estimated 120,000 people in this age group becomes infected with HIV every year.⁶

An ILO study⁷, *Access to and Effects of Social Protection on Workers living with HIV and their Households*, found that stigma and discrimination, lack of awareness about programmes and complicated procedures were the top three barriers for PLHIV in accessing social protection. The barriers were greater for vulnerable groups, such as informal workers, men having sex with men, sex workers, transgender people, intravenous drug users, migrant workers and women. The study also showed that social protection had a very positive effect on PLHIV and their families when they were able to access it: 63– 95 per cent of PLHIV were able to retain their jobs or some form of productive activities; 49 – 99 per cent of their children remained in school; and 72 – 96 per cent were able to access ART.

The ILO-led Inter Agency Task Team on Workplace and Private Sector Engagement (IATT)⁸ acknowledged the need to develop this advocacy brief, which is based on literature review, including good practices and consultations within the IATT.⁹

This brief is to help public and private sector insurance/social protection providers as well as other stakeholders engaged in the HIV response to work together for expanding the insurance coverage for PLHIV.

Expanding private health insurance coverage for HIV and AIDS in Sub-Saharan Africa

This brief builds on a publication, developed with support from USAID, through PEPFAR, that reviewed private health insurance that provide coverage for HIV treatment and prevention in several sub-Saharan African countries with some good practices.¹⁰ Its findings show:

- *There is scant published literature examining the extent to which private insurance plans cover HIV treatment and testing benefits in sub-Saharan Africa. The majority of people living with HIV seek*

⁵ UNAIDS, *Fact Sheet 2016: Global statistics 2015*, 2016, p. 1. Available at: <http://www.unaids.org/en/resources/fact-sheet>

⁶ UNAIDS, *The Gap Report*, 2014, at page 21. Available at:

http://www.unaids.org/sites/default/files/en/media/unaids/contentassets/documents/unaidspublication/2014/UNAIDS_Gap_report_en.pdf.

⁷ ILO, *Access to and Effects of Social Protection on Workers Living with HIV and their Households: An analytical report*, Geneva, 2015. Available at: http://www.ilo.org/wcmsp5/groups/public/---ed_protect/---protrav/---ilo_aids/documents/publication/wcms_248447.pdf

⁸ www.ilo.org/iatt

⁹ This paper was developed by a Working Group set up by the IATT. The Working Group included: ILO, the Global Fund, the Swedish HIV and AIDS Workplace Programme (SWHAP), UNAIDS and USAID.

¹⁰ Talib, Aisha and Laurel Hatt, *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. Available at: http://www.shopsproject.org/sites/default/files/resources/Expanding%20Private%20Health%20Insurance%20Coverage%20for%20HIV_AIDS%20in%20Sub-Saharan%20Africa.pdf

treatment from overstretched public providers. Less than seven per cent of total health expenditures for HIV and AIDS are managed by private firms or private insurance.

- *Private voluntary health insurance in sub-Saharan Africa rarely covers more than 2 per cent 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 national health insurance system works with private health maintenance organizations. This mechanism has helped sustain and expand the private insurance market.*
- *The perception that HIV treatment is more expensive than treatment for other chronic or serious conditions is not supported by actuarial data.*
- *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.*
- *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.*
- *National policy plays a crucial role in 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.*

Case studies

Jubilee Insurance

Based in Kenya with presence in several other countries, Jubilee Insurance decided to include HIV in its health insurance for two reasons: the high prevalence of HIV in Kenya and the decision by management to offer non-discriminatory insurance solutions aligned with the Kenyan national policy.

The company's HIV and AIDS coverage includes ART, laboratory tests, inpatient and outpatient treatment and treatment of opportunistic infections. The annual inpatient coverage limit for chronic conditions, which includes HIV and AIDS, starts at a standard 300,000 Kenyan Shilling (about USD 2,900) and ranges higher, based on the needs of the individual or the scheme the employer had subscribed. There is no sub-limit on outpatient care for HIV, 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 per cent of corporate clients (employer-based groups) buy the optional HIV and AIDS coverage.

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 testing campaigns, PLHIV 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. Thus, the gains made in HIV awareness and testing have positively impacted the actuarial costs of treating HIV and AIDS.

Levi Strauss & Co.

Employers can play a key role in negotiating group health insurance plans for their employees to cover HIV as well. Multinational companies often supply additional healthcare coverage through supplemental local medical insurance to assist their employees. Levi Strauss & Co. (LS&Co.) challenged insurers to provide HIV coverage without limitations and with minimal costs as part of the annual supplemental medical plan.

Since 2012, LS&Co. has commissioned Mercer LLC (Mercer) to monitor local medical insurance markets for HIV coverage in 24 selected countries. Mercer's annual analysis of the LS&Co.'s HIV coverage through supplemental medical plans identified local insurer benefit enhancement opportunities. Local brokers negotiate with insurers to include the benefit, or remove limitations/exclusions at no or minimal cost increase, defined as less than 10 per cent premium impact. 20 of the 24 countries had excluded HIV or had limited HIV coverage, through the supplemental medical plan.

Through sustained efforts on negotiating HIV coverage through supplemental medical plans, LS&Co. was able to identify opportunities to improve HIV benefits in five countries and with minimal cost increase in four of the 20 countries.

In instances where the premium impact is greater than 10 per cent (i.e., South Korea), negotiations continue to ensure coverage costs are not disproportionately higher than other infectious or chronic disorders. LS&Co. and Mercer have developed a toolkit to educate local brokers and insurers on HIV, and improved HIV coverage is part of the annual benefit renewal negotiations each year, particularly in the remaining countries where disproportionate exclusions persist.

Sri Lanka

As HIV was excluded by private insurers, the ILO undertook evidence-based advocacy with companies. ILO assessed the cost of including HIV and found it would be minimal, given the low prevalence of HIV in the country. Thereafter an advocacy initiative was carried out with the aim of encouraging all the insurance companies to remove the HIV exclusion clause. Advocacy efforts were aimed at the highest level officials in the insurance industry, involving PLHIV and the Insurance Board of Sri Lanka (IBSL).

As a result of this advocacy, three companies removed HIV exclusion from health insurance policies. Janashakthi Insurance PLC developed a life insurance policy for PLHIV and was able to finalise it after negotiating with their re-insurers. They also included full blown AIDS under critical illness cover.

"Thanks to the ILO, we realized that the exclusion of HIV from insurance makes no sense in this day and age with advances made in medical research.

Now, **we cover HIV and AIDS in our medical insurance policies.** This gives people living with HIV more peace of mind and security."

- Surekha Alles, CEO, Allianz Insurance Lanka Ltd. Sri

The main challenge was to get the opportunity to discuss the issue with the CEOs of insurance companies. This was made possible through the involvement of the IBSL. The other challenge was to apply for a life policy since PLHIV had to get a medical report from the attending physician. Considering that the key healthcare providers to PLHIV are medical officers from the National STD/AIDS Control Programme (NSACP), it was necessary to get them to agree to fill the information requested in the report, which included their clinic records, adherence to ART and CD4 count for the past year. Another issue that came up during the discussion was revealing confidential information. After several discussions with the Director and Consultants of the NSACP it was possible to come to an agreement. In order to prevent breach of confidentiality it was decided to have a PLHIV organization, the AIDS Foundation of Lanka, to be the intermediary between the insurance company and the PLHIV, thus avoiding the need to reveal the identity of the person insured.

Thailand

In September 2013, the Government of Thailand launched a HIV sensitive Compulsory Migrant Health Insurance Scheme.¹¹ The Scheme expanded the Universal Health Coverage scheme to cover non-nationals residing and working in Thailand, irrespective if they are regular or irregular migrant workers. It is designed to ensure access to health care for all migrants, representing an estimated 3 million workers and their dependents (with approximately 1.8 million undocumented).

The scheme is promoted and implemented through collaborative efforts of government bodies, NGOs, those implementing grants from the Global Fund to Fight AIDS, Tuberculosis and Malaria, and United Nations agencies.

The scheme is managed and coordinated by the Ministry of Public Health and is based on payment for annual insurance cards purchased by the migrant workers. The costs for a child under the age of seven years are 365 Thai baht (USD 10.90) and 2,800 Thai baht (USD 83.60) for children above seven years of age and adults. It is expected that the scheme will become self-sustained when more than 200,000 adults have enrolled each year. 63,000 migrant workers enrolled in the scheme during the first three months, with an estimated 140,000 having enrolled by 2014.

The success of the scheme is due to strong commitment from the highest political levels, the establishment of partnerships and collaborative multi-sectoral efforts utilizing local opportunities to identify and remove bottle necks. In order to stimulate both the demand and adherence to treatment for this very mobile population, collaboration between public health and community-based organizations will be essential.

Senegal

Transvie is a mutual insurance for transport sector workers in Senegal. It currently covers over 50,000 workers, with both health insurance and retirement funds. In 2014, an OFID funded ILO project in Senegal partnered with Transvie to strengthen HIV coverage for transport workers. Even though HIV related costs were already covered by the health insurance, the successful partnership led to additional HIV related activities, including voluntary HIV testing with pre- and post-counselling for over 1,000 transport workers in the first year.

“Within the scope of our daily activities, TRANSVI assumes the coverage for up to 80 per cent of all costs related to the medical examination of persons living with HIV. This is carried out in strict respect of confidentiality rules and non-discrimination, which are both at the very heart of our integration policy for services related to HIV.”

-Abdou DIAGEN, Director General of TRANSVIE

Transvie also developed an internal policy to better address HIV and AIDS, with a dedicated budget to finance annual HIV programmes and services including the provision of voluntary HIV testing services for transport workers and a referral system for those needing to access treatment, care and support services.

Uruguay

Transgender people in Uruguay, 99 per cent being transgender women, are a key group with higher risk of becoming infected with HIV. They are also the most socially excluded group within their families, and when accessing education, workplace and health-care settings. The government’s social protection programme scheme was previously only applicable to pregnant women and families with children under the age of 18 living in extreme poverty, thus excluding transgender people.

The government took a human rights approach in its guidelines *2010 Social Protection Policies*. The Tarjeta Uruguay Social (TUS)¹² is an affirmative social protection action scheme focussing on extreme poverty, inequality and exclusion. Since September 2012, it is the very first action focused programme for transgender people. This affirmative action scheme for transgender people is part of the government’s social protection programme. By introducing a TUS Card beneficiaries are provided with monthly cash transfer consisting of USD

¹¹ UNAIDS, *Social Protection: Advancing the response to HIV*, Reference Brief, 2015, at pp. 13-14.

¹² Ibid. at pp. 15-16.

30 for buying essential commodities (food, soap and washing powder) at shops participating in the programme. There is an estimated population of 1,200-1,800 transgender people in Uruguay. TUS have now reached out to 1,088 transgender people.

Transgender people having previously been subject to social exclusion. More than 1,200 transgender people have now received training on sexual diversity and non-discrimination, increasing their knowledge of their rights. In addition, the Parade for Diversity, including a number of transgender organizations, has now become one of the most popular parades in Uruguay, as well as an important platform for sexual minority group rights. Laws have been amended and now permit transgender people to change their name and sex, as well as establishing equal rights to marriage.

Indonesia

Following a comprehensive ILO research on the access to social protection for people living with HIV and vulnerable groups, in 2011 Indonesia removed all existing exclusions that previously prevented people with HIV from accessing health insurance provided through the public system. Subsequently, when the national universal health insurance scheme was introduced in 2012/13, the rights of people living with HIV to access health insurance were retained.

The Universal Health Coverage (UHC) was launched 1 January 2014 with the target to cover all Indonesian citizens by 2019. The benefit package of the UHC includes personal health care covering preventive, curative and rehabilitative services. It also covers both medical and non-medical expenses, such as hospital accommodation and ambulance costs. Workers in formal employment, self and non-employed pay their own premium, while the government pays for people below the poverty line.

Even when social protection policies do not exclude PLHIV and key populations (men who have sex with men, injecting drug users and female and male commercial sex workers, they face challenges in accessing them.

The ILO and its social partners engaged key populations communities, including PLHIV, to monitor instances of discrimination and to identify barriers in accessing the UHC. The ILO also established a community led group under the National AIDS Commission to provide on-going feed-back to the government for improving access to services for key populations. The group included the National Social Protection Agency, the health technology assessment team of the Ministry of Health, and health providers.

After two years of implementation of the new scheme, 90 per cent of key populations involved in the programme had gained access to UHC. The engagement of key populations groups into policy making process is currently being replicated in other areas in Indonesia.

Conclusions

- People living with HIV have a right to access social protection.
- Supportive government policies are essential for providing appropriate incentives to promote sustainable health financing mechanisms.
- HIV-sensitive social protection programmes strengthen resilience by enabling people living with HIV to receive life-saving treatment, benefits and employment assistance. These programmes in turn enhance the health, welfare and productivity of the entire national workforce, including migrant and mobile workers.
- National policy plays a crucial role in motivating insurance companies to expand coverage for HIV and AIDS. For example, in Kenya, the National AIDS Control Policy on non-discrimination towards people living with HIV positively influenced Jubilee insurance to expand coverage for HIV and AIDS.
- The extension of public insurance schemes to cover workers in the informal economy such as the Thailand's scheme for migrant workers is a good example to extend coverage to migrant workers irrespective if they are documented or not.
- Uruguay's TUS card provides a good example on how to reach out to one of the most-at-risk groups of the HIV epidemic - the transgender people.
- Public-Private Partnerships are a good mechanism to enhance insurance coverage for PLHIV.

Recommendations

- National social protection policies and programmes should be reviewed to include workers living with HIV in formal as well as informal economy to ensure that all have access to essential health care and to basic income security.
- Insurers, where necessary with the help of development partners, should perform a risk analysis to decide on the coverage issues, depending upon the country policy scenario, HIV prevalence, status of treatment and other social protection available to PLHIV. Such an analysis would dispel the myth that covering HIV is a costly business.
- There is a need to explore public-private partnership based options for enhancing the coverage of workers in the informal economy. The example of Nigeria where the government is contracting with private Health Maintenance Organisations in its national health insurance plan is a good approach for other countries to follow.
- Advocacy with insurance companies should be evidence-based and should give clear evidence of cost implications and the benefits to insurance companies, PLHIV and the national response.
- PLHIV organizations should be engaged in advocacy efforts with insurance companies.
- Enterprises, both public and private as well as multinational companies should review their health insurance policies and negotiate with the providers for inclusion of HIV.
- Insurance companies that remove HIV exclusion should receive appreciation and recognition by national governments/AIDS programmes and international organizations.
- Insurance industry officials should be given opportunity to participate in HIV meetings/conferences as it will give them more knowledge and information on HIV and AIDS. This would help them in taking appropriate decisions to modify their insurance policies and products to cover HIV and AIDS.
- Governments, development partners and insurers should join hands to educate PLHIV, those at risk and most affected by HIV about their right to health insurance.