

Financing HIV/AIDS Prevention through Social Health Insurance

A Cross-cutting Issue for Public Health in Developing Countries

Challenges – Implications – Questions

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The paper is the sole work of its author, who had full academic independence and autonomy over its content. It does not necessarily reflect the views of GTZ.

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ACRONYMS USED

AIDS	Acquired Immunodeficiency Syndrome
BCC	Behaviour change communication
CHI	Community health insurance/Community-based health insurance
DFID	UK Department for International Development
GFATM	The Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria
GTZ	Deutsche Gesellschaft für Technische Zusammenarbeit GmbH
HIV	Human Immunodeficiency Virus
HMO	Health maintenance organisation
IEC	Information, education and communication
ILO	International Labour Organization
ISSA	International Social Security Association
KABP	Knowledge, attitudes, behaviour and practices
M&E	Monitoring and evaluation
MHO	Mutual health organisation
PEPFAR	The President's Emergency Plan for AIDS Relief
PLWHA	Persons living with HIV/AIDS
PMTCT	Prevention of mother-to-child transmission
SHI	Social health insurance
STD/STI	Sexually transmitted disease/sexually transmitted infection
UNAIDS	The Joint UN Programme on HIV/AIDS
UNESCO	UN Educational, Scientific and Cultural Organization
US	The United States of America
VCT	Voluntary Counselling and Testing
WHO	World Health Organization

i. Foreword

This report outlines the current debate regarding up-to-date, culturally sensitive HIV/AIDS preventive measures for adolescents. It also focuses on linking this debate to the question of how these interventions can be financed in a sustainable manner. Thus the report considers the perspectives, challenges and implications of integrating prevention measures into social security systems such as social health insurance (SHI).

It is important to underline that in the context of developing countries, this approach is rather new – especially when looking at how to finance prevention through SHI. A closer look at the current research literature shows that there has been little discussion of this topic, and little practical experience in the field. Given this lack of past experience, the goal of this short report is to explore the issue via brainstorming, rather than to elaborate the topic systematically.

ii. Methodology

The report is based on a series of key informant interviews, in conjunction with an assessment of the relevant literature and conference papers.

1. HIV/AIDS Prevention and Adolescence¹: The Role of Prevention in the Fight against AIDS

To tackle the AIDS epidemic effectively, there is general consensus that HIV prevention efforts must be scaled up and intensified (UNAIDS 2005). However, prevention is but one approach designed to tackle the epidemic, and must be enhanced by efforts in terms of support, care and treatment.

Young people are most vulnerable to HIV/AIDS. They are, in many respects, at the centre of the global HIV/AIDS epidemic (WHO 2004): over 10 million people of an estimated total of 40 million people living with HIV/AIDS at the end of 2004 were young people aged between 15 and 24, and half of all new HIV infections are estimated to occur in this age group (UNAIDS 2004).

But why is this the case? One interesting fact is that while in many parts of Sub-Saharan Africa, HIV/AIDS-related awareness and knowledge have increased, this has nevertheless not necessarily paved the way to behaviour change. As numerous knowledge, attitudes, behaviour and practices (KABP) studies have proven, knowledge is not automatically transferred into action. Knowledge is a necessary but not a sufficient determinant of behaviour that reduces the risk of HIV transmission. There are many conditions that have to be met in order to ensure that preventive behaviour is consistently adopted. And behaviour change is a process: it needs a trigger, motivation; benefits; new skills have to be learned; and personal, social and cultural barriers must be overcome. The ability to act in a preventive way can only be pursued in an enabling environment.

¹ The World Health Organization (WHO) defines “adolescence” as the second decade of life, between the age of 10 and 19. The term “adolescence” or “young people” as used in the context of this paper encompasses the age range 10-24.

Regions where HIV/AIDS is declining are especially characterised by increased efforts and access to HIV prevention measures, particularly among young people. Focusing on young people is one way of halting the spread of HIV/AIDS. In addition, the following basic facts need to be underlined:

- Young people do not constitute a homogeneous group, and therefore interventions should be designed for specific subgroups. There is no single successful prevention strategy, but rather multiple strategies – just as there are multiple social bands, milieus and living conditions.
- Data are needed that could help define and understand young people who are especially vulnerable, e.g. injecting drug users, commercial sex workers, men who have sex with men, etc.
- In its causes and effects, HIV/AIDS is linked to other public health problems that affect young people, e.g. sexually transmitted infections (STIs), unplanned pregnancies, alcohol abuse, gender-based violence, etc.
- There is a need for data that differentiate between individual and contextual factors which increase young people's likelihood of engaging in high-risk behaviour. The importance of determinants (risk and protective factors) in influencing individual behaviour needs to be conceptualised. (WHO 2004: 4)

In general, HIV/AIDS prevention programming needs to take into account the fact that there is no single AIDS epidemic – even within a country itself, epidemics can be extremely diverse. Prevention strategies therefore need to address this diversity, for example by taking into account the different socio-cultural factors that might fuel (or hinder) the further spread of HIV. To be effective, HIV prevention programmes must address the contexts in which young people grow up and live their lives.

A comprehensive discussion of all existing prevention strategies for young people lies outside the scope of this paper. Instead, the following two sub-sections explore some of the general challenges for HIV/AIDS prevention in young people, and detail best practice in the form of some up-to-date and proven prevention strategies.

1.1 Challenges for HIV/AIDS Prevention

On a general level, most existing theoretical models that aim to conceptualise individual risk behaviour are simplistic and reduce the background of individual behaviour to a few determinants, making them inadequate for modelling social reality. For example, the *Health Belief Model* (Becker 1974), which guides many prevention strategies, draws on the perception that behaviour is formed by *knowledge, attitudes and beliefs* (KAB)* under the rational control of the individual as an independent actor. Other theories that seek to explain behaviour follow the same train of thought as the *Theory of Reasoned Action* (Fishbein et al. 1975) or the *Social Cognitive Theory* (Bandura 1986). Rooting programmes in these rather basic models relies on a narrow-minded understanding of sexual behaviour that cannot capture the complex realities and the social and cultural dimension of sexual processes – in particular in regions that might also have more group-oriented decision-making concepts.

Moreover, there are plenty of other challenges that set a field of preconditions for successful prevention campaigns:

- the necessities of decision-making in risk environments, vulnerability, dependencies and configurations of power
- challenges arising from individual abstraction of long-range risks*
- the specific nature of HIV (its long latency period, transmission through sexual behaviour)
- patterns of public discourse and social taboos
- differing cultural norms and notions (concepts of the future, decision-making, rationality, body, sexuality, health/illness; translation of biomedical concepts into local language and healing concepts) (Rompel 2004).

Considering this, a framework for successful prevention needs to tackle three different levels. At the **societal level**, there are a number of social factors that contribute to HIV infection including, poverty, labour migration, rapid urbanisation, unemployment, illiteracy, the inferior social position of women, domestic violence, lack of access to health and social services, etc.

At the **behavioural level**, the above-mentioned factors underline that personal choice is not always the main reason that a person becomes HIV-positive. Behaviour is shaped by cultural, social and economic factors.

At the **biological level**, women are more physiologically vulnerable, and the strong connection between sexually transmitted diseases (STDs) and HIV infection must be considered.

HIV/AIDS prevention needs to follow an approach that recognises all these factors. A thorough understanding of both individual behaviour as well as the complex social factors that lead to HIV infection is critical.

In current intervention strategies the behavioural level is usually addressed in information, education and communication (IEC) approaches, and in behaviour change communication (BCC). The former is currently evolving into the latter, and is designed to tackle the wide gap between knowledge and action.

IEC for example focuses on information and education through the mass media, interpersonal media (such as school based programmes), outdoor media (e.g. wall paintings) and folk media (such as drama and puppetry).

BCC provides a more comprehensive approach that is adapted to local settings, including needs assessments, KAPB studies, developing clear goals for the campaign, using multiple communication channels, conducting monitoring and evaluation (M&E), pre-testing messages and materials, and ensuring the involvement of multiple stakeholders, etc. (NACO 2004).

1.2 Best Practice with Regard to Prevention Efforts for Young People

The challenges and levels identified above clearly underline that interventions must be relevant to local social and cultural conditions. Prevention can only be successful when it is tailored to different gender and age groups, to the differences between rural and urban lifestyles, to different sexual orientations and practices, and to different cultural backgrounds. Because young people are not all the same, they can only be reached via a wide range of different channels; only through such an approach will means and methods lead to success in promoting and maintaining safe behaviour.

Despite this diversity, several studies (see Darbes et al. 2002) have found that there is some consistency to successful preventive interventions. Criteria by which “success” can be measured include increasing condom use, a lower the number of sexual partners, less sharing of needles, delayed onset of intercourse, increasing self-efficacy for protective behaviour, and improved communication with partners regarding safer sexual practices. All of these outcomes are associated with decreasing HIV infection. Most successful interventions that fulfil these criteria are consistent in that they are grounded in theory, provide participants with skills training, are culturally sensitive, and are conducted with multiple follow-up contacts and over longer periods of time.

At this point, it seems necessary to clarify the term “culturally sensitive”, as despite the fact that the term is frequently used in the literature, rarely is it explained what exactly is meant on a conceptual level – *how* can campaigns really be culturally sensitive?

Drawing on the UN Educational, Scientific and Cultural Organization (UNESCO) definition of culture as a basic factor influencing individual actors, culture needs to be taken into account when designing prevention at various levels:

- as **context** – the social environment in which HIV/AIDS prevention takes place;

- as **content** – being aware of local cultural values and resources that can influence prevention and including them in designing culturally appropriate content with regard to sensitisation messages is mandatory if they are to be well understood and received;
- and as a **method** that enables people to participate, which in turn helps to ensure that HIV/AIDS prevention is embedded in local cultural contexts in a stimulating and accessible way (UNESCO 2004).

When discussing prevention approaches, it is important to make some basic distinctions. Helping people to avoid contracting HIV infections is usually labelled *primary prevention* whereas *secondary prevention* is defined as alleviating factors of vulnerability, mitigating risk environments and any adverse consequences for persons living with HIV or AIDS (PLWHA). Research has also shown the effectiveness of risk reduction interventions undertaken with individuals, couples, small groups, communities, and at a social policy/structural level, all of which *combine* primary and secondary preventive approaches. Thus, looking at some comprehensive prevention efforts, it is not meaningful to differentiate primary from secondary prevention; rather, both areas should be addressed in a comprehensive way – even within a single measure. This poses some problems regarding the question of how to integrate these approaches into social security systems, and this issue will be outlined later in this paper.

There is also evidence that some comprehensive prevention approaches can be successful in different cultural settings. These include:

Personal, dialogue-oriented interaction

There is a growing body of evidence that mass-media campaigns which reach many people have a rather limited impact if they do not focus on a dialogue-oriented or participatory way of discussing topics. On radio talk shows, for example, youth put forward contrasting opinions and discuss different options for action, while countering popular misconceptions and myths. Such approaches can also be adopted in other interactive and participatory settings, such as in puppetry and drama performances.

Life skills approach

It is not enough simply to understand how HIV/AIDS is transmitted in technical terms (addressing the question “how to use a condom properly”), but also to see how it is embedded in social relationships (addressing for example the question “how to talk with one’s partner about condom use”). This makes it necessary to focus on the respective relationships. The so-called life skills approach tries to enhance competence in negotiation, conflict resolution, critical thinking, decision-making and communication, and thus seeks to equip adolescents with the right skills to put HIV/AIDS-relevant knowledge into social practice.

Role model approaches

Adolescents orient themselves towards adult role models, who they use as guidance on how life as an adult should be. Involving celebrities (e.g. actors, artists and musicians) who are idols for young people in preventive efforts can thus provide adolescents with positive role models.

Peer education

A very effective strategy for personally communicating information is to train peer educators, as for many young people, their peers serve as a major source of information on sexual issues.

Greater involvement of young people

In order to get target the messages properly, and to have them understood and disseminated in an effective format and language that is accessible to young people, a prerequisite is that the target group is involved at all stages of intervention design, testing, development and evaluation.

Adapting institutional responses

Beside the above-mentioned measures that try to address adolescents within their own worlds, additional campaigns tackling the existing institutions are needed to ensure a comprehensive and diverse prevention approach, including the support of sex/family education within schools, adolescent-friendly health services in health facilities, etc.

Scaling up “new” techniques – the female condom

Beside the male condom, there are other barrier contraceptives available that have not yet promoted in a meaningful way to date – such as the female condom. Although this is shown to be effective in preventing pregnancy and is acceptable to users, the female condom has not achieved its full potential because of its relatively high cost. However, there is evidence from several studies that it might be the better choice for vulnerable women, because they do not have to ask their sexual partners to use a condom. In terms of access to one's own and one's partner's body (possible violation of the body sphere), it is thus easier to maintain and adhere to preventive behaviour.

Innovative new ideas for prevention

Beside these (more or less) practised approaches, other innovative ideas are currently being discussed that focus on supporting existing customs and traditions rather than introducing new structures. When talking about culturally sensitive prevention approaches, the following should definitely be taken into consideration:

- Strengthening helpful customs, e.g. male circumcision ...

Research shows that circumcised men are less likely to become infected with HIV than uncircumcised men. Traditional male circumcision may help increase the available proven options for HIV prevention. Male circumcision does not of course eliminate the risk of HIV transmission for men.

- or initiation rituals

The customary way to transfer knowledge and life skills from adults to adolescents is in many traditional societies embedded in initiation rituals (which, for example, usually comprise male circumcision). This social practice incorporates a culturally accepted form of “life skill” training. These customs still exist in some rural communities, but have so far seldom been integrated into the design of prevention measures. They could however be a powerful tool for addressing HIV prevention.

- ... and family education carried out by other adults, not the parents (intergenerational dialogue)

In most cultural settings, biological parents often find it rather difficult to talk directly about questions of sexuality with their children. However, some societies have (depending on the kinship system) other male or female relatives (either on the mother's or the father's side) who can act as important reference points with whom children may find it easier to discuss sensitive questions, for example ones about sexual behaviour. Facilitating family education through such adults is piloted in some prevention programmes.

- ... focusing on responsibility to the group rather than responsibility for one's own body

There is evidence that in societies where the collective (extended family, relatives, etc.) plays a more important role for people than in the more individualised western societies, it might be helpful to focus on the responsibility of each person to this group, rather than addressing the individual in terms of taking care of himself or herself.

Alongside these more social and interaction-based approaches are other so-called classical strategies that address prevention from a more medical and institutional-based perspective, or tackle co-factors for infection. These include:

- ***Voluntary counselling and testing (VCT)***
- ***Prevention of mother-to-child transmission (PMTCT)***
- ***Treatment of STIs.***

2. HIV/AIDS Prevention and Social Security Systems

2.1 Social Health Insurance/Community-based Health Insurance

Broadly speaking, healthcare systems can be funded in three different ways: by private contributions, through social health insurance contributions, or by taxes and other revenues such as development aid. SHI schemes are typically ones that receive a proportional contribution from their members. Out of these insurance contributions, the funds generally pay part of the medical costs of their members, to the extent of the services that are included in the respective benefit package. SHI schemes are thus one stepping-stone in building an advanced social security system, and most existing SHI schemes on a national scale were indeed initiated by central governments. Core components in most countries include a payroll tax and benefits from the formal sector.

SHI schemes need to be differentiated from community-based health insurance (CHI) schemes², which operate on a smaller community or regional level and cover individuals in the informal sector (whereas SHIs usually operate on a larger scale and typically insure individuals in formal employment). CHIs are designed by and for people in the informal and rural sectors who are unable to obtain adequate public, private or employer-sponsored health insurance. Sometimes they are registered formal entities, while in other cases they may operate quite informally and only on a volunteer basis. Overall, one can conclude that the organisational structures of CHIs are quite diverse and cover a broad spectrum of different institutional forms.

CHIs are designed to ensure access to acceptable quality healthcare, particularly among poorer communities. They pool risk, and allow members to prepay for services. They have as a result been proposed as one way of reducing economic barriers to care and, consequently, have emerged as a promising means of increasing the utilisation and quality of health services.

Both SHIs and CHIs are based on the concepts of mutual aid and social solidarity. In CHIs in particular, resource allocation decisions can also be made by the community itself, which decides on the dimension of the benefit package.

SHIs and CHIs both seek to tackle the risk of impoverishment of households and individuals by lowering out-of-pocket spending at the point of care. They therefore lessen the risk of household debt that can result from paying for health services, may increase the level of utilisation of health services, and reduce delay in seeking care. Following the insurance concept and linking it up with the idea of solidarity, health insurance schemes can pool risks for their members and function as a mechanism that effectively subsidises poorer households.

The possible advantages of SHI and CHI schemes in comparison to tax-financed health systems are that they:

- formalise cost-sharing and solidarity in the formal/informal sector
- increase health sector revenue
- improve access to the health system
- improve risk-sharing

² CHIs are known by different names in different countries: in Anglophone West Africa, they are most commonly called "mutual health organisations" (MHOs), whereas in Francophone West Africa the term "mutuelles de santé" is used. In this report, all such approaches are subsumed under the acronym "CHI".

- improve equity in revenue collection
- improve the efficiency of revenue collection
- make extensive out-of-pocket expenditure more equitable for poorer people (DFID 2002).

If these advantages can be realised, health insurance schemes can become key instruments that are capable of addressing health-related poverty, and can reduce the financial barriers to accessing health services.

SHI and CHI schemes can also be embedded into a broader range of social services, social security systems and financing mechanisms of risk pooling such as occupational schemes, commercial private insurance schemes and national health services.

Little research has been conducted so far into this issue. However, the few existing studies do indicate that SHI schemes might indeed be able to deliver the projected results mentioned above.

For example, the International Labour Organization (ILO), in cooperation with the Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ) GmbH and the World Health Organization (WHO), recently commissioned a comparative study (Scheil-Adlung, Jütting, Xu et al. 2005) with the aim of analysing the quantitative impact of health insurance coverage in Kenya, Senegal and South Africa, with special focus on health service utilisation, distribution of spending in case of a catastrophe, healthcare financing strategies and poverty.

The study revealed that in the three countries studied, the insured use more outpatient services than the uninsured. This result indicates that health insurance can overcome financial barriers to accessing health services.

The analysis of the impact of health insurance on poverty showed that insured households are less likely to face catastrophic healthcare costs that exceed their capacity to pay.

However, the research also revealed that households may still experience enormous financial consequences even when covered by an insurance scheme if the benefits package is not comprehensive. Therefore, despite these encouraging results, social health protection schemes remain far from perfect, especially because the insured are often unable to obtain or afford all they need in terms of health coverage.

Other studies have come to similar conclusions. A good example of this is a recent study analysing the costs and use of HIV/AIDS services by PLWHA who are members and non-members in a Community Health Fund, a prepaid health scheme in the Hanang district of Tanzania. The study collected data on the direct cost of providing HIV/AIDS services within the benefit package. It found that members are 1.6 times more likely to access outpatient care than non-members. They moreover use outpatient services more regularly than non-members, with an average number of revisits per patient per year of 1.8 for members vs. 1.6 for non-members. They are 40 percent less likely to have inpatient care compared to non-members, and require a shorter inpatient stay. Members consume 30 percent more outpatient resources per year, but require 40 percent less inpatient resources than non-members. (Chanfreau, Musau and Kidane 2005)

2.2 SHI and HIV/AIDS Financing

In high-income countries, most curative HIV/AIDS interventions and treatments are paid by SHI schemes – although it should of course be pointed out that in such countries SHIs tend to enjoy high revenues and relatively low HIV sero-prevalence rates. However, even middle-income countries with much higher infection rates – such as Brazil, Mexico and Thailand – have demonstrated that tax-based contributions can – together with SHI – play a major role in financing HIV/AIDS services. Brazil's SHI programme, for example, annually provides over US\$300 million in financing to HIV/AIDS programmes (UNAIDS 2001).

And, as the example of the Tanzanian Community Health Fund study shows, even CHIs can offer schemes from which HIV-positive and AIDS-ill patients can benefit.

Although they cannot be elaborated extensively in this report owing to space considerations, financing HIV/AIDS interventions through SHI rather than through a public health system offers many key advantages, some of which have been mentioned above. The particular challenges that financing prevention through SHI/sCHIs poses will be discussed in sub-section 2.2.2 below.

2.2.1 Channelling International Funds into Sustainable Strategies

This leads to the question of whether it is possible (or even more desirable) to channel international grants earmarked for financing AIDS interventions in recent years (e.g. GFATM, The President's Emergency Plan for AIDS Relief (PEPFAR), etc.) into SHI and CHI schemes, in order to realise the outlined advantages and to strengthen existing health systems. SHIs/CHIs could be an effective mechanism through which external funds could be channelled to provide care to HIV-positive people. Thus the funds would, in addition to helping to reach the addressed objectives, also be used to build sustainable health system structures and to finance them. Discussion of this issue lies outside the scope of this paper; however, the importance of this debate should be underlined. There is good evidence that suggests that this approach should be followed and elaborated – particularly following the idea of sustainability. And for German development cooperation in particular, developing further strategies in this sector could bring a clear competitive advantage.

2.2.2 Health Insurance Schemes and Financing HIV/AIDS Prevention

This sub-section discusses how SHIs (and CHIs) could play a role in financing HIV/AIDS prevention measures, as considered earlier. The possibility of taking advantage of the international grants discussed in the previous section is also discussed, but in a more general way.

The basic question: is prevention an individual responsibility or a public good?

In order to appraise the role of prevention within the framework of health insurance schemes, the first question that needs to be discussed is whether prevention is up to the individual, or whether it needs to be facilitated by public institutions.

Going back as far as the WHO's Bamako Initiative in 1987, prevention has usually played a key role in the field of public health *on top of* curative approaches. The Bamako Initiative successfully reshaped public health policies and structures in many African countries. It aimed at improving immunisation coverage and other preventive activities that grew afterwards as governments increased their capacity to provide essential drugs, vaccines and other preventive efforts. However, at the core of this initiative was the understanding that scaling up prevention is first and foremost a public good that should be realised by public stakeholders and not by individual actors. It is the responsibility of the state and of public structures to provide coverage with prevention. In this sense, prevention is part of health promotion and thus a public good.

The system of insurance schemes on the other hand aims at securing the actor with regard to individual risks such as impoverishment through illness. In particular, people affected by HIV/AIDS often bear the financial burden of ill-health and the related loss of income and savings. If not covered by social security, they can easily be pushed into poverty, or their existing poverty is made still worse by health expenditure. The impact of this vicious circle should not be underestimated: the WHO estimates that every year about 100 million people are forced into poverty due to healthcare costs (WHO 2005; ISSA 2005).

These individual risks can be reduced by insurance schemes like SHIs or CHIs, which provide the individual with security and allow him or her to access quality healthcare services. However, beyond this there remains a very general question about the responsibility of the public sector in offering quality health services. The general question of

how to finance public health systems should not be mixed up with the role of health insurance schemes as a component designed to ensure individual protection against certain risks (which of course also lowers public health expenditure). It might be an illusion that in general the financing of public health systems can be shifted completely to mechanisms of insurance, as it will always be necessary to finance certain goods through the public sector – on their own or additionally.

Against this background, various vital concerns about the appropriate policy responses to these issues have arisen, particularly with regard to preventive efforts. Drawing on the arguments discussed above, we need to talk about offering preventive services through SHIs or CHIs *in addition* to the broad and comprehensive range of prevention efforts in and through the public sector – but not instead of them. This cannot be a viable alternative. SHIs and CHIs might address certain target groups, and the schemes themselves could seek to lower possible costs by avoiding future curative utilisation through prevention. However, this can only work by offering services in addition to other prevention efforts. Public health systems and donors should not channel funds for prevention to SHIs/CHIs *instead* of funding other instruments; bettering the coverage of the population (or certain groups) with prevention approaches should represent an additional effort.

If the financing of prevention were to be shifted completely from public responsibility to health insurance systems, certain population groups and social bands could be excluded, creating a worse situation than before in terms of universal prevention coverage.

The key advantage: coverage of certain population bands, social groups and income cohorts

There are key advantages in taking up prevention as part of CHI and SHI benefit packages, as most CHIs and SHIs cover a very particular and consistent set of social groups. For example, SHIs in most Sub-Saharan Africa countries insure employees with a certain minimum wage in an urban context, which more or less means the middle and upper classes. CHIs, by contrast, either bring together either certain groups within the informal sector and with a special socio-economic background, or specialise in geographical coverage of specific rural areas or regions. This makes it possible to tailor prevention campaigns very specifically to geographical (and in most cases also ethnic) groups, to certain occupational groups (such as street vendors, etc.), or social bands (e.g. the urban middle class) – each with their own specific situations and needs when it comes to prevention.

Further advocating prevention within SHIs and CHIs could thus also result in extremely targeted preventive approaches that would suit the needs of certain groups and could be very effective.

The vital question: does prevention entail an additional burden for constrained schemes, or a possible cost reduction?

The aim of prevention, in addition to allowing the actor to pursue health and avoid illness, is naturally also a cost-reducing factor for any insurance scheme – at least in the long run. The best way to save money is to avoid demand for curative services. Hence HIV/AIDS prevention is one means for either SHIs or CHIs to avoid costs for HIV/AIDS care and treatment (assuming that this is covered by the scheme). In short, prevention activities can lower health providers' costs. And this is the key advantage which can help persuade schemes to offer preventive services. The main problem, however, is that these preventive measures do have an immediate cost, which means that they *first of all increase the cost* of schemes, whereas the future cost savings can only be estimated.

In some countries, even in ones where some kind of social health protection is provided, benefit packages do not adequately address basic healthcare needs because of costs (ISSA 2005). This probably means that ill-health will have devastating financial consequences even

when there is some degree of social protection. In these cases, the performance of the scheme in question would be even more constrained by prevention costs, further worsening the quality of coverage at the point of illness.

It is therefore essential to balance curative and preventive measures within a single benefit package. The comprehensiveness of benefit packages must be weighed against premium levels. Schemes that promise an extensive package of services (and include broad prevention campaigns) will need to set higher premia that may deter people from joining. Most members prefer a limited package of priority services that keeps payments low. The precise level of this balancing has not yet been elaborated or incorporated into theoretical models, and thus further research is needed into the problem of finding the equilibrium in the portfolio of whole schemes and individual benefit packages between curative and preventive coverage.

Moreover, the state of the respective SHI or CHI scheme seems to be one factor that needs to be considered within the course of developing, gradually upgrading and strengthening insurance schemes and integrating preventive efforts. It might be hard to imagine starting up a scheme with an extensive focus on prevention for the above-mentioned reasons, but it could prove easier to upgrade the proportion of preventive services while further developing an established scheme. Basic curative healthcare needs might be the first to be dealt with in a certain scheme, because the first and main interest of the user must be to be insured in case of illness. And this is the only way to advertise and attract new members, who may well be interested in a good level of curative coverage at points of illness, but not in paying for a good level of prevention*.

This brings us to another topic to be considered:

The key problem: health-seeking vs. health-keeping behaviour

One basic problem in integrating prevention into an insurance scheme is the fact that such schemes work according to the principle of demand. They are utilised when needed, which this is when the individual is ill (“breakdown maintenance”). The problem is that prevention follows a completely different logic, because prevention is *always* needed in order to ensure that recipients stay healthy. The need for prevention is therefore high at *any* given point of time, whereas the need for curative treatment is *limited* to certain periods.

That leads to several connected problems. The results and impacts of successful prevention are invisible to the actor, because the rationale of prevention is to *keep* the individual healthy. While the impact of being cured of any kind of illness can clearly be experienced, given that the rationale of curative treatment is to restore a sick person to a state of health, the impact of prevention is a non-impact: *when prevention is successful, nothing changes* for a healthy person.

That also means that *health-seeking behaviour* when someone is ill can be conceptualised easily by an insurance scheme, whereas *health-keeping behaviour* is much more difficult to measure and address. Preventive measures are not utilised by themselves; they need to be promoted, and incentives must be established. Otherwise, prevention might not be utilised because it is not self-evident to the individual that preventive behaviour is worth adopting.

- The problem of the perception of benefits in preventive vs. curative measures

This leads to the question of how to communicate the inclusion of preventive measures into a benefit package. For curative measures, the benefit of the insurance scheme might be very evident to the user, whereas for preventive measures this may not be so. This can be observed within the context of CHIs: in practice, one empirical finding is that the membership of certain schemes often increases when individuals can benefit from services and disseminate this message within their extended family – i.e. when they experience the

advantage of being insured. In successful prevention, on the other hand, the benefit of preventive behaviour is not obvious to the actor, leading to a basic communication problem. The question of how to communicate the advantages of including preventive measures into benefit packages (especially in CHIs where the members themselves participate in deciding on the size of the package) is therefore a difficult one.

Including preventive measures could prove particularly difficult when the financial situation of the scheme is already constrained, and when including preventive measures would lead to other benefits being reduced or even services removed from the package because of the costs of prevention. This will not make any sense from the perspective of the insured person.

Overall, it can be assumed that without further information, education, communication and training, SHI/CHI beneficiaries are unlikely to demand preventive measures. Without adequate efforts to promote their use, it is far from certain that merely the existence of preventive benefits will lead to their automatic use by members.

Other challenges

- The interconnections between public-financed prevention and prevention measures of SHI/CHI schemes

The question of utilisation also arises in the context of comparing public-financed prevention services with insurance-financed services. If prevention services are offered free of charge at public health facilities (e.g. the distribution of condoms), there is no incentive to include these services in the SHI/CHI benefit package.

- Institutional strength and capacity of providers

One dimension when it comes to appraising the possibility of adding prevention measures to health insurance schemes is the question of whether the respective providers are able to cope with the additional workload that a more proactive strategy such as prevention entails. The fact that community-based schemes in particular are often maintained on a volunteer basis needs to be taken into account. The question remains as to whether these schemes have the institutional capacity to offer the services discussed.

- The background of CHI providers could also be a critical dimension

Another important dimension that needs to be taken into consideration regarding prevention is the religious background of the CHI. Churches are involved in many of the local schemes at community level, and this might lead to a biased perspective as to which preventive measures should be included or excluded by a CHI scheme. CHI providers with a religious affiliation may be unwilling to offer particular prevention services, or might only promote services that could prove counterproductive (e.g. the abstinence-only debate, etc.).

- Accounting for comprehensive prevention efforts

The model under which all insurance schemes operate is to pay for several services which are included in the benefit package and which are utilised by individual beneficiaries. Further to the discussion on culturally sensitive HIV/AIDS prevention campaigns, it is clear that trying to adapt meaningful prevention campaigns to health insurance schemes creates another basic problem. Many of the up-to-date preventive measures try to address at least the individual in his or her social context, if not a broader social group of people, or various individuals in order to act as multipliers to influence others (peer education, etc.).

The question that needs to be raised is how to convince people of the necessity to charge for services if the respective services are not addressed to a *single* individual but rather to a group of people or a community in which only some are insured.

There are certainly prevention services that can be targeted very specifically, such as PMTCT and VCT, but others are more problematic to incorporate within the operating mode of an insurance scheme.

On the other hand, more measures than just specific prevention ones for HIV need to be discussed in this regard. The prevention of opportunistic infections and STIs can be a meaningful way of reducing the risk of HIV transmission or the likelihood of becoming ill if HIV-infected.

Developing new possibilities: prevention in targeted schemes for PLWHA

It has been suggested in the context of HIV/AIDS treatment to test a variety of different schemes, depending on the HIV status of SHI/CHI beneficiaries. The high costs associated with the treatment of opportunistic infections or antiretroviral therapy are an issue for the financial sustainability of the schemes. If a high proportion (or at least a higher than expected proportion) of the members of a scheme are HIV-positive, then the cost of their care may be greater than initially budgeted for, and the scheme will face financial instability unless it can adjust the price of premia upwards, or obtain other additional funding. However, if premia increase substantially to reflect the higher cost of care associated with HIV/AIDS, then the scheme may become unattractive for those who do not anticipate needing such an intensive use of healthcare services. Accordingly, few HIV-negative people would join, and the relative cost per capita would be driven up even further in a vicious circle. In this situation, the only mechanism that the scheme can employ to prevent total breakdown is to require HIV testing and charge differential premia for HIV-positive people, or seek external subsidies for HIV-positive members. Given that many schemes are motivated by promoting the welfare of the community and are influenced by notions of social solidarity, a CHI will probably be unwilling to exclude HIV-positive people. Moreover, it would be ethically unacceptable for the scheme to require HIV testing. However, one could think of a system of incentives that awards HIV-negative members: From the management perspective of a scheme, it is desirable to help HIV-negative members to stay that way. Thus schemes could envisage developing incentives (for instance lower premia) for members who are able to remain HIV-negative over a certain period of time.

Situations where prevention can be addressed

In terms of reaching the clients, the preconditions of SHI and CHI are quite different. SHIs involve employers and employees in the formal sector, all of whom are registered. Hence they can easily be reached through written communication or via meetings. The accessibility of the beneficiaries of CHIs is fundamentally different, as they tend to live in rural settings with no access to postal services or telephone communication. Thus the only way of addressing them with preventive measures is while seeking healthcare in a health facility, or upon paying fees for an insurance scheme (usually once or twice a year). These different preconditions define how they can be addressed in terms of prevention.

It might be worth considering offering preventive services at these contact points. It would, for instance, be possible to offer VCT services (or treatment of SHIs, etc.) to CHI beneficiaries when they come to pay their premia, or to send out VCT vouchers to SHI members.

The general problem: access for the most vulnerable and impoverished groups

A common critique of SHI schemes is that they leave the poor behind, especially with regard to the coverage of prevention. The available evidence suggests that SHI schemes are mainly available for employees in the formal sector, thus predominantly among the urban middle and high-income class. CHI schemes, by contrast, are most successful among the rural middle class. This means that insurance protection is mainly granted to those who can afford to belong to a health insurance scheme. Sometimes even relatively modest contributions can be too high for the poorest to pay.

In looking for ways to solve this situation, some authors focus on the “role of the state in assuming overall responsibility for ensuring adequate social health protection for the whole population, and in particular for people with HIV/AIDS and the poor. This includes development of an inclusive legal framework, ensuring adequate funding and comprehensive benefits.” (Scheil-Adlung 2005)

One alternative option would also be to channel international funds to fight HIV/AIDS into SHI schemes, as discussed above. However, there are further possible options that in some cases have not received sufficient attention so far. These are each outlined below:

- Setting up an International Solidarity Fund

Using the Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria (GFATM) as an example, it could also be possible to advocate an international instrument that allows money to be transferred on a global scale to support social security systems in the developing world and to transform countries by providing coverage to the poor.

- Integrating SHIs and CHIs/cross-sectoral subsidisation

In their current form, most SHIs in developing countries do not follow the idea of solidarity as much as they could, because – as mentioned before – each insurance type mainly consists of people from one income band: employees in the formal sector in SHIs, the unemployed rural and informal workers in CHIs. So the (relatively) “rich” and the (relatively) “poor” both pool risk among themselves. However, there is no subsidising between the income bands. A highly innovative approach would be to install systems where the “poor” and the “rich” are classified as one insurance type, thus requiring cross-sectoral subsidisation and support based on a societal idea of solidarity. This would also help preventive measures, which would be more likely to be financed because more resources would be available.

Thinking in the broader context: integrating prevention into other social security systems

Thinking further, and taking into account the fact that it is somewhat idealistic (let alone inappropriate) to regard CHIs and SHIs as the core alternative to solely public-financed health services, even more instruments could be included in a comprehensive approach to financing prevention. The key advantages and complementary factors of SHI and CHI have already been highlighted. The picture could be further rounded up with the inclusion of additional innovative approaches such as community-based micro-credit schemes, the combination of micro-credit schemes and micro-insurance schemes, targeted social assistance, or social cash transfers.

All these approaches need to be integrated at the same time as prevention is integrated into the existing curative-oriented system of health insurance.

Learning from the German experience

Germany has a long-established SHI system, with mechanisms for financing and steering health expenses and securing universal access to health service delivery (and of course, some obvious problems as well).

Since the last health sector reform in 2000, the SHI schemes have been expected to coordinate their primary prevention efforts (§ 20 German SGB V). However, the schemes have so far not been able to reach their programme goals. In 2002 the German SHI schemes only spent half of the possible expenditure on prevention, and the available prevention measures are not being properly utilised for the following three reasons:

- The field of primary prevention is characterised by a completely different constellation than the curative healthcare field, with substantial differences in terms of actors, methods and instruments.
- This is not compensated by a clear political and scientific consensus regarding concepts, evidence, successful approaches and quality standards of prevention.

- Unlike in the curative field of health service delivery, there is also no political or scientific conformity with regard to the involved stakeholders, the decision-making structures or the necessity for cooperation and a sufficiently developed division of labour between the involved counterparts.

To tackle these issues, the German government drafted a national prevention law, the “Bundespräventionsgesetz (BPrävG)“. This new law did not undergo the legislation process as planned in the last parliament, but will most likely be passed into law in the legislative period which has just started.

This draft law foresees establishing national coordination mechanisms instead of leaving responsibility for the planning and scaling up of prevention measures to the SHI schemes.

The draft law also defines preventive measures as a priority strategy in order to work towards achieving universal health of the population. Prevention will even be established as the fourth pillar of the health system, alongside curative medicine, rehabilitation and care. The formulated goal is designed, in addition to reducing health system expenses, to enhance citizens’ quality of life.

The theoretical debate and the practical experiences and implications of this new approach might enrich the discussions concerning the mainstreaming of prevention into existing social security approaches.

3. Recommendations

Much has already been said about the many aspects, challenges, implications and questions concerning the integration of prevention efforts into SHI/CHI that more or less directly lead to the main recommendations. Hence this section focuses only on recommendations without explaining the issues in detail; more information can be found in the final section.

3.1 Advocacy and Policy Development

- Identify areas of consensus, issues of relevance to countries and issues for further work with regard to the intersection of social security and prevention.
- Develop a political strategy that sets priorities for extending the coverage of social protection schemes to prevention and to the coverage of PLWHA, in addition to other comprehensive prevention financing.
- Develop a strategy paper on social security and prevention for the two GTZ sectoral projects entitled “AIDS in Developing Countries” and “Social Health Insurance”.
- Stimulate the debate around HIV/AIDS prevention and SHI/CHI, and make social security and HIV prevention a theme for discussion and reflection.
Advocate the possibility of integrating HIV/AIDS prevention approaches into social security systems:
 - o within the German development policy debate,
 - o among GTZ personnel in the Head Office and in the field,
 - o within the European development policy debate,
 - o among international donors (e.g. GFATM), and
 - o in developing countries relevant to German development cooperation.So far it is not advisable to advocate specific approaches but rather to advocate the documented experiences, the key chances and advantages and the lessons learned.
- Discuss the possibility of establishing a global solidarity fund and other global financing mechanisms to subsidise health insurance for the poor on a global scale, alongside the traditional official development assistance structure (e.g. GFATM in the field of AIDS).
- Develop strategies for advocating and discussing cross-sectoral subsidising between income bands.

3.2 Research/Operational Research/Monitoring and Evaluation

More and better information is needed on existing SHI/CHI coverage of prevention services, with the aim of:

- Developing a research framework and agenda for HIV/AIDS prevention and SHI/CHI.
- Securing ongoing research and monitoring and evaluation (M&E) measures in the countries and projects where preventive measures are used (M&E of emerging SHIs in certain African countries (such as Tanzania) and in countries where such measures have been long established (e.g. Kenya), or where international

HIV/AIDS resources are currently channelled through health insurance (Round 5 of GFATM funding in Rwanda).

- Identifying a site and launching a pilot project (operational research) regarding the integration of HIV prevention into CHI/SHI.
- Enquiring further about balancing models between preventive and curative coverage of services within SHI/CHI.
- Identifying experiences from Germany (BpräventionsG, etc.) that might partly be transferable/adaptable to the context of developing countries.
- Inquiring further about experiences from developing countries about preventive measures and their utilisation in the context of tuberculosis and malaria – within SHI/CHI.
- Discussing and analysing the health maintenance organisation (HMO) concept with regard to prevention, and investigating experiences with HMO in the US and Switzerland.
- Making sure that experiences and lessons learned are properly documented.

3.3 Training and Capacity-building

- Create networks for backing up and building human capacity for SHI/CHI and prevention.
- Investigate possible key informants with experience in developing prevention strategies within the framework of SHI/CHI.

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