

POLICY BRIEFS ON

# ECONOMIC IMPACT OF HIV



# 14.

## EXTERNAL AND DOMESTIC HEALTH FINANCING, AND THE ROLE OF PUBLIC VS. PRIVATE DOMESTIC HEALTH FUNDING

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# 14.

## EXTERNAL AND DOMESTIC HEALTH FINANCING, AND THE ROLE OF PUBLIC VS. PRIVATE DOMESTIC HEALTH FUNDING

### KEY POINTS

- Financing of HIV programmes is more dependent on foreign assistance than health financing in general, which makes them more vulnerable to a slowdown in external funding, in particular during the current phase of increased uncertainty as a result of COVID-19. This situation makes domestic resource generation – through the government or from the private sector – more pertinent.
- Domestic funding may come from public or private sources. From a public policy perspective, both sources can be assessed in terms of the incidence of taxes or costs borne by households and the degree of risk protection they offer.
- Raising resources from increased out-of-pocket spending runs against the principles of the “public health” approach to HIV and moving towards universal health coverage.
- Raising revenues through contributory schemes has become more feasible (owing to reduced unit costs of treatment) but such policies need to consider equity issues, the objective of increasing coverage overall, and a fair distribution of costs.

External financing plays a large role in the area of HIV, even more so than in the health sector overall. As the share of external funding is projected to decline (e.g., as the economy is growing), and in light of the uncertainties introduced by the Covid-19 pandemic, increasing domestic resource mobilization is pertinent. One such route is increasing domestic public funding, especially if economic growth is accompanied by a disproportionate increase in tax revenues

as the role of the formal sector of the economy expands (see brief #11). Alternatively, additional domestic resources may come from the private sector. While this does not directly draw on public resources, private sector funding can nevertheless be interpreted from a public policy perspective and compared to public funding in terms of the incidence of the financial burden to households and the degrees of risk protection alternative arrangements offer.

### Role of domestic and external health financing

To provide some context on the changing role of domestic financing, we discuss how the role of domestic and external financing of health spending differs across countries by level of economic development, and illustrate that these differences are even more pronounced for HIV spending.

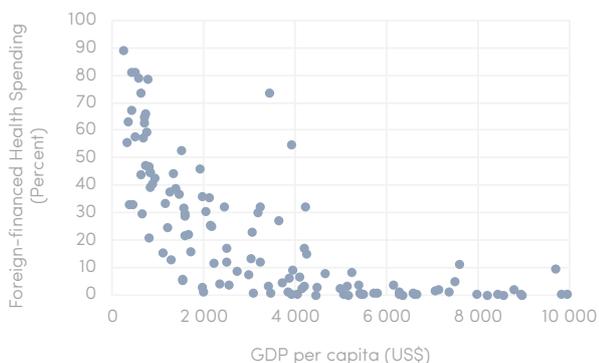
Between 2003 and 2018, GDP per capita in many countries most affected by HIV has grown steeply – on average by 36 per cent in sub-Saharan Africa, the region where most countries facing high HIV prevalence are located. Such increases in GDP per capita are associated with a declining

role of foreign assistance, as illustrated in Figure 14.1 with cross-sectional data. Whereas in 2017 foreign assistance accounted for up to 90 per cent of health spending financed by the domestic government and donors in countries with a level of GDP per capita below US\$1,000, it accounted for less than 35 per cent of such spending in countries with GDP per capita exceeding US\$2,000.

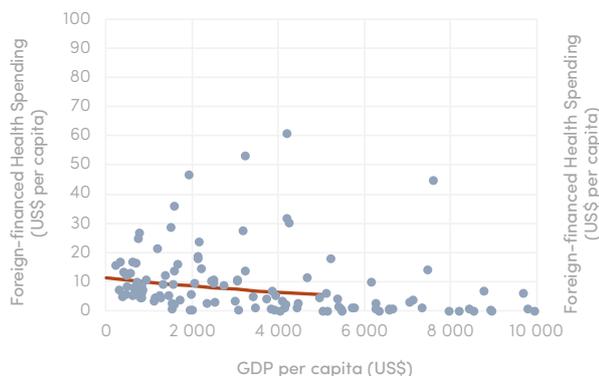
These differences in the role of domestic public health financing across countries are predominantly driven by increasing domestic resources. The average amount of foreign financing per capita changes very little across low- and lower-middle-income countries with different levels of GDP per capita. For example, as GDP per capita doubles from US\$1,000 to US\$2,000, the typical level of

foreign assistance for health declines from about US\$9.70 per capita to US\$8.40 per capita (Figure 14.3). Domestically financed public spending (Figure 14.4) increases from 1.5 per cent of GDP to 2.0 per cent of GDP, and nearly trebles in absolute terms (from US\$15.50 per capita to US\$40.60 per capita). Private health spending across countries is roughly proportional to GDP, with levels of out-of-pocket spending around 1.3 per cent of GDP, and voluntary prepaid schemes around 0.3 per cent of GDP (with many observations at or around zero). This means that the sharp drop in the share of foreign funding as GDP increases across low- and lower-middle-income countries is almost entirely a consequence of increased domestic resources, which is accompanied by a very gradual tapering off in foreign support.

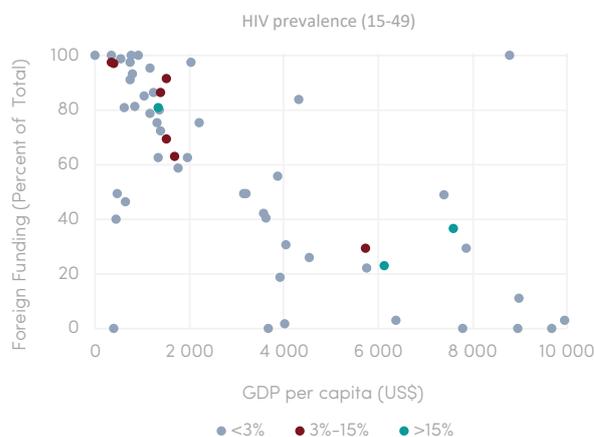
**Figure 14.1: Foreign-financed health spending (percent of domestic public plus foreign-financed spending, 2017)**



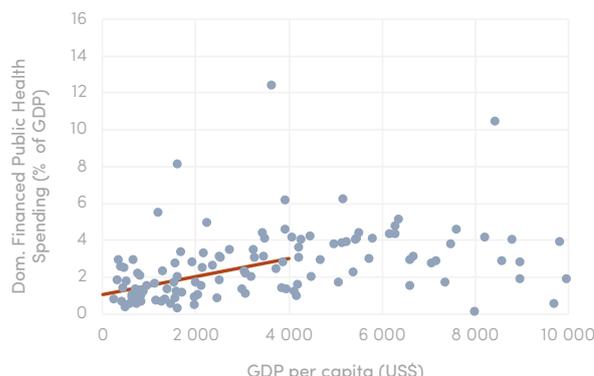
**Figure 14.3: Foreign-financed health spending (US\$, 2017)**



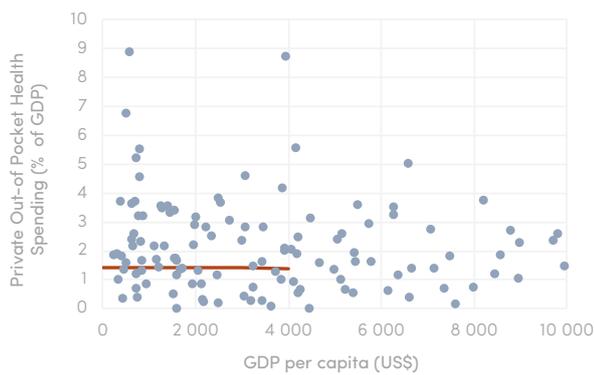
**Figure 14.2: Share of foreign funding in HIV spending (latest year, median 2017) HIV prevalence (15-49)**



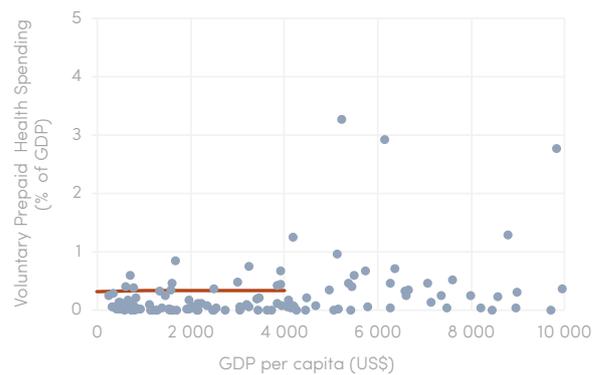
**Figure 14.4: Domestically financed public health spending (percent of GDP, 2017)**



**Figure 14.5: Private out-of-pocket health spending (percent of GDP, 2017)**



**Figure 14.6: Voluntary prepaid private health expenditures (percent of GDP, 2017)**



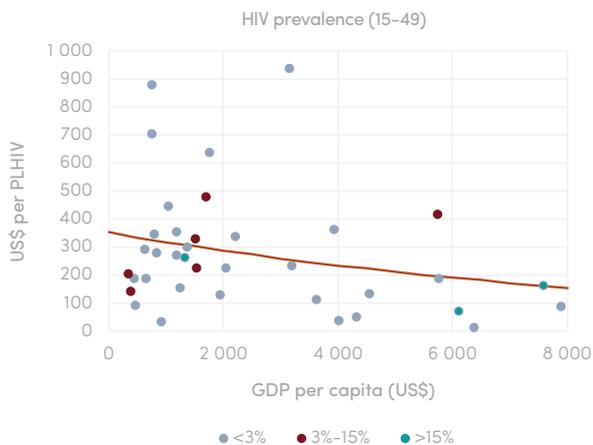
**Source:** WHO (2020) for health spending and financing overall, UNAIDS (2020) for HIV spending and funding, and IMF (2019) for GDP per capita.

**Note:** Trend lines have been estimated for countries with GDP per capita of less than US\$4,000 (broadly corresponding to low-income and lower-middle-income countries), and exclude countries with a population of less than 1 million.

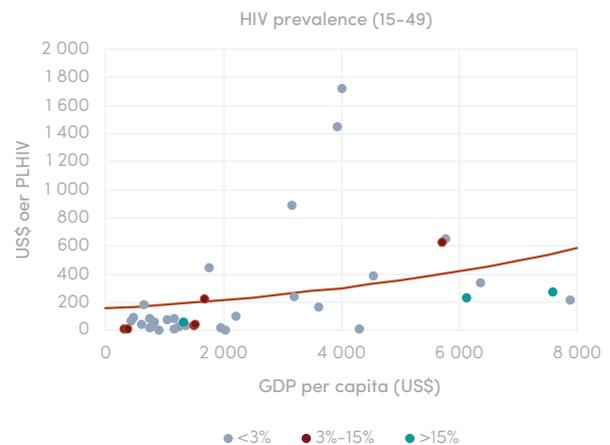
The roles of domestic and foreign funding for HIV are similar to the respective roles in health financing in general, with a high share of foreign funding at low levels of GDP per capita, and a much lower rate for middle-income countries. However, there are some important differences. First, foreign funding accounts for a higher proportion of the costs of HIV programmes than of health programmes in general (up to 100 per cent in some low-income countries), but also declines steeply as GDP per capita increases (Figure 14.2). Second, perhaps surprisingly, the severity of the epidemic does not play an apparent role in the share of foreign funding (see breakdown by HIV prevalence, Figure 14.2).

Donors have prioritized HIV in general over other areas of development assistance, including health, and support countries facing a more severe burden by (proportionally) larger disbursement. However, financial support is not disproportionately targeted at countries where HIV prevalence is higher. Third, foreign funding per person living with HIV declines with GDP per capita, but more slowly than for foreign support of health programmes in general (Figure 14.7, compare Figure 14.3). Fourth, domestically financed public HIV spending increases with GDP per capita, but less than proportionally (Figure 14.8).

**Figure 14.7: Foreign HIV funding per PLHIV (latest year, median 2017)**



**Figure 14.8: Domestically financed public HIV spending per PLHIV (latest year, median 2017)**



**Source:** UNAIDS (2020) for HIV financing and spending data, UNAIDS (2019) for HIV prevalence and the number of people living with HIV, IMF (2019) for GDP per capita.

**Note:** Figures exclude countries with a population living with HIV of less than 10,000. PLWH = people living with HIV.

Our review suggests that vulnerabilities in the financing of HIV programmes with respect to shortfalls in external funding arise for two reasons. First, changes in donor priorities impact on HIV funding more than other health funding. HIV programmes are to a much larger extent financed from foreign sources than health spending in general. Comparing Figures 14.1 and 14.2 suggests that the share of foreign funding in HIV programmes is about 20 percentage points higher than for the health sector overall. A perception that HIV no longer constitutes an exceptional health challenge could expose HIV programmes to steep declines in external support. Second, declines in external assistance for health are usually dwarfed by increased

domestic health spending made possible by economic growth. Because of the higher share of external financing, this is not necessarily the case for HIV programmes. This means that accommodating shortfalls in HIV funding may require reallocations of domestic public funding— across the health sector (see brief #12B) or from other sectors (brief #10) – or additional contributions from the private sector. If this process is driven by economic growth, though, it is useful to bear in mind that the increased domestic allocation to HIV would come out of fiscal resources which are increasing overall, and that HIV programs could benefit from improved health sector capacities, e.g., by realizing efficiency gains from integration.

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## Raising revenues directly from the private sector

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**Private contributions could make a contribution to the financial sustainability of HIV programmes by complementing funding from other sources, but their potential needs to be assessed in the context of households' ability to pay and the broader drive towards attaining universal health care (UHC).**

Private domestic funding is not additional to public domestic funding in the sense that in both cases the costs of providing HIV services are raised from the private sector. For tax financing or compulsory national insurance schemes, the costs are distributed in line with the incidence of the relevant taxes and contributions. With voluntary contributory schemes, the distribution of costs depends on the schedule of contributions and uptake across the population, but also on the extent to which the scheme is co-financed by contributions from the government or donors. With out-of-pocket payments, the beneficiaries of services pay at least some of the costs directly. Private (and public) contributions therefore need to be assessed in terms of the fairness or equity of the distribution of the costs (directly or indirectly) and the degree of risk protection alternative arrangements offer. Relatedly, alternative financing arrangements have implications for progress towards universal health coverage.

Private contributions in the form of out-of-pocket payments have played virtually no role in HIV programmes across low- and middle-income countries, reflecting a consensus that treatment should be provided free of charge. This consensus has been spelled out in the World Health Organisation's (WHO) "public health approach" to HIV (Gilks et al., 2006), which advocated free access to antiretroviral therapy (ART) from the perspective of the human right to health, and for efficiency reasons. WHO argued that, "even with sliding fee scales or full reimbursement", user fees would reduce the

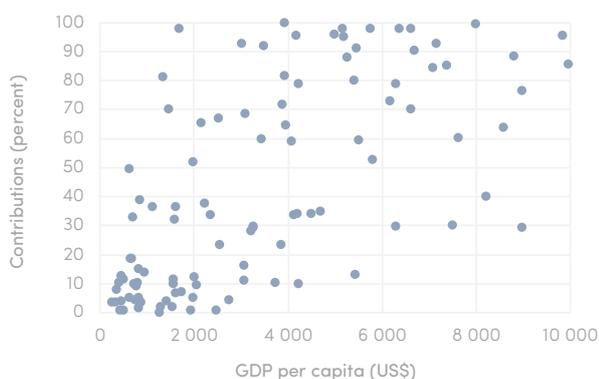
uptake of HIV services and would compromise treatment effectiveness if they resulted in reduced adherence, and that treatment costs would create "an insurmountable, highly inequitable barrier" for many poor people. This approach has recently been reaffirmed in a stock-taking by WHO staff (Ford et al., 2018), which emphasised that "financial barriers associated with ART lead to weak adherence, poor clinical outcomes, and catastrophic health-related expenditures." More generally, reliance on out-of-pocket payments runs against the drive towards UHC, specifically its financial protection pillar (WHO, 2010).

The other broad option for raising private funding is through some form of pre-payment arrangement, either through a compulsory national insurance or through a voluntary (i.e., non-compulsory) arrangement. A compulsory scheme closely resembles a tax, and we do not discuss them further here, and therefore raises similar issues as public funding of HIV spending (see Brief #11). For this reason, our discussion below focuses on the potential contributions from voluntary health insurance.

Voluntary health insurance schemes include private health insurance, the coverage of which is typically restricted to beneficiaries employed in the formal sector, and schemes designed to improve pre-paid access to basic health services across the population, often heavily subsidized by donors or the national government (Giedion et al., 2013). Especially in low-income countries, the latter type of voluntary insurance schemes dominates – across least-developed countries, member contributions account for at most 20 per cent of the funds administered through these schemes (WHO 2020, see Figure 14.9). Assigning responsibilities for funding some HIV-related services to voluntary contributory schemes thus does not necessarily shift some of the financing burden

to the private sector. Instead, the increased costs may get passed through to the government or donors, to keep contributions easily affordable for households and help to raise coverage of contributory schemes.

**Figure 14.9: Private contributions (percent of funds administered through voluntary contributory schemes, 2017)**



Source: See Figures 14.1-14.6

Funding of HIV treatment through private insurance schemes played a role in Southern Africa early on when publicly-funded treatment was not widely available and largely unaffordable for much of the population. Indeed one of the earliest models of the progression of HIV in South Africa (the Metropolitan-Doyle model) was developed on behalf of a large insurance company (Geffen and Welte, 2018), and some private (company) health programs for employees and their family members were among the first to offer antiretroviral therapy in South Africa (Connelly and Rosen, 2005 and 2006). One obvious challenge with this form of HIV care financing is the limited coverage of private insurance and inequity in access in many countries. In any case, the issue of including antiretroviral therapy in medical benefit packages became largely obsolete with the roll-out of free treatment of HIV funded by donors and the domestic government.

However, prepaid voluntary insurance could play a more prominent role in the future, because of the shift towards domestic financing and two developments which would reduce the costs of including antiretroviral therapy in a medical benefit package – (1) treatment has become much cheaper and (2) HIV incidence in most countries has declined steeply. Consequently, the cost of insuring against the risk of contracting HIV and requiring treatment (HIV incidence times lifetime cost of treatment) are often very low.

However, if the responsibility for financing treatment is shifted to a contributory scheme, the scheme assumes the liability for funding treatment for (1) all members already living with HIV (many of whom already receive treatment through other means, including the public sector), and (2) all members newly diagnosed HIV-positive. Where HIV incidence has been declining, the latter group of members could be insured at relatively low cost, while the costs of funding treatment for existing cases – distributed across members of the scheme – could be very substantial (National AIDS Control Council of Kenya, 2014), and the resulting increase in monthly contributions could compromise the objective of expanding insurance coverage. Consequently, decisions on involving contributory schemes in funding HIV treatment and care should distinguish between funding the financial liability implied by the health needs of people already living with HIV, and insurance for those newly diagnosed with HIV.

The other challenge in expanding the role of voluntary health insurance in financing HIV services regards equity and access, with respect to the population overall and specific populations.

Expanding UHC is about extending pre-paid (and affordable) access to health services to population groups to whom they were previously not available, or available only at low quality. In contrast, HIV treatment services across low- and middle-income countries are normally functioning well, and they are delivered free of charge. The pathway to a partly contribution-based funding of the HIV response would therefore need to be defined clearly, avoiding (1) discrimination against contributors (who would pay for HIV services delivered free of charge elsewhere) and thus compromising the objective of extending coverage of pre-paid schemes overall, or (2) a departure from the goal of universal access to treatment and the WHO’s public health approach, by making treatment contingent on membership of a contributory scheme. For both reasons, the public sector would have to continue to cover the bulk of the costs of HIV services at least for poorest through (otherwise also common) subsidies to the insurance program.

While contributory schemes in the context of achieving UHC are designed to mitigate exclusion due to poverty, gender or geographical inequalities, the global HIV/AIDS response additionally “accords special attention to exclusion due to sexual orientation and gender identity, sex work or drug use” (Ooms & Kruja, 2019). If HIV services are integrated in national health services and health financing schemes, this would have to be introduced in a way that preserves a priority for “key at-risk populations” (Ford et al., 2018) in line with the WHO’s public health approach.

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