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### **Change is the constant**

If change is as good as holiday, then *AIDS Analysis Africa Online* has just completed a round-the-world cruise! Since last December, we have been working behind the scenes to make the transition from the hard copy to electronic format a smooth and seamless one. We are therefore proud to present our publication's new 'look-'n-feel', designed in the PDF format to make downloading and printing as easy as 'click'. We recognise the need that readers may have to print, pack and peruse later, and our new AAO is has been tailored for you to do just that, so that what you see on your screen is what will eventually emerge from your printer. We hope that you approve.



On to the business of this issue, as usual we tackle a handful of boiling hot potatoes. Our articles on insurance; the anti-retroviral treatment situation in Southern Africa and the recent elections in South Africa, all make for interesting reading this month. I sincerely hope that they will be informative and useful to you.

*Gillian*

### **Gillian Núr Samuels**

Editor: AIDS Analysis Africa Online

### **What you'll find in this edition...**

#### **[HIV and life cover: what are the issues?](#)**

*By Stephen Kramer*

The many insurance underwriting dilemmas around AIDS have existed almost as long as the epidemic itself. Stephen Kramer unpacks some of the themes that have underpinned the life insurance industry for more than two decades. He also evaluates how anti-retroviral treatment could have a significant impact on future underwriting trends.

#### **[HIV/AIDS and South Africa's elections: what are the issues?](#)**

*By Nina Veenstra*

With election fever still high in South Africa, Nina Veenstra reports on HIV/AIDS in the context of our current political environment, and in particular on the impact of the epidemic on our election process.

#### **[Anti-retroviral therapy in Southern Africa: the key issues](#)**

*By Alan Whiteside*

On February 12, 2002 in a Department of Defence news briefing, US Secretary of Defence Donald Rumsfeld said, "As we know, there are known knowns. There are things we know we know. We also know there are known unknowns. That is to say we know there are some things we do not know. But there are also unknown unknowns, the ones we don't know we don't know." This is appropriate terminology for talking about the anti-retroviral therapy issue and HIV/AIDS.

# HIV and life cover: what are the issues?

By Stephen Kramer

## Background

The event of death or disability is often an unexpected one. The loss of an individual also implies the loss of the income that the person would be earning, and thus the ability to repay debt and care for dependents. It is these two aspects of financial security that life assurance mostly seeks to ensure. An individual might typically have a mortgage on his home, and may have other debt such as that on a credit card. Dependents may include children who may need support during their education, or a partner who may themselves not work.

The fact that death, for the most part, is a relatively unlikely event, and that under normal circumstances only a small number of the general population die each year, allows quite large sums to be paid out in exchange for a relatively affordable premium. Any circumstance that increases the likelihood of mortality thus impacts on the ability of the industry to provide life assurance at affordable rates.

The types of life cover typically sold include group life cover, which is sold to a group of individuals (usually as a group of employees as part of their remuneration) and individual life cover that is sold to an individual in a one-on-one contract. These two classes of insurance are treated very differently for pricing purposes.

## Group life cover

Group life cover is rated on an annual basis, and adjustments made to the premium on an ongoing basis according to the experience of the group. The long-term risk is lower for this type of insurance, as rates can be adjusted, but adverse events in the short-term can seriously affect the insurer. This type of insurance is often not subject to underwriting (a form of selection which excludes high-risk assured lives), and may thus be more susceptible to adverse trends. Cover is obtained without proof of insurability, rendering this form of cover more exposed to AIDS-related increases in claims. However, the nature of the product allows this impact to be managed more thoroughly than would be the case with individual life cover: premium rates may be changed annually to accommodate increases in the experience of claims; the fact that this cover is offered as a benefit in an employment context reduces significantly the risk of anti-selection. (Anti-selection being the situation where higher risk individuals buy the product in larger numbers as they perceive it to be of greater value).

## Individual life cover

Individual life cover on the other hand does suffer from serious long-term risk, as once a contract has been entered into, the individual will be entitled to remain insured over a long term for the premium agreed to, or for a premium within a stipulated range. It is critically important for the insurer to determine the long-term risk of the person being insured in order to ensure correct pricing and classification into a pool of risk – hence the need for HIV testing at inception. (Policies do exist that do not require testing – although the sums assured are usually small, and the premium higher relative to the sum assured).

In addition, policies specifically designed for HIV positive people do exist – the provision of cover is dependent on widely accepted indicators of the staging of HIV infection and disease. These indicators include the count of CD4 cells per unit of blood, the concentration of the virus in the blood, and other clinical measures. Cover may be declined if staging is too advanced, or provided at varying levels of cover and premium rate dependent on staging indicators.

As treatment becomes more readily accessible in South Africa, life assurers would be wise to begin to more seriously consider the large market of HIV positive people which is largely untapped at present.

In the case of some products (excluding for those specifically designed for HIV positive individuals) AIDS exclusion clauses have in the past applied. These have been difficult to apply, and many have regarded this practice as undesirable and discriminatory. The Life Offices Association (LOA) of South

Africa recently urged its members to phase out exclusion clauses due to their limited effectiveness and questionable fairness.

## **Fairness and underwriting**

It is essential in the context of individual life cover that the perception of value for money exists – that a fair amount of cover is being offered in exchange for a certain premium. Differentiation in the context of individual cover is thus essential.

The natural progression, were HIV testing not to occur, would be expected to be the following:

Individuals who believe themselves not to be at risk of infection would see the pooling of their risk with riskier individuals as being unfair. Value for money would not exist for those at less risk, as they would be subsidising death benefits to those at higher risk.

The lower risk individuals would be expected to withdraw, and the product would probably also attract higher risk individuals who perceive the product to be very good value.

The pool of higher risk would necessitate a higher premium, with the ongoing process of anti-selection resulting ultimately in only HIV positives or the most risky being in the pool.

The premium in this case would have to be so high as to render life cover almost obsolete.

HIV testing and medical underwriting are essential for the fair pooling of risk in an individual life assurance context. The underwriting response of the life assurance industry to HIV has been largely in line with the response to other medical conditions. The appropriateness of this approach is probably not seriously questioned in most countries – without underwriting the process of anti-selection would set in, and life assurance would likely become unaffordable to all. Life assurance is widely regarded as having positive social repercussions, and the continued existence of this product is held to be more important than the negative effects of underwriting. Underwriting has been regarded in some quarters as discriminatory, but as yet no serious alternatives have been put forward.

The increasing availability of treatment is likely to have a substantial effect on the underwriting exercise in the medium to long term. Treatment of HIV is still relatively new in actuarial terms. The duration of treatment success has been medically theorised, but not practically proven as yet. As treatment is shown to provide long term suppression of HIV, the pressure to include treatment considerations will grow. Despite the lack of long-term evidence, some assurers are already attempting to include expectations of treatment in their modelling – even a few years delay in death does have a substantial impact on the pricing of individual life products.

## **Life assurance and anti-retroviral therapy**

We know that the introduction of anti-retroviral therapy (ARV) is likely to have an enormous impact on the mortality risk of those fortunate enough to be able to access it. A more active approach with regard to treatment could well have averted many deaths and saved insurers a great deal. Many problems exist – is treating with ARV's affordable as a strategy to avoid payouts? How does one find those that need treatment? How will stigma practically affect the idea? The approach of life insurers with regard to treatment has likely been encouraged by these practical difficulties.

In developing countries, many may have life assurance but not have the medical insurances that provide for anti-retroviral treatment. This is the case especially for many employed people who may have group life cover, but little or no medical insurance. In this context, simply waiting for the event of death could well be the most costly option. In many cases, the net present value of cash flows is likely to be less where treatment is offered and paid for (despite this not being the obligation of the insurer). There are three problems to be overcome to make this option successful – ensuring those who have access to treatment via other channels use those other channels; ensuring treatment is successful (adherence is critically important here); and structural barriers such as resistant regulators, tax laws that make treatment a taxable benefit and legislation.

## Conclusion

The life industry has the ability to assist in changing the course of the epidemic at many levels. Products can alleviate some of the negative consequences of dying. Thorough consideration of creative strategies (including treatment-linked products) could make life products more profitable, while at the same time reducing premium costs, saving lives and benefiting society. The extent and impact of the epidemic calls for the industry to use its specialist knowledge to think beyond traditional boundaries – benefiting society, its customers and ultimately itself.

**Stephen Kramer is a freelance consultant attached to Aidsintelligence. This article is a reworked version of an "AIDS Brief" on the life assurance industry, written for the Health Economics and AIDS Research Division (HEARD) at the University of Natal. HEARD has generously allowed use of the material for this article.**

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## HIV/AIDS and South Africa's elections: what are the issues now and going forward?

By Nina Veenstra

Ten years into democracy and South Africa faced its third national democratic elections on 14 April 2004. HIV/AIDS featured prominently in nearly all the manifestos and it was used as a campaigning tool. This has the obvious relevance for most people – HIV/AIDS as one issue against which to assess potential support for various parties.



The challenge addressed by this article is in looking beyond the politicisation of HIV/AIDS, to the ways in which democracy and governance might be affected in a context of high HIV prevalence. The electoral processes will not remain unscathed, with HIV/AIDS touching lives in Southern Africa in so many different ways.

*Democracy – with elections as a central feature – happens to be by far the most popular system of governance not only in Africa but the entire globe. Free and fair elections constitute a key benchmark, which democratic countries must regularly achieve to enable voters to have a say in political outcomes.<sup>1</sup>*

### The politicisation of HIV/AIDS

Using HIV/AIDS as an election campaigning tool might appear to be insensitive and inhumane, as an ANC member has recently suggested. However, an IFP spokesman retorted by saying:

*'...no political party worth its salt could leave HIV/AIDS out of its manifesto because it is a national tragedy that requires all parties to pronounce on the measures needed to combat it.'<sup>2</sup>*

In South Africa, the ANC government's response to HIV/AIDS has heightened the politicisation of the epidemic. Significant civil society mobilisation has grown largely through a lack of political commitment in tackling the relevant issues. The question that remains to be answered is whether this politicisation is a bad thing. A prominent TAC member suggests otherwise:

*'...it is precisely because of the politicisation of the HIV epidemic that there is a growing awareness globally of the inequities in health-care between rich and poor countries that go far beyond AIDS.'<sup>3</sup>*

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<sup>1</sup> Chirambo K (2003) *Impact of HIV/AIDS on electoral processes in Southern Africa: A presentation to the 13<sup>th</sup> ICASA, Nairobi September 2003*. UNDP/IDASA Satellite on Aids and Governance.

<sup>2</sup> Chief Political Correspondent, Business Day (16 March 2004) *ANC is reaping AIDS whirlwind, say parties*.

<sup>3</sup> Geffen N (2004) *Rian Malan Spreads Confusion about AIDS Statistics*. TAC News Service, 1 January 2004.

## **HIV/AIDS impacts on electoral processes**

### ***How accurate is the voters' roll?***

Increasing numbers of deaths in a context of HIV/AIDS has the potential to give rise to increased numbers of "ghost voters". This occurs where dead voters are not identified, because systems used by Home Affairs and the Electoral Commission are not properly integrated, or because vital registration is weak<sup>4</sup>.

In South Africa the database maintained by the IEC is cross-checked against the National Population Register (currently outsourced by the Department of Home Affairs) on a daily basis in the run-up to the elections, suggesting well integrated systems<sup>5</sup>. However there are two problems: time lags in registering deaths and the percentage of deaths actually registered. The most recent assessment of the extent of death registration was in 1996<sup>6</sup>, where Statistics South Africa estimated that of all deaths occurring in that year, only 67% were registered<sup>7</sup>.

### ***Planning considerations***

Electoral processes have to function effectively for an election to be considered truly democratic and this requires specialised skills. Just as HIV/AIDS is exacerbating skills shortages in industry, electoral management bodies are equally threatened. Effects experienced could be a depleted skills base from which to recruit personnel, a loss of institutional memory and increased costs involved in re-training.<sup>8</sup> Illness or death of electoral officers during the elections could also seriously undermine efficiency.<sup>9</sup>

### ***Mobility during election time***

The running of elections requires that electoral officers, observers and others move around to areas where they are needed. Nationally for the 2004 elections, there were around 16 966 voting stations staffed by 215 064 people.<sup>10</sup> While many of these people were recruited locally in communities, co-ordination and trouble-shooting required roving personnel in each ward. People dislocated from their homes for the purpose of work, and with some disposable income, are at risk of participating in risky behaviours. We would also note that during election time political parties have members travelling around to hold rallies and canvass support, while police and military personnel may have been deployed to 'hot spots'. All these groups could be considered at higher risk.

### ***How might voting patterns be affected?***

Perhaps the most obvious impacts of HIV/AIDS on the election process relate to who comes forward to register, who actually votes, and how voting patterns are affected as a result. Illness within households will limit the ability of those who are ill or caring for sick family members to access registration centres or polling stations, due to distance, incentives to participate, time and other resource availability<sup>11</sup>. In this regard it is interesting to note that in South Africa, on average, the distance between the outer boundary of a voting district and the voting station is 7.5-8km in urban areas and 12.5-13km in rural areas.<sup>12</sup> Where there is no transport sick people may not be able to cover these distances. HIV/AIDS is rarely considered as a reason for disparities in voter registration,

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<sup>4</sup> Chirambo *ibid.*

<sup>5</sup> IEC. Personal communication.

<sup>6</sup> StatsSA. Personal communication.

<sup>7</sup> Bradshaw D, Schneider M, Dorrington R, Bourne D, Laubscher R (2002) South African cause-of-death profile in transition – 1996 and future trends. *South African Medical Journal*, 92 (8): 618-623.

<sup>8</sup> Chirambo *ibid.*

<sup>9</sup> Whiteside A *The Threat of HIV/AIDS to Democracy and Governance*. Briefing prepared for USAID. Summarised in Willan S (2000) *Considering the impact of HIV/AIDS on Democratic Governance and visa versa: A Concept Paper*.

<sup>10</sup> IEC. Personal communication.

<sup>11</sup> Mattes R (2003) *Healthy democracies? The potential impact of AIDS on democracy in Southern Africa*. ISS Occasional Paper 71, April 2003. <http://www.iss.co.za/Pubs/Papers/71/Paper71.html>

<sup>12</sup> IEC. Personal communication.

yet in Zambia it was found that the provinces hardest hit by HIV/AIDS had shown declining numbers in registered voters when examining statistics from the 1991, 1996 and 2001 elections.<sup>13</sup>

As HIV/AIDS disproportionately affects younger adults, this sector of the population is going to have more sick people who might not be able to travel to registration centres or voting stations. If one considers that older people might be more conservative and resistant to change, while younger people might prefer promises of change, then it becomes apparent that smaller parties and/or those with younger membership might be most vulnerable in the context of HIV/AIDS.

During elections, women are less likely to be freed up in order to register and subsequently vote. This is because women bear more of the burden of illness due to HIV/AIDS, as a result of higher prevalence rates in the female population and their role as caregivers in the household. It is therefore possible that smaller numbers of women voting might affect the support base of parties which focus attention on issues of concern to women.

Finally, HIV prevalence is higher in contexts of poverty and amongst the unskilled/semi-skilled sector of the population. If fewer people in the lower socio-economic strata of society cast their vote, then pro-poor parties could lose support. Poverty could be exacerbated even further.

## **Beyond the elections**

The impact of HIV/AIDS on democracy and governance will not only be felt during election time. While this article does not look at how this might occur, it is still important to think about what will happen when elected MPs are forced to relinquish their positions. In a time of HIV/AIDS this is going to happen more frequently, as politicians fall ill and die as a result of the epidemic. A study by IDASA in Zambia showed a marked increase in the number of deaths of MPs and subsequent by-elections during recent times, which were attributed to the impacts of HIV/AIDS.<sup>14</sup>

The impacts of increasing deaths amongst MPs will be felt more by countries using the First-Past-the-Post electoral system, where by-elections have to be staged to replace deceased members. These by-elections also have to be organised and are expensive. In South Africa, some protection against the uncertainty and costs of by-elections is assured by the Proportional Representation electoral system.<sup>15</sup> However the issue of by-elections is still relevant at local government level. Frequent replacement of members results in uncertainty and disruptions to programmes and delivery to the electorate.

HIV/AIDS is an issue for elections and democracy. We ignore it at our peril.

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## **Anti-retroviral therapy in Southern Africa.**

*by Alan Whiteside*

### **Introduction**

On February 12, 2002 in a Department of Defence news briefing, US Secretary of Defence Donald Rumsfeld said, "As we know, there are known knowns. There are things we know we know. We also know there are known unknowns. That is to say we know there are some things we do not know. But there are also unknown unknowns, the ones we don't know we don't know." This is appropriate terminology for talking about the anti-retroviral therapy issue and HIV/AIDS.



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<sup>13</sup> Chirambo *ibid.*

<sup>14</sup> Tapfumaneyi W (2003) *Impact of HIV/AIDS on electoral systems in Zambia*. Idasa. As cited in Chirambo (2003).

<sup>15</sup> Chirambo *ibid.*, Whiteside *ibid.*

## **What we do and don't know**

### ***Knowns***

There is evidence of a huge flow of resources to poor countries in support of their response to HIV/AIDS. A significant proportion of this money will for treatment of people living with AIDS and in particular anti-retroviral therapy. There are global targets. The WHO says they will put 3 million people on treatment by 2005, the US PEPFAR fund aims to have 2 million people being treated by the same date.

There is a growing number of countries planning some form of public anti-retroviral therapy. In most instances their targets are modest.

We know what the lowest price of drugs and testing will be. At the World Economic Forum Meeting in Davos in January, former President Clinton announced that drugs could be provided a \$139 per person per year and testing for \$110 giving a total of \$249 per person, per year. (It is worth noting that it will cost at least twice as much to treat people with brand name drugs than generics – and it also requires many more tablets – affecting compliance. If PEPFAR takes the route of buying only brand name drugs then they will treat significantly fewer people).

With regard to human capacity we know that the majority of African countries face a severe shortage of medical and ancillary staff and there is much movement of staff within and between countries, to neighbouring countries, or overseas.

### ***Unknowns***

There is a great deal unknown. For example the price of drugs may well fall further. We have no idea how long the therapy will keep people alive, the current estimate is five years, with the hope that the development of new drugs will extend this. We do not know what it costs to provide scaled-up anti-retrovirals. In addition to drugs there are the costs of procurement, distribution, storage and administering the medication.

The uptake of anti-retrovirals is not known. Before getting treatment people must know their status and that means being confidentially counselled and tested. The experience of places like Botswana is that uptake is far slower than anticipated. Once potential patients have identified then we require the services of doctors, nurses and possibly community workers to ensure that therapies are taken.

The most serious issue though is the gap in the information on the health care staff in various countries. For example in Malawi in 1998 some 27 per cent of clinical officer posts and 36 per cent of medical officer posts were vacant. There is also little information on how AIDS is impacting on numbers (through illness and death of workers and their families) and morale among medical staff.

There have been few attempts to identify knowledge on the human capacity needs for the provision of anti-retrovirals. How many health workers at various levels will be required? We don't know.

We do not know what needs to be in place for treatment to work. There has been little discussion of how nutrition and food supply needs will be met. People cannot be simply provided with drugs, they need to have access to food.

There is no information on how anti-retrovirals will fit in with other treatments – not only of opportunistic infections – but also of other diseases. For example most patients will need treatments for various diseases before they need anti-retrovirals, and even once they are on these drugs, there will still be the background diseases. The patient on anti-retroviral therapy in rural Mozambique is not protected against malaria and faces a parasite burden.

### ***Unknown unknowns***

There is currently a commendable effort by UNAIDS to develop scenarios for HIV/AIDS in Africa. One of the lessons of scenario development is that the further into the future one goes the less certain one can be.

There is however, with regard to AIDS, a real tendency toward 'unknown unknowns' being questions that people do not want to ask. These include:

- the true costs;
- the real benefits;
- the trade-offs;
- the potential for resource diversion; and
- equity and choice issues.

## Pointers

We need to be aware of key issues as we look at anti-retroviral therapy. The actual number of medical staff required is something that needs to be assessed carefully and here **parallel** or **integrated** models can be adopted. The current pilots of anti-retroviral therapy are almost all parallel models. Treatment is being parachuted into sites, taking no cognisance of what is already available. Moreover, the treatment is also sometimes exclusively being targeted at AIDS patients no matter what background health problems other people have. The alternative is to work within existing health systems, but this means that, for example, a nurse cannot be labelled as an 'AIDS delivery nurse'. Of course existing systems have their own constraints and priorities.

We must be aware that the experiences of the pilot sites such as those in Malawi, Khayelitsha in South Africa, and Mali cannot be applied to massive roll-out. As one of my medical colleagues said, "We need to appreciate that these pilot sites have cherry-picked those patients who are most likely to be compliant". They have also cherry-picked the staff.

## The research agenda

There needs to be a proper estimate of financial and human costs of anti-retrovirals. This would not be hard to do – we can estimate the cost of drugs and the staff needs. For example a quick survey of pilot sites around the African continent seems to indicate that one doctor for every 1000 patients would be about right but we don't know if this is the case or if this is too generous. We have been told that anti-retroviral provision in South Africa will require an additional 15 000 nurses while the Clinton Foundation estimates that an additional 10 000 health staff will be needed in Tanzania.

It is time to ask the questions that need to be asked in an open and honest way. AIDS and anti-retroviral provision have been politicised but good data are essential.

This article is in part based on a briefing requested by colleagues at UNAIDS.

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