The Role of The Private Sector in Preventing and Treating HIV/AIDS in Uganda:

An Assessment of Current Activities and the Outlook for Future Action

Rich Feeley\textsuperscript{a}, Paul Bukuluki\textsuperscript{b}, Dr. Peter Cowley\textsuperscript{c}

April 1, 2004

\textsuperscript{a}Center for International Health and Development, Boston University School of Public Health, Boston, USA
\textsuperscript{b}Department of Social Work and Social Administration, Makerere University, Kampala, Uganda
\textsuperscript{c}Commercial Market Strategies Project, Kampala, Uganda

Author for correspondence: Rich Feeley
Center for International and Development
Boston University School of Public Health
85 E. Concord Street, 5th Floor, Boston, MA 02118 USA

617-414-1260 ffeeley@bu.edu
Acknowledgements

The authors would like to acknowledge the financial support of USAID and the technical guidance received from Rob Cunnane, Amy Cunningham and Suzanne McQueen of USAID Kampala. The support received from Dr David Kihumuro Apuuli, Director General for the Uganda AIDS Commission, and from the Uganda AIDS Commission and the Ministry of Health, made this study possible. Dr. Chainaba Achol of the Ministry was extremely helpful in explaining Ministry oversight of private providers and supplying a list from which we drew the sample of clinics to be interviewed. The Uganda Investment Authority was most helpful and provided a list of approved investments that was the basis for our initial sample. Thanks to Alizanne Collier for assistance on the report.

Above all, we would like to thank the managers, employee representatives, clinic and insurance program directors and doctors who generously made themselves available for interview. Without their willing cooperation, this study would have been impossible. Copies of this report are being distributed to all who participated in the survey, and we hope that the rest of Uganda can learn from the information they shared with us.

This report was made possible through the support provided to the ARCH project by United States Agency for International Development, through the ARCH project, under terms of Co-operative Agreement No. HRN-A-00-96-90010-00 awarded to the Center for International Health and Development (CIHD) at Boston University.

The opinions expressed herein are those of the authors and do not necessarily reflect the views of the U.S. Agency for International Development.
Outline

List of Acronyms

List of Graphs and Tables

1. EXECUTIVE SUMMARY .................................................................................. 7
2. OBJECTIVE OF THE STUDY ....................................................................... 11
3. BACKGROUND ............................................................................................. 11
4. METHODOLOGY .......................................................................................... 13
5. EMPLOYER-BASED ACTIVITIES .............................................................. 17
   5.1 Pattern of Ownership, Industry Segment and Policy ................................. 17
   5.2 Level of Concern About HIV/AIDS ....................................................... 18
   5.3 Level of Attrition in the Workforce due to HIV/AIDS ................................ 20
   5.4 Corporate Policies Towards HIV Positive Workers .................................. 20
   5.5 Medical Benefits ...................................................................................... 21
      5.5.1 The Role of Employer-provided (or -financed) Medical Services .......... 21
      5.5.2 HIV/AIDS Specific Services ............................................................... 23
   5.6 Other Benefits Potentially Used by Workers Ill with HIV/AIDS ............... 24
   5.7 Pressures for Change ............................................................................. 25
   5.8 The Dynamics of Policy Change ............................................................. 26
   5.9 The Role of Information in Policy Change .............................................. 26
6. THE EMPLOYEE VIEW .............................................................................. 27
   6.1 HIV/AIDS in the Hierarchy of Employee Concerns ................................. 27
   6.2 Specific Concerns .................................................................................... 28
7. WHAT ARE PRIVATE SECTOR MEDICAL PROVIDERS DOING? .......... 30
7.1 HIV/AIDS Services Available ................................................................. 30
7.2 Cost, Quality and Access ........................................................................ 30
7.3 Constraints to Expansion ...................................................................... 32

8. THE ROLE OF HEALTH INSURANCE .................................................. 34

9. THE FUTURE: HOW MUCH OF A ROLE FOR THE PRIVATE SECTOR? 37

10. REFERENCES ........................................................................................ 43

11. APPENDICES ....................................................................................... 44

11.1 Interview Guides ................................................................................ 44
    Appendix A: Employer Interview Guides ............................................... 44
    Appendix B: Employee Representative Interview Guide .................... 54
    Appendix C: Clinical Service Providers Interview Guide ..................... 57
    Appendix D: Insurers and Health Maintenance Organization Interview Guide .... 66
# List of Acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIDS</td>
<td>Acquired Immune-deficiency Syndrome</td>
</tr>
<tr>
<td>ARCH</td>
<td>Applied Research in Child Health</td>
</tr>
<tr>
<td>ARV</td>
<td>Antiretroviral</td>
</tr>
<tr>
<td>DOT</td>
<td>Directly observed therapy</td>
</tr>
<tr>
<td>FUE</td>
<td>Federation of Ugandan Employers</td>
</tr>
<tr>
<td>HAART</td>
<td>Highly active antiretroviral therapy</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
</tr>
<tr>
<td>HMO</td>
<td>Health Maintenance Organization</td>
</tr>
<tr>
<td>IAA</td>
<td>International Air Ambulance</td>
</tr>
<tr>
<td>ILO</td>
<td>International Labor Organization</td>
</tr>
<tr>
<td>JCRC</td>
<td>Joint Clinical Research Center</td>
</tr>
<tr>
<td>MTCT</td>
<td>Mother-to-child transmission</td>
</tr>
<tr>
<td>NA</td>
<td>Not available</td>
</tr>
<tr>
<td>NGO</td>
<td>Non-governmental organization</td>
</tr>
<tr>
<td>OI</td>
<td>Opportunistic infection</td>
</tr>
<tr>
<td>PMTCT</td>
<td>Prevention of mother-to-child transmission</td>
</tr>
<tr>
<td>STI</td>
<td>Sexually transmitted infection</td>
</tr>
<tr>
<td>TB</td>
<td>Tuberculosis</td>
</tr>
<tr>
<td>TPA</td>
<td>Third Party Administrator</td>
</tr>
<tr>
<td>UIA</td>
<td>Uganda Investment Authority</td>
</tr>
<tr>
<td>USAID</td>
<td>United States Agency for International Development</td>
</tr>
<tr>
<td>VCT</td>
<td>Voluntary counseling and testing</td>
</tr>
</tbody>
</table>
List of Tables and Graphs

Table 1  Firms interviewed
Table 2  Characteristics of private HAART providers interviewed
Table 3  Industry and benefits offered
Table 4  HIV/AIDS is not a major management issue
Table 5  Benefits provided by interviewed employees
Table 6  HIV services offered
Table 7  Company sick leave policies (annual maximum)
Table 8  Employee representative ranking of priority for improvement in medical benefit
Table 9  Charge policies at the clinics
Table 10 Factors important in increasing the number of private patients
Table 11 Possible actions to expand demand for HIV services
Table 12 Possible actions to expand supply of HIV services

Graph 1  Employee ranking of importance of HIV/AIDS policies and benefits as an employee relations issue
1. Executive Summary

Can the private sector contribute more to the fight against HIV/AIDS in Uganda? To what extent are Ugandan businesses providing HIV education and treatment services, and what is the potential to expand overall “demand” for critical services using the funds and management capacity of private employers?

We must also ask: What is the current and potential future supply of HIV/AIDS services in the private healthcare sector in Uganda? What factors constrain the quantity and quality of private sector HIV/AIDS services---particularly highly active antiretroviral treatment (“HAART”)? Going forward, we want to know how the current supply of privately purchased and privately provided services might be expanded.

We attempted to answer these questions through structured interviews with managers at 37 different private sector businesses in Uganda. The respondents come from a variety of medium to large enterprises, with different ownership patterns, across the industrial spectrum. We did not attempt to reach small companies (less than 25-50 workers). At most of the companies, we also interviewed an employee or union representative to obtain the workers’ perspective. To better understand private sector provision of HIV services, we interviewed nine of the private clinics on a Ministry of Health list of facilities accredited to provide antiretrovirals, or known to be doing so. We also interviewed the managers of three health insurance plans, which run their own clinics, as well as the dominant provider of Third Party Administrator services for corporate medical benefit plans. These interviews helped us to better understand how the existing health insurance industry influences access to HIV/AIDS care in Uganda.

Although there is a full spectrum in the development of corporate HIV policies and benefits in Uganda, the firms interviewed can, with a little difficulty, be divided into three categories.

**Category One**
Category One employers have defined HIV/AIDS policies and established medical and sick leave benefits for the full time labor force. Many of these companies already have policies that prohibit discrimination against HIV positive employees. They provide periodic HIV/AIDS education for workers. Most offer voluntary counseling and testing as a separate benefit or part of a medical package. They are increasingly covering full HIV benefits in their medical plan, including HAART. Such firms have a professional human resource department, and are most often part of a multi-national corporation and/or in a modern industry sector (media, telecommunication, finance). They may also be partially owned by the government of Uganda. Despite their relative sophistication, these companies have not conducted a seroprevalence test among employees, and do not rank HIV/AIDS as one of the most important management issues.
**Category Two**
Category Two employers typically have established employee benefits, including sick leave and a medical care reimbursement program. These companies are less likely to have a professional human resources department and less likely to have adopted a formal HIV/AIDS workplace policy. They have often provided some HIV/AIDS education to their workers in the past. HIV/AIDS care and HAART are not explicitly covered in the company medical benefit program, but may be available with the consent of the management. Expensive treatment is usually only reimbursed after management approves a medical treatment order; as a result, many workers are reluctant to seek company support for treatment because they do not want to reveal their HIV status.

Companies in this category are likely to be in modern industry sectors such as finance and communication, and are mid-sized employers with a substantial portion of well-educated workers. They are usually not part of a multi-national corporation, although they may have partial foreign ownership or affiliations (such as the accounting firms). These firms lack information on which to base decisions about HIV/AIDS policies and benefits and could benefit from the experience of some of the Category 1 firms.

**Category Three**
Category Three firms were usually not part of a multi-national or para-statal organization. They may have offered an AIDS prevention training session in the past, or distributed condoms provided free by a donor. We saw most firms like this in the agricultural and manufacturing sectors. Firms in this third category have a large proportion of unskilled workers. Medium sized firms in this category have no human resources department. They have no written HIV/AIDS policy. They offer no medical benefit, other than any required occupational health clinic, and formal sick leave benefits are poor to non-existent. They do not see HIV in the workforce as any problem at all.

Category One firms have shown social responsibility in offering support for people living with HIV/AIDS, with many already offering HAART as part of the medical benefit and others actively considering it. Many have a written HIV/AIDS policy that prohibits discrimination. Additional information on the cost of HIV/AIDS treatment may accelerate the decision to offer a HAART benefit by lagging companies in this category.

There is little potential to expand demand for HIV/AIDS services through Category Three companies. There is no medical benefit program to which HIV/AIDS treatment could be added. These companies claim to be unaware of significant AIDS mortality in the workforce, presumably because workers receive little sick leave and the company does not follow-up on prolonged absenteeism. These firms would probably respond to a government requirement, perhaps to adopt a non-discrimination policy, if it was not seen as requiring them to retain unproductive workers. They are unlikely to make significant financial contributions to treatment and prevention costs. A few of the larger agricultural employers may have clinics at remote sites that could be used as additional sites for government or donor supported treatment programs.

The greatest potential to boost private sector “demand” for HIV/AIDS services lies with the Category Two companies. They already offer some medical and sick leave benefits,
and are competing in the market for skilled or educated labor. Some have supported an employee with expensive medical care in the past. Several initiatives could expand HIV/AIDS benefits in these companies, and thus the number of formal sector employees that receive employer-sponsored HAART. Such initiatives could include:

1. Providing information from the more experienced Category One companies on the cost of HIV/AIDS treatment programs, and the extent to which HAART treated workers remain in productive employment. Phase II of this study will contribute to the information base on the cost actually incurred by employers due to HIV infection. Human Resources managers in Category One companies can also help the multi-tasking managers of Category Two companies to work out the policy issues associated with HAART coverage and the adoption of non-discrimination policies;

2. Encouraging such companies to shift from internally managed medical reimbursement programs to health insurance or Third Party Administration (TPA) of medical claims. Insurers and the dominant TPA in Uganda are developing extensive experience on the actual cost of HIV treatment. They also understand the conditions necessary for a clinic to offer quality HIV care. Insurance or properly structured TPA removes the need for the employee to reveal his HIV infection to management in order to obtain reimbursement for treatment expenses;

3. Providing model HIV/AIDS policies that can be adopted by these companies.

Interviews reveal that, at least in Kampala-Entebbe, the supply of HIV treatment in the private sector has not yet been constrained by factors other than the affordability of care. Exclusive of lab testing costs, first line triple therapy drugs and medical supervision are now available throughout the metropolitan area at a cost of $1.10 to $1.65 per day. However, all of the clinics still see many patients who need HAART, but cannot afford it. Physicians interviewed stated that a further fall of 30% to 50% in the price of ARV treatment would result in doubling the number of private HAART patients. In the nine clinics interviewed, HAART caseload had already grown by a factor of five in four years. All of the interviewed clinics had been offering antiretroviral drugs since 1999 or earlier.

Although commercial health insurance policies in Uganda have traditionally excluded HIV/AIDS (and other chronic diseases), this is beginning to change. STIs and some lesser opportunistic infections are already covered. Both major commercial insurers run their own clinics. They will cover HIV/AIDS, including antiretroviral drugs and treatment of opportunistic infections, for an increase of 20-25% in the typical annual premium of $160 to $200 per adult. These companies and the dominant TPA will also administer an HIV/AIDS benefit where the employer “takes the risk” of HIV treatment costs, rather than insuring it. As treatment prices drop and evidence continues to mount that prevalence has stabilized or is falling, insurers are showing a willingness to include HIV/AIDS care in the standard benefit without additional cost. International Air Ambulance announced in January 2004 that it is taking this step with its existing corporate accounts.
Training levels vary among physicians providing HAART in private clinics. Some are specialists trained by the government and research institutes and work part-time at these sites. Others are full time general practitioners who have taught themselves through textbooks, package inserts and continuing medical education courses in order to serve their HIV positive patients. While most of the clinics use non-physician counselors for VCT, the physician does all counseling associated with treatment. Greater use of non-physician counselors to prepare patients for HAART and its related problems could free up physician labor for medical management. However, most doctors feel that private patients are reluctant to talk about HIV with anyone other than the doctor.

For the two clinics with the largest HAART caseload, space and physician staffing will be a constraint to further major expansion. Clinics with smaller caseloads felt they could absorb additional HAART treatment cases without adding staff and space. While the space problem could be solved in number of ways (moving other services, rental, etc.), the physician constraint is real, and will exist in the public sector as well. As public sector physicians are trained, more “trickle down” of this training may reach the private sector as these physicians moonlight in private clinics. However, HAART training programs specifically targeted at full time general practitioners in the private sector, scheduled to reflect the realities of a private practice, would increase both the quality and quantity of private physician HIV care. At least in the larger clinics, experiments with the use of non-physician counseling of HAART patients (as is done in the West and in South Africa) might also be a feasible way to expand the number of HAART cases that a given private physician can treat.

The final constraint to expanding the supply of private sector HIV/AIDS care is laboratory capacity. Today, private sector clinics use JCRC or the Virus Research Institute for both CD4 and viral load tests. If Western protocols were used, laboratory tests could easily exceed 50% of the lower range of annual physician and drug costs for first line triple therapy. The costs, plus concerns about timing and accuracy, cause some private physicians to dispense with CD4 and viral load tests.

The larger clinics are beginning to consider buying CD4 machines and conducting their own tests. If the caseload is sufficient, this may be a good economic decision. Clinics could be assisted with this analysis, and might acquire the machines more quickly if they could be obtained through a creative lease arrangement where repayments are aligned with the volume of tests performed. In the longer run, adoption of protocols that minimize expensive testing (as will almost surely happen in the public sector), or development of much lower cost monitoring tests, would further expand the supply and affordability of private sector HIV treatment.
2. Objective of the Study

The overall goal of the research was to determine the capacity of the private sector in Uganda to assist in fighting the epidemic of HIV/AIDS. We investigated both the supply of HIV services, particularly diagnosis and treatment (including HAART), and the demand for such services from employers, or formal sector employees receiving employer support.

To assess employer-based demand, we used structured interviews with the following objectives:
- Obtaining an understanding of what employers are currently doing about HIV/AIDS;
- Identifying the factors that determine corporate HIV/AIDS policies;
- Assessing current employer-provided benefits such as medical care, sick and disability leave and the extent to which such benefits might specifically relieve the burden on the government to provide care and assistance for workers who are HIV positive;
- Assessing the business sector’s current and potential demand for HIV/AIDS prevention, treatment and support services.

In a second phase of the study, we will select two employers with good personnel data and a history of losing employees to HIV/AIDS and measure the costs to the employer associated with HIV/AIDS infections in the workforce.

To evaluate the supply of HIV/AIDS services in the private sector, we again used structured interviews to:
- Determine what private medical providers are currently doing to diagnose and treat HIV/AIDS, and the price charged for these services;
- Estimate the extent to which HIV treatment is covered under existing health insurance policies sold in the Uganda market;
- Assess the factors constraining both the volume and quality of HIV/AIDS services, including HAART, in the private market.

3. Background

The private sector in African economies has much to lose in the HIV/AIDS epidemic, and potentially much to contribute to alleviating the burden of the disease. However, the magnitude of the costs that HIV/AIDS imposes on employers is only now being researched. Most of the data on the positive steps being taken by private employers to prevent and treat the disease are anecdotal: newspapers have reported the commitment of major companies like Debswana, Anglo American, and Heineken to provide antiretroviral therapy for African employees. However, it is not yet clear if these initiatives are starting a trend in African business, or if they will remain isolated experiments by large, sophisticated employers with deep pockets. As yet unpublished
data from a recent survey by Boston University colleagues in the Republic of South Africa show a lower level of management focus on HIV-related issues in small and medium sized enterprises.

In Uganda, nationwide prevalence of HIV infections measured in antenatal sentinel surveys conducted at maternal health facilities has fallen to 6.2% nationwide (7.9% in major urban areas and 5.1% elsewhere). At Nsambaya Hospital in Kampala, antenatal surveillance showed HIV prevalence falling from 29% in 1992 to 8.5% in 2002. These data seem to support the conclusion that prevention efforts are having an effect and reducing the rate of HIV transmission. Similar longitudinal data on HIV prevalence in various sectors of the Uganda workforce are not available, so we cannot necessarily conclude that the burden of HIV on employers in Uganda has peaked. Many infections acquired a decade ago are now progressing to the terminal phases of AIDS. An ILO report published in 1995 reviewed five Uganda employers and found AIDS deaths over the five years from 1989-1993 totaling from 0.4% to 3.5% of the peak workforce in the period. One purpose of our study was to obtain updated information on the level of AIDS mortality (and associated cost) currently occurring in Ugandan industry.

Research in South Africa has recently calculated the cost to employers of HIV infections at 0.4% to 5.9% of the annual wage bill in the companies studied. The HIV epidemic in Southern Africa is more recent than that in Uganda, but has now reached much higher levels of seroprevalence. South Africa is also different from Uganda in many respects; it has a much larger formal economy, larger and more diverse manufacturing and service sectors, and higher per capita income. One therefore expects higher average levels of employee education and better employee benefits. By studying Ugandan industry, we are looking at a more mature epidemic in a less developed economy. This enables us to assess the burden of HIV/AIDS in an economy with different wage and benefit profiles, and with a presumed larger proportion of HIV cases at or near the terminal phase of AIDS.

Uganda has been at the forefront of efforts in Africa to treat HIV infections with HAART. The Joint Clinical Research Center (JCRC) in Kampala conducted some of the earliest clinical research on the use of antiretroviral drugs in a resource-poor setting. The government of Uganda (with the help of the Global Fund, World Bank and other donors) is now expanding the availability of HAART in public health facilities. However, even before the receipt of outside funding for publicly provided ARVs, the number of individuals receiving HAART grew substantially beyond those in JCRC clinical trials. Estimates in 2002, presumably based on imports of ARVs, put the number of Ugandans receiving HAART at 10,000, 13% of all the adult HAART patients in Africa south of the Sahara. Most of these patients are being treated in the Kampala area, which has a population of 1.5 million. If 8% of the adult population in this conurbation is infected with HIV, and 15% of these infections have progressed to the point where HAART is indicated, then there are 9,000 adult residents eligible for HAART. If two thirds of the 10,000 reported HAART patients in Uganda are in the Kampala area, then more than

---

*b Estimate by the International Treatment Access Coalition (ITAC), December 2002.
one-half of the need for HAART in the city’s population is already being met. Since public sector HAART treatment facilities and clinical trials in Kampala currently do not have sufficient capacity, many of these patients are, perforce, being treated privately. They are paying for their treatment personally, or with the support of employers or family. The existence of extensive private purchase and provision of HAART can be inferred from this analysis, but the extent and pattern of employer funding or private provision has not yet been documented. This study was designed to better profile employer efforts in both prevention and treatment, and to fill in some of the gaps in understanding about the HAART services offered by non-governmental clinics in the Kampala/Entebbe area.

By studying the personnel and benefit policies of Uganda employers, we gain insight into the level of resources that are, or might be, committed by employers to HIV/AIDS prevention and treatment. By profiling private sector HAART providers, we shed some light on the quality of private sector care, the extent to which the private sector could participate in an expansion of national HAART programs, and the constraints to improving quality and volume of private sector HAART care. We hoped to learn lessons that would be applicable to other relatively stable sub-Saharan countries with low per capita income and moderate HIV epidemics.

4. Methodology

The study was based on structured interviews with four key groups: employers, employee representatives, private health care providers offering ARV treatment, and health insurers. Staff of the Department of Social Work and Social Administration at Makerere University, under the leadership of Paul Bukuluki, interviewed employers and employee representatives. Providers and health insurers were interviewed by Dr. Peter Cowley, an American physician and director for five years of the Commercial Market Strategies program in Uganda. Interview guides, attached in the Appendix, were developed by Boston University with input from Mr. Bukuluki, Dr. Cowley and USAID. We selected the structured interview format, rather than a more rigorous questionnaire, because we were venturing into unchartered territory, and wanted to probe motivation and nuance in the management of benefits and patients, rather than relying on simple “yes/no” or quantifiable answers. The insights elicited from the additional responses during the interviews justify this approach.

Firms for the employer interviews were originally identified using a database compiled by the Uganda Investment Authority (“UIA”). This list of firms is derived from the approval of investment projects by UIA and indicates the amount of expected employment resulting from the licensed investments. All of the companies on the UIA list were characterized as to industry segment and number of employees, and the planned 40 interviews distributed according to the relative totals of employment in each industry.

\[c\] The number of interviews was determined by the available budget.
segment. Within the quota of interviews for each category defined by industry segment and size of employment, employers were selected for interview at random.

It was apparent by inspection that the UIA database did not contain many multi-national firms known to be active in Uganda. This may be because investment in multi-national operations comes from retained profits of the Uganda subsidiary or transfers from the multi-national parent, and is not subject to requirements to report to UIA. In any case, we added to the sample a selection of multi-nationals active in Uganda, including some known to be providing antiretroviral drugs to employees, or considering doing so.

Of the originally selected list of 44 employers, 24 firms could not be found\(^d\) or would not agree to an interview. In these cases, another firm in the same industry and the same general size category (as defined by number of employees) was selected for interview. In addition, several multi-national companies active in Uganda and not listed with the UIA were identified for interview. A total of 37 corporate interviews were completed. It was most difficult to obtain additional interviews with medium sized firms in manufacturing and agribusiness,\(^e\) where the pattern of policy and conduct was consistent in the companies already interviewed, and we did not press to complete the originally planned sample of 40 firms. Table 1 shows the industry segment, ownership and totals for regular and contract employment for each firm interviewed. The respondent was usually the manager or a senior staff member in the HR or personnel department. However, in agribusiness, manufacturing, and some service industry firms, there was often no HR Department, instead we interviewed the owner or senior operations manager.

At the conclusion of the employer interview, we asked permission to interview a representative from the labor union or employee association, representing workers at the firm. In some cases, there was no formal employee organization, but we were referred to an employee thought to be interested in matters of HIV/AIDS policy. In some companies, management refused to arrange an employee contact. Table 1 indicates whether an employee representative was interviewed at a firm; we reached employee representatives at 26 of the 37 companies.

In addition to the employer and employee interviews, we held one in-depth focus group with three senior human resources managers at large employers now offering, or planning to offer, HAART. This session was convened to develop a better understanding of the factors that motivate or facilitate the implementation of a HAART benefit.

\(^d\) Apparently, the approved investment had never been made or the company identity had changed in a way we could not trace.

\(^e\) These companies did not have a Human Resource Department, so the General Manager or owner was the only person knowledgeable enough to interview. These individuals were more reluctant to cooperate than HR Directors in larger companies.
<table>
<thead>
<tr>
<th>Firm #</th>
<th>Sector (NAICS classification)</th>
<th>Ownership</th>
<th>Employment</th>
<th>Employee Rep Interviewed</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Accommodation and Food Services</td>
<td>Domestic</td>
<td>&lt;50</td>
<td>N</td>
</tr>
<tr>
<td>2</td>
<td>Accommodation and Food Services</td>
<td>Domestic</td>
<td>50-249</td>
<td>N</td>
</tr>
<tr>
<td>3</td>
<td>Accommodation and Food Services</td>
<td>Domestic</td>
<td>50-249</td>
<td>Y</td>
</tr>
<tr>
<td>4</td>
<td>Administrative Support</td>
<td>Domestic</td>
<td>&gt;500</td>
<td>Y</td>
</tr>
<tr>
<td>5</td>
<td>Administrative Support</td>
<td>Multi-national</td>
<td>&gt;500</td>
<td>N</td>
</tr>
<tr>
<td>6</td>
<td>Agriculture, Forestry, Fishing and Hunting</td>
<td>Domestic</td>
<td>&gt;500</td>
<td>Y</td>
</tr>
<tr>
<td>7</td>
<td>Agriculture, Forestry, Fishing and Hunting</td>
<td>Domestic</td>
<td>&gt;500</td>
<td>Y</td>
</tr>
<tr>
<td>8</td>
<td>Agriculture, Forestry, Fishing and Hunting</td>
<td>Domestic</td>
<td>50-249</td>
<td>Y</td>
</tr>
<tr>
<td>9</td>
<td>Agriculture, Forestry, Fishing and Hunting</td>
<td>Domestic</td>
<td>50-249</td>
<td>Y</td>
</tr>
<tr>
<td>10</td>
<td>Agriculture, Forestry, Fishing and Hunting</td>
<td>Domestic</td>
<td>50-249</td>
<td>N</td>
</tr>
<tr>
<td>11</td>
<td>Agriculture, Forestry, Fishing and Hunting</td>
<td>Multi-national</td>
<td>&gt;500</td>
<td>Y</td>
</tr>
<tr>
<td>12</td>
<td>Construction</td>
<td>Domestic</td>
<td>50-249</td>
<td>Y</td>
</tr>
<tr>
<td>13</td>
<td>Educational Services</td>
<td>Domestic</td>
<td>&lt;50</td>
<td>Y</td>
</tr>
<tr>
<td>14</td>
<td>Finance and Insurance</td>
<td>Domestic</td>
<td>&gt;500</td>
<td>Y</td>
</tr>
<tr>
<td>15</td>
<td>Finance and Insurance</td>
<td>Domestic</td>
<td>50-249</td>
<td>Y</td>
</tr>
<tr>
<td>16</td>
<td>Finance and Insurance</td>
<td>Multi-national</td>
<td>50-249</td>
<td>Y</td>
</tr>
<tr>
<td>17</td>
<td>Finance and Insurance</td>
<td>Multi-national</td>
<td>50-249</td>
<td>Y</td>
</tr>
<tr>
<td>18</td>
<td>Information</td>
<td>Domestic</td>
<td>250-500</td>
<td>Y</td>
</tr>
<tr>
<td>19</td>
<td>Information</td>
<td>Domestic</td>
<td>250-500</td>
<td>Y</td>
</tr>
<tr>
<td>20</td>
<td>Information</td>
<td>Domestic</td>
<td>50-249</td>
<td>Y</td>
</tr>
<tr>
<td>21</td>
<td>Information</td>
<td>Domestic</td>
<td>50-249</td>
<td>Y</td>
</tr>
<tr>
<td>22</td>
<td>Manufacturing</td>
<td>Domestic</td>
<td>&lt;50</td>
<td>N</td>
</tr>
<tr>
<td>23</td>
<td>Manufacturing</td>
<td>Domestic</td>
<td>250-500</td>
<td>Y</td>
</tr>
<tr>
<td>24</td>
<td>Manufacturing</td>
<td>Domestic</td>
<td>250-500</td>
<td>N</td>
</tr>
<tr>
<td>25</td>
<td>Manufacturing</td>
<td>Domestic</td>
<td>50-249</td>
<td>N</td>
</tr>
<tr>
<td>26</td>
<td>Manufacturing</td>
<td>Domestic</td>
<td>50-249</td>
<td>N</td>
</tr>
<tr>
<td>27</td>
<td>Manufacturing</td>
<td>Domestic</td>
<td>50-249</td>
<td>Y</td>
</tr>
<tr>
<td>28</td>
<td>Manufacturing</td>
<td>Domestic</td>
<td>50-249</td>
<td>Y</td>
</tr>
<tr>
<td>29</td>
<td>Manufacturing</td>
<td>Domestic</td>
<td>50-249</td>
<td>N</td>
</tr>
<tr>
<td>30</td>
<td>Manufacturing</td>
<td>Domestic</td>
<td>50-249</td>
<td>N</td>
</tr>
<tr>
<td>31</td>
<td>Manufacturing</td>
<td>Multi-national</td>
<td>&gt;500</td>
<td>Y</td>
</tr>
<tr>
<td>32</td>
<td>Manufacturing</td>
<td>Multi-national</td>
<td>250-500</td>
<td>Y</td>
</tr>
<tr>
<td>33</td>
<td>Mining</td>
<td>Multi-national</td>
<td>250-500</td>
<td>N</td>
</tr>
<tr>
<td>34</td>
<td>Mining</td>
<td>Multi-national</td>
<td>50-249</td>
<td>Y</td>
</tr>
<tr>
<td>35</td>
<td>Professional, Scientific and Technical services</td>
<td>Domestic</td>
<td>50-249</td>
<td>Y</td>
</tr>
<tr>
<td>36</td>
<td>Retail Trade</td>
<td>Multi-national</td>
<td>50-249</td>
<td>Y</td>
</tr>
<tr>
<td>37</td>
<td>Utilities</td>
<td>Domestic</td>
<td>&gt;500</td>
<td>Y</td>
</tr>
</tbody>
</table>
To identify medical providers, we met with the Ministry of Health (MoH) officer, Dr. Chainaba Achol, responsible for the accreditation of providers offering HAART. Uganda, with the assistance of UNAIDS, developed a set of criteria for public and private facilities offering HAART, and grants accreditation to those facilities which comply, as confirmed by on-site inspection. The MoH also maintains a list of providers known to be providing antiretrovirals, but not yet accredited. From these lists, we selected at random a total of 10 clinics operating in the Kampala/Entebbe area for interview. In one case, the selected clinic could not be located. Interviews were conducted with the Clinic Director or physician in charge of HIV/AIDS care. A total of 9 clinic interviews were completed. Table 2 characterizes the clinics surveyed by size (total number of outpatient visits per year for all causes), ownership, and the number of patients currently receiving treatment with antiretroviral drugs.

Where respondents were asked to give a current price or cost (insurance premiums, medical care and drug prices, death benefits), these amounts were recorded in Ugandan shillings. In the body of this report, such amounts are converted to US dollars at 2,000 Ugandan shillings to the dollar, the approximate rate in effect at the end of 2003.

<table>
<thead>
<tr>
<th>Table 2: Characteristics of Private HAART Providers Interviewed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider</td>
</tr>
<tr>
<td>----------</td>
</tr>
<tr>
<td>1</td>
</tr>
<tr>
<td>2</td>
</tr>
<tr>
<td>3</td>
</tr>
<tr>
<td>4</td>
</tr>
<tr>
<td>5</td>
</tr>
<tr>
<td>6</td>
</tr>
<tr>
<td>7</td>
</tr>
<tr>
<td>8</td>
</tr>
<tr>
<td>9</td>
</tr>
<tr>
<td>10</td>
</tr>
<tr>
<td>11</td>
</tr>
<tr>
<td>12</td>
</tr>
<tr>
<td>13</td>
</tr>
</tbody>
</table>

* These organizations are insurers/HMOs and were not asked to disclose the number of their members on HAART
NA: Not available

Regulation of health insurers is at a very early stage in Uganda, and we did not attempt to identify a database of those currently offering such policies. African Air Rescue and International Air Ambulance were widely recognized as active in the market for health insurance in Kampala, and were interviewed. Aon (a multi-national insurance conglomerate) was understood to be offering Third Party Administrator Services to Ugandan employers: Aon takes on the responsibility of paying a company’s medical benefits, verifying claims and enforcing benefit limitations, but leaving the “risk” of total claims costs to the employer. Aon also qualifies providers for participation in its plans,
and receives a fee from the employer for providing these services. Managers at all three firms were interviewed. In addition, we identified two Kampala clinics which offer a prepaid plan (in effect, a Health Maintenance Organization or HMO) to patients enrolled at the clinic. We interviewed one of these clinics about its HMO plan. All employers interviewed were asked how they insured or paid available medical benefit, and no additional insurers or prepaid health plans were identified by this question.

5. Employer-based Activities

5.1 Pattern of Ownership, Industry Segment and Policy

The interviews showed a diversity of response on everything from the availability of medical benefits and sick leave to the existence of explicit policies regarding HIV/AIDS in the workforce. However, a general trend was apparent. The level of concern and sophistication about HIV/AIDS was higher in multi-national companies and in those firms in which the Uganda government maintains some ownership interest. These firms also offer better medical benefits to their employees. Many of these “more sophisticated” firms are in more “advanced” sectors of the economy: banking, telecommunications, media, etc. Firms in the agribusiness, manufacturing and service (security, hospitality) industries had inferior worker benefits and relatively little concern about the impact of HIV on the company or its workers. In general, these companies were also Ugandan owned. Where a company in one of these industry segments was controlled by a multi-national, it was more likely to have a developed HIV/AIDS policy, and to be considering extending HAART benefits to its employees.

This conclusion is supported by the data in Table 3. Firms are divided into the ownership categories: multi-national, partially state controlled, mixed foreign and local private ownership, and 100% local ownership. The difference between “multi-national” and “mixed” ownership is crucial. “Multi-national” refers to the subsidiary or affiliate of a large publicly-held company with global operations and headquarters in the developed world. Mixed ownership refers to a company with non-Ugandan shareholders, but which is not part of a sophisticated global corporation. For each category, the table shows the number and percentage of responding firms that:

1. Had a written HIV/AIDS policy
2. Offered any medical benefit to the general workforce
3. Provided regular employee education on HIV/AIDS
4. Offered, or were considering, a HAART benefit for employees
### Table 3: Industry and Benefits Offered

<table>
<thead>
<tr>
<th>Ownership structure</th>
<th>Firms interviewed</th>
<th>Written HIV policy</th>
<th>General medical benefits</th>
<th>Regular HIV education</th>
<th>HAART now</th>
<th>HAART planned</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td>Multi-national</td>
<td>9</td>
<td>33.3</td>
<td>7</td>
<td>77.8</td>
<td>4</td>
<td>44.4</td>
</tr>
<tr>
<td>Partial state control</td>
<td>2</td>
<td>100.0</td>
<td>2</td>
<td>100.0</td>
<td>1</td>
<td>50.0</td>
</tr>
<tr>
<td>Mixed foreign/local</td>
<td>4</td>
<td>0.0</td>
<td>2</td>
<td>50.0</td>
<td>1</td>
<td>25.0</td>
</tr>
<tr>
<td>Ugandan</td>
<td>22</td>
<td>2</td>
<td>14</td>
<td>63.6</td>
<td>7</td>
<td>31.8</td>
</tr>
<tr>
<td>TOTAL</td>
<td>37</td>
<td>16.2</td>
<td>25</td>
<td>67.6</td>
<td>16</td>
<td>43.2</td>
</tr>
</tbody>
</table>

5.2 Level of Concern About HIV/AIDS

For Uganda employers in agribusiness and manufacturing, HIV/AIDS is simply not a management issue at this time. These companies offer little in the way of sick leave or benefits. Most have no medical benefit for workers; at best they run a small clinic for occupational injuries. One respondent noted that the employer does not really know which workers have a chronic illness; workers are not paid once they stop coming to work, for whatever reason. Training for most workers in the agriculture and manufacturing sectors is minimal, and when a worker is lost, the firm simply hires another worker from the large pool of labor seeking employment. Such firms might consider paying for HIV/AIDS care on a discretionary basis for a key member of the small management team, but have not even considered a general medical benefit for workers, let alone comprehensive HIV/AIDS care. When asked to rate the importance of HIV/AIDS as a management issue, almost all firms in these categories responded that HIV/AIDS is “Not an issue” or “Mentioned occasionally but never considered important.” Table 4 shows the response of each company to this question with “Not an issue” rated as 1 and “HIV/AIDS is the most important management issue” rated as 5. The average response was 1.9. One company out of 37 rated HIV/AIDS as the most important management issue, and only 3 more rated it in the top five management issues.
<table>
<thead>
<tr>
<th>#</th>
<th>Sector (NAICS classification)</th>
<th>Ownership</th>
<th>Size of Workforce</th>
<th>Rating of HIV/AIDS as a management issue</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Accommodation and Food Services</td>
<td>Domestic</td>
<td>&lt;50</td>
<td>1</td>
</tr>
<tr>
<td>2</td>
<td>Accommodation and Food Services</td>
<td>Domestic</td>
<td>51-250</td>
<td>1</td>
</tr>
<tr>
<td>3</td>
<td>Accommodation and Food Services</td>
<td>Domestic</td>
<td>51-250</td>
<td>4</td>
</tr>
<tr>
<td>4</td>
<td>Administrative Support</td>
<td>Multi-national</td>
<td>&gt;1000</td>
<td>1</td>
</tr>
<tr>
<td>5</td>
<td>Administrative Support</td>
<td>Ugandan</td>
<td>751-1000</td>
<td>2</td>
</tr>
<tr>
<td>6</td>
<td>Agriculture</td>
<td>Mixed foreign/local</td>
<td>51-250</td>
<td>1</td>
</tr>
<tr>
<td>7</td>
<td>Agriculture</td>
<td>Multi-national</td>
<td>&gt;1000</td>
<td>2</td>
</tr>
<tr>
<td>8</td>
<td>Agriculture</td>
<td>Ugandan</td>
<td>&gt;1000</td>
<td>1</td>
</tr>
<tr>
<td>9</td>
<td>Agriculture</td>
<td>Ugandan</td>
<td>51-250</td>
<td>1</td>
</tr>
<tr>
<td>10</td>
<td>Agriculture</td>
<td>Ugandan</td>
<td>51-250</td>
<td>1</td>
</tr>
<tr>
<td>11</td>
<td>Agriculture</td>
<td>Ugandan</td>
<td>51-250</td>
<td>1</td>
</tr>
<tr>
<td>12</td>
<td>Construction</td>
<td>Ugandan</td>
<td>51-250</td>
<td>3</td>
</tr>
<tr>
<td>13</td>
<td>Educational Services</td>
<td>Ugandan</td>
<td>&lt;50</td>
<td>1</td>
</tr>
<tr>
<td>14</td>
<td>Finance and Insurance</td>
<td>Mixed foreign/local</td>
<td>51-250</td>
<td>1</td>
</tr>
<tr>
<td>15</td>
<td>Finance and Insurance</td>
<td>Multi-national</td>
<td>51-250</td>
<td>2</td>
</tr>
<tr>
<td>16</td>
<td>Finance and Insurance</td>
<td>Multi-national</td>
<td>51-250</td>
<td>2</td>
</tr>
<tr>
<td>17</td>
<td>Finance and Insurance</td>
<td>Ugandan</td>
<td>501-750</td>
<td>4</td>
</tr>
<tr>
<td>18</td>
<td>Information</td>
<td>State control</td>
<td>251-500</td>
<td>3</td>
</tr>
<tr>
<td>19</td>
<td>Information</td>
<td>Ugandan</td>
<td>51-250</td>
<td>3</td>
</tr>
<tr>
<td>20</td>
<td>Information</td>
<td>Ugandan</td>
<td>51-250</td>
<td>3</td>
</tr>
<tr>
<td>21</td>
<td>Information</td>
<td>Ugandan</td>
<td>51-250</td>
<td>3</td>
</tr>
<tr>
<td>22</td>
<td>Manufacturing</td>
<td>Mixed foreign/local</td>
<td>51-250</td>
<td>4</td>
</tr>
<tr>
<td>23</td>
<td>Manufacturing</td>
<td>Mixed foreign/local</td>
<td>51-250</td>
<td>3</td>
</tr>
<tr>
<td>24</td>
<td>Manufacturing</td>
<td>Multi-national</td>
<td>251-500</td>
<td>2</td>
</tr>
<tr>
<td>25</td>
<td>Manufacturing</td>
<td>Multi-national</td>
<td>501-750</td>
<td>2</td>
</tr>
<tr>
<td>26</td>
<td>Manufacturing</td>
<td>Ugandan</td>
<td>&lt;50</td>
<td>5</td>
</tr>
<tr>
<td>27</td>
<td>Manufacturing</td>
<td>Ugandan</td>
<td>251-500</td>
<td>1</td>
</tr>
<tr>
<td>28</td>
<td>Manufacturing</td>
<td>Ugandan</td>
<td>251-500</td>
<td>1</td>
</tr>
<tr>
<td>29</td>
<td>Manufacturing</td>
<td>Ugandan</td>
<td>51-250</td>
<td>1</td>
</tr>
<tr>
<td>30</td>
<td>Manufacturing</td>
<td>Ugandan</td>
<td>51-250</td>
<td>1</td>
</tr>
<tr>
<td>31</td>
<td>Manufacturing</td>
<td>Ugandan</td>
<td>51-250</td>
<td>1</td>
</tr>
<tr>
<td>32</td>
<td>Manufacturing</td>
<td>Ugandan</td>
<td>51-250</td>
<td>1</td>
</tr>
<tr>
<td>33</td>
<td>Mining</td>
<td>Multi-national</td>
<td>251-500</td>
<td>3</td>
</tr>
<tr>
<td>34</td>
<td>Mining</td>
<td>Multi-national</td>
<td>51-250</td>
<td>1</td>
</tr>
<tr>
<td>35</td>
<td>Professional, Scientific and Technical services</td>
<td>Ugandan</td>
<td>51-250</td>
<td>3</td>
</tr>
<tr>
<td>36</td>
<td>Retail Trade</td>
<td>Multi-national</td>
<td>51-250</td>
<td>1</td>
</tr>
<tr>
<td>37</td>
<td>Utilities</td>
<td>State control</td>
<td>751-1000</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td><strong>Average (mean)</strong></td>
<td></td>
<td></td>
<td><strong>1.9</strong></td>
</tr>
</tbody>
</table>
5.3 Level of Attrition in the Workforce due to HIV/AIDS

Workers at the companies interviewed are not dying in large numbers from HIV/AIDS. Companies in manufacturing and agribusiness have no records to show worker deaths, since these companies have very limited sick leave policies and workers simply “fall off the payroll” after they stop coming to work. For companies with better data, worker mortality in the last year varied from 0% to 5.4% of the workforce. Loss of key workers was one reason why some companies have adopted a HAART benefit, or are considering it. But many companies felt no threat from HIV-based worker attrition.

It may well be that the peak of epidemic mortality has passed for companies in the modern sector of the Ugandan economy. Better education makes people more likely to respond to public health education programs, and companies in banking, telecommunications, the media and other business services have a highly educated workforce. Behaviors may have changed in this workforce, with a resultant decrease in the infection rate. One multi-national in the finance sector is perhaps illustrative: current employment places the company in the 50-249-worker category. From 1992-1996, the company lost 6 workers to HIV/AIDS. Since 1996, it has not lost a worker to the disease. This company does provide HAART to its employees, so the dramatically reduced death rate may reflect treatment as well as epidemiological change. Nevertheless, firms with highly educated workforces may be benefiting from the policies and trends that have reduced national HIV prevalence in Uganda. Although reduced HIV prevalence may lower management priority placed on HIV/AIDS, it can also make a comprehensive corporate response, including HIV treatment, a more manageable and predictable cost item.

5.4 Corporate Policies Towards HIV Positive Workers

16.2% of the companies interviewed reported that they had developed specific policies dealing with HIV-positive individuals (see Table 3). Where such policies exist, they generally call for non-discriminatory treatment in hiring, training and promotion. The policies are less explicit about any accommodation for workers sick with HIV and unable to perform their normal duties. In general, the written policies have some sections limiting the disclosure by supervisors and management of information that a patient is HIV positive. Development of such policies is more likely if the company is part of a multi-national enterprise, or has a professional human resources department. In the companies we interviewed without an HR Department, we found no written HIV policies.

---

¹Numerous studies show that maternal education improves child survival. As evidence mounted about the harmful effects of tobacco use, smoking rates fell first among better educated Americans. Data from the recent Uganda DHS shows condom use with non-cohabiting partners by women with a secondary education was five times the rate of women with a primary education and more than fifteen times the rate among women with no education. Males with a secondary education were 2.5 times more likely to use a condom with a non-primary partner than males with a primary education, and almost five times as likely to use a condom as those with no education.¹
5.5 Medical Benefits

5.5.1 The Role of Employer-provided (or -financed) Medical Services

There is no uniformity in the medical benefits offered by Uganda employers. As a general rule, the more highly educated and compensated the staff, the better the medical benefit. At one time, the medical benefit was offered through a company clinic or by reimbursing employees for medical expenses incurred, up to some fixed annual maximum amount. Very large employers ran a medical clinic that provided services beyond required occupational health care. There seems to be a trend to replace company-run claim reimbursement and medical clinic arrangements with insurance, TPA payment of claims or contract operation of clinics. This offers potential advantages in protecting the confidentiality of AIDS patients and in understanding and adding new benefits, such as ARVs. With a TPA, the company continues to bear the risk of medical care costs, while this risk is transferred to the health insurer in return for a fixed premium. Like the adoption of explicit corporate HIV/AIDS policies, the trend toward use of TPA and health insurance seems to be confined to divisions of multi-national corporations or relatively high wage employers operating in the more modern segment of the economy. Table 5 shows how administrative arrangements and covered benefits vary by corporate ownership and size.

While some companies offer extensive treatment through company-run clinics, others have a minimal on-site facility that deals only with occupational injuries. We therefore viewed the existence of an occupational clinic separately from the provision of a medical benefit.

---

Sometimes the company approved direct payment to the provider in advance, while in other cases they reimbursed the employee after the fact. Both arrangements give management access to information about a patient’s diagnosis.
Table 5: Benefits Provided by Interviewed Employers (% of companies in category)

<table>
<thead>
<tr>
<th>Benefit Mechanism</th>
<th>Benefits to Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Company Clinic</td>
<td>22 11 0 44 22 100 100 89 89 89 89 89</td>
</tr>
<tr>
<td>Direct Payment to Provider</td>
<td>25 50 0 0 0 25 25 25 25 25 25 25</td>
</tr>
<tr>
<td>Employee Reimbursement</td>
<td>8 17 33 17 4 75 71 67 63 50 46</td>
</tr>
<tr>
<td>Health Insurance</td>
<td>8 17 33 17 4 75 71 67 63 50 46</td>
</tr>
<tr>
<td>Third Party Administrator</td>
<td>100 100 89 89 89 89 89 89 89 89 89 89 89</td>
</tr>
<tr>
<td>Occupational Healthcare*</td>
<td>100 100 89 89 89 89 89 89 89 89 89 89 89 89</td>
</tr>
<tr>
<td>Primary Care</td>
<td>100 100 89 89 89 89 89 89 89 89 89 89 89 89</td>
</tr>
<tr>
<td>Inpatient Care</td>
<td>100 100 89 89 89 89 89 89 89 89 89 89 89 89</td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td>100 100 89 89 89 89 89 89 89 89 89 89 89 89</td>
</tr>
<tr>
<td>Spouse Coverage</td>
<td>100 100 89 89 89 89 89 89 89 89 89 89 89 89</td>
</tr>
<tr>
<td>Dependent Coverage</td>
<td>100 100 89 89 89 89 89 89 89 89 89 89 89 89</td>
</tr>
</tbody>
</table>

Ownership

| Multi-national (9) | 22 11 0 44 22 100 100 89 89 89 89 89 |
| Mixed Foreign Local (4) | 25 50 0 0 0 25 25 25 25 25 25 25 |
| Ugandan (24) | 8 17 33 17 4 75 71 67 63 50 46 |
| Total (37) | 14 19 22 19 8 76 73 68 65 57 54 |

Size of Workforce

| <50 (3) | 0 33 0 0 0 33 33 33 33 33 |
| 50-249 (20) | 10 15 20 30 5 70 65 60 60 60 60 |
| 250-500 (6) | 50 17 17 17 0 100 100 83 67 50 50 |
| >500 (8) | 0 25 38 13 25 88 88 88 88 63 50 |
| Total (37) | 14 19 22 22 8 76 73 68 65 57 54 |

Ownership

| Multi-national | 22 11 0 33 22 89 89 78 78 78 78 78 |
| Mixed Foreign Local | 25 25 0 0 0 25 25 25 25 25 25 25 |
| Ugandan | 17 13 33 13 4 83 75 63 25 25 |
| Total (37) | 19 14 22 16 8 78 73 57 62 38 38 |

Size of Workforce

| <50 | 0 33 0 0 0 67 33 33 33 0 0 |
| 50-249 | 15 10 20 20 5 65 60 45 55 40 40 |
| 250-500 | 50 17 17 17 0 100 100 83 67 33 33 |
| >500 | 13 13 38 13 25 100 100 75 88 50 50 |
| Total (37) | 19 14 22 16 8 78 73 57 62 38 38 |

*Occupational health care (on-site health for on-the-job injuries) is not counted as a employee benefit

Just as the existence and terms of a medical benefit vary substantially, corporate spending on medical benefits varies widely. Some companies reported that they spent nothing on medical benefits, or paid only for a part time occupational health nurse and for care for any injury occurring on the job. At the high end of the range, employers reported per employee medical costs of up to $417.00 per year. As noted below, basic medical insurance is available to corporate purchasers for an annual premium of $160 to $200 per covered adult.
### 5.5.2 HIV/AIDS Specific Services

Table 6 shows the AIDS-related services offered by the respondent companies that provide general medical benefit to the workers.

<table>
<thead>
<tr>
<th>#</th>
<th>Ownership</th>
<th>Size of workforce</th>
<th>VCT</th>
<th>STI treatment</th>
<th>OI treatment</th>
<th>HAART</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Mixed foreign/local</td>
<td>51-250</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>2</td>
<td>Mixed foreign/local</td>
<td>51-250</td>
<td>N</td>
<td>Y</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>3</td>
<td>Mixed foreign/local</td>
<td>51-250</td>
<td>N</td>
<td>Y</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>4</td>
<td>Mixed foreign/local</td>
<td>51-250</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>5</td>
<td>Multi-national</td>
<td>&gt;1000</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>N</td>
</tr>
<tr>
<td>6</td>
<td>Multi-national</td>
<td>&gt;1000</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>P</td>
</tr>
<tr>
<td>7</td>
<td>Multi-national</td>
<td>251-500</td>
<td>N</td>
<td>Y</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>8</td>
<td>Multi-national</td>
<td>251-500</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>9</td>
<td>Multi-national</td>
<td>501-750</td>
<td>R</td>
<td>Y</td>
<td>Y</td>
<td>D</td>
</tr>
<tr>
<td>10</td>
<td>Multi-national</td>
<td>51-250</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>11</td>
<td>Multi-national</td>
<td>51-250</td>
<td>R</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>12</td>
<td>Multi-national</td>
<td>51-250</td>
<td>R</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>13</td>
<td>Multi-national</td>
<td>51-250</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>14</td>
<td>State control</td>
<td>251-500</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>15</td>
<td>State control</td>
<td>751-1000</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>16</td>
<td>Ugandan</td>
<td>&lt;50</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>17</td>
<td>Ugandan</td>
<td>&lt;50</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>18</td>
<td>Ugandan</td>
<td>&lt;50</td>
<td>N</td>
<td>N</td>
<td>NA</td>
<td>N</td>
</tr>
<tr>
<td>19</td>
<td>Ugandan</td>
<td>&gt;1000</td>
<td>N</td>
<td>Y</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>20</td>
<td>Ugandan</td>
<td>&gt;1000</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>21</td>
<td>Ugandan</td>
<td>251-500</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>22</td>
<td>Ugandan</td>
<td>251-500</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>23</td>
<td>Ugandan</td>
<td>501-750</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>24</td>
<td>Ugandan</td>
<td>51-250</td>
<td>N</td>
<td>N</td>
<td>NA</td>
<td>N</td>
</tr>
<tr>
<td>25</td>
<td>Ugandan</td>
<td>51-250</td>
<td>N</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>26</td>
<td>Ugandan</td>
<td>51-250</td>
<td>N</td>
<td>N</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>27</td>
<td>Ugandan</td>
<td>51-250</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>28</td>
<td>Ugandan</td>
<td>51-250</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>29</td>
<td>Ugandan</td>
<td>51-250</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>30</td>
<td>Ugandan</td>
<td>51-250</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>31</td>
<td>Ugandan</td>
<td>51-250</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>32</td>
<td>Ugandan</td>
<td>51-250</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>33</td>
<td>Ugandan</td>
<td>51-250</td>
<td>R</td>
<td>N</td>
<td>N</td>
<td>N</td>
</tr>
<tr>
<td>34</td>
<td>Ugandan</td>
<td>51-250</td>
<td>R</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>35</td>
<td>Ugandan</td>
<td>51-250</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>36</td>
<td>Ugandan</td>
<td>51-250</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>37</td>
<td>Ugandan</td>
<td>51-250</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
</tr>
</tbody>
</table>

*R means the service is paid for, but referred to a service provider.*
Companies have been willing to sponsor some HIV/AIDS education for their workers. Of the companies interviewed, 54% (20) sponsored some HIV/AIDS education for their workforce. However, only 40.5% (15) companies interviewed have ongoing AIDS education programs, and only 10.8% report that they have trained employees as peer educators. Most often, companies report obtaining HIV/AIDS education from NGOs or from the Federation of Uganda Employers.

About a third of the companies (11 of 37) interviewed have made condoms available to employees, at least at some time in the past. Some of these companies offered condoms, which they received for free, but did not continue the program once the free supply ran out.

As detailed in Table 6, 35.1% of respondents (13) reported that VCT was available to employees, either through a company-sponsored medical plan or a special program. The availability of treatment for STIs and opportunistic infections depended on the company’s general support for employee medical benefits, and the level of control exercised in administering those benefits. If the employee has medical coverage, s/he will likely receive treatment for sexually transmitted infections and simple opportunistic infections through the medical plan. When the company elects to use a health insurer or third party administrator to provide medical benefits, more sophisticated care for opportunistic infections directly linked to HIV/AIDS has been excluded under the terms of the medical plan. HAART has similarly been excluded by such plans unless the company specifically agrees to pay an additional amount to cover HIV-related conditions and HAART. Of the 37 companies interviewed, 10 (27%) specifically reported that they offer full HIV/AIDS coverage, including HAART. One additional company reported that they were in the process of making a decision to offer HAART benefits.

For employees facing death or medical retirement due to AIDS, companies are not providing special counseling. The interviews asked about both legal advice and psychological counseling for such employees. Although some NGOs and self help groups have been providing counseling to dying patients in Uganda, we found no evidence of similar formal programs in the corporate setting.

### 5.6 Other Benefits Potentially Used by Workers Ill with HIV/AIDS

Most companies offer some form of sick leave, although a few companies in the agribusiness and manufacturing sector said that they pay only for days worked, and make no allowance for paid sick leave. Sick leave policies reported are shown in Table 7:
Table 7: Company Sick Leave Policies (Annual Maximum)

<table>
<thead>
<tr>
<th>No of days of leave allowed</th>
<th>Leave at full pay</th>
<th>Leave at half pay</th>
<th>Leave with no pay</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0-29</td>
<td>30-90</td>
<td>&gt;90</td>
</tr>
<tr>
<td>All employees</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>14</td>
<td>16</td>
<td>1</td>
</tr>
<tr>
<td>1</td>
<td>16</td>
<td>13</td>
<td>2</td>
</tr>
<tr>
<td>2</td>
<td>25</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Management only</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>10</td>
<td>18</td>
<td>2</td>
</tr>
<tr>
<td>1</td>
<td>15</td>
<td>14</td>
<td>2</td>
</tr>
<tr>
<td>2</td>
<td>26</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

As with medical benefits, some Ugandan companies appear to allow considerable management discretion in the area of leave determination. A key employee or long time loyal retainer may be informally allowed a greater amount of sick leave (particularly if unpaid) before being discharged. When companies codify their sick leave policies and create a professional HR Department, it becomes more difficult to use such ad hoc policies.

Most companies (31 of 37) reported that they provided some benefits for workers who die while still employed. Traditionally, this has included a contribution towards funeral expenses. Within this group, a majority (18 of 31) reported that they paid death benefits to the estate or survivors in addition to funeral-related allowances.

5.7 Pressures for Change

Managers said they feel little outside pressure to improve HIV/AIDS polices or offer HIV/AIDS treatment benefits. Some felt that peer pressure through the Federation of Uganda Employers (FUE) motivated the firm (or at least the HR manager) to consider adopting an HIV/AIDS policy and offering some HIV education and prevention services. Divisions or subsidiaries of multi-national companies feel pressure from headquarters to adopt HIV/AIDS policies. Local NGOs were occasionally cited as a source of pressure to adopt HIV/AIDS policies. Conversely, shareholders and bankers were never cited as a source of such pressure, and only a little pressure was felt from the Uganda government. Ugandan-owned companies in industries such as agribusiness and manufacturing made it clear that they viewed the HIV/AIDS epidemic (and any treatment of AIDS) as a government, not a business, responsibility. However, these companies did indicate that they would respond to a government requirement, for example, to adopt an HIV policy.

Most employers said that they did not feel pressure from employees to add HIV/AIDS benefits. This was confirmed in the employee representative interviews, where respondents generally rated wages and working conditions as more important labor/management issues than HIV/AIDS policies and benefits. However, HIV/AIDS is a more important issue for the workers than it is for management, and workers are more concerned than their employers think they are. A disparity between total lack of employer interest in HIV/AIDS and a modest level of employee concern was most notable in Ugandan-owned agribusiness and manufacturing industries.
Where the employer had a well-developed HIV policy and provided HIV benefits, employee representatives were generally aware of these policies and applauded the company initiative. In only a few companies was the employee representative interviewed aware of HIV positive employees who had self-identified and lobbied for benefits. When asked why employees did not pressure the employer for better HIV benefits, respondents stated that stigma prevents employees from being more proactive, or that the respondent was unaware of any HIV positive employee.

5.8 The Dynamics of Policy Change

A focus group was held with representatives from three companies that have a comprehensive HIV policy and offer HAART benefits. Two of the companies have offered HAART for over two years, the third recently made the benefit available. Two of the companies are parastatal; the third is the local branch of a large multi-national. In all cases, the participant in the focus group was a Ugandan manager in the Human Resources Department.

For the two state-linked firms, the drive to add a HAART benefit came from the Human Resources Manager, who had known key employees who had died of the disease. One of the managers explored the cost and availability of antiretroviral therapy, then “sold” a new policy of antiretroviral coverage to the Managing Director and the Board.

At the multi-national, the policy change was triggered, at least in part, by a realization of the amount of money being spent for palliative medical care for employees with AIDS. The company recently hired a TPA to manage its medical benefit. Better claims processing and reporting by this administrator showed that a substantial portion of all medical benefits were being spent on hospitalization of terminally ill individuals with AIDS. At the same time, the parent company was pressing local subsidiaries to adopt a policy on HIV, and providing technical assistance in developing such policies. Pushed by the HR department, local management decided to set aside a fixed amount for antiretroviral treatment in the next year. This budget was developed with technical advice from the claims administrator. What will happen if uptake in excess of the predicted levels drives costs above the budgeted amount is unclear.

5.9 The Role of Information in Policy Change

The focus groups confirmed that human resource managers are pressed to give top management estimates of the costs of covering antiretroviral therapy. These top managers are not necessarily opposed to spending money on enhanced HIV treatment, but want to know that a HAART benefit will not become an unpredictable, open-ended expenditure. When asked what would influence the company to adopt more “generous” policies towards HIV positive employees, 59.5% of the employer respondents cited the need for better data on costs and benefits of enhanced treatment. 81.1% of the
respondents said that they would be more likely to act if they had better information on what other employers were doing.

The sources of additional information on the costs and benefits of treating HIV are limited. It is not easy for advocates of enhanced HIV benefits to answer the questions posed by senior management: How do we structure the benefit? How much will it cost? Multi-nationals get much of the information they need to develop HIV policies from regional or global corporate headquarters. Some multi-nationals even provide a model HIV policy for local offices. This “technical assistance” role should not be underestimated in explaining the better performance of multi-national companies with respect to HIV policies and benefits.

Local sources of information are more limited. The Federation of Uganda Employers was often cited, both as a source of employee HIV education, and as a forum where human resource managers could obtain information on HIV. Some companies also looked to NGOs such as TASO for HIV training and advice. To determine the costs of expanding medical care benefits to cover HIV treatment, companies turned to their existing medical provider, insurer or claims administrator. For employers that do not have such a relationship—a company that offers no real medical benefit, or reimburses employee medical claims through an in-house accounting system—there is no readily identifiable way to estimate the likely costs of adding HIV benefits. No company interviewed knew with certainty the percentage of employees who are HIV positive, and no respondent reported conducting an anonymous workforce seroprevalence study such as those that have become commonplace in South African industry. Company representatives that ventured an opinion on the level of HIV infection in the workforce based this on observation of the number of employees who have taken ill with AIDS-like illnesses, or extrapolated from national prevalence estimates.

6. The Employee View

6.1 HIV/AIDS in the Hierarchy of Employee Concerns

Bread and butter economic issues—salaries and wages, job security—clearly trump HIV policies and benefits in the hierarchy of worker concerns. Employee representatives were asked, “From the point of view of members/constituents, how important an issue are the Company’s HIV/AIDS policies?” On a scale from 1 (“Not an issue in employee relations”) to 5 (“The most important issue in employee relations”), the average response was 2.3, compared to 1.9 when employer responses are rated on the same scale. The histogram (Graph 1 below) shows the distribution of responses. There was no notable difference in the responses between companies where we interviewed a member of a formal employee organization and those where we interviewed an “interested” employee identified by management. An employee representative at a manufacturing company summed it up this way: “(Union) members are not even aware that it is possible for an
employer to offer HAART. They are pre-occupied with salaries and job security.” Where workers had bargained collectively with management, HIV/AIDS had not been a subject of such bargaining.

**Graph 1: Employee Ranking of Importance of HIV/AIDS Policies and Benefits as an Employee Relations Issue**

<table>
<thead>
<tr>
<th># of Employees responding</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>9</td>
<td>1</td>
</tr>
<tr>
<td>8</td>
<td>2</td>
</tr>
<tr>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>3</td>
<td>5</td>
</tr>
</tbody>
</table>

**Legend for Graph 1**

1. HIV/AIDS is not an issue in employee relations
2. HIV/AIDS is a secondary issue for some members, rarely raised with the employer
3. HIV/AIDS policies/services are important for some members, discussed with the employer, but not in the top issues for management
4. HIV/AIDS is an important issue to many members, often discussed with the employer, but not the most important issue for the membership as a whole
5. HIV/AIDS is the most important employee relations issue

**6.2 Specific Concerns**

When asked why employees are not more concerned about employer HIV policies or benefits, employee representatives confirmed that stigma is still a powerful deterrent to lobbying for such benefits, or to requesting them when made available. In addition to any shame in revealing that they are infected, workers worry that employers may discriminate against them in the future (in promotions and layoffs) if they disclose that they are HIV positive. Employee representatives said that employees rarely disclose their HIV status to fellow workers. One representative noted that employees never bother to
get tested, so they do not know their HIV status and do not raise the issue with management. However, one union representative said that the union does advocate for the protection of workers who are weakened by AIDS and seeks to enable a worker to retain his job when he has recovered from an ailment (opportunistic infection).

Where the employer has adopted HIV policies or provides HIV benefits, the employee representatives were generally knowledgeable about these initiatives and approved of them. Those interviewed generally considered themselves to be reasonably informed on HIV prevention and the availability of treatment, and several advocated greater corporate prevention and treatment efforts even while recognizing that expansion of such services was not at the top of the list in collective bargaining. In a company that had not addressed HIV/AIDS, the worker representative wanted to see the employer hire experts to run an AIDS education program and send workers to HIV/AIDS seminars. One representative lamented that the company focused on maximizing production, not worker training, and wanted to see a condom distribution program and more in-house HIV training workshops. Another representative from a large employer felt that the two trainers currently available to run HIV training programs were insufficient given the size of the staff.

Despite the relatively low ranking of HIV as an issue to be addressed with management, employee representatives see added HIV benefits as important. Table 8 shows how employee representatives rank possible changes in health benefits. Not every employee representative was willing to answer this question, or felt able to assign a priority to each benefit change: this explains why the rows do not total to 26 (the number of interviews). 17 of the 26 respondents said that it was a high priority for the employer to provide coverage for HAART. One multi-national employer acknowledged that employees want ARV coverage because they feel that only treating opportunistic infections will not “prolong a healthy life.” Fifteen of the 26 employee representatives gave high priority to eliminating any exclusion for HIV/AIDS in a medical benefit. Better HIV/AIDS coverage received the largest number of “high priority” responses in this question. The relatively high level of support for expanded medical benefits for dependents carried over to the desire for coverage of HAART. One representative stated it well: “The employee, spouse and children are in a partnership. They need one another. You cater for the employee, but the partner is down. It makes no sense. These people are intimate, and what happens to one affects the other.”

---

h Employee representative; multi-national employer.
Table 8: Employee Representative Ranking of Priority for Improvement in Medical Benefit

<table>
<thead>
<tr>
<th>Benefit Improvement</th>
<th>Number showing priority as:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>High</td>
</tr>
<tr>
<td>Add/expand outpatient services</td>
<td>8</td>
</tr>
<tr>
<td>Add/expand inpatient services</td>
<td>5</td>
</tr>
<tr>
<td>Add/expand pharmaceutical benefits</td>
<td>6</td>
</tr>
<tr>
<td>Increase the current annual ceiling on medical benefit payments</td>
<td>9</td>
</tr>
<tr>
<td>Broaden coverage for dependents</td>
<td>11</td>
</tr>
<tr>
<td>Reduce co-payments or deductibles</td>
<td>0</td>
</tr>
<tr>
<td>Reduce employee contribution to health insurance premium</td>
<td>0</td>
</tr>
<tr>
<td>Provide access to higher quality providers</td>
<td>13</td>
</tr>
<tr>
<td>Eliminate any exclusions for chronic diseases</td>
<td>6</td>
</tr>
<tr>
<td>Eliminate any exclusions for maternity</td>
<td>5</td>
</tr>
<tr>
<td>Eliminate exclusion for HIV/AIDS</td>
<td>15</td>
</tr>
<tr>
<td>Provide coverage for HAART</td>
<td>17</td>
</tr>
</tbody>
</table>

7. What are Private Sector Medical Providers Doing?

7.1 HIV/AIDS Services Available

All nine of the private providers identified for interview from the government inventory of clinics providing HAART are currently offering the service. So are the three clinics, which also run health maintenance organizations/insurance programs, and are discussed in Section 8I. Eight of the nine clinics interviewed for this section reported the number of private patients currently on HAART: a total of 1,281 patients. Two thirds (834) of these were at Nsambaya Hospital. One clinic had 150 HAART patients currently, and most of the rest had between 40 and 80, with one reporting 20 and the smallest reporting 12 HAART patients.

HIV treatment, including antiretroviral therapy, is not a new service for any of these clinics. Most reported they have been offering ARVs since 1999 or earlier. Six clinics that reported a total of 232 private patients on antiretroviral therapy in 1999 reported 1,194 HAART patients at the time of the interview, more than five times the number four years earlier. One clinic increased the number of HAART patients from 4 to 150 in the four year period, but most reported the patient population growing by four to five times.

7.2 Cost, Quality and Access

All clinics interviewed perform VCT. Some, but not all, use trained non-physician counselors for this service. In several of the clinics, it is the doctor, not a nurse or counselor, who performs VCT-related counseling. Charges for VCT counseling range from $0.50 to $10 plus an additional $4 to $10 for the test itself. Some clinics have no separate “VCT fee,” but presumably charge for a physician visit plus the test itself. None of the clinics use non-physician counselors to work with patients on issues related to
HAART: adherence, expectations for side effects, etc. This is very much a function that private physicians reserve to themselves.

Most private facilities do not have the equipment to perform CD4 or viral load tests. Patients are referred, or samples taken and sent for analysis, to JCRC or the Viral Research Institute. Typical charges are $23 to $35 for CD4, $100 to $125 for a viral load test.

Typically, patients obtain their antiretroviral drugs through the treating clinic, and not by taking a prescription to a pharmacy. Some clinics cover the costs of physician consultation by marking up the drugs, others charge a separate amount for consultation (per visit or per month) and pass the drugs through at cost. Most will charge additional amounts for consultation and drugs for treatment of opportunistic infections, although some include the consultation for such treatment in the standard monthly charge (a “package price” for outpatient AIDS care). Charge policies (fall 2003) at the nine clinics interviewed are shown in the following table.

<table>
<thead>
<tr>
<th>#</th>
<th>No. of HAART patients</th>
<th>Inclusive Monthly Fee</th>
<th>Monthly drug cost (1st line therapy)</th>
<th>Explicit physician fees</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>40</td>
<td>$100-125</td>
<td>$75-95</td>
<td>NA</td>
</tr>
<tr>
<td>2</td>
<td>834</td>
<td>NA</td>
<td>$63-68</td>
<td>$2.50 per visit</td>
</tr>
<tr>
<td>3</td>
<td>12</td>
<td>$35</td>
<td>$32.50</td>
<td>NA</td>
</tr>
<tr>
<td>4</td>
<td>Not available</td>
<td>$40-50</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>5</td>
<td>150</td>
<td>NA</td>
<td>$63</td>
<td>NA</td>
</tr>
<tr>
<td>6</td>
<td>75</td>
<td>NA</td>
<td>$30</td>
<td>NA</td>
</tr>
<tr>
<td>7</td>
<td>20</td>
<td>NA</td>
<td>$80</td>
<td>NA</td>
</tr>
<tr>
<td>8</td>
<td>80</td>
<td>$50</td>
<td>$35</td>
<td>NA</td>
</tr>
<tr>
<td>9</td>
<td>70</td>
<td>NA</td>
<td>$80</td>
<td>$20 per month</td>
</tr>
</tbody>
</table>

NA: not available

The lower drug costs reflect the use of Indian-manufactured generics, notably Trioimmune. Higher costs are typically brand name drugs, often Combivir plus a third agent. Several doctors report that they and their patients are wary of generic products. As can be seen, triple therapy and accompanying medical consultation can be obtained in the private sector beginning at an annual total cost of $400-$600, or $1.10 to $1.65 per day. Laboratory monitoring tests are charged in addition to these amounts. If Western protocols were used, laboratory costs in the first year of triple therapy could nearly equal the low end of this range of costs for drugs and consultation.\(^1\) It is not surprising that some doctors said they do not always order CD4 or viral load tests. Besides the additional cost to the patient, doctors express concern about the delays in obtaining test results, and some state that they are skeptical of the accuracy of the tests.

\(^1\) 2 X $100 for viral load, plus 4 X $25 for CD4, plus liver function and other tests to monitor for side effects.
Physicians treating patients in these clinics seem to acquire their knowledge of HIV in two different ways. Some are specialists who have been trained in research or government programs at facilities like JCRC, Mildmay or Mulago, and have continuing practices at these facilities while moonlighting at the private clinic. Others, however, are full time private practitioners who acquired their knowledge of HIV and HAART from medical school training, continuing medical education, textbooks, and pharmaceutical package inserts.

In general, the clinics provided comprehensive HIV services in addition to testing and antiretroviral treatment. All clinics provided care for simple opportunistic infections and sexually transmitted diseases. Seven of the nine clinics managed inpatient care for HIV patients. Seven of the nine also treat TB and more complicated opportunistic infections, while the other two refer these to mission or government hospitals. Only four of the nine provided PMTCT. The others refer pregnant HIV positive women, usually to Nsambaya Hospital. Some of the clinic physicians who were general practitioners start patients on first line therapy, but refer children and pregnant women to a specialist (particularly if the patient can afford it). At least one physician routinely refers patients after the first three months of HAART treatment.

### 7.3 Constraints to Expansion

Physicians working in these clinics see treatment cost as the number one barrier to expansion of the number of patients treated, and to improved adherence by those who start on HAART. All the clinics see many patients who need HAART treatment but cannot afford it. One clinician estimated that half of patients who start on HAART drop out, usually for economic reasons, and usually within the first six months of treatment. Treatment failure is rarely the reason for dropping out; this clinician estimated that about 7% of those who go on first line HAART fail to respond to the ARVs prescribed.

While providers are aware of the danger that poor adherence will result in the virus developing resistance to the prescribed ARVs, the clinics do not seem to have protocols for stopping treatment in non-adherent patients. Presumably, these patients ultimately drop out of therapy because the expense is not producing the expected improvement in health status. Respondents were asked if they offer directly supervised ARV therapy (DOT), and if they have specific criteria for taking non-compliant patients off antiretroviral therapy. None provide daily directly observed ARV therapy, but some see the patient as often as once a week to distribute the prescribed drugs, and this gives them a chance to query the patient about adherence. No clinician identified specific criteria for terminating ARVs, and it appears that it is rarely the physician’s decision to terminate HAART.

Five of the nine clinics said that they would have no problem handling double the current demand for HAART if this were to develop due to a fall in price or additional coverage from employers or external donors. The two providers with the largest number of
HAART patients today anticipate problems if asked to double their caseload. Both foresee the same three needs: more space, more trained physicians, and a CD4 testing machine. While the typical clinic with a few HAART patients in a large caseload can quickly increase the number of patients in treatment, there is a clear perception from those treating the largest number of HAART patients that more trained physicians will be needed for a rapid major expansion of private sector care.

Table 10 shows how these private providers perceive the factors affecting demand for HAART and the barriers to increasing the number of private HAART patients. Some respondents had no opinion on the ability of certain factors to change patient demand, so we did not receive nine responses for every factor.

<table>
<thead>
<tr>
<th>Factor</th>
<th>Number of Respondents Rating the Factor as:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Very Important</td>
</tr>
<tr>
<td>More employers provide explicit coverage for HAART</td>
<td>2</td>
</tr>
<tr>
<td>More insurance policies provide explicit coverage for HAART</td>
<td>2</td>
</tr>
<tr>
<td>HAART drugs available at government cost</td>
<td>1</td>
</tr>
<tr>
<td>Further fall in price of ARVs</td>
<td>8</td>
</tr>
<tr>
<td>Government contracts out to private facilities for HAART for state employees or other groups</td>
<td>1</td>
</tr>
<tr>
<td>Better public education about HAART</td>
<td>0</td>
</tr>
</tbody>
</table>

*Respondents occasionally omitted options

Employer or insurance coverage for HAART, or contractual arrangements for other patients, all have the same effect as a lower drug price; to increase the number of patients who can afford to obtain ARVs in the private sector. When asked how much of a fall in the effective price of the drugs would be necessary to double the number of HAART patients, four respondents guessed about 50%. Two guessed that a 30% fall in price would be sufficient to double patient numbers, while one thought that more than a 50% fall in drug price would be required.

Providers perceive that firms reimbursing medical costs directly, rather than using an insurer or third party administrator, make very selective decisions on antiretroviral therapy coverage. To be sure of reimbursement, the provider does not begin expensive treatments until it receives a medical treatment order from the employer. The willingness to give such an order will depend on the place of the employee in the hierarchy and his/her perceived value to the company. Executives and critical skilled workers may receive approval for HAART, while unskilled workers may not. Where annual limits on total benefits would preclude HAART, a worker so favored may be exempted from such ceilings. In addition, workers may be reluctant to request a medical treatment order for
HIV from the company because it would reveal the worker’s HIV status. A shift to health insurance or uniform third party medical benefits administration may have the effect of increasing the number of patients on HAART: because any covered HIV benefit will be available to all employees, and because the employee need not seek a medical treatment order from management.

Some providers were wary of any government contracting for private sector care, although they recognize that it could increase demand. We asked an additional question not shown in Table 9, seeking to find if providers thought an explicit “user fee” policy for ARV’s in government clinics would effect private demand. Are some patients waiting for “free” government drugs rather than seeking private sector care? This question was difficult to explain to the respondents and most did not answer it. To the extent they did, they did not think that announcement of ARV user fees by the government would have much of an effect on the private market.

8. The Role of Health Insurance

As in most African countries at a level of development similar to Uganda, private health insurance policies are on offer, but are used by only a small fraction of the population----those working in a few modern industries with highly compensated employees. Traditionally, companies that offered a medical benefit to their employees directly reimbursed the employee for medical bills presented, usually up to some maximum annual amount. There was little confidentiality in this payment scheme---the accounting department was aware of every major illness. This lack of confidentiality may be one reason that employees are reluctant to come forward for HIV treatment, even when such services are eligible for employer reimbursement. Employee reimbursement plans also are subject to substantial discretion in some companies, with the company reimbursing more medical costs for an influential or highly valued staff member.

For a number of reasons, there seems to be a modest trend in Uganda (among large and sophisticated employers) to shift away from direct medical reimbursement programs to health insurance or third party administrator arrangements. Insurance or third party administration offers more uniform application of rules governing medical benefit, and insurance offers the company a more predictable annual expenditure. The predictability of medical expenses is clearly of importance to senior managers. Of the companies interviewed, 78.4% offered a medical benefit, 20.7% of these offered the benefit through a health insurer, and an additional 10.3% used a third party claims administrator. The three entities interviewed in Kampala (African Air Rescue, International Air Ambulance and Savannah Sunrise Clinic) that offer insurance or HMO-type products insure approximately 19,000 lives. The principal Third Party Administrator (Aon) handles claims on another 7,000 lives. Just fewer than 11,000 formal sector employees are covered by these modern health insurance plans or third party payment arrangements, with a total of 26,000 beneficiaries.
A few employers (usually in a remote location) run a medical clinic for their workers that treats general illness, not just occupational injuries. Other companies offering a medical benefit still reimburse employee medical costs directly, or pay bills submitted by a preferred provider.

To some extent, the major health insurers in Uganda are responding to the AIDS epidemic. However, at the time of the interviews (October 2003) standard health insurance products did not cover anything more than the most basic care for opportunistic HIV infections. STD treatment and VCT are covered in all the basic benefit packages, while all exclude care for high cost opportunistic infections and Karposi’s sarcoma. Two of the three insurers treat TB within the basic benefit package; the third refers this (and fungal infections requiring fluconazole) to government clinics where treatment is free. The standard benefit package offered through the Third Party Administrator includes most services for opportunistic infections, but excludes ARVs unless the employer specifically requests HAART coverage.

The two largest provider-based insurance plans (International Air Ambulance and African Air Rescue) sold a “rider” to employers that extends the policy to cover HIV---both treatment of opportunistic infections and supply of HAART. This coverage can be purchased for about $40 per covered adult per year in addition to the basic annual premium of $160 to $200 per adult per year charged for a package of inpatient and outpatient services.¹ The basic policies typically have an annual inpatient expenditure limit of $4,000 per insured. One insurer offers a “lower option” product with extensive outpatient care and an inpatient limit of $250 to $375 per year for a premium of $90 per year. This insurer does not yet have sufficient experience to estimate an incremental premium for coverage of HIV/AIDS treatments.

One insurer (African Air Rescue) offers a combined insurance and third party payment arrangement that can be extended to cover HIV/AIDS. The client firm buys the insured basic benefit package for its employees, and then provides a separate fund from which AAR pays for services excluded from the basic benefit. With the employer’s approval, both pre-existing chronic conditions and HIV/AIDS can be treated using this fund.

In January 2004, after completion of the interviews, International Air Ambulance (IAA) announced that it would provide treatment of AIDS, including first line antiretroviral therapy, to insured employee groups at no additional cost above the standard premium. IAA has apparently concluded that it can afford to do this because of the moderate prevalence rate in its insured population and the potential to avoid the costs of treating opportunistic infections that it cannot now avoid.

Aon, the company offering Third Party Administration (TPA) services in this market, will arrange to cover HIV and HAART as well, passing the costs through to the employer. Both insurance and a TPA arrangement offer the potential to “blind” the employer to the identity of the individual employees receiving HIV services. Since

¹ These prices are for care obtained through private providers within Uganda. More expensive options are sold which include medical evacuation and treatment outside the country.
insurers are assuming the risk, the employer has no need to monitor claims payments and potentially learn the identity of HIV patients. With TPA, medical costs are “passed through” to the employer and the extent to which the Administrator protects confidentiality is a function of its contract with the employer. Diagnosis-related information on specific employees may be released to the employer under the TPA contract.

There is no question that stigma remains an issue that inhibits patients from obtaining employer-supported HIV care. One provider described a case with a multi-national that offers a generous medical benefit to its employees. The employer was willing to pay for ARVs, but was concerned about fraud, and required that any HAART patient be identified. In this case, the patient received ARVs, but elected to pay for them privately rather than disclose his identity to the employer. The Aon representative also found that stigma reduces demand for ARVs in the programs it administers for employers willing to pay for HAART. On the other hand, one of the insurers observed that, by the time that an employee needs ARVs, the employer is aware of the illness and has a pretty good idea of the cause.

The two health insurers interviewed run their own clinics, and an additional local clinic is beginning to market an HMO-type product based at its facility. All three have physicians with experience and training in management of antiretroviral therapy. None run their own laboratories providing CD4 or viral load tests, although at least one is considering purchase of the necessary equipment. Such tests are provided at the physician’s order by separate national laboratories, but are included in the “HIV benefit” when it is purchased by the employer. The TPA channels all patients requiring HAART to JCRC and its satellites. Although this study did not specifically measure the quality of care provided through insurance and third party administrator programs, there was an emphasis on adhering to sound treatment protocols among the insurers/HMOs, while the TPA limits HAART benefits to a recognized leader in the field, JCRC.

The smallest of the insurers interviewed is reluctant to offer a product including ARV coverage because it does not have enough data and expertise to set a premium for this benefit. This entity was also concerned that adding ARVs to the standard benefit would cause “sticker shock” among employers and render the basic policy unmarketable.

Reinsurance of HIV risk is an issue for these insurers. Where they have reinsurance, it does not extend to HIV coverage. At the two plans that offer insured HIV coverage, the plan itself retains all of the risk associated with this additional benefit, and usually only agrees to offer the supplemental coverage after it has some experience with the insured group. More generally available reinsurance covering HIV care might encourage an insurer to offer HAART coverage before the insurer has experience with the level of claims and distribution of illness in a newly insured population.
9. The Future: How Much of a Role for the Private Sector?

Analysis of the potential for development of a private sector response may best be structured by separately considering “supply” and “demand” for HIV care and treatment services. For supply, we must ask the questions: To what extent is the private sector now supplying HIV services? Are these of reasonable quality? How readily can this supply be expanded, and what are the barriers to expansion? What policies would encourage the expansion of HIV diagnosis and treatment services in the private sector?

In looking at “demand,” we must ask how much private sector employers will contribute to the purchase of HIV prevention, diagnosis and treatment services for their employees and employee dependents. In addition to the assessment of the current level of corporate support described above, we must ask how much more employer-driven “demand” could be mobilized, and what actions are necessary to mobilize this demand.

The supply of private sector HIV services is already substantial, at least in the Kampala-Entebbe area. This is consistent with a long history in the developing world where those with money seek acute outpatient care and much chronic disease care from private sector physicians and clinics. Private clinics offering HIV services from VCT through opportunistic infections and HAART are an extension of this tradition. All of the clinics interviewed see patients with HIV and offer VCT. These nine clinics are already treating 1,281 patients with HAART, and estimate that the number treated would double if drug prices fall by 50%. Presumably, employer contributions, which effectively cut the cost of treatment by this amount, would also lead to an expansion in private sector demand for HAART.

The availability of private sector physical facilities is only a partial barrier to expanding the number of patients in HAART treatment. Many candidate patients are already being seen for opportunistic infections in the private sector, but are unable to afford HAART drugs. Continuing decreases in the price of ARV drugs will, by themselves, increase the uptake of HAART at these clinics. Constraints to expansion include the lack of formal training for some providers and counselors, as well as the fact that lab tests (CD4, viral load) are expensive, and not currently available through the actual providers outside the centers of clinical excellence (JCRC). Training programs oriented towards private sector physicians and counselors could increase the quality of care in some of the clinics interviewed, where formal training in HAART was lacking and physicians were largely self-taught. However, we note that many of the better clinics offer consultation with doctors trained in HAART in government and research programs, and there will likely be further trickle down of trained staff as training of public sector providers occurs with the expansion of public HAART treatment.

At the time of the study, drugs for first line triple therapy are obtained from private distributors and the UNAIDS-organized import program and are sold in private sector clinics for $30 to $100 per month. If international efforts and government tenders bring the price of antiretroviral drugs down substantially, there should be a way of making these prices available to private clinics on the condition that such savings are passed
through to patients. The number of patients obtaining HAART in the private sector would then expand, even without expansion of employer contributions.

Our research shows that many private sector patients are treated without benefit of the key laboratory tests (CD4, viral load) used in most HAART protocols. Private sector clinics do not offer these tests themselves, and are reluctant to order patients to go elsewhere for such tests because of the high cost—and some concern about the accuracy of the test results. Innovative financing arrangements for laboratory equipment might encourage additional clinics to perform the tests themselves. These clinics are currently put off by the high capital costs of purchasing the equipment. If the machines could be leased, with the supplier offering training and reagents and recapturing the capital cost through a reasonable per test fee, the number of testing sites might increase and the cost could come down. In the alternative, new technologies for rapid tests of CD4 count or viral load might lower the cost of improved quality care. It is unlikely that many public sector HAART patients will receive the optimum number of tests; antiretroviral therapy for most in a vastly expanded public treatment program will be based on clinical indications and simple tests (white cell count). Should private sector clinics doing HAART be held to a higher standard? In fact, accreditation to perform HAART at this time does not require a provider to offer the necessary monitoring tests on its own.

The interviews show that the physician is both counselor and medical manager when HAART is offered in the private sector. There are several reasons for this. Patient confidentiality is maintained when additional individuals are not involved in the care. Patients paying private sector fees expect to see a physician, not a counselor or nurse. And the physician may have more credibility with the patient. On the other hand, physician supply is limited, and there is little time for lengthy patient education sessions. This may be one factor, in addition to high drug costs, contributing to the high rate of HAART treatment dropouts. In the West, and in South Africa, nurses and non-physicians with special training handle much of the burden of patient counseling. As the cohort of HAART patients at a clinic expands, care may be more economically provided if non-physicians are used for patient counseling. An experiment in the use of trained counselors at one or more private clinics may be indicated.

In summary, private sector “supply” of HAART services will expand relatively spontaneously. In urban areas, the number of additional patients treated and the quality of care will depend on:

1. The price to the patient of antiretroviral drugs (including any employer or public subsidies for such costs);
2. The availability of training for private practitioners, either directly or through “trickle down” from government supported training programs. The busiest private HIV clinics will have to acquire additional physicians, which could be a drain on the public system;
3. Innovative arrangements to lower the cost of monitoring tests;
4. Expanding the use of non-physician counselors to enhance patient education and adherence.
The above summary applies to providers in major urban areas, particularly those that are in close proximity to a government or mission hospital that offers HAART and serves as a source of “moonlighting” medical practitioners. In more remote areas, supply will not expand so spontaneously, as all of the problems of drug supply, provider training, critical minimal patient volumes, and supervision will also apply in the private sector. However, most Ugandans with enough money (or employer support) to purchase HIV care live in urban areas. The exception is workers in a few resource extraction industries located at remote sites where the employer operates its own medical clinic. If employers at these sites begin offering ARVs in their clinics, special efforts should be made to open this treatment capacity to the general public in the area.

The health insurance industry in Uganda has been innovative in making HAART care available to its target population. The decision of International Air Ambulance to include HAART in its basic benefit package is to be applauded. A transition from “employer paid” medical benefit plans to insured or Third Party Administrator Plans will provide protection for the identity of HIV positive employees, and will encourage them to come forward for covered treatment. This transition should be encouraged, but there are a limited number of things that outsiders can do to expand the availability of medical benefits through insurance and TPA arrangements. The providers of these services have strong incentives to sign up employers that already offer a substantial medical benefit; these companies already allocate substantial sums to employee care and may save significant money if the insurer/TPA controls fraud, waste and unnecessary utilization. But insurance will not, by itself, expand the number of employees covered by good medical benefits.

Giving corporate medical plans and insurers access to lower priced ARVs will lower treatment costs, and will thus lower the incremental premium required for full HIV care, or encourage others to follow the example of International Air Ambulance and include ARVs in the basic benefit package at no additional cost. The availability of reinsurance might further encourage insurers to take the risk of offering ARVs within a standard benefit package. If additional Ugandan clinics indicate an interest in starting HMO-type arrangements, this could increase plan choice and competition and lower prices in the medical insurance industry. However, these facilities will need help in making the actuarial projections to price a benefit package, including one that offers full HIV/AIDS treatment.

In assessing the “demand” for HIV/AIDS services, we conclude that Uganda industry can be divided into three categories:

**Category One**: Divisions of multi-national corporations as well as parastatal companies in modern industries with a high percentage of well-educated and highly compensated employees

**Category Two**: Smaller companies with a high proportion of skilled or educated workers (hospitality, professional services, financial services, sales and repair of imported technical equipment)
Category Three: Domestically-owned companies employing mostly unskilled workers (sectors such as agribusiness, manufacturing and security).

The companies that we interviewed in Category One were well along in the development of HIV/AIDS policies and benefits. 6 of 11 companies were already offering medical benefits that included HAART. One-half had written HIV policies, or were in the process of developing them. The companies had reached this point despite the fact that HIV/AIDS is not seen as a major management issue. However, the presence of a professional Human Resources Department, and the focus on the issue from multi-national owners, has moved these companies towards a constructive approach towards HIV positive employees.

We identified a few things that would accelerate positive developments among Category One companies. Projections of the cost of HIV treatment (including HAART) will be critical to obtaining coverage of this service by additional employers. Financial managers in these companies are not opposed in theory to providing such a benefit, but want predictable costs, which can be budgeted. Insurers and third party administrators are already assisting companies in making these estimates. However, where a company continues to administer its own medical benefit, it does not have access to such expertise. In addition, no Uganda firm we interviewed had accurate data on the HIV prevalence in their workforce. There is some suggestion that prevalence may be falling in these companies, as respondents in this Category reported higher death rates five to ten years ago. Reported death rates in the last year are lower than those reported in the ILO study in 1995. Donors could assist these companies by providing a model and relevant data to calculate the cost of a medical benefit that includes AIDS treatment and HAART, and perhaps by sponsoring anonymous seroprevalence tests in a few representative companies. The recent decision by International Air Ambulance to offer first line antiretroviral therapy without additional charge suggests that the best-informed providers think that the incremental cost is modest in this employment group.

Expanding HIV services in Category Two employers will be trickier, and we find it difficult to estimate the impact because of the difficulty of determining total employment in different segments of Uganda industry. These companies are more likely to have informal (rather than formal) programs that reimburse employee medical costs. A decision to cover high cost care (including HAART) may be made based on the influence or perceived value of the employee. HIV positive workers will be unlikely to seek corporate support for treatment in this environment because such a request effectively discloses the worker’s HIV status. HIV positive workers fear they will loose promotional opportunities, or be a victim of the next retrenchment.

Category Two companies are much less likely to use a health insurer or TPA, and often do not impose any restriction on the providers that are reimbursed when an employee seeks medical care. Through business forums, such as the FUE, companies should be encouraged to reimburse for HAART only when it is provided through a clinic that meets minimum accreditation standards set by the government or is affiliated with a program providing physician training and appropriate medical protocols. Another way to broaden
the availability of HIV care of reasonable quality would be for new or existing insurers to offer a product with more limited inpatient benefits, but including full HIV care. This could be offered for a lower premium, and providers might even be paid using some adjusted capitation mechanism. However, only those providers meeting minimum standards for HAART care would be included in such a plan.

The following steps may increase the extent to which companies in this Category will provide better HIV/AIDS benefits, including medical treatment and explicit non-discrimination policies:

1. Encourage a shift from company managed medical reimbursement policies to health insurance/HMOs or TPA arrangements which provide equal benefit for all employees and protect patient identity and diagnosis from the employer;
2. Circulate estimates of the incremental costs of medical coverage for HIV/AIDS given current private sector treatment costs for HAART in Uganda and a range of scenarios for seroprevalence in the work place;
3. Develop and distribute model HIV/AIDS workplace polices that can be adopted without major effort by the employer;
4. Develop and effectively market health insurance policies with a moderate benefit package that includes first line HAART administered with minimum monitoring tests. (To meet the cost target, this product may have lower inpatient benefit limits and retain classic chronic disease exclusions such as those for cancer, diabetes or heart disease);
5. Share (through forums such as the Uganda Federation of Employers) the specific experience—with treatment costs and worker retention---of Category One companies that have explicit HIV/AIDS policies and provide medical coverage for AIDS treatment;
6. Encourage companies to limit payment for HAART benefits to providers of proven quality.

We are not optimistic about the potential to expand HIV/AIDS services through employers in Category Three. Despite the widespread attention to HIV/AIDS in the Ugandan press and government (which has apparently helped to reduce HIV infection rates), these companies do not see the disease as a threat to their business. They do not now provide medical benefits, beyond required occupational health services, and they have very limited sick leave policies. They do not perceive a shortage of workers with the necessary skills. They do not have a professional HR Department. None of these factors are likely to change at the current level of national economic development. Where such companies have occupational health facilities, even modest ones, such clinics might be used as a base for government or donor-subsidized HIV testing and treatment programs. Particularly in rural areas where large agricultural employers are located, this might provide an additional site for treatment. However, significant financial contributions to HIV/AIDS care by these employers are unlikely, and the additional information that may “sell” a Category Two employer on offering better benefits for HIV positive employees is unlikely to move managers in this group.
Table 11 provides a brief summary of these recommendations, including the entities that would be responsible for action, the relative priority of the intervention, and the time frame over which the intervention could be implemented. In this final column, short term refers to actions that can have an impact over the next twelve months. Medium term refers to the next 1-3 years, with longer-term action requiring more than three years to have an impact.

<table>
<thead>
<tr>
<th>Action</th>
<th>Responsible Parties</th>
<th>Priority</th>
<th>Time Frame</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Special HIV/HAART training programs targeted at private physicians</td>
<td>donors, centers of excellence in Uganda (JCRC)</td>
<td>high</td>
</tr>
<tr>
<td>2</td>
<td>Pass lowest available ARV drug costs through to private sector</td>
<td>drug purchasing</td>
<td>high</td>
</tr>
<tr>
<td>3</td>
<td>Innovative financing mechanisms for testing equipment (CD4, viral load)</td>
<td>equipment manufacturers, donors</td>
<td>medium</td>
</tr>
<tr>
<td>4</td>
<td>Establish mechanism to identify and support good quality HAART providers (accreditation, franchising, advertising)</td>
<td>donors, government, professional organisations</td>
<td>medium</td>
</tr>
<tr>
<td>5</td>
<td>Experiment with non-doctor treatment counsellors in large clinics</td>
<td>donors, providers</td>
<td>medium</td>
</tr>
</tbody>
</table>

Table 12: Summary of Possible Interventions to Expand Supply for HIV services

<table>
<thead>
<tr>
<th>Action</th>
<th>Responsible Parties</th>
<th>Priority</th>
<th>Time Frame</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Provide data on treatment costs</td>
<td>progressive employers, FUE and other business groups, donors</td>
<td>high</td>
</tr>
<tr>
<td>2</td>
<td>Encourage use of insurance/HMO arrangements in preference to direct reimbursement</td>
<td>insurers, business organisations (some donor advocacy)</td>
<td>medium-high</td>
</tr>
<tr>
<td>3</td>
<td>Encourage development of lower cost, lower benefit insurance policies that cover HIV/HAART</td>
<td>insurers and large clinics- some donor support for actuarial work</td>
<td>medium-high</td>
</tr>
<tr>
<td>4</td>
<td>Support selective anonymous seroprevalence studies and better estimate of correct HIV-illness related costs and cost/benefit of treatment</td>
<td>donors</td>
<td>medium</td>
</tr>
<tr>
<td>5</td>
<td>Full HIV coverage (including HAART) in standard insurance policies</td>
<td>insurers (employers and donor advocacy)</td>
<td>medium</td>
</tr>
</tbody>
</table>
10. References


11. Appendices

11.1 Interview Guides

Appendix A: Employer Interview Guides

BASIC EMPLOYER DATA

Company name: 
Type of Business: 

Ownership:
_____ Individual or Family
_____ Multiple Shareholders
_____ Majority shareholding Ugandan
_____ Majority shareholding non-Ugandan
_____ Unit of Multinational Corporation

Locations (10 or more employees)

Year Founded_______ (if multinational, date of first operation in Uganda)

Informant
Name
Position
Contact Info:

Number of Employees:

<table>
<thead>
<tr>
<th></th>
<th># FT Now</th>
<th>Change (last 2 yrs)</th>
<th># Contract/PT</th>
<th>Change (at annual peak) (last 2 yrs)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Managerial/Professional</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clerical</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skilled Manual</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unskilled Manual</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

% of Employees belonging to Union

<table>
<thead>
<tr>
<th></th>
<th>% Subject to Collective Bargaining</th>
</tr>
</thead>
<tbody>
<tr>
<td>Managerial/Professional</td>
<td></td>
</tr>
<tr>
<td>Clerical</td>
<td></td>
</tr>
<tr>
<td>Skilled Manual</td>
<td></td>
</tr>
<tr>
<td>Unskilled Manual</td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td></td>
</tr>
</tbody>
</table>

Get a sense of the quality of Company record keeping on personnel, medical costs, absenteeism? Is this a Company that would consider participation in the in-depth study?
TOTAL STAFF TURNOVER

What is the total annual staff turnover for all causes (resignation, death, discharge, normal retirement). State as total number of employees or as a % of employees in class.

FT Staff turnover now                Trend in last five years

Managerial/Professional
Clerical
Skilled Manual
Unskilled Manual
TOTAL

DEATHS

Does the company keep data on employee deaths? If so, record below

Total Deaths

Last Year   Last Five Years

Managerial/Professional
Clerical
Skilled Manual
Unskilled Manual
TOTAL

Does the Company have any idea how many of these were due to HIV/AIDS? If so, what % by job type?

Percent HIV/AIDS Deaths

Last Year   Last Five Years

Managerial/Professional
Clerical
Skilled Manual
Unskilled Manual
TOTAL

MEDICAL RETIREMENTS/DISCHARGES

Does the company keep data on retirement/discharge/resignation due to illness? If so, record below?

# of FT Employees Retired/Discharged Due to Illness

Last Year   Last Five Years

Managerial/Professional
Clerical
Skilled Manual
Unskilled Manual
TOTAL

HIV/AIDS IN THE WORK PLACE

1. Does the Company have a written policy concerning HIV+ employees?
   When was it first adopted?
   When was it last updated?
   OBTAIN COPY, IF POSSIBLE
   How is the policy communicated to employees? (obtain examples, if possible)
   . Routine company publications (employee newsletters, etc?)
   . Special written bulletins to all employees
   . Through employee associations or unions
1. In regular staff meetings
   Does the company hold training sessions on the policy?
   . For supervisors and managers
     How often?
   . For workers
     How often?
   Who conducts the training?
   . Company staff ______
   . Outside consultants ______  What consultants ______

2. Does the HIV Policy?
   Forbid discrimination against HIV+ individuals in:
     Hiring?
     Retrenchment?
     Selection for training?
     Job assignment?
     Promotion?
   Forbid disclosure of HIV status:
     To managers/supervisors?
     To fellow workers?
   Provide for transfers to more appropriate assignments for those who have AIDS but are still able to work?

3. Does the Company provide education to its employees on AIDS prevention?
   Through outside consultants?
     Since when?
     What consultants (NGOs, etc.)
   Through medical staff or outside physicians?
     Since when?
   Through supervisors?
     Since when?
   Through peer educators?
     Since when?
   HIV/AIDS training sessions (for the typical employee)
     How frequent
     What is the duration of the typical session
     (an hour, half a day, etc?)

4. What is covered in the AIDS education provided to employees?
   (OBTAIN COPIES OF TRAINING DOCUMENTS, IF POSSIBLE)
   . Basic facts about HIV (lethality, how it is communicated, life expectancy, how it is manifested, etc.)?
   . Dispelling myths (casual transmission, insects, etc.)?
   . Means of preventing HIV infection:
     Safe blood supply?
     Abstinence?
     Fidelity?
     Condoms?
     Needles and razors?
     Other?
. VCT
   What it is?
   Where to obtain it?
   Are employees referred to a specific VCT center/s?
   Which one/s?
   Importance of testing?

. Maternal to child transmission
   Risks?
   Means of preventing?
   Sources of PTMCT?

. Treatment when HIV positive
   Good nutrition?
   Prophylaxis?
   Treating opportunistic infections?
   Positive living
   Safe sex
   HAART?
   Information on cost and survival?

. Options for obtaining treatment
   Are HAART sites identified?
   Does the Company recommend/refer to a specific provider?
   Which one?

COMPANY’S GENERAL MEDICAL BENEFITS

5. Benefits offered: Try to fill in the following matrix
   (Indicate limits and exclusions. If no benefit, put NO). Indicate if benefit covers:
   “E” employee only
   “E+S” employee and spouse/partner
   “E+S+D” employee, spouse and children
   Indicate differences in limits/exclusions for non employees

<table>
<thead>
<tr>
<th>EMPLOYEE CATEGORY</th>
<th>Casual</th>
<th>Regular Blue</th>
<th>White</th>
<th>Senior</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Collar/Union</td>
<td>Collar</td>
<td>Managers</td>
<td></td>
</tr>
</tbody>
</table>

. Primary care OP
   . Occupational only
      (on site nurse/doctor)

. General
   . Basic IP
   . Specialist OP
   . Specialist IP
   . Drugs
6. How is the benefit provided?
   A. company run facility?
   B. direct company payment to contracted provider?
   C. insurance policy?
   D. employee reimbursed?

   . Primary care OP
   . Basic IP
   . Specialist OP
   . Specialist IP
      (referral hosp.
   . Drugs

7. **Show ceiling on total amount of medical benefits received in a year?**
   (Indicate if calculated separately for each eligible employee/spouse/dependent, or a single limit for all covered individuals)

8. **Show employee co-payments deductibles/required?**  Indicate if different for employee/spouse/other dependents?
   . Primary care OP
   . Basic IP
   . Specialist OP
   . Specialist IP
      (referral hosp.
   . Drugs

9. **Amount of employee cost sharing in health insurance premium?**

10. **Does the medical benefit have any special restrictions applying to patients with AIDS?**  If so, describe these limitations/exclusions, such as:
   . HIV/AIDS care formally excluded, but “don’t ask/don’t tell” policy for opportunistic infections, palliative care?
   . Coverage for treatment of STIs, Opportunistic Infections but not HAART

11. **If the Company runs its own health facilities, is there any spare capacity?**  Indicate the percentage increase in workload that could be absorbed without hiring new staff or expanding the facility?
   a. Occupational health clinics?
   b. General health clinics?
   c. Inpatient units?
12. What is the Company’s policy on sick leave:
   - Maximum number of days per year at full pay (show any variation by length of service)
     - casual
     - regular manual
     - white collar
     - management
   - At partial pay (Indicate pay percentage and maximum duration of sick leave; show any variation by length of service)
     - casual
     - regular manual
     - white collar
     - management
   - Without pay? (Indicate duration and any variation by length of service)
     - casual
     - regular manual
     - white collar
     - management
   - Are these policies uniformly enforced, or are there special exceptions?
   - Maximum continuous period of sick leave allowed before worker is discharged? Show any variation by length of service
     - casual
     - regular manual
     - white collar
     - management

13. Does the Company provide disability or pension benefits for those forced to retire for medical reasons? For job related illness or injury only? For other disease or injury? Show available benefit for non-job related medical retirement, by job category. Indicate any variation by duration of service?
   - casual
   - regular manual
   - white collar
   - management

14. What is the death benefit offered by the Company to those who die in post of non-work related illness? Indicate components (funeral allowance, pension to survivors, lump sum payments) and the amount or formula used to determine the benefit. Show any variation by duration of service.
   - casual
   - regular manual
   - white collar
   - management

COST OF MEDICAL BENEFIT

15. Company’s total annual medical care expenditure in last year?

<table>
<thead>
<tr>
<th></th>
<th>Casual</th>
<th>Blue Collar</th>
<th>White Collar</th>
<th>Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary care OP</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Basic IP</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specialist OP</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specialist IP</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(referral hosp.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drugs</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OR Health Insurance</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Premium</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
It may not be possible to break out by benefit type. If the only information available is for insurance premiums or the cost of company clinics, show this information. If health insurance is offered only to certain employee categories, indicate total premium in these categories.

16. **Per employee cost of total medical benefit?** (Divide total cost or premium by current total employment in category---see background information on firm)

17. **Rate of increase in medical expenditure?**
   - Total?
   - Per employee?
   - (By category or benefit type, if known?)

18. **Any changes in the health benefit in the past three years?**
   - Covered groups?
   - Dependent coverage?
   - Benefits covered?
   - Providers/insurers?

19. **Medical benefit costs as a proportion of total employee compensation (all job categories)?**
   Request company’s own calculation----medical benefit expenditures as a percentage of total labor costs, including salary, overtime, payroll taxes, pension contributions and fringe benefits. If the Company has not made the calculation, ask if they will share total labor cost for most recent year and we will calculate.

**COMPANY SERVICES FOR HIV/AIDS**

20. **Does the Company provide condoms in the workplace?**
   - For free? At what cost to the employee? How/where are they distributed?

21. **Does the Company provide condoms in company clinics or nurses’ office?**
   - For free? At what cost to the employee?
   - Where does the company obtain these condoms (commercial, MOH, etc.)

22. **Does the company offer VCT services?**
   - At the work site?
   - In a Company clinic?
   - Under a special contract at an outside site?
   - Through a health insurance plan?
   - Through direct reimbursement of employee costs?
   - What steps are taken to:
     - preserve confidentiality of result?
     - convince employees of confidentiality?

23. **Does the Company sponsor or encourage support groups for HIV positive employees?**

24. **Does the Company provide counseling for those who are forced to resign/retire because of illness (including AIDS)?**

25. **Does the Company provide any counseling (legal, etc) for dying employees or their families?**
26. Has the Company made any special arrangements for the treatment of patients with AIDS?
Describe the nature of the benefit and the provider/s
  . To cover prophylactic drugs?
  . To treat STIs?
  . To cover the cost of treating opportunistic infections?
  . For palliative or home-based care?
  . For HAART (antiretroviral drugs)?

27. If the Company offers a HAART benefit:
When was the benefit first offered?
  To which employee groups is the HAART benefit offered?
    . To any dependents of this group (which ones)?
Through which provider(s)?
    (name facilities)
How does the Company pay?
  . Directly (company clinic)
  . Directly (contracted provider)
  . Insurer
    . Insured benefit
    . Third party administrator
  . Employee reimbursement
    (Describe any arrangements to protect confidentiality)
Who in the Company knows an employee is receiving HAART?
  . No one?
  . Medical director?
  . Other company medical staff?
  . Employee’s supervisor?
  . Human resources staff?
  . Accounting staff (medical bills reimbursed)?

28. What is covered by the HAART benefit?
  . Antiretrovirals
    . Any limitations on drugs used?
      (first line therapy only, generics only, maximum cost per month)
  . Testing
    CD4? Frequency?
    Viral load? Frequency?
    Other tests?
  . Specialist consultations
    Any limit on frequency

29. Does the Company have any protocols for HAART treatment? (e.g.; minimum and maximum CD4 counts, requirements for adherence, etc.)Where were they obtained?

30. What are the requirements for employee contribution to HAART treatment (co-payment, fixed rate of reimbursement below typical cost, etc.)

31. Has the HAART benefit been used?
  . Number ever on HAART?
  . Number currently receiving HAART benefit?
  . Employees/dependents on HAART who died?
32. Does the Company know the amount it has spent on the HAART benefit? Past year? Since inception?

CONCERNS AND MOTIVATION

33. Who in the Company is responsible for managing HIV/AIDS policies? (Medical Director, HR Director, other)? What is the training/background of this individual? Have they had any special training on HIV/AIDS?

34. Does the Company know what % of workers are HIV positive?
   What is the known/assumed percentage?
   How does the Company know this (compulsory screening, anonymous seroprevalence study of own workers, extrapolation from death/disability data, seroprevalence in other companies, etc).

35. How important an issue is HIV/AIDS in managing the Company?
   a. The most important?
   b. In the top five issues?
   c. In the top twenty issues?
   d. Mentioned occasionally, but never considered important?
   e. Not an issue?

36. What aspect (if any) of HIV/AIDS concerns the Company, and how great is that concern?
   Indicate on a scale from 1-5 (1 being no concern, 5 being great concern) the level of concern? (This scale applies to all issues in managing the company, not just a relative ranking of HIV/AIDS related issues. In a company unconcerned about HIV/AIDS, all of the aspects below may be rated “1”). Include relevant comments

   Level of concern
   . Payment of death and disability benefits?
   . Medical care costs?
   . Absenteeism?
   . Employee sick
   . Family sick
   . Funerals
   . Lowered productivity of workers on job?
   . Loss of staff due to death/illness
   . Training costs?
   . Difficulty of filling vacancies?
   . Impact on market for Company’s product/services?
   . Impact on growth of Uganda economy?
   . Impact on political stability of Uganda?

37. If the Company considers HIV/AIDS to be an important issue, how has the Company coped?
   (For example, by training additional employees for all key positions, by contracting out various tasks or services, by substituting capital for labor, etc.)

38. If the Company has well developed HIV/AIDS policies and benefits, or an active debate on these, who in Company management has taken the lead in developing or advocating for these policies/benefits? (CEO, HR Director, Medical Director, Operations Manager, etc.)

39. If the Company does not have well developed HIV/AIDS policies and benefits, which should take the lead (within management) in developing these? Or should the Company only respond to external requirements (Government regulations, etc.)?
40. Does the issue of company HIV policy or benefits ever arise in labor negotiations or meetings with employee groups/unions? What are the unions/employees asking the employer to do? What has been the Company response?

41. How does top Company management receive information about HIV/AIDS and possible policies or benefits?
   - From the local press
   - From the international press
   - From industry associations (which one/s) FUE
   - From foreign parent/affiliates
   - Other

42. Is the Company feeling pressure from any other group to adopt HIV/AIDS policies or benefits? Indicate the group, and the policies/benefits/changes the Company is being pressured to adopt? (For example, NGOs want Company to offer ARVs? Bankers want company to reduce staff turnover?)
   - Directors
   - Shareholders
   - Banks/financiers
   - Customers
   - Uganda Government
   - Home Government (for multi-nationals)
   - NGOs/activist groups
     - local
     - international
   - Other

43. What would cause the Company to spend more on AIDS benefits or devote a greater proportion of management effort to AIDS policy issues?
   - Greater pressure from
     - employees/unions?
     - lenders
     - shareholders
     - Uganda Government
     - home Government (multinationals)
   - Quantitative evidence of the impact of AIDS on labor cost and profitability?
   - Evidence that HIV prevention/treatment is effective and will lower costs?
   - Tax incentives from Government?
   - Better knowledge of what other companies are doing in high HIV environments?
   - Better knowledge of resources available in Uganda to provide HIV/AIDS services and the cost of such services?
   - Other?

REQUEST
We would like to discuss with employee representatives their concerns about HIV/AIDS and their expectations (if any) for obtaining HIV/AIDS services through employment. Could you please indicate the name (and contact information) of the union/employee association representative who would be most knowledgeable on these issues.
Appendix B: Employee Representative Interview Guide

Informant

   Employer:
   
   Name of Employee Organization

Name of Informant:

   Position/Organization:
   Contact Information:

Nature of Organization
   . Union Involved in Collective Bargaining
   . Professional Association (does not do CB)
   . Other employee association

Number of members

Percentage of firm’s total employment

1. Do you consider yourself knowledgeable (from a non-clinician perspective) on matters relating to HIV/AIDS? Where do you get your information on HIV/AIDS?
   . Local press
   . International press
   . Peers in other corporations/unions
   . International affiliates
   . NGOs and advocacy groups
   . Government of Uganda
   . Other (describe)

2. How often do you attend meetings, seminars or training sessions that are specifically directed to HIV/AIDS policies or treatment?
   . Once a month or more
   . Several times a year
   . Once or twice a year
   . Have attended, but not in the last year
   . Never

3. From the point of view of your members/constituents, how important an issue is the Company’s HIV/AIDS policies and benefits? Rate as follows:
   1. HIV/AIDS is not an issue in employee relations
   2. HIV/AIDS is a secondary issue for some members, rarely raised with the employer
   3. HIV/AIDS policies/services are important for some members, discussed with the Employer, but not in the top issues for the membership
   4. HIV/AIDS is important to many members, often discussed with the Employer, but not the most important issue for the membership as a whole
   5. HIV/AIDS is the most important employee relations issue
4. For your members, are HIV/AIDS policies more (“M”) or less (“L”) important than the following issues:
   - overall wage and salary levels
   - job security
   - promotional opportunities
   - pension benefits
   - general medical benefits

5. Is your organization involved in formal or informal bargaining for wages and benefits?
   If so, in such bargaining has your organization ever requested specific HIV/AIDS policies or benefits?
   Which ones?
   What has been the Corporation’s response?

6. Do you think that your Employer’s current policies with reference to HIV/AIDS in the workplace are adequate? Where do you think they need to be improved? Wait for spontaneous response, then probe. Indicate if response is spontaneous.
   - Non-discrimination in hiring
   - Non-discrimination in promotion/training
   - Maintenance of confidentiality
   - Transfer to other jobs with HIV/AIDS
   - Sick leave for those with AIDS
   - Other

7. Do you think that your Employer is doing an adequate job with respect to workplace education on HIV/AIDS? If not, how do you think the education program should be improved? (Note if respondent says there is no program)

8. Do any of your members disclose that they are living with HIV/AIDS and advocate within your organization for improved HIV policies or services from the Employer?

9. Does your organization (as opposed to the Employer) sponsor any training on HIV/AIDS prevention and treatment, or sponsor any support groups for HIV positive patients? Describe these activities.

10. Does your membership think that your employer is doing an adequate job in offering AIDS related treatment services? Note if the Respondent is aware that the Employer is currently offering the service, and how the members think that the Employer should improve the service. If the service is not offered, do your members think the Employer should offer the service (directly, or through the medical benefit). Answer separately for each service:
    - Free condoms at the workplace:
    - VCT
    - Treatment of STIs
    - Prophylactic medications
    - Treatment of opportunistic infections
    - Palliative care/home care for those dying of AIDS
    - HAART

11. If HIV/AIDS policies/services are not an important issue for your members, why do you think this is so?
    - The Employer is already doing a good job with HIV/AIDS services
    - Not many members have HIV/AIDS
    - Members are ignorant about HIV/AIDS and the policy issues
. HIV/AIDS stigma is such that members are unwilling to raise the issue
. Members think that HIV/AIDS is an issue for Government policy/health services, not Employer/Employee relations
. Members are fatalistic about HIV/AIDS and think little can be done to treat the disease

12. If the Employer were to expand its medical benefit, which expansion would your members prefer? Please rate from “1” ---least wanted up to “12” ---most wanted. Cross-out if not relevant. Give the respondent the attached card

13. If your Employer were to offer HAART benefit, which of the following do you think your members would choose?
   . Lower/no co-payments for employees but no benefits for spouse/dependents
   . HAART coverage for spouse/dependents with a higher co-payment overall

Why would they make this choice?

MEDICAL SERVICE BENEFIT PREFERENCES

RESPONSE CARD

The following are various ways in which your Employer might expand medical benefits available to workers/dependents. From the point of view of your members, which are most desirable. Please cross out any which are not applicable, and rate the remaining benefit expansions from “1” (least wanted) upwards:

Desirability for members

Add/expand outpatient services generally
Add/expand inpatient services generally
Add/expand pharmaceutical benefits
Increase the current annual ceiling on medical benefit payments
Broaden coverage for dependents
Reduce co-payments or deductibles
Reduce employee contribution to health insurance premium
Provide access to higher quality providers
Eliminate any exclusion for chronic diseases (diabetes, hypertension)
Eliminate any exclusion for maternity
Eliminate any exclusion for HIV/AIDS
Provide coverage for HAART (antiretroviral drugs and associated treatment/testing)
Appendix C: Clinical Service Providers Interview Guide

ORGANIZATIONAL DATA

Name of Organization:
Location(s)
Number of years in business in Uganda
Contact Information
Name
Title/Position
Contact Information

NATURE OF ORGANIZATION

Provider is:

. Physician Private Practice
  . Single physician
  . Group practice
  . Free standing clinic
  . For profit

Owned by:

Ugandans (%) __________
Other nationals or foreign corporation (indicate country) (%) __________

. Not for profit (NGO). Includes religious. _______
Sponsor _______

. Hospital
  . Inpatient only
  . Inpatient and outpatient services
  . For profit

Owned by:

Ugandans (%) __________
Other nationals or foreign corporation (indicate country) (%) __________

. Not for profit (NGO); includes religious
Sponsor _______

Does the provider have a foreign affiliation for staffing, or training of clinical staff? If so, identify the foreign partner(s) and describe the nature of the affiliation.

SIZE

Most Recent Year
% Change
Last 2 Years

. Number of outpatient visits
. Number of admissions
. Number of individual patients served in a year
. Total annual revenue from clinical services
. Number of FTE physicians
. Total staffing
PAYMENT ARRANGEMENTS

EMPLOYERS

1. Does the Provider have contractual relationships with Employers to treat employees at one or more of Provider’s facilities?
   For what services?
   Names of typical Employer clients
   - Non-exclusive (employees can obtain Employer reimbursed service with several providers).
   - Exclusive (this is the only Provider where Employer pays for the service)

2. Does the Employer typically pay the Provider directly, or reimburse the Employee?

3. Does the Provider have contracts to provide health services at Employer sites?
   Describe the nature of these contracts (services provided, is staffing full time or part time at the employer site) Under these contracts, is the Employer or the Provider responsible for:
   - Equipment
   - Laboratory tests
   - Purchasing and providing drugs

4. Proportion of total income earned (approximate amounts OK) from:
   - Employer paid care provided under contracts at Provider’s sites
     - Exclusive
     - Non-exclusive
   - Contracts to provide services at Employer’s sites

EMPLOYER COVERAGE FOR HIV/AIDS

5. Do Employer contracts TYPICALLY limit the care reimbursed for HIV patients? What are these limits and how are the limits enforced?

6. Do Employer contracts TYPICALLY provide payment for specific services for HIV patients (VCT, PMTCT, HAART). Which ones?

7. For each of the three largest Employer contracts, please describe the limits and benefits in detail.
   Employer contract #1 (largest amount of revenue to Provider)
   - # of Employees
   - Limits on services to HIV/AIDS patients AIDS services covered:
     - VCT
     - Is/must result be reported to Employer?
     - Treatment of OI’s
     - PMTCT
     - HAART
     - Monthly co-payment for patient

   Employer contract #2 (second largest amount of revenue to Provider)
   - # of Employees
   - Limits on services to HIV/AIDS patients

   AIDS services covered:
VCT
  Is/must result be reported to Employer?
Treatment of OI’s
PMTCT
HAART
Monthly co-payment for patient

Employer contract #3 (third largest amount of revenue to Provider)
Employees covered by this policy

Limits on services to HIV/AIDS patients

AIDS services covered:
  VCT
    Is/must result be reported to Employer?
  Treatment of OI’s
  PMTCT
  HAART
  Monthly co-payment for patient

INSURANCE

8. Does the Provider have contracts under which it is reimbursed directly by health insurance companies for services rendered?

9. Which insurance companies (list)?

10. Do any of the contracts have reimbursement arrangements other than fee for service? (Capitation, incentive fees) Describe

11. Proportion of patients covered by these insurance arrangements

12. Proportion of total Provider revenue for health services earned under insurance contracts

INSURANCE COVERAGE FOR HIV/AIDS

13. Do insurance contracts TYPICALLY limit the care reimbursed for HIV patients, and how are these limits enforced?

14. Do the insurance contracts TYPICALLY cover specific services for HIV patients (VCT, PMTCT, HAART). Which ones?

15. For each of the three largest insurance contracts, please describe the limits and benefits in detail.
   Insurance contract #1 (largest number of insured patients for this Provider)
   Insurance company
   Employers covered by this policy
   Limits on services to HIV/AIDS patients
   AIDS services covered:
   VCT
      Is/must result be reported to insurer?
   Treatment of OI’s
   PMTCT
HAART
Monthly co-payment for patient

Insurance contract #2 (second largest number of insured patients for this Provider)

Insurance company

Employers covered by this policy

Limits on services to HIV/AIDS patients

AIDS services covered:

VCT
    . Is/must result be reported to insurer?

Treatment of OI’s

PMTCT

HAART

Monthly co-payment for patient

Insurance contract #3 (third largest number of insured patients for this Provider)

Insurance company

Employers covered by this policy

Limits on services to HIV/AIDS patients

AIDS services covered:

VCT
    . Is/must result be reported to insurer?

Treatment of OI’s

PMTCT

HAART

Monthly co-payment for patient

HIV/AIDS RELATED SERVICES CURRENTLY OFFERED

16. Which of the following services are currently provided at one or more of the Provider’s facilities or at Employer sites where the Provider staffs the health facility under contract?

<table>
<thead>
<tr>
<th>Service</th>
<th>Own Facilities</th>
<th>At Employer Facility</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV Prevention Education</td>
<td></td>
<td></td>
</tr>
<tr>
<td>VCT</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Treatment of OI’s</td>
<td></td>
<td></td>
</tr>
<tr>
<td>. (which ones)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>. TB?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>. prophylaxis for common OI’s</td>
<td></td>
<td></td>
</tr>
<tr>
<td>. nutritional counseling</td>
<td></td>
<td></td>
</tr>
<tr>
<td>. OP only</td>
<td></td>
<td></td>
</tr>
<tr>
<td>. IP also</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Treatment of STIs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PMTCT</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
CD4 Monitoring of HIV positives

Palliative care
  . IP in own facilities
  . IP in other facilities
  . home based

HAART
  . first line only
  . first and second line
  . all

Laboratory Tests
  . CD4
    . Own laboratory
    . Other (identify)
    . Typical charge
    . Approx. annual volume
  . Viral load
    . Own laboratory
    . Other (identify)
    . Typical charge
    . Approx annual volume

17. How many new HIV positives does the Provider identify in a year?

18. How many HIV positives are being followed now?

19. History of HAART treatment
   When did Provider begin offering HAART to patients?
   Number of patients for which Provider is managed HAART?
   At end of 1999
     2000
     2001
     2002
     Now

   What proportion of patients fail first line treatment (Approximately)?
     Within the first six months?
     Within the first year?
     After three years?

20. If HAART treatment is provided, does the Provider generally report the name/identifying number of the patient being treated?
   . To the Employer providing reimbursement?
   . To the insurer paying for care?

21. Is any mechanism in place to provide confidentiality of HAART treatment; e.g.; a method to prevent Employer management from discovering the identity of an employee receiving HAART? If so, describe the mechanism and the proportion of HAART patients paid for by Employers to which it applies?
22. Does the Provider have any idea of the number of patients seen this year who are ready for HAART (severe OI and/or CD4<250) who are not receiving HAART? Is this because of:
   - No Employer assistance with cost of drugs?
   - Employee co-payments too much?
   - Other reason (describe)

COUNSELING

21. Does the Provider employ specially trained individuals to counsel HIV patients?
   - For prevention training
   - For VCT
   - For HAART

22. How many staff members are trained and designated to provide counseling for HIV patients?
   - What is the basic clinical or professional training of counselors for HAART patients? (nurse, social worker, clinical officer, etc.)
   - Have counselors working with HAART patients/candidates received special HAART training?
     - Duration of special training
     - Source of special training

23. Typical counseling charges
   - For VCT
   - Does provider charge for HAART counseling separate from physician care? How much?

24. Do physicians working at the clinic have special training in:

<table>
<thead>
<tr>
<th># Individuals</th>
<th>Special Training</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Source</td>
</tr>
<tr>
<td>HIV/Opportunistic Infections</td>
<td></td>
</tr>
<tr>
<td>Counseling HIV patients</td>
<td></td>
</tr>
<tr>
<td>PMTCT</td>
<td></td>
</tr>
<tr>
<td>HAART</td>
<td></td>
</tr>
</tbody>
</table>

25. Are non-physician clinical officers used in the treatment of HIV patients?
   - For which services?
   - HIV/Opportunistic Infections
   - Counseling HIV patients
   - PMTCT
   - HAART

26. If clinical officers are used in providing HIV services, do they receive special training? Ignore if the service is not provided or clinical officers are not used in providing the service.

<table>
<thead>
<tr>
<th># Individuals</th>
<th>Special Training</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Source</td>
</tr>
<tr>
<td>HIV/Opportunistic Infections</td>
<td></td>
</tr>
<tr>
<td>Counseling HIV patients</td>
<td></td>
</tr>
<tr>
<td>PMTCT</td>
<td></td>
</tr>
</tbody>
</table>
HAART

HAART DRUGS

27. Is the Provider certified by MOH to offer HAART?
   If so, was this certification difficult to obtain?
   If not, has Provider attempted to obtain certification? What were the problems?

28. Does the Provider dispense HAART drugs directly to patients?
   If not, how do patients obtain the drugs (any pharmacy, designated pharmacies, etc)
   How much do you think patients are paying for one month of triple therapy at these sites?

29. If HAART drugs dispensed, where does the Provider obtain the drugs (manufacturer, wholesaler, government drug stores). Be as specific as possible
   Typical cost for one month of first line triple therapy
   Provider’s purchase price
   Price at which Provider sells to patient/employer
   Describe any difference in the price charged “self pay” patients and those with employer/insurer coverage?

30. Does Provider offer Directly Observed Therapy (DOT) for those with adherence problems?
   When and how does Provider initiate DOT?
   When and how does Provider terminate HAART if patient is non-compliant and or treatment ails?
   Are there specific criteria for termination?

31. Has Provider adopted specific protocols for HAART treatment?
   What is the source of these protocols?
   Does the Provider have a system to monitor/enforce protocols for HAART? Describe

CONSTRAINTS ON EXPANSION OF HIV/AIDS RELATED SERVICES

32. Look at the list of HIV related services in Question #16 above. If the Provider does not offer some of these services SHORT OF HAART, why is this? Indicate the “missing services” (VCT, PMTCT, treating OI’s, etc.) to which the comment below is relevant.
   . Cannot get paid for the service by
     . Employers
     . Insurers
   . Patients cannot afford the service
   . Price Provider could get for the service is inadequate to cover costs
   . Inadequate demand from existing clients (not related to price).
   If so, is this because of:
     . Stigma around HIV
     . Low prevalence in your patient population
     . Government provides service for free
Patients already getting service elsewhere
. Other reasons (describe)
. Cannot hire staff with the necessary skills/training
. Cannot obtain necessary training for existing staff
. Other reasons (describe)

33. If the Provider offers most HIV related services, but not HAART, why is it not offering HAART?
(More than one reason may apply—indicate most important (“M”), less important (“L”)

. Cannot get paid for HAART by:
  . Employers
  . Insurers
. Patients cannot afford to buy drugs/tests not covered by employers/insurance?
. Patients cannot afford co-payments for HAART drugs/tests?
. Price Provider could get for the service is inadequate to cover costs?
. Cannot obtain/do not know where to get laboratory tests?
. Cannot obtain/do not know where to obtain HAART drugs that patients can afford?
. Cannot obtain Government certification for HAART treatment?
. Unsure if demand would be sufficient to cover added costs?
. Inadequate demand (not related to cost) from existing clients.
  If so, is this because of:
    Stigma around HIV
    Low prevalence in your patient population
    Government provides service for free
    Patients already getting service elsewhere
    Patients not knowledgeable about HAART
    Patients afraid of side effects
    Other reasons (describe)
. Provider does not know enough clinically about HAART?
. Provider cannot hire staff with the necessary skills/training
. Cannot obtain HAART training for existing staff?
  Do not know where to get training?
  Cannot afford available courses?
  Cannot afford to release existing staff for training?
. Other (describe)

INCENTIVES TO ADD HAART SERVICE

34. For Providers that do not now offer HAART, which policy initiatives or incentives listed below
might induce the Provider to add HAART services? Indicate Very Important (“V”), incentive/policy; some impact (“S”); no impact (“N”). If provider is clear that there is a single dominant policy change or
incentive that would induce it to offer HAART services, so indicate. Include specific comments as
appropriate.

. More Employers with which you now work provide explicit coverage for HAART?
. More insurers/insurance policies provide explicit coverage for HAART?
. Government certification requirements to offer HAART serviced are modified (Specifically, what modification)
. HAART training courses for existing personnel are available free or heavily subsidized?
. Provider obtains access to HAART drugs at same prices available to Government or other
purchasers now getting the lowest priced drugs?
. Prices of ARV drugs in the general market fall further (Indicate the retail price pre month for
triple therapy which would be required)

64
. Government makes it clear that most Ugandans will have to pay something for antiretrovirals in Government facilities (Some press reports now indicate that the Government will make ARVs available free to all citizens)
. Free or low cost technical assistance is available to clinic management/medical director to understand what is required to offer HAART (protocols, etc).
. Government announces a policy of “contracting” with private providers to obtain HAART services for Government employees or other groups
. Better publicity/public education about HAART
. Lower cost or free training in HAART for existing staff?
. Other? (Specify)

INCENTIVES TO EXPAND HAART SERVICE

35. The Provider already offers HAART services. Which of the following will increase the number of patients seeking HAART from the Provider? Indicate Very Important (“V”) to expanding HAART patient volume at the Provider, Somewhat Important (“S”), Not Important (“N”).

. More Employers provide explicit coverage for HAART?
. More insurers (or policies) provide explicit coverage for HAART?
. Provider can lower the price it offers for HAART by obtaining access to HAART drugs at same prices available to Government or other purchasers now getting the lowest priced drugs?
. Prices of ARV drugs in the general market fall further (If possible, estimate the retail price per month for triple therapy which would be required to double the number of patients now treated)
. Government makes it clear that most Ugandans will have to pay something for antiretrovirals in Government facilities (Some press reports now indicate that the Government will make ARVs available free to all citizens). Perhaps some patients are waiting for “free” HAART care.
. Government announces a policy of “contracting” with private providers to obtain HAART services for Government employees or other groups
. Better publicity/public education about HAART
. Other? (Specify)

36. If the number of patients seeking HAART care and able to afford it (directly or through employer/insurer support) were to double in two years, could the Provider meet this demand? If not, why not? Check one or more below?

. Would require capital investment in new/expanded facilities? Provider’s current financial position does not enable it to borrow or otherwise raise money for such expansion?
. Would require capital investment in expansion of laboratory equipment which Provider cannot now afford?
. Provider could not hire the additional qualified staff required?
. Provider could not obtain the special training to expand the number of staff qualified to provide HAART?

Proper training courses not available?
Provider cannot afford charges for available training?
Provider cannot afford to release staff for necessary training and/or continue their salary during training period?
. Does not want to be perceived as an HIV/AIDS specialist clinic because of impact on other clientele?
. Other? (Specify)
Appendix D: Insurers and Health Maintenance Organization Interview Guide

ORGANIZATIONAL DATA

Name of Organization:

Type of Organization:
   Health Insurer (no health care facilities)______
   Facility Based Prepaid Health Plan______

Ownership
   Non-profit
   Individual proprietor
      Ugandan
   Other
   Private ownership (multiple individuals)
      >50% Ugandan
      <50% Ugandan
   Are some or all owners physicians?

Division of foreign corporation
   Name and headquarters of parent company
   Is parent company:
      A health care provider?
      A health insurance specialist?
      A multi-line insurer?

Informant
   Name
   Position
   Contact Info

Try to obtain an idea of whether current health insurance operations are profitable per se?

GENERAL INFORMATION ON HEALTH INSURANCE BUSINESS

Health insurance policies in force:
   Primary insured______
   Dependents______
   Total lives______

1. Total annual revenue from health insurance/pre-paid medical plans
   . health insurance revenue as a % of total revenue in Uganda
   . for provider based plans--prepaid revenue as % of total

2. Does the Company sell health insurance policies in the individual market?

3. Does the Company sell health insurance policies in the group market?
   a. To employers?
   b. To affinity groups?
   c. # of groups/employers enrolled
4. Does the Company sell health insurance:
   a. As a primary line of business
   b. To expand sales of a package including life and disability insurance
   c. To support health care facilities which it owns

5. Does the Company sell the following types of policies in Uganda
   a. Indemnity (insured pays expense, company reimburses in whole or in part; no direct contracts with health providers)
   b. Policies providing for direct fee for service payment of providers (contract between provider and insurer; may be additional co-payment or deductible for insured)
      i. Limited network, or any willing provider?
   c. Policies involving pre-payment to contracted providers
      i. If capitation, for what services, and on what formula
   d. Policies which restrict some or all benefits to provider’s own facilities
      i. What restrictions?
   e. Third party administrator arrangements (processes claims, but takes no risk)

6. Describe any techniques used to control utilization or quality (computerized claim screening, prior approvals, continued stay reviews, medical audits, continuing education of accreditation requirements)
   a. Primary care
   b. Specialist care
   c. Inpatient care
   d. Drugs

7. Describe any incentives to encourage provider efficiency
   a. Primary care (fund holding, capitation, incentive payments)
   b. Specialist care (capitation, PCP fund holding)
   c. Inpatient (DRG type reimbursement)
   d. Drugs (PCP fund holding)

9. How is risk distributed? Describe any reinsurance arrangements?

10. Does Company typically release patient specific utilization information to group purchasers?
11. **What benefits are offered in Company policies?** If more than one standard policy, show benefits for different policies below in order of total enrollment?

<table>
<thead>
<tr>
<th>BENEFIT</th>
<th>Policy 1</th>
<th>Policy 2</th>
<th>Policy 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient primary</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>. Preventive care?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>. Must enroll with specified MD?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>. Maternity?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>. Limits</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>. Which providers?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>. Exclusions (STD?)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>. Co pay</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient (basic)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>. Maternity?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>. Limits</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>. Which providers?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>. Excluded conditions?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>. Co pay</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specialist (outpatient)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>. PCP referral required?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>. Which provider?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>. Limits</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>. Excluded conditions</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>. Co-pay</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specialist (inpatient)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>. PCP referral required?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>. Which provider?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>. Limits</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>. Excluded conditions</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>. Co-pay</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drugs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>. IP/OP, or both?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>. Formulary (describe)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>. Which providers?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>. Limits</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>. Excluded conditions</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>. Co pay</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Typical Premium</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>. Individual</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>. Family</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**HEALTH INSURANCE AND HIV/AIDS**

12. **Are HIV positive patients excluded from coverage in standard plans?**
   a. Is there a testing requirement before enrollment?
   b. What happens if the patient develops HIV after enrollment?
13. **Is there a specific exclusion or limitation on HIV related services in standard plans?** 

(Describe) Which of the following are covered benefits:

- a. VCT
- b. PTMCT
- c. Treatment of opportunistic infections. Describe any limits
  - i. TB
  - ii. Pneumonia
  - iii. Karposi, other cancers
  - iv. Fungal infections
  - v. Diarrhea
  - vi. Other
- d. Prophylactic treatments (which)
- e. Counseling
  - i. General
  - ii. Nutritional
- f. STD treatment
- g. HAART
  - i. Testing
    - 1. CD4 (Frequency) Where?
    - 2. Viral Load (Frequency) Where?
    - 3. Other
  - ii. Antiretroviral drugs
  - iii. Counseling and consultation

14. **If normal benefits required for treatment of HIV/AIDS related illness are limited, describe monitoring and enforcement technique?** “Don’t ask, don’t tell?” Require HIV test? Request medical records? Other?

15. **If VCT is covered, does Company receive result? Employer?**

16. **If HAART is covered in the standard plan:**

- . How are HAART providers chosen?
- . Does Company require providers to follow treatment protocols? What is the source of these protocols? What do they require?
  - . What therapies allowed?
    - . At what point in progression of disease are ARVs begun (CD4 level, etc.)
- . Does Company provide any training in offering of HAART? What training and how is it offered?
- . What monetary limits on cost of HAART treatment?
- . What co-payments are required?

17. **Does the Company cut off HAART benefits if the patient is non-complaint or non-responsive to treatment?** How is this determined?

18. **Does the Company typically release identity of employees on HAART to the employer?** Would Company issue a policy that protected the identity of employees/dependents on HAART?

**SPECIAL POLICIES**

19. **Does the Company now sell any special product that provides an HIV/AIDS benefit beyond that in the normal policy?**

   . How many groups/lives are included in such plans?
Would the Company sell enhanced HIV/AIDS coverage if specifically requested to do so by a client?

How does/would the insurer determine the additional premium?

How would/does it take the risk created by offering an expanded HIV benefit?

If it will not take risk, would the insurer serve as a Third Party Administrator for HAART claims if the employer were willing to reimburse it?

Could it keep the identify of individual HAART patients secret?

**20. Special policies with HAART coverage:** (Ignore if initial answer to #19 is ”No”)
- How are HAART providers chosen?
- Does Company require providers to follow treatment protocols? What is the source of these protocols? What do they require:
  - What therapies allowed?
  - At what point in progression of disease are ARVs begun (CD4 level, etc.)
- Does Company provide any training in offering of HAART? What training and how is it offered?
- What monetary limits on cost of HAART treatment?
- What co-payments are required?

**21. Does the Company cut off HAART benefits if the patient is non-complaint or non-responsive to treatment?** How is this determined? (Ignore if initial answer to #19 is “No”)

**22. Does the Company typically identify employees on HAART to the employer?** Would Company issue a policy that protected the identity of employees/dependents on HAART?

**23. What does the Company see as barriers to offering/expanding HIV/AIDS coverage?**
- It would raise the price of coverage to the point where no one would buy a policy?
- The uncertainty (uptake rates, cost) is too great for the insurer to take the risk?
- Is there a specific concern about adverse selection (the only companies that would sign up are the ones who know they have a high number of HIV positive beneficiaries?)
- Would doing an unlinked seroprevalence study of the group prior to underwriting make any difference in the decision?
- There is no demand for this benefit from the employers to whom the Company sells?
- Company does not know enough about HIV/AIDS and its care to make a decision or manage the offering of the HAART benefit?
- The providers with which the Company works are not trained/qualified to offer HAART?
- HAART will not work in the patient population?
- There are no competent and affordable laboratories to perform tests (CD4?, viral load?)
- Insurer would be forced to pay high prices for drugs when the Government can get them cheaply?
- HIV/AIDS is a “risk” that the individual can control and should not be included in a health insurance policy?
- Patients will not come forward because of stigma and the fear they will be identified to their employer?
- Other?

**24. If the Company does not now cover HAART, what developments might cause it to reconsider this decisions?**
- Further decrease in the price of ARVs in the general market?
- Lower prices and greater availability for lab tests (CD4?, viral load?)
- Specific demands from employers/groups?
- Improvement in the quality of HAART care available from the usual providers?
Outside funding/technical assistance for:
   - training providers?
   - training counselors?
   - expanding laboratory capacity (CD4, viral load)?
   - actuarial analysis and rate setting by the insurer?
   - Special reinsurance facility for risks associated with adding a HAART benefit?
   - Government tax incentives for employers to include HAART coverage?
   - A Government requirement that all policies include a specified HAART benefit?
   - Would the Company oppose such a requirement if it were assured of equitable enforcement against all insurers?
   - Other?