

***Covering Treatment for
HIV and AIDS in India***

A Feasibility Study



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The Authors

Institute of Economic Growth

Indrani Gupta,
Mayur Trivedi

Freedom Foundation

Christopher Skill,
Ashok Rau

United Nations

Development Programme

Alka Narang,
Hari Mohan

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Abbreviations

AIDS	Acquired Immuno Deficiency Syndrome
ART	Anti Retroviral Therapy
ARV	Anti Retro Viral
BPL	Below Poverty Line
CBO	Community Based Organisation
CD4+	T cells (helper cells) – which are crucial to the normal function of the human immune system
CGHS	Central Government Health Scheme
CSO	Care and Support Organisation
ESIS	Employees State Insurance Scheme
FF	Freedom Foundation
GSACS	Gujarat State AIDS Control Society
HAART	Highly Active Anti Retroviral Therapy
HCP	Health Care Provider
HIV	Human Immuno-deficiency Virus
HPRU	Health Policy Research Unit
IEC	Information Education and Communication
IEG	Institute of Economic Growth
IP	Inpatient
KSAPS	Karnataka State AIDS Prevention Society
NGO	Non Governmental Organisation
NIC	National Insurance Company (public sector insurer)
OI	Opportunistic infections
OPD	Outpatient Department
PLHIV	People Living with HIV/AIDS
PPTCT	Prevention of Parent to Child Transmission
Rs.	Rupees
SACS	State AIDS Control Society
STI	Sexually Transmitted Infection
TPA	Third Party Administrators
UNDP	United Nations Development Programme
VCTC	Voluntary Counselling and Testing Centre
WHO	World Health Organization

Introduction

Despite falling prices of anti-retroviral (ARV) drugs, the expenses involved for individuals and families living with HIV/AIDS who need to be on ARV therapy (ART) continue to be high enough to impose serious economic hardships on individuals and families which act as major deterrents to accessing such treatment. The need for coverage or insurance for ART takes on greater urgency given the economic status of the majority of the detected cases of HIV/AIDS in India; while no firm data is available, evidence from the handful of care and support organisations (CSOs) around the country indicates that most of their clients are in urgent need of financial help if they are to access ART. The only individuals who are currently covered by insurance for ART are: Central Government employees through the Central Government Health Scheme (CGHS); employees covered under Employees State Insurance Scheme (ESIS); employees of the Railways and the Armed Forces; and employees of various other public sector undertakings.

While insurance for ART can be also offered by private insurance companies and efforts are being made to get some of these companies to incorporate coverage for HIV/AIDS treatment (Gupta et al, Population Council 2004) – these amended insurance products will continue to be out of reach for the bulk

of those seeking treatment unless ways can be found to pay part or all of the premium on their behalf.

Recently the Government of India announced a scheme that would give free ARV drugs to selected HIV-positive individuals, including children and pregnant mothers. The free ARV programme has been implemented since April 2004 in six high-prevalence states. It is planned that the number of ART centres will be increased to 25 and cover a total of 25,000 patients by the end of 2004-05 and that ART facilities will be extended to 1,00,000 patients by the end of 2007. This raises the question as to whether there is still a need for non-governmental schemes to cover ARV treatment. The key factor that will separate the government initiative from schemes implemented by CSOs is the quality of care and treatment offered. Free drugs are only a small part of the picture; quality of care and treatment with maximum adherence is the key. While no study exists that has evaluated the government's free ART initiative, anecdotal evidence does indicate that there are some issues regarding the quality and management of the programme. This means that at present if an organisation can ensure that its clients get quality care with follow-up under a programme of coverage for ART,

The need for coverage or insurance for ART takes on greater urgency given the economic status of the majority of the detected cases of HIV/AIDS in India.

An essential element in the design of a non-governmental scheme would be putting in place an operationally feasible set-up of HIV/AIDS-related healthcare services.

it would make the programme superior to the current government initiative. Thus an essential element in the design of a non-governmental scheme would be putting in place an operationally feasible set-up of HIV/AIDS-related healthcare services, which would include trained healthcare providers, availability of ARV drugs, medicines and tests, and other required infrastructure.

The urgent need to find ways to cover treatment for individuals trying to access ART has prompted the UNDP, Delhi, to initiate a study to explore potential schemes that can

be piloted in order to test their financial and operational feasibility. Freedom Foundation (FF), a Care and Support Organisation (CSO) based in Bangalore and with widespread and extensive experience in the provision of ART to the general population, was used as a case study to conduct the feasibility exercise. The Health Policy Research Unit (HPRU) of the Institute of Economic Growth, an economic research think-tank based in Delhi, was commissioned to conduct the study. This report was prepared by the HPRU team in close collaboration and consultation with the FF and UNDP, Delhi.

Literature Review

The falling prices of ARVs have raised hopes of expanding access to treatment for those who need it the most. It is only recently that the impact of various global and regional initiatives for improving access to ART has been felt in India. For example, out of estimated 7,50,000 ART eligible individuals in India, only around 13,000 (or less than 2%) were on ART by the end of 2003. (*Gupta et al, Population Council 2004*). A major public initiative to increase access to ART was the recent roll-out of the Government of India's scheme of providing free ARV drugs to selected HIV-positive individuals, including children and pregnant mothers. Since April 2004, the free ARV programme has been implemented in six high-prevalence states, and under the revised target, is eventually expected to cover 100,000 individuals across various states in a phased manner by 2007.

According to WHO, some 7,70,000 individuals in India were in need of ART in 2004 and as of April 2005, only an estimated 35,000 people were receiving ART, including those enrolled in private facilities (WHO 2005). Thus, while access has improved, only 4.5% of the people in India who need ART are getting it, leaving the vast majority of the target population uncovered and untreated. And of those currently receiving ART, only an estimated 10,000 individuals are covered by the government programme, which means

that many of those accessing ART are paying out-of-pocket for the costs of treatment.

Given the high costs of the life-long treatment of HIV and AIDS, traditional approaches to financing care and treatment are insufficient. It is, therefore, important to explore the potential of extending coverage under various existing and new approaches to healthcare financing, including social insurance, private insurance and community financing schemes.

Before exploring the options available in India, it is important to understand the various global initiatives regarding the financing of access to ARVs through risk-pooling mechanisms. In one of the earliest works on insurance and HIV, Oppenheimer and Padgug (1986) reported that various methods - ranging from antibody testing to charging unaffordable, high prices - were explored in the US to exclude HIV-positive individuals from insurance risk pools. Currently in the US, HIV/AIDS care is largely financed through the Medicaid scheme by the public sector (Katherine and Charles Gilks 2000) and as of today several federally-funded initiatives cover HIV treatment.

Many global and regional initiatives to improve access to ART took place during 1998-2002 (Lucchini et al, 2003) and resulted in further reduction in the price of treatment. The trend of lowering ART costs also allowed exploration

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With the dramatic reduction in prices of ART and various national programmes to provide access to ART, the movement to explore different ways of financing ART gained momentum.

of the possibility of including HIV/AIDS under existing insurance financing schemes. For example, prior to the development of medical/health insurance which covered HIV/AIDS, at least three life insurance products were available in South Africa to cover HIV-positive individuals and similar products were also available in other countries like the USA and France (Stuart Land 2003). Similarly, there are numerous instances of insurance products such as “Critical Illness” policies being offered to individuals for medically or occupationally acquired HIV individuals in countries including Australia, New Zealand, Hong Kong, United States and South Africa. In Uganda, while individual policies were not available, several group insurance plans were available with a “rider” to employers which extended insurance policies to cover treatment of opportunistic infections (OIs) and supply of ART at an additional premium. Subsequently, in January 2004 the major insurance company in Uganda announced that it would provide insurance for treatment of HIV/AIDS, including first-line ART, to insured employee groups at no additional cost above the standard premium (Feeley et al 2003). And in South Africa, the insurance company Capital Alliance reportedly offered South Africa’s first HIV/AIDS insurance product in 2001, which allowed employers to take out insurance against the risk of their employees contracting HIV/AIDS (www.cidi/humanitarian/hivaids/01b/ix15.html).

With the dramatic reduction in prices of ART and various national programmes to provide access to ART, the movement to explore different ways of financing ART gained momentum. Access to ART in India, however, remained poor until the roll-out of the government programme in April 2004.

Until then, the only individuals who were fully covered for ART were employees included under ESIS, CGHS, or by the Railways or Defence departments (Gupta et al, Population Council 2004), all of which offered coverage of ART as a part of their responsibility to cover *all* the medical costs of beneficiaries. Apart from these, various CSOs offered their own ad hoc schemes or programmes for covering access to ART for their clients; most of the coverage was in the form of subsidies. As for coverage of ART under formal health insurance policies, both private and public sector insurance companies continue to exclude the expenses of HIV-related treatment. There have been a few instances of community insurance covering HIV-related treatment and run in partnership with insurance companies, but only where no HIV/AIDS exclusion clauses were included in the relevant policies. For example, the UNDP-funded scheme run by Karuna Trust, Karnataka, offers coverage for all treatment, including for HIV/AIDS, within the stipulated amount of coverage. Although the coverage ceiling was, in practice, too low to cover the full expenses of ART, in principle such a scheme raises numerous possibilities for further exploration and experimentation regarding the provision of ART coverage. In addition, a Population Council project (Gupta et al, Population Council 2004) emphasised the need for dialogue between different stakeholders; specifically, it attempted to facilitate the partnership between the Gujarat State AIDS Control Society (GSACS) and a public sector insurer (NIC Ltd.) to explore the possibility of extending coverage to the HIV/AIDS-vulnerable population of the state.

With this background in mind we now turn to the objectives and rationale for this feasibility study.

Objectives and Rationale of the Study

III

The aim of the feasibility study is to identify one or multiple potential schemes that offer coverage by non-governmental healthcare providers to individuals who need access to ARV treatment and to indicate which schemes can be piloted/put into practice. The following issues need to be kept in mind before designing the actual schemes:

- Rationale for such schemes
- Basic principles on which the scheme(s) should be based
- From whose perspective the scheme should be designed
- The kind and scope of coverage: only ART and/or HIV-related treatment, or other treatment as well, and if so, to what extent (i.e. opportunistic infections or general health)
- Stand-alone or integrated schemes
- Type of providers included in the scheme

1. Why do we need schemes to cover treatment expenses of HIV-positive patients?

To re-emphasise the basic reason behind coverage, it is clear from numerous studies that there is burden of treatment on individuals and households for general curative/palliative healthcare. This burden is even higher for specific chronic conditions

and illnesses because of the recurrent and long-term nature of the related expenditures. In relation to HIV/AIDS, for those in need of ART the costs of tests and drugs are substantial and not sustainable even for individuals/families with reasonable income streams. The necessity of life long treatment for HIV/AIDS makes it a necessary challenge to find sustainable financing mechanisms.

2. Principles that should guide the structure of the schemes

Current thinking on insurance/financing schemes is that of graduated cost recovery. It is clear that no scheme can be sustainable unless attention is paid to recovering costs. The best option is to make the scheme self-sustainable, which means that the premiums, time-frame and payouts are charted out in such a way that the insurance pool does not need any outside funding to sustain itself. The greater the pooling range across risk and income, the greater the potential sustainability of the scheme and the greater the possibility of cross-subsidisation. For a CSO, however, the majority of the clients come from the lowest-income sections of society and thus a significant amount of subsidies for premiums is often required. If such subsidies are involved, they should be based on proven and sound equity issues and

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mechanisms need to be found to recover the full costs of running the project.

3. Stakeholders: Whose point of view should be kept in mind?

Clearly, the main beneficiaries of financing schemes are the individuals seeking treatment. Barring a perfect health insurance market (where an individual's demand for coverage is dependent only on that individual's preferences and initiative) there will always be other intermediaries involved. The possibilities are many: Non Governmental Organisations (NGOs) working on care and support, NGOs/CSOs - Community Based Organisations - working with communities, CSOs, networks of positive people/self-help groups, the government, donors and insurance companies etc. The perspectives of any and all these groups may be relevant to a given scheme for coverage of ART and HIV-related treatment.

It is clear that the design of the scheme is closely related to the organisational set-up selected to deliver the scheme. For example, if a CSO wants to assist its clients with the economic burden of treatment of HIV/AIDS, then the focus of the scheme will be the organisation and its clients. In a general coverage scheme, however, the focus will cease to be clients of NGOs; instead it will be the community at large. Regardless of who the specific target is, the role of the government and donors cannot be over-emphasised; the government can play several crucial roles – as provider, financier, facilitator etc. It is our contention that any scheme which targets vulnerable populations needs the support of the government acting in one role or another.

The donors are also critical to the financial sustainability of such tailor-made schemes.

4. What kind of coverage is being offered?

A key decision to be made when devising an insurance package is what type of coverage to offer: should only ART and tests be covered, or should expenses for opportunistic infections be included or even other primary healthcare services. On the one hand, the more general the scheme, the greater its utility in terms of catering to a larger segment of the population but on the other hand, making the scheme too broad may make it operationally difficult and insufficient in meeting the demands of those who need ART the most.

5. Stand-alone scheme or an integrated scheme?

A critical issue on coverage that will have to be addressed is whether the scheme should only be available to HIV-positive individuals or to the community as a whole, with the possibility of coverage for anyone who later becomes HIV-positive. In addition, should there be one general scheme or two schemes: one for those who are not HIV-positive at inception and one for those who are already HIV-positive? How will an HIV-specific scheme be integrated with other schemes? Should the existing health schemes be amended to incorporate ART and related treatments or should new schemes be devised? If the focus is on the CSOs, should the schemes cover only ART-eligible individuals or all HIV-positive individuals? These are some of the issues which must be resolved before developing any coverage scheme in the context of HIV/AIDS.

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TABLE 1: Optional elements of ART financing

Parameters	Details of the scheme	Alternative schemes			
		A	B	C	D
Coverage area	Block, Taluk				
	Specified cities				
	States				
Who are covered	General public				
	Specific community (ex. High Risk, BPL)				
	Specific community visiting a specific NGO/s (HIV-positive)				
	Others (specify)				
What is covered	Outpatient services				
	Inpatient services				
	Diagnostics				
	Operative procedures				
	STI treatment				
	OI treatment				
	Initial tests for ARV				
	ARV drugs				
	Monitoring tests				
Where to get services from	Public facilities				
	Private facilities				
	Specified public/private providers				
	NGO-owned facilities				
	Others (specify)				
Who will administer the scheme	Government				
	Insurance company				
	Network of NGOs				
	NGO				
Role of insurance company	Marketing of the policy				
	Policy handling (including selling)				
	Risk undertaking				
	Claims processing				
Role of NGO(s)	Marketing of the policy				
	Policy handling (including selling)				
	Risk undertaking				
	Claims processing				
	Service provision				
	Financing (Paying partial/full premium for clients)				
	Others (specify)				
Role of Government	Marketing of the policy				
	Service provision				
	Financing (paying partial/full premium for clients)				
	Others (specify)				

6. Provision of healthcare for insured individuals

Other issues to be considered relate to the details of the provision of healthcare in the context of HIV/AIDS. For example, where should the individuals being covered go for accessing treatment? What kind of healthcare providers be included on the list of the scheme's approved providers? How will the scheme ensure access to reliable and quality services? Should the scheme be restricted to only those HCP who provide ART? The services to be included in the scheme will also depend on the issues discussed in items 4 and 5 above.

Each of the issues outlined above are intricately inter-related, and a decision about one affects all the others. To understand the range of possibilities and the associated implications for schemes that may be implemented, a framework has been developed (Table 1). Table 1 displays the various dimensions that need to be considered while deciding on financing options for ART.

The last four columns indicate the four alternative schemes to be considered, which can be used by analysts in coordination with the list of the parameters' optional

elements to determine which of the schemes is most appropriate/relevant. It is important to note that there could be many possible combinations of optional elements and that each will, in turn, give rise to a series of required actions and decisions that are not costless. In other words, the inclusion of an optional element in an actual scheme/insurance package would have implications for each of the involved agents and the costs, in terms of reorganisation, additional investment, restructuring etc. would need to be tallied in order to determine which combination of elements and which overall scheme has the lowest cost. In addition, each stakeholder group may look at its own costs and decide on whether or not to be involved in the project/scheme. Finally, if the government is the one doing the decision-making, then there is the possibility of covering all or part of the costs of some or all stakeholders which flow from implementing a given optional element.

This table can be used generally as a guideline for any agency or group wanting to provide insurance to groups of people, regardless of the type of disease they may share. Depending on the situation, the aspects of the table which are specifically related to HIV/AIDS can easily be modified.

It is important to note that there could be many possible combinations of optional elements and that each will, in turn, give rise to a series of required actions and decisions that are not costless.

Financing Schemes for ART at a CSO Centre

IV

While all the optional elements combinations from Table 1 are important, for the purposes of this report only three broad optional elements are considered because the data in this analysis is from the primary stakeholder, FF. FF was selected as a case study as it is widely recognised by NACO and other agencies to be an ideal model of the provision of comprehensive, community-based care and support services for HIV/AIDS. Some of the components of FF's comprehensive approach to HIV/AIDS that are relevant to this study include: the provision of medical care; palliative care; counselling; awareness, prevention, care and support and community education; prevention of parent to child transmission of HIV; and home-based care. Most importantly, FF has been offering and trying to increase its provision of ART to eligible HIV-positive people since 1999 and today it has over 500 patients accessing ART across its various centres. Furthermore, FF is responsive to the fact that a number of its clients need or would like to access ART but cannot afford it. FF's extensive experience and its established presence throughout the country made it an ideal candidate to "represent" CSOs in India in relation to HIV/AIDS and the provision of ART. Thus, the findings and conclusions of the study may specifically be based on FF's data, but

they are considered to be applicable to Indian HIV/AIDS-related CSOs in general.

The study and this report mainly considered the options open to NGOs, such as FF, if they want to extend coverage for ART to their clients in the short-term. It must be understood that in the long run, all optional elements included in Table 1 are open to NGOs as well if they can be brought under one umbrella of coverage implemented at the state or national level.

A review of the three options considered in this analysis can be found below. The baseline option is that of not doing anything more than what is currently available (the "do-nothing" option). To reiterate, all the options discussed are based on the experience, activities and data of FF.

1. Baseline or "do-nothing" Option: Continue with the ad hoc provision of ART for those in need

The baseline scenario or "do-nothing" scenario is simply the maintenance of services currently available at FF. To-date, FF is providing free or subsidised ART to 81 individuals on an ad hoc, as-needed basis at their Bangalore City Centre. All children get free ART.

FF has been offering and trying to increase its provision of ART to eligible HIV-positive people since 1999 and today it has over 500 patients accessing ART across its various centres.

2. Option I: Coverage for those who are currently on ART and for those who are ART-eligible but not on ART (*pertains only to FF's Bangalore branch*)

Option I entails offering coverage to clients of FF who are currently on ART and those who are ART-eligible. The most-used criterion for judging ART-eligibility is a CD4 count of less than 250, but the FF medical staff can relax the criterion if necessary. Currently, 183 individuals are eligible but not getting ART at FF. All of these statistics have been adjusted to account for deaths of FF clients. Under this option, the goal will be to cover about 264 individuals with the ART financing scheme, including those who were on ART for the year 2003-2004.

3. Option II: Coverage for all people who are HIV-positive who visit FF and/or who test positive for HIV/AIDS at FF (*pertains only to FF's Bangalore branch*)

Option II will cover all those who test HIV-positive at FF and those who were already HIV-positive when they approached FF. This is estimated to include 2452 individuals, which is based on the FF Voluntary Counselling and Testing Centre's (VCTC) inpatient and outpatient data and is cumulative until the date of study. For the single year 2003-04, the estimate for this group is 800 individuals. Under this scheme, the VCTC programme of FF will be strengthened and individuals will be encouraged to go for HIV testing. FF would offer to reimburse the cost of the HIV test if the individual agrees to enrol in FF's

coverage scheme in the event she or he tests HIV-positive.

4. Option III: Coverage for vulnerable but HIV-negative populations or for all those who come to FF regardless of HIV-status

Option III entails covering the entire client population of FF, assuming that they all comprise vulnerable people. This includes all those covered by targeted interventions in all the centres of FF. This is the most ambitious of all three options, and will cover about a target population of one lakh. Since the National Insurance Corporation is already working closely with the Gujarat State AIDS Control Society (GSACS) on a similar scheme, the details of that scheme will be discussed here until a revision can be done which specifically takes FF's data into consideration.

Basic parameters of graduated cost recovery

Since the basic premise of ARV coverage is graduated cost recovery based on individuals' ability to pay, two basic parameters were developed from the FF data: (1) The distribution of individuals across economic categories; and (2) the costs of running the ART programme.

(1) **Economic categories:** The two alternative approaches which were used to arrive at the percentage of individuals across different economic categories are described below:

- In the first approach, three economic categories were adopted based on the data, which yielded the following

The most-used criterion for judging ART-eligibility is a CD4 count of less than 250.

group distribution that was used in the analysis: very poor (16%), poor and low (65%) and middle and above group (19%).

- In the second approach, an additional category – the wealthy – was added. As will be seen, this category comprised those who would be willing to pay significant amounts in premiums for coverage of ART.

In the analysis, it was assumed that when additional individuals are considered in each of the categories, the proportion remains basically the same. This assumption, however, can be altered and be used as a parameter for more sensitised analyses.

(2) **Costs of ART programme:** These include current and capital cost estimates and the costs of drugs and tests.

- Since performing replacement costing for capital items is difficult, for now the analysis uses FF's current estimates for capital cost, which can be suitably adjusted for the various components involved in running an ART programme.
- The ART programme is assumed to require VCTC, an outpatient department (OPD) and a minimum Inpatient (IP) facility. The apportionment of costs is accordingly done for both recurrent and capital costs. These estimates can, however, be improved/adjusted to account for a longer time horizon.

The calculation of premiums for Options I and II

There are two ways of approaching the premium calculation. The first is to look

at the current per head costs of FF's ART programme, factor in targeted cost recovery, and then fix the premiums accordingly. Since the number of people currently covered by FF is small, however, and the total cost of the ART programme is significant, this option is not operationally appealing.

The other method is to calculate what it currently costs FF to provide ARV drugs and tests (assuming that a reimbursement scheme can function even if the tests are done outside FF) and base the premiums on a percentage of that. This was considered a more feasible method from an operational perspective, and it would yield reasonable premium rates. This second methodology is the one used in this analysis for calculating premiums. The difference between this and the baseline option described above is that:

- Premiums will be fixed based on the sliding scale and applied to all individuals who enrol in a systematic fashion;
- Premiums will be collected annually or biannually; and
- Coverage will extend to tests as well as ARV drugs.

To give an incentive for individuals to join this programme, the first people to get tested for ART-eligibility by FF will get the costs of the included with the costs of the ART programme which are covered.

The premiums can be based either on the market price of ARV or on what it costs FF to procure these drugs. Since FF has been able to procure the drugs at wholesale rates, this has been factored into the analysis. As of August 2005, per individual it cost Rs. 6,120 for ARVs and Rs. 2,500 for the various tests (excluding initial tests), including

The premiums can be based either on the market price of ARV or on what it costs FF to procure these drugs.

monitoring tests. In addition, a maximum ceiling amount of Rs. 5,000 is provided for the treatment of OIs. Thus the cost of ART per person amounts to Rs. 13,620 and the premiums have been calculated as a percentage of this, after accounting for the economic status of the individual. These costs are not fixed, however, and can change in the future or under alternative assumptions, thus they should be treated as input variables in the calculations. The following table presents these cost figures.

TABLE 2: Cost estimates

As on August 2005

Particulars	Unit cost	Frequency in a year	Annual cost Rs.
Misc. tests	1000	1	1000
Monitoring tests	375	4	1500
ARV drugs	510	12	6120
OI treatment/ drugs (upto)			5000
ART			13620
ART sustenance costs			
ARV drugs	510	12	6120
Monitoring tests - CD4 count	375	2	750
Total			6870

The costs to FF would cover all the above tests, plus the cost of the initial test, which will be offered as an incentive.

Clarifications on Options I and II

Before turning to the results, some clarification is necessary in regard to Options I and II. Option III will be discussed separately since it is entirely different from the first two options.

1. It is important to separate *schemes* from *options*. Schemes are the alternative

scenarios for calculating premiums. Options refer to the broad categories of target clientele described above. Under the first two options, three alternative premium scenarios – schemes – will be discussed.

2. The total cost of the ART programme was calculated for each of the options, including the baseline option. This includes the cost of drugs and tests in the new programmes, as well as other costs involved in running the ART programme.
3. One set of calculations involved finding out the marginal cost of the “ART-insurance” options; in other words, what is the net increase in costs to FF (over/above the baseline) if any of these options is carried out? Thus, three sets of marginal costs were obtained based on the three schemes for both the options. The comparisons of each of these marginal costs help to give an idea of how much FF may have initially contributed if it wants to adopt any of these programmes.
4. Ideally, the analysis should also assess the proportions of different sources of funding for the ART programme, including cost recovery. All the sources of funding for the ART programme that FF currently receives should be looked at and cost recovery needs to be added as another source of funding. The distribution of sources of total costs across the three options will reveal the extent to which FF is dependent on different donors. However, the potential resource gap calculation represents a future possibility, as the current data of FF do not permit such calculations.
5. The above analysis is potentially useful

The cost of ART per person amounts to Rs. 13,620 and the premiums have been calculated as a percentage of this, after accounting for the economic status of the individual.

for the purposes of scaling up and for replicability and, therefore, is of immediate use to potential donors who may be interested in funding FF in order to include “ART-insurance” as another component of FF’s care and support programme.

6. The flow of costs critically depends on the time span over which they are spread, therefore, a limited five-year period analysis was done. While the choice of five years may seem somewhat arbitrary, it was selected as offering a middle ground, being a time period which is long enough to assess and evaluate feasibility issues and short enough to

interest potential donors. The critical parameters that were assumed to change over the five-year span are:

- a. The number of people who will need ART
- b. The number of people who will access ART

Concomitantly, changes in these parameters will change the overall cost of a given option. It is also possible that the costs of drugs and tests may come down, in which case the premium calculations will change as well. For the purpose of this analysis, however, it is assumed that prices will remain the same for five years.

The flow of costs critically depends on the time span over which they are spread.

Three alternative schemes for determining premiums have been analysed. The premiums are on a sliding scale based on the economic category targeted.

Before turning to the analysis, some additional terminologies need to be re-emphasised:

1. Entry incentives

- a. **For Option I:** to encourage individuals to join the scheme, the initial tests to assess ART eligibility will be offered for free
- b. **For Option II:** to encourage individuals to join the scheme, the initial tests to determine HIV-status as well as ART eligibility will be offered free.
- c. **Option III** will include all vulnerable individuals visiting FF; in other words, all the clients of FF including those who are currently HIV-negative. The first two options are completely internal to and run entirely by FF, unlike the third option, which is visualised as a collaboration between FF and an insurance company. This option can be seen as complementary to the first two options.

2. **Economic categories:** As mentioned above, two alternative income categories distribution methods were used based on FF's data: the first distribution was 16% (very poor), 65% (poor & low) and 19% (middle & above) and the second was 15% (very poor), 45% (poor & low), 30% (middle) and 10% (wealthy). Unlike

the first set of distributions (which were based on FF's current data on clients), the second set was additionally based on the assumption that a higher proportion of clients can possibly afford higher premiums than what the current data show. It is also assumed that the poorest clients are not subject to any payment at all.

3. **Premium:** This is to be fixed as a percentage of the total annual cost of ART including the costs of drugs, tests and OI treatment. Three alternative schemes for determining premiums have been analysed, as indicated in Tables 3A and 3B (three-way and four-way classifications of income categories). The premiums are on a sliding scale based on the economic category targeted. Thus, in Scheme I (based on the three-way classification of economic category), the percentage of the total cost of drugs, tests and OI treatment annually which has been set as the premium for the various income categories are: 0% (very poor), 20% (poor & low) and 50% (middle & above). Under Scheme II, the percentages representing the premiums are 5%, 30% and 60% respectively, and under Scheme III these are even higher. Clearly, each scheme has different implications for cost recovery, with scheme III offering

the highest cost recovery.

Similarly, under the four-way classification shown in Table 3B, the premium for the four income categories is 0%, 20%, 50%, 90% respectively, of the total cost of drugs, tests and OI treatment. Unlike the three-way classification, in all three schemes the very poor and the wealthy contribute the same as premiums (0% and 90% respectively); the middle two categories pay progressively higher in each of the three schemes.

5. **ART cost:** This will include total annual costs of ARV medicine (at a negotiated

price of Rs. 510 per month) and the costs of monitoring and other miscellaneous tests per person. In addition, it will include OI treatment of up to Rs. 5,000 per individual per annum, as well as the entry incentives mentioned above.

6. **ART programme management cost:** This is the cost of the care centre apportioned to the ART programme, as per the details provided by FF. This includes the cost of personnel, infrastructure, overhead, etc. in both current and capital accounts. This excludes the ART cost mentioned above.

TABLE 3A: Alternative scenarios of premium (Three income categories)

Premium across income categories	Distribution in (%) across categories	Scheme I		Scheme II		Scheme III	
		Proportion (%) of total ART cost	Annual premium in Rs.	Proportion (%) of total ART cost	Annual premium in Rs.	Proportion (%) of total ART cost	Annual premium in Rs.
Very poor*	16	0	0	5	681	10	1362
Poor and low*	65	20	2724	30	4086	40	5448
Middle and above*	19	50	6810	60	8172	70	9534

TABLE 3B: Alternative scenarios of premium (Four income categories)

Premium across income categories	Distribution in (%) across categories	Scheme I		Scheme II		Scheme III	
		Proportion (%) of total ART cost	Annual premium in Rs.	Proportion (%) of total ART cost	Annual premium in Rs.	Proportion (%) of total ART cost	Annual premium in Rs.
Very poor	15	0	0	0	0	0	0
Poor and low	45	20	2724	30	4086	40	5448
Middle and above	30	50	6810	60	8172	70	9534
Wealthy	10	90	12258	90	12258	90	12258

*

Indicator	Very poor	Poor and Low	Middle and above
1. Income (Rs.) per annum	<3000	3001-6000	6001-10000
2. Occupation	Unemployed, Unskilled, Casual, Seasonal, Student	Semi-skilled, Farmers, Shop-owners	Skilled, White-collar

7. **ART programme cost:** This is the total cost arrived at by adding ART cost to ART programme management cost.
8. **Net ART programme cost:** This is the ART programme cost minus the cost recovery. Unlike ART programme costs, net ART programme costs will be different for the three schemes according to their respective differences in cost recovery.
9. **Committed ART expenditure:** This is the cost assessment of sustaining those individuals who have been put on ART in the event the project terminates after the two years' pilot (due to a variety of reasons). This would include ART drugs and biannual CD4 monitoring tests, the annual cost of which is calculated to be Rs. 6,870 per annum. It would be applicable only to those who have been on ART during the scheme period, and will not include OI costs for any clients (including those under option II). Since these clients will continue to pay their premiums, the cost recovery would continue as a source of income for the insurance pool.

Based on the calculations and analysis, three different types of "gaps" were identified, which differ across the schemes:

- **Cost recovery gap:** This is the difference between the ART cost and the cost recovery under the alternative scenarios.
- **Resource gap:** This is the difference between all the funds currently allocated to the ART programme minus the

cost of the insurance-enhanced ART programme.

- **Marginal cost of insurance-enhanced ART programme:** This is the marginal cost (adjusting for cost recovery) of running the insurance programme which is over the baseline costs.

The various assumptions made for the proposed five-year period as well as changes in parameter values have been incorporated in the calculations by developing a "Costing Tool for ART Coverage" that makes the analysis much simpler. The tool has been developed separately for Options I and II and essentially comprises the following interconnected figures:

1. Entry-costing estimates
2. Entry-baseline
3. Entry-income statement
4. Option-entry
5. Output year 0
6. Output projection
7. Output for five years
8. Committed ART expenditure

Clearly, assumptions needed to be made to chart out the path of ART demand for the next five years. These assumptions are given in Annexes I and II for Options I and II and only for the three-way income category classification. It is important to understand that these assumptions can subsequently be changed and a different path of demand can be charted out to account for changing realities.

The various assumptions made for the proposed five-year period as well as changes in parameter values have been incorporated in the calculations by developing a "Costing Tool for ART Coverage" that makes the analysis much simpler.

Results and Implications

Option I

This option would cover all ART-eligible individuals who visit FF. Basically this option entails offering free testing of individuals to ensure their ART eligibility and then offering those eligible a coverage package which covered their ART, some OI treatment and miscellaneous tests.

As can be seen from Tables 4A and 4B, the increase in ART-eligible individuals visiting FF and thus the number of eligible individuals entering the scheme are modest. If the scheme is made popular and if individual clients understand that they are saving out-of-pocket expenses in the long run by being on the scheme, the numbers may be more encouraging. The incentive of free ART-eligibility testing might also prove to be more effective than has been assumed in these calculations.

These tables reflect: (1) the higher the subsidy element in the premium fixation, the lower the cost recovery and the higher the various kinds of costs; and (2) costs are going to go up over the years as the extent of coverage keeps increasing. The difference in results between Tables 4A and 4B lies in the fact that the four-way classification – with no premium for the poorest and a steep premium for the wealthy – yields a

more favourable scenario in terms of cost implications.

The resource gap – of great relevance to potential donors – is not presented here because the current accounting of FF does not allow a neat apportioning of different sources of funds for different uses. If this limitation can be overcome in following years, then it will offer an additional variable that can be used during funds negotiations with donors.

To sum up Table 4A, if FF wants to start a sustainable low premium scheme (Scheme I), it would have to raise an additional Rs. 10 lakh in the initial year (marginal cost) and about Rs. 45.4 lakh in the fifth year. These amounts are lower (Rs 6.7 lakh and Rs. 32 lakh) for the higher premium scheme (Scheme III). This means that even with the most optimistic assumption about premiums, the cost recovery gap between the costs of provision of drugs/tests and the costs recovered remains high – Rs. 13.9 lakh for year 0 and Rs. 57.7 lakh for year 5. The implications are similar in Table 4B, only the gaps are smaller.

Finally, when considering both these schemes, the possibility that the coverage scheme will be discontinued due to sustainability problems

The four-way classification – with no premium for the poorest and a steep premium for the wealthy — yields a more favourable scenario in terms of cost implications.

TABLE 4A: Option I: Results for five years (Three-way income classification)

Item		Year 0	Year 1	Year 2	Year 3	Year 4	Year 5
Number of ART eligible individuals visiting FF		264	333	432	584	788	1064
Number of ART eligible individuals given subsidised ART in the baseline		81	100	126	158	200	252
Number of ART-eligible individuals entering the scheme		132	158	202	277	388	536
Costs of baseline scenario (in Rs. lakhs)		21.1	26.5	34.2	45.6	60.9	81.3
Net costs of Option I (in Rs. lakhs) (<i>ART Programme cost - cost recovery</i>)	Premium Scheme I	31.0	38.5	49.7	67.7	92.9	126.7
	Premium Scheme II	29.4	36.5	47.2	64.2	88.0	121.4
	Premium Scheme III	27.7	34.5	44.6	60.7	83.2	113.3
Marginal cost of Option I (in Rs. lakhs) (<i>Net ART programme costs - (through scheme) - Net ART programme cost - (baseline)</i>)	Premium Scheme I	10.0	12.0	15.5	22.1	32.0	45.4
	Premium Scheme II	8.3	10.0	13.0	18.6	27.1	40.1
	Premium Scheme III	6.7	8.1	10.4	15.1	22.3	32.0
Cost recovery gap (in Rs. lakhs) (<i>Total ART costs - cost recovery</i>)	Premium Scheme I	13.9	16.9	21.7	29.8	41.8	57.7
	Premium Scheme II	12.3	14.9	19.1	26.4	36.9	52.4
	Premium Scheme III	10.6	12.9	16.6	22.9	32.1	44.3
Resource gap (in Rs. lakhs) (<i>Net ART programme costs - donor funds apportioned to ART programme</i>)	Premium Scheme I	12.1					
	Premium Scheme II	10.4					
	Premium Scheme III	8.8					

after the pilot phase must be considered and accounted for. Such a possibility raises the ethical issue of the need to sustain individuals who are already receiving ART even if fresh enrolments in the scheme are not taking place. In Annex 3, the cost implications for sustaining ART for at least five years for those already in the programme are presented—these figures represent the committed ART cost as defined above. This “worst-case” exercise is useful for any organisation that may want to fund a coverage initiative. For

instance, if a donor wants to fund the pilot and plans to bear the expenses in case the scheme fails after the first two years of pilot phase, then based on FF’s data, to sustain the enrolled individuals (158) under option I (all three schemes) for the next three years would involve a net cost of Rs 11.26, 6.42, and 1.58 lakh respectively (for the four-way classification of income categories) for a total of 19.26 lakh. Of course, this also raises the question of sustainability beyond the project period of five years. This analysis

TABLE 4B: Option I: Results for five years (Four-way income classification)

Item		Year 0	Year 1	Year 2	Year 3	Year 4	Year 5
Number of ART eligible individuals visiting FF		264	333	432	584	788	1064
Number of ART eligible individuals given subsidised ART in the baseline		81	100	126	158	200	252
Number of ART-eligible individuals entering the scheme		132	158	202	277	388	536
Costs of baseline scenario (in Rs. lakhs)		21.1	26.5	34.2	45.6	60.9	81.3
Net costs of Option I (in Rs. lakhs) (<i>ART Programme cost - cost recovery</i>)	Premium Scheme I	29.2	36.2	46.8	63.7	87.3	119.0
	Premium Scheme II	27.8	34.6	44.7	60.9	83.4	113.5
	Premium Scheme III	26.5	33.0	42.7	58.1	79.4	108.1
Marginal cost of Option I (in Rs. lakhs) (<i>Net ART programme costs - (through scheme) - Net ART programme cost - (baseline)</i>)	Premium Scheme I	8.1	9.8	12.6	18.1	26.5	37.7
	Premium Scheme II	6.8	8.1	10.6	15.3	22.5	32.3
	Premium Scheme III	5.4	6.5	8.5	12.4	18.5	26.8
Cost recovery gap (in Rs. lakhs) (<i>Total ART costs - cost recovery</i>)	Premium Scheme I	12.0	14.6	18.8	25.9	36.2	50.0
	Premium Scheme II	10.7	13.0	16.7	23.0	32.3	44.6
	Premium Scheme III	9.3	11.4	14.7	20.2	28.3	39.1
Resource gap (in Rs. lakhs) (<i>Net ART programme costs - donor funds apportioned to ART programme</i>)	Premium Scheme I	10.2					
	Premium Scheme II	8.8					
	Premium Scheme III	7.5					

restricts the calculations to five years, but any organisation or donor aiming to get involved in this initiative should weigh carefully the financial and ethical implications of long run sustainability.

Option II

This option aims to cover HIV-positive individuals who visit FF and those who test HIV-positive at FF. As in the case of Option I, the projections of numbers as well as costs were done for a five-year period. Basically,

this option entails offering individuals free HIV and ART-eligibility testing and then offering those HIV-positive individuals a package which covered ART, OI treatment and other tests. This option also offers OI treatment to individuals who are not ART-eligible yet.

The results in Tables 5A and 5B are interesting, particularly when compared with those in Tables 4A and 4B. Over the five years, despite the increased coverage in Option II

TABLE 5A: Option II: Results for five years (Three-way income classification)

Item		Year 0	Year 1	Year 2	Year 3	Year 4	Year 5
Number of ART eligible individuals visiting FF		264	316	411	536	673	813
Number of ART eligible individuals given subsidised ART in the baseline		81	95	119	150	189	238
Number of positive people entering the scheme		440	531	664	845	1091	1400
ART-eligible individuals entering the scheme		158	175	223	292	373	455
OI - eligible individuals entering the scheme		242	283	354	461	617	815
Costs of baseline scenario (in Rs. lakhs)		21.1	25.2	32.6	42.2	53.0	64.6
Net costs of Option I (in Rs. lakhs) (<i>ART Programme cost - cost recovery</i>)	Premium Scheme I	49.6	55.2	71.1	93.6	119.7	146.4
	Premium Scheme II	44.0	48.5	62.8	83.0	106.0	128.9
	Premium Scheme III	38.5	41.9	54.4	72.4	92.3	111.3
Marginal cost of Option I (in Rs. lakhs) (<i>Net ART programme costs - (through scheme) - Net ART programme cost - (baseline)</i>)	Premium Scheme I	28.5	30.0	38.5	51.3	66.6	81.8
	Premium Scheme II	23.0	23.3	30.2	40.7	53.0	64.3
	Premium Scheme III	17.5	16.7	21.9	30.1	39.3	46.8
Cost recovery gap (in Rs. lakhs) (<i>Total ART costs - cost recovery</i>)	Premium Scheme I	32.4	34.7	44.4	58.8	76.1	93.7
	Premium Scheme II	26.9	28.0	36.1	48.2	62.4	76.2
	Premium Scheme III	21.4	21.4	27.8	37.6	48.7	58.6
Resource gap (in Rs. lakhs) (<i>Net ART programme costs - donor funds apportioned to ART programme</i>)	Premium Scheme I	30.6					
	Premium Scheme II	25.1					
	Premium Scheme III	19.5					

which covers all HIV-positive individuals (people are insured for OI needs irrespective of their ART-eligibility status), the inflow of premiums is not enough to narrow down the various gaps. Thus while this option is more inclusive, it is offered to more individuals and offers more benefits, it also gives rise to higher gaps compared to Option I.

As in Option I, sustaining 175 individuals for the entire five-year period (in the event that the pilot project was not sustained after two years) would entail a cost of Rs. 11.41, 6.04 and 0.67 lakh respectively (based on the four-way classification) for a total of 18.12 lakh. These costs are quite similar to the net costs in Option I (Annex 3).

TABLE 5B: Option II: Results for five years (Four-way classification)

Item		Year 0	Year 1	Year 2	Year 3	Year 4	Year 5
Number of ART eligible individuals visiting FF		264	316	411	536	673	813
Number of ART eligible individuals given subsidised ART in the baseline		81	95	119	150	189	238
Number of positive people entering the scheme		440	531	664	845	1091	1400
ART-eligible individuals entering the scheme		158	175	223	292	373	455
OI - eligible individuals entering the scheme		242	283	354	461	617	815
Costs of baseline scenario (in Rs. lakhs)		21.1	25.2	32.6	42.2	53.0	64.6
Net costs of Option I (in Rs. lakhs) (<i>ART Programme cost - cost recovery</i>)	Premium Scheme I	42.4	46.5	60.2	79.8	101.8	123.5
	Premium Scheme II	37.9	41.1	53.4	71.1	90.7	109.2
	Premium Scheme III	33.4	35.6	46.6	62.5	79.5	94.9
Marginal cost of Option I (in Rs. lakhs) (<i>Net ART programme costs - (through scheme) - Net ART programme cost - (baseline)</i>)	Premium Scheme I	21.3	21.3	27.7	37.5	48.8	59.0
	Premium Scheme II	16.8	15.9	20.9	28.9	37.7	44.7
	Premium Scheme III	12.3	10.5	14.1	20.2	26.5	30.4
Cost recovery gap (in Rs. lakhs) (<i>Total ART costs - cost recovery</i>)	Premium Scheme I	25.3	26.0	33.6	45.0	58.2	70.8
	Premium Scheme II	20.8	20.6	26.8	36.3	47.1	56.5
	Premium Scheme III	16.3	15.2	20.0	27.7	35.9	42.2
Resource gap (in Rs. lakhs) (<i>Net ART programme costs - donor funds apportioned to ART programme</i>)	Premium Scheme I	23.4					
	Premium Scheme II	18.9					
	Premium Scheme III	14.4					

Option III

This option entails covering all the vulnerable but currently HIV-negative clients of FF in collaboration with an insurance company. This may require a tripartite or bilateral arrangement involving FF, National Insurance Company (NIC) and/or the State AIDS Prevention Society (KSAPS) in Karnataka. Such an experiment is already going on between NIC and the GSACS and

a new tailor-made Mediclaim policy has been formulated which has the following features:

1. The policy will be an amendment to the existing Mediclaim policy, which is essentially a hospitalisation policy. The amended policy will be more inclusive in its coverage.
2. It will not be exclusively for HIV/AIDS-related treatment but will be a more general health insurance policy, which

will not exclude coverage for HIV status.

3. In the initial design, the policy will be for an insured sum of Rs. 50,000. In order to make it a low-cost policy, caps will be put on hospital room rent.
4. Unlike the normal Mediclaim policy, HIV and STI, OPD treatment will also be covered. The OPD treatment will include ARV drugs as well as cover various tests such as CD4 count.
5. A proposed condition of the policy is that for HIV and AIDS there will be no direct reimbursement to the person insured by NIC. Instead, it will be mandatory for the patient to get his/her treatment and drugs through nominated nodal agencies.
6. The policy will be for one year and may subsequently be renewed.
7. The policy will not cover pre-existing diseases, including HIV, thus if a person is already HIV-positive he/she will not be covered.
8. The premium is still being finalised for the pilot with GSACS, but is likely to be around Rs 1000/year for coverage of Rs 50,000.

To reiterate, there are two major differences between this option and the previous two options. Option III will cover those who are HIV-negative and will include treatment of other general illnesses as well. Its more generalised nature makes it very different from

options I and II. From the insurance company's point of view, the larger the number of people who enrol, the more reasonable the premium offered and the more likely that other rebates may be offered as well. As a result, it will probably be in FF's interest to extend this option to its other areas of operation and to network with other CSOs to include them in the coverage scheme.

As in other options, the entry point will continue to be the VCTC services offered by the organisation. This option's coverage should be offered to all those who test negative for HIV at FF. An incentive to get tested could be included in the form of a waiver of the HIV test cost, which will be covered by FF. The insurance company is not concerned about how the premium payment is made, so FF will have to ensure that it and any potential donor like the KSAPS enforces the implementation of the sliding scale for premiums. In other words, the premium of Rs. 1000 may potentially be high enough to act as an entry barrier; to counteract this effect, FF could offer subsidies based on the same principle of ability-to-pay based on economic categorisation, as in Options I and II. There are examples of other insurance schemes and collaboration (for example, Karuna Trust in Karnataka, which is partnering with NIC as well as the Government of Karnataka) where subsidies are being offered by way of covering all or part of the premium for economically backward populations.

From the insurance company's point of view, the larger the number of people who enrol, the more reasonable the premium offered and the more likely that other rebates may be offered as well.

Issues, Recommendations and Prerequisites

VII

It is clear from the above analysis that an organisation like FF has numerous options available to it for providing coverage for HIV-related treatment. This report has looked at three main options, and for the first two options, an additional three schemes each. Thus, in all there are seven possible scenarios that have been discussed. For the first two options – which can be administered and implemented by FF independently - the overall cost implications for FF (or a similar organisation) have been reviewed and the key issues raised by the analysis have been highlighted:

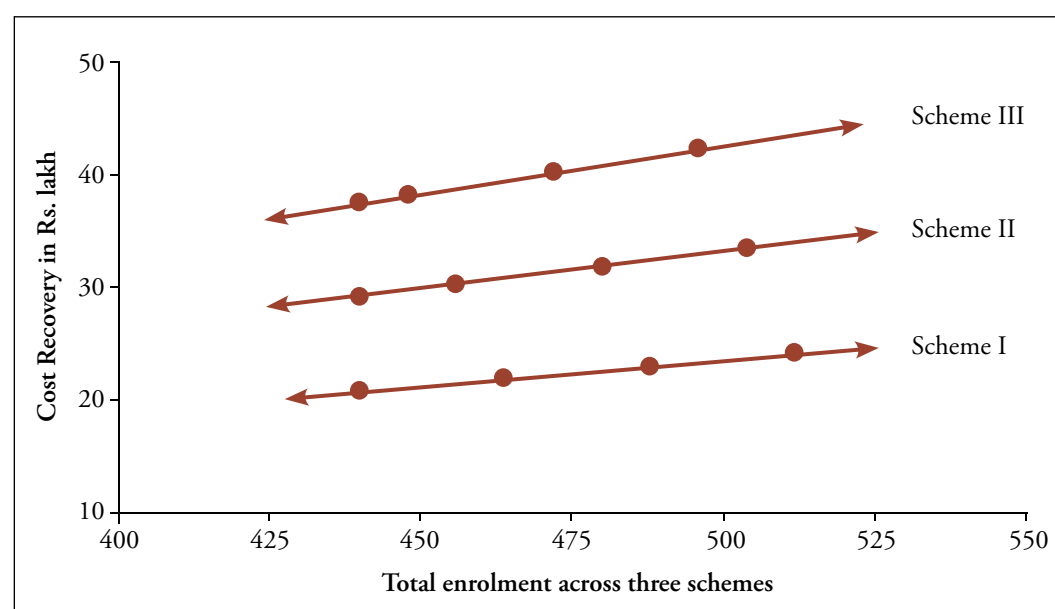
- How should economic classifications be selected to reflect the true distribution

of clients across income categories?

- Which option(s)/scheme(s) meet(s) the objective of maximum coverage for those with the greatest need?
- What are the cost implications of each of these options/schemes?
- Depending on all the above, which option(s)/scheme(s) should be selected?

The selection of an option/scheme would depend to a great extent on its financial feasibility, as well as the non-financial objective of meeting the needs of the maximum number of individuals. Much depends on how FF interprets the economic status of

FIGURE 1: **Enrolment and cost recovery implications across the schemes**



Once a decision on the classification is made, the number of individuals covered would depend on the demand for the option/scheme, which in turn would depend to a great extent on the structure of the premium and any incentives.

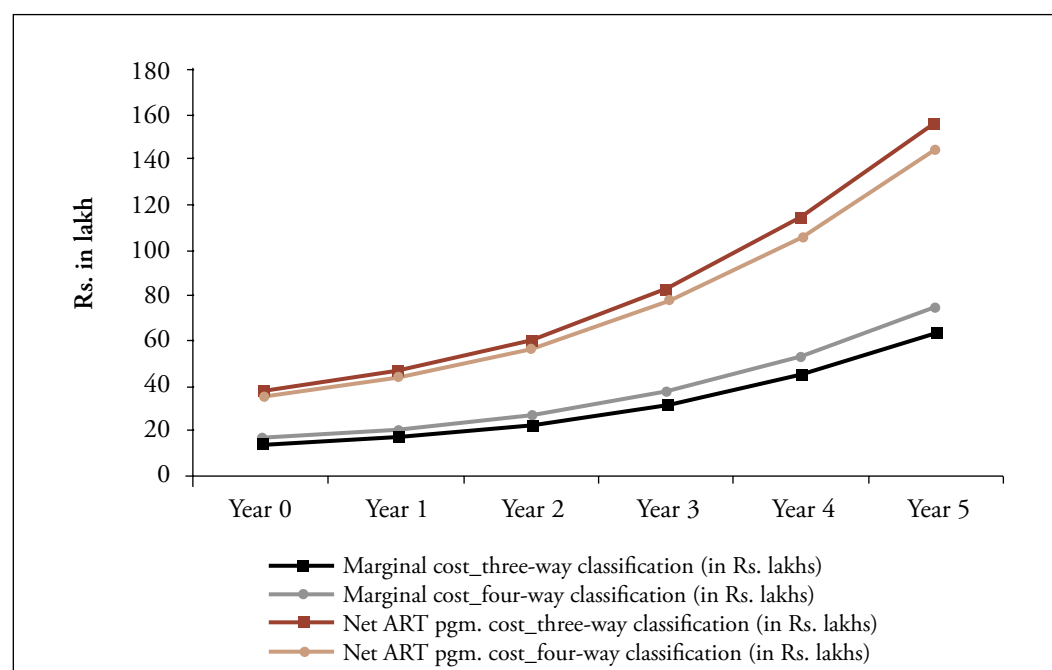
its clients, as the analysis considered two alternative income-distribution frameworks to demonstrate that the choice of economic category classification is key to the twin objectives of cost recovery and welfare of clients. Once a decision on the classification is made, the number of individuals covered would depend on the demand for the option/scheme, which in turn would depend to a great extent on the structure of the premium and any incentives: the options/schemes with higher cost recovery may experience a downward pressure on demand due to higher premiums.

Operationally, there is only one critical issue: how does one ensure the options/schemes success in terms of enrolment? All other aspects of an option/scheme depend on the total number enrolled. Though specific incentives have been folded into the various options, it is not clear whether these would be enough to step up the demand.

Figure 1 sums up the dilemma that an organisation like FF will face when implementing any coverage scheme. This figure uses the most general of the options-Option II for illustration. On the x-axis, the total coverage enrolment is indicated and on the y-axis the cost recovery.

- (1) The higher the enrolment, the higher the cost recovery for any given scheme of premiums.
- (2) The higher the targeted amount of cost recovery, the higher the premiums will have to be. For example, to have a cost recovery over Rs. 40 lakh, the optimal premium structure is scheme 3 with its higher average premiums.
- (3) A targeted amount of cost recovery will be met only if the necessary enrolment is forthcoming. If the aim is to have a cost recovery of Rs. 40 lakh, scheme 3 will have to be operational and a minimum enrolment will have to be about 475.

FIGURE 2: Economic categorisation and cost implications



Another dimension also needs to be considered - how a CSO like FF wants to categorise its clients' economic status and, therefore, their ability to pay. Figure 1 demonstrates the outcomes of two alternate economic status classifications. Both the marginal costs and net ART costs are higher over the five years with the three-way classification; with the four-way classification, the costs are lower despite the zero premium paid by the lowest economic category because of the high premiums paid by the wealthy. This figure indicates that the choice of the income-distribution (and thus the sliding scale of premiums) plays a key role in cost recovery as well as the welfare objective of helping the clients of CSOs like FF get subsidised treatment. Clearly, this classification has to be decided first and foremost before any other choices on magnitude or cost recovery are made.

Once the economic classifications are selected, an organisation like FF has three choices: 1) to fix the cost recovery amount and then decide on the option/scheme; 2) to fix the enrolment amount and let the cost recovery take its own course; or, 3) to fix the enrolment amount and targeted cost recovery and decide on a particular option/scheme. These figures do not take into account the variation in enrolment that may ensue within the three different premium structures over the years. Given the fact that lowest premium rate is zero, there may be an additional price effect that will increase demand and upwardly affect cost recovery. Differences in demand over time are difficult to predict at the outset, however, and the need for a set of pilot studies to track such differences may be necessary to properly account for them. Ultimately, the

key variable will be demand for the coverage option/scheme, which will determine both the financial and non-financial feasibility of the insurance-enhanced services of FF and similar organisations that hope to start in-house coverage schemes for HIV-related treatment. Innovative ways of disseminating the new product will have to be developed so that clients visiting FF and similar organisations are convinced that taking insurance is better than not taking it. Of course, the costs of such activities will have to be included in various cost calculations. The operational part of such an IEC strategy can be worked out in detail at a later date, and again, the set of pilots studies may be vital to understanding what will work.

It is suggested that both Options I and II be implemented with at least two of the schemes in different locations of FF in order to calculate differences in demand; thus, ideally four pilots of the in-house schemes should be launched. As explained before, an essential element of the design of any option/scheme will be putting in place the required services, which will include trained healthcare providers, availability of drugs, medicines and tests, and other required infrastructure and resources. Since FF is already offering various services, including ART, to its clients, the marginal cost of strengthening these services should not be too high. The increased demand on services as a result of the pilots, however, will have to be carefully planned in order to anticipate the additional pressures on infrastructure and services. The costs of whatever changes FF makes will have to be factored into the overall cost, thus arriving at a more realistic cost assessment for the options/schemes.

The choice of the income-distribution (and thus the sliding scale of premiums) plays a key role in cost recovery as well as the welfare objective of helping the clients of CSOs like FF get subsidised treatment.

In addition to Options I and II, Option III should concurrently be piloted in conjunction with the NIC at an additional site. Since the nature of this option is very different from the previous ones, NIC and FF can jointly work out the administrative and financial implications of this option.

All the pilots should run for a minimum of 18 months to allow time to evaluate and understand their financial and administrative ramifications. Data from each site should be meticulously kept and monitored by a team of experts, and at the end of the trial period the same team can do an analysis of what works and why.

Pilot Projects: The Way Forward

VIII

This study was an example of how a CSO can plan to finance HIV-related treatment for its clients. The outcome of the study was a set of ideas and specific schemes on how this could be done. The three options were the following:

1. **Option I:** Coverage for those currently on ART and those who are ART-eligible
2. **Option II:** Coverage for HIV-positive clients who visit FF or who test positive at FF
3. **Option III:** Coverage for vulnerable populations or all those who come to FF

A draft report covering the three options, and three schemes each under Options I and II, was submitted to the UNDP in December 2004. A series of discussions were held with various stakeholders to finalise the pilot project(s) and related modalities. A consensus was built for piloting three different models of health insurance packages for different target groups at different locations, as is explained below.

The project with FF would be carried out along the lines of the various options described in the report with the UNDP playing the role of the main risk-taker in terms of absorbing any shortfall in cost recovery. The other initiatives would involve an insurance company as an integral partner. A brief description of other initiatives is given below.

Coverage of vulnerable population – Gujarat SACS: The main vision behind this proposed initiative is to cover vulnerable populations, who may be more susceptible to HIV but are not all HIV-positive. The aim was to foster a partnership between an insurance company and an organisation working with such populations. Any SACS could be a prime candidate for such a partnership. During this project, the research team was able to bring together Gujarat SACS and NIC, and after several rounds of talks/discussions a tentative tailor-made scheme was drawn up, the details of which have been discussed above. Currently, further efforts are being made to operationalise this scheme.

The main vision behind this proposed initiative is to cover vulnerable populations, who may be more susceptible to HIV but are not all HIV-positive.

Target group	Implementing agency	Implementing state
Positive people	FF	Karnataka
High-risk/vulnerable population	Gujarat State AIDS Control Society	Gujarat
General population	Karuna Trust	Karnataka

General population, Karuna Trust: The UNDP is already part of a partnership between Karuna Trust, the Government of Karnataka and the NIC. This collaboration has made it possible to offer general health insurance schemes to two talukas of Karnataka that do not have any exclusion clauses for HIV/AIDS. In other words while the total scope of coverage offered is low, any type of treatment expenditure, including for HIV/AIDS, can be covered under it. The objective is to find ways of specifically including ART into such schemes and to work with Karuna Trust and NIC to come up with an amended policy, including ART, that can be offered to policy-holders. As in the case of the previous initiative, this project is currently being considered from the operational perspective.

The following steps should be kept in mind at the planning stage:

1. **Framework:** as discussed in Section 2, Table 1 on “Optional Elements for ART financing” offers a useful framework for planning a financing programme. Under this framework, implementers should consider the following parameters:
 - a. Coverage area
 - b. Who are to be covered
 - c. What is being covered- scope
 - d. Where services will be accessed
 - e. Who is responsible for administering the scheme
 - f. What is the role of insurance company
 - g. What is the role of (nodal) NGO and other partner NGOs
 - h. What is the role of the state government and central government

Of course, more details are needed to be accounted for under each of these

parameters. Each decision on these parameters would have cost implications which may make a difference in the overall costs and thus affect the success of a given option/scheme. In the options considered, many of these parameters are already fleshed out and well defined, but not all. For example, under Option III, which is to operate in conjunction with an insurance company, all the parameters can vary depending on the decisions taken by different stakeholders. If all these parameters are clearly defined and thought out from the beginning, it will be much easier to put the framework in place and to accurately anticipate the overall costs.

A matrix using the framework on Table 1 can be fixed ahead of time and already includes all the various choices on parameters through consultations with the stakeholders. It is crucial to recognise that the premiums and pay-outs would critically depend on the numbers used for costing and volume of demand. For example, the in-flows in Option II can be improved by lowering costs related to treating opportunistic infections.

2. **Final revisions of figures:** For the purposes of this study, these options/schemes were explored based on data from FF related to both volume and costing. Given that it was a pilot project, such considerations were not taken into account when the accounts were set up in FF; therefore, the essential data inputs into the costing tool/calculations were basically educated best guesses. It should be emphasised here that the basic premise of such an exercise and the use of a costing tool is that the information being used is accurate, since anything less than substantial accuracy is

It is crucial to recognise that the premiums and pay-outs would critically depend on the numbers used for costing and volume of demand.

likely to result in inaccurate final figures that would have major implications in regard to the financial feasibility of these projects. For options/schemes that are primarily based on cost figures and volume of demand, such inaccurate results would prove to be costly in terms of implementation. Thus, it is imperative to re-visit the costing and volume numbers before planning out and executing any of the options/schemes.

3. **Initial stakeholder meeting:** All the stakeholders should be brought together early, in one meeting, and given explanations of the various options, considerations and possibilities.
4. **Identifying nodal points in each stakeholder group:** Since there will have to be continuous back and forth communication between the planners and the various concerned parties, it would be useful to know who to contact and how. These relevant groups would include:
 - i. Healthcare/Care & Support Providers

- ii. NGOs, including network of positive people
 - iii. Insurance company
 - iv. Third Party Administrators (TPA)
 - v. Donors
5. **Role of each stakeholder group:** These need to be clearly established before the launch of any programmes, with and functions and responsibilities assigned before time.
6. **Blueprint of options/schemes and stakeholder inputs:** Each stakeholder group needs to understand the full implications of the study in terms of the various financing options.
7. **Demand generation:** Prior to and throughout the run of an initiative, it will be important to have aggressive marketing of the coverage product through IEC/ advertisement, since volume of demand will critically determine the fate of such a project. Insurance companies, in particular, may only be interested if sufficient volume of business is ensured.

It is imperative to re-visit the costing and volume numbers before planning out and executing any of the options/schemes.

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Annexures

Annex 1 Assumptions for option I

Target group details	ART eligible visiting FF	Likely enrolment for ART scheme - Year 0
	264	132

Projections	Item	%					Number				
		Year 1	Year 2	Year 3	Year 4	Year 5	Year 1	Year 2	Year 3	Year 4	Year 5
	ART eligible visiting FF	26%	30%	35%	35%	35%	69	100	151	204	276
	New entrants in the scheme	50%	55%	60%	65%	65%	34	55	91	133	179
	Attrition	5%	5%	5%	5%	5%	8	11	16	22	31

Resource	Item	Year 0	Year 1	Year 2	Year 3	Year 4	Year 5
	Donor grant	1047789					
	Donation	845518					
	Miscellaneous income	634					
	Indirect income	4762					
	Bank Interest						

Annex II

Assumptions for option II

Target group details	Positive clients visiting FF	ART eligible/ Total	Enrolled/ Total	ART eligible enrolled/Total ART eligible	OI eligible enrolled/ Total enrolled
	800	33%	55%	60%	55%
		Estimated ART eligible clients visiting FF	Clients enrolled for ART scheme - Year 0 (all positive)	Estimation of ART eligible entering the scheme - Year 0	Estimation of OI clients - Year 0
	Number	264	440	158	242

Projections	Item	%					Number				
		Year 1	Year 2	Year 3	Year 4	Year 5	Year 1	Year 2	Year 3	Year 4	Year 5
	Positive clients visiting FF	25%	25%	25%	25%	25%	200	250	313	391	488
	ART eligible clients visiting FF	26%	30%	35%	35%	35%	52	95	126	136	140
	New entrants in the scheme	50%	55%	60%	65%	65%	100	138	188	254	317
	New ART eligible entering the scheme	50%	55%	60%	65%	65%	26	52	75	89	91
	New OI entrants	50%	55%	60%	65%	65%	50	76	113	165	206
	Attrition	5%	5%	5%	5%	5%	9	4	6	8	9

Resource	Item	Year 0	Year 1	Year 2	Year 3	Year 4	Year 5
	Donor grant	1047789					
	Donation	845518					
	Miscellaneous income	634					
	Indirect income	4762					
	Bank interest						

Annex 3

Committed ART expenditure

OPTION I – ART eligible (Three-way classification)

If pilot fails, individuals to be sustained for next three years		158	
If pilot fails, total costs (in Rs. lakhs) to sustain individuals on ART for next three years		32.56	
Cost recovery from clients across premium categories for the next three years (in Rs. lakhs)		If pilot fails, net costs (in Rs. lakhs) to sustain individuals on ART for next three years	
Premium scheme I	7.23	Premium scheme I	25.33
Premium scheme II	9.81	Premium scheme II	22.75
Premium scheme III	12.40	Premium scheme III	20.17

OPTION I – ART eligible (Four-way classification)

If pilot fails, individuals to be sustained for next three years		158	
If pilot fails, total costs (in Rs. lakhs) to sustain individuals on ART for next three years		32.56	
Cost recovery from clients across premium categories for the next three years (in Rs. lakhs)		If pilot fails, net costs (in Rs. lakhs) to sustain individuals on ART for next three years	
Premium scheme I	21.30	Premium scheme I	11.26
Premium scheme II	26.15	Premium scheme II	6.42
Premium scheme III	30.99	Premium scheme III	1.58

OPTION II – All positive (Three-way classification)

If pilot fails, individuals to be sustained for next three years		175	
If pilot fails, total costs (in Rs. lakhs) to sustain individuals on ART for next three years		36.10	
Cost recovery from clients across premium categories for the next three years (in Rs. lakhs)		If pilot fails, net costs (in Rs. lakhs) to sustain individuals on ART for next three years	
Premium scheme I	16.11	Premium scheme I	20.00
Premium scheme II	22.69	Premium scheme II	13.41
Premium scheme III	29.28	Premium scheme III	6.83

OPTION II – All positive (Four-way classification)

If pilot fails, individuals to be sustained for next three years		175	
If pilot fails, total costs (in Rs. lakhs) to sustain individuals on ART for next three years		36.10	
Cost recovery from clients across premium categories for the next three years (in Rs. lakhs)		If pilot fails, net costs (in Rs. lakhs) to sustain individuals on ART for next three years	
Premium scheme I	24.69	Premium scheme I	11.41
Premium scheme II	30.06	Premium scheme II	6.04
Premium scheme III	35.43	Premium scheme III	0.67

United Nations Development Programme
55, Lodi Estate, New Delhi-110003
India
<http://www.undp.org.in>