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HIV/AIDS RESEARCH BRIEF

Examining the Role of the Private Sector in HIV Prevention and Treatment: Focus on Financing and Utilization

BACKGROUND

The number of people infected by HIV has exploded over the last two decades. An estimated 33.2 million people worldwide were living with HIV by the end of 2007, with 2.5 million people newly infected that year (UNAIDS 2008). The epidemic generates tremendous and growing demands for HIV/AIDS-related health services, especially as more people living with HIV/AIDS (PLWHIV) begin antiretroviral therapy (ART) and need regular care to monitor progression of the disease.

Recently, there has been an unprecedented increase in financing the HIV/AIDS response, driven by three major funders: the President's Emergency Program for AIDS Relief (PEPFAR), the Global Fund to Fight AIDS, TB and Malaria (GFATM), and the World Bank Multi-country AIDS Program. This donor influx —totaling more than $10 billion in 2007— has played an essential role in expanding access to lifesaving ART (UNAIDS 2008).

A relatively unexamined aspect of the global response to HIV/AIDS is the role of the private sector. Anecdotal evidence suggests that the private health sector is active in a wide range of HIV/AIDS areas such as counseling and testing (CT), sexually transmitted infection (STI) and TB treatment, and provision of ART. The private sector also plays a role in financing HIV/AIDS services (e.g., through private companies or household out-of-pocket (OOP) payments).

Outside of HIV/AIDS services, private sector participation in financing and service provision is well documented. Focusing on the sub-Saharan Africa region, nearly 60 percent of total health expenditures in 2005 were financed by private entities— largely through OOP payments (International Finance Corporation 2007). Demographic and Health Survey (DHS) data show that among 17 African countries, an average of 32 percent of family planning users obtained their contraceptive method from a private sector source (PSP-*One* 2005.) Furthermore, use of the private health sector is not confined to the wealthy. DHS data from 10 African countries found that even among the poorest families, an average of 44 percent sought care from a private sector source for their sick child (Marek et al. 2005).

However, little is known about the extent to which the private sector is financing or delivering HIV/AIDS services, nor how this may be changing over time. In many African countries, large private companies were the first providers of ART (via workplace clinics) (Feeley et al. 2007). Prior to the establishment of national ART programs, PLWHIV presumably had to pay OOP for

treatment. How has this changed as a result of the considerable increase in donor funding? Moreover, what do we know about provision of HIV/AIDS services through the private health sector? As PEPFAR and other global aid programs evolve from emergency relief to sustainable programs, understanding current and potential contributions of the private sector is increasingly important.

To this end, PSP-*One* examined existing data sources—national household surveys and National Health Accounts (NHA), which allow for comparable analysis of data relevant to the private sector. The research seeks to document the role of the private sector in the financing and provision of HIV/AIDS services and, to the extent possible, assess trends over time.

Research focused on the private-for-profit (PFP) segment of the private sector, which previously has received little attention.

METHODOLOGY

To assess utilization of HIV/AIDS services from the private-for-profit sector, data were analyzed from DHS[1] and AIDS Indicators Surveys (AIS)[2] in 12 countries, primarily in Africa. The key indicator of interest is source of HIV testing, which has only recently been included in these national surveys. Source of ART is not yet available.

Source of HIV testing was analyzed by wealth, education level, and area of residence.

To assess the extent to which private contributions have financed HIV/AIDS services and how these contributions have changed over time, we used time series NHA data for five African countries: Kenya, Malawi, Rwanda, Tanzania, and Zambia. These countries share similar socioeconomic contexts and epidemiological profiles for HIV/AIDS and have NHA HIV/AIDS subaccount data for 2002 and 2006—key time points to assess the impact of the donor influx, largely felt at the country level in 2004.

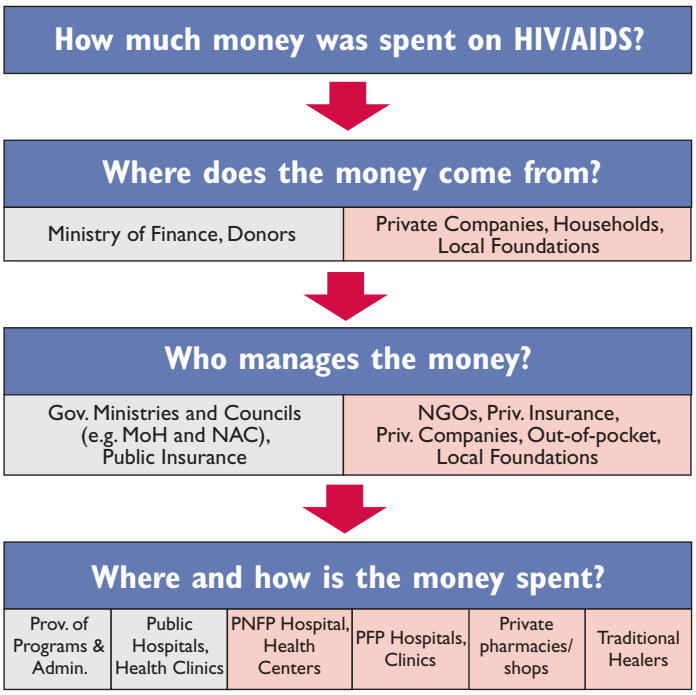
NHA is a tool for comprehensively tracking actual expenditures (as opposed to commitments or allocations) for health care, including public, private, and donor contributions (WHO 2003). As shown in Figure 1, NHA allows examination of private sector contributions at all levels of health care, from source to use. HIV/AIDS subaccounts include a survey of PLWHIV.

FINDINGS

Utilization

Although global efforts have made HIV counseling and testing increasingly available, actual uptake of these services remains low, as indicated by most recently available DHS and AIS data. In most countries examined, the majority of respondents received an HIV test from a public provider (Table 1). The highest reported private sector use for HIV testing was in Haiti (44.5 percent of women and 42.0 percent of men). Among African countries, Ethiopian women were most likely to have been tested in the private sector (23.6 percent) as were men in Chad (23.7 percent). In Vietnam, public sector providers were the predominant source of HIV testing: only 6 percent of women and 6.7 percent of men

Figure 1: Public and Private Sector Aspects of HIV/AIDS Financing



[1] National representative household surveys in about 80 countries providing data on population and health indicators.

[2] Provide nationally representative estimates of HIV prevalence and data on HIV/AIDS-related knowledge, attitudes, and behaviors.

Table 1: Percentage of Population Tested for HIV and Source of Last HIV Test

Country	Women				Men			
	% tested	Public sector	Private sector	NGO sector	% tested	Public sector	Private sector	NGO sector
Africa region								
Benin	17.7	82.0	14.9	0.5	13.1	87.3	11.0	0
Chad	2.1	44.7	10.0	0	3.9	64.2	23.7	0
Cote d'Ivoire	12.6	88.0	8.5	0.4	9.6	79.9	13.6	0.7
Ethiopia	4.1	67.8	23.6	5.1	5.1	71.8	18.6	6.0
Guinea	2.5	53.0	14.6	0.0	6.6	71.1	20.2	0
Rwanda	24.0	55.2	7.9	1.7	20.9	82.4	14.3	3.3
Tanzania*	13.7	--	--	--	13.6	57.0	6.4	27.8
Uganda	29.4	71.5	17.2	7.0	23.1	63.6	17.9	16.2
Zimbabwe	25.8	69.6	11.2	16.7	18.6	39.3	12.7	38.8
LAC region								
Guyana	28.7	39.4	18.2	12.2	21.1	50.8	29.9	13.7
Haiti	18.3	40.0	44.5	13.2	10.5	33.2	42.0	18.5
Asia region								
Vietnam	5.0	94.0	6.0	0	5.8	92.9	6.7	0

* Women's data not available
Note: Percentages may not total 100, as not all respondents reported HIV testing source

obtained HIV testing in the private sector. This is likely due to limited availability of HIV test kits outside the public sector.

The choice of provider varied by gender. With the exception of the countries of Benin, Ethiopia, and Haiti, men more frequently reported a private sector source for HIV testing than did women. Men also were more likely than women to report receiving an HIV test from a nongovernmental organization (NGO) clinic, although overall use of NGO services was low.

Previous studies have shown that socioeconomic status is one of the most important predictors of whether, and where, people seek care for illness (Ahmed et al. 2005; Larson et al. 2006). Using a standard wealth index based on household assets and characteristics, we examined the relationship between wealth and utilization of the private sector for an HIV test.

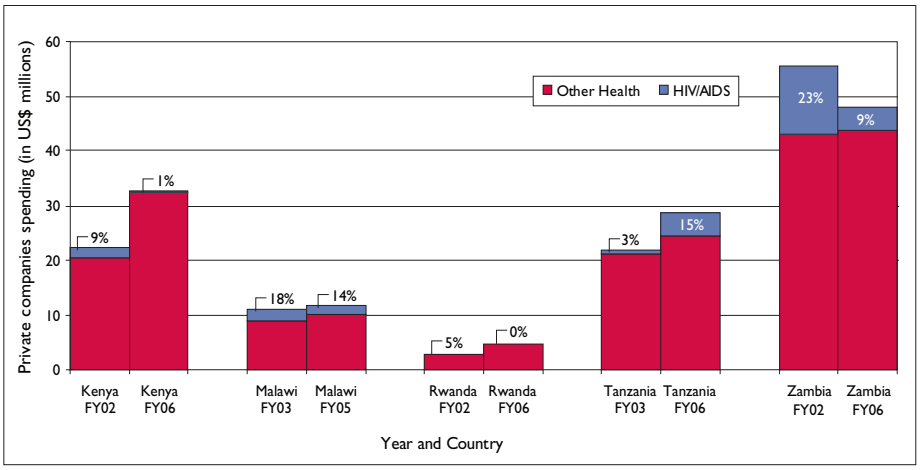
While there was some variation, generally women and men in the richest wealth quintile were more likely to receive an HIV test from the private sector than were respondents in the other four wealth groups. Due to small sample sizes, a positive association between wealth status and private sector utilization did not emerge in some countries. In Haiti, high use of the private sector was reported by women across the wealth groups, possibly signaling a lack of public provision of CT services.

Financing

On average, absolute spending on HIV/AIDS increased by a magnitude of 4 in the five African countries between 2002 to 2006. Expenditures for HIV/AIDS comprised one-quarter to one-third of overall health spending in these countries in 2006. Donors were the largest financial contributors to national HIV/AIDS responses. The relative private sector share declined significantly, from 27 percent of all HIV/AIDS health expenditures in 2002 to 12 percent in 2006. Whereas private companies in Africa played a key role in the provision of HIV/AIDS services early on in the epidemic, in absolute terms our analysis shows contributions from this sector decreased in all countries except Tanzania[3] (Figure 2). Private company reductions ranged from 18 percent (Malawi) to 85 percent (Rwanda). In Kenya and Zambia, government spending also decreased by 35 percent and

[3] In Tanzania, a few multinational companies have recently stepped up efforts to offer HIV care and treatment programs, which was not the case in 2002.

Figure 2: Absolute Private Company Contributions to HIV/AIDS and as a Percentage of Total Private Company Contributions to Health



51 percent respectively, over the four-year period.

Private-for-profit entities, such as private insurance schemes and companies, are managing fewer resources since the donor influx began, in both relative and absolute terms. In Kenya, Zambia, and Rwanda, NGOs were responsible for allocating more than 50 percent of all HIV/AIDS funds in 2006. Interestingly, the trend for general health services was the inverse: the private sector is playing an increasing role in managing these resources.

HIV/AIDS resources are largely channeled to public providers, and our analysis shows this trend increased during the four-year period. Despite recent donor commitment to encourage public-private partnerships, including contracting out with the private health sector, very little if any public funds are transferred or contracted out to private health facilities. Funding for private facilities and hospitals, in fact, largely comes from OOP payments.

In terms of OOP payments, we found that spending by PLWHIV on health care decreased over the period in three countries (Kenya, Malawi, and Zambia), suggesting increased access to free or subsidized services. In all countries except Malawi, the largest share of OOP payments among PLWHIV went to private health providers.

For complete findings, please refer to full reports available from the PSP-*One* website.

CONCLUSIONS

Analyzing utilization of HIV/AIDS and related services from the private health sector is a first step in examining the extent to which private providers are delivering these services. Despite the limited data available to date, the results of this analysis add to the small but growing body of literature indicating that the private health sector is active in HIV/AIDS service delivery, although the level of participation varies as a function of overall private sector development, donor funding, availability of government services, and the regulatory environment.

Analysis of DHS and AIS data further revealed that the poor are indeed seeking HIV and related services from the private health sector, though not at the same levels as wealthier households. For both women and men, respondents from the top wealth quintiles reported the highest level of private sector utilization. Although the relationship is not obvious in study countries with a small sample size, previous research has shown that the influence of economic status on source of care is less significant in low-income countries than for middle- or high-income countries (Asafu-Adjaye 2004). Further analysis, as new countries are added and subsequent surveys are conducted in the existing countries, will help interpret these initial observations.

The analysis of NHA HIV/AIDS subaccount data in five African countries revealed mixed results associated with the recent expansion of donor funding. First, the findings provide evidence of a decreased burden on PLWHIV to pay for health care, indicating that user fees at public and NGO facilities have been reduced or eliminated. While OOP payments among PLWHIV have decreased overall during the four-year period, a noticeable shift has occurred in OOP spending towards private health providers. Whereas multinational companies were among the first to provide ART (via workplace clinics) in many African

countries, our findings indicate that private company contributions have decreased in all countries except Tanzania. The implication is that donor funds appear to be displacing private investment in HIV/AIDS. This is compounded by the finding that government contributions also dropped for two of the countries between 2002 and 2006.

Moreover, the role of the private sector in managing resources, viewed as a proxy for the sector's involvement and engagement in HIV/AIDS, has decreased in four out of five countries. These findings are not consistent with the emerging recognition among major HIV donors that the private sector may be a viable partner in sustaining the HIV/AIDS response.

As the characterization of the global HIV response shifts from emergency relief to sustainable programs, continued exploration of the role of the private sector, in financing and delivering HIV/AIDS services, is warranted. Private companies led the HIV treatment effort before the donor response was galvanized, and they can still play an important role in fighting the disease. Private health providers are already delivering essential HIV and related services and are poised to do more. In both cases, partnerships with the government and/or donors may be key to effectively using and leveraging resources for maximum impact.

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About PSP-*One*

The PSP-*One* project is USAID's flagship project, funded under Contract No. GPO-I-00-04-00007-00, to increase the private sector's provision of high-quality reproductive health and family planning (RH/FP) and other health products and services in developing countries. PSP-*One* is led by Abt Associates Inc. and implemented in collaboration with eight partners:

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Tulane University School of Public Health and Tropical Medicine

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