Leveraging the Private Health Sector to Enhance HIV Service Delivery in Lower-Income Countries

Pamela Rao, MA, PGDBA, MPH, MIME, Tesfai Gabre-Kidan, MD,† Deus Bazira Mubangizi, MPH, MBA, BPharm, PGDPM,‡ and Sara Sulzbach, MPH§*

Abstract: Evidence that the private health sector is a key player in delivering health services and impacting health outcomes, including those related to HIV/AIDS, underscores the need to optimize the role of the private health sector to scale up national HIV responses in lower-income countries. This article reviews findings on the types of HIV/AIDS services provided by the private health sector in developing countries and elaborates on the role of private providers of HIV services in Ethiopia. Drawing on data from the nation's innovative Private Health Sector Project, a pilot project that has demonstrated the feasibility of public–private partnerships in this area, the article highlights the potential for national governments to scale up HIV/AIDS services by leveraging private health sector resources, innovations, and expertise while working to regulate quality and cost of services. Although concerns about uneven quality and affordability of private sector health services must be addressed through regulation, policy, or other innovative approaches, we argue that the benefits of leveraging the private sector outweigh these challenges, particularly in light of finite donor and public domestic resources.

Key Words: private health sector, public–private partnerships, scaling up, HIV/AIDS response

(*J Acquir Immune Defic Syndr* 2011;57:S116–S119)

INTRODUCTION

The public health sector in many developing and emerging economies is in a state of crisis and suffers from a lack of financial and human resources.[1] Public health sector resources are constrained; yet, the demand for health services is increasing and the situation has been exacerbated by the strain on these resources posed by new health challenges such as HIV. In many countries, the HIV pandemic has increased the need to rapidly expand the availability of HIV services, such as counseling and testing, antiretroviral therapy (ART), and treatment for tuberculosis (TB) in addition to other priority health services.[2] The ambitious goals of many countries to achieve universal access to HIV/AIDS services are not matched by commensurate budget allocations for health care or health workforce development.[3]

In contrast, the private health sector continues to grow in many developing countries, and there is evidence that it plays a crucial and significant role.[4] Although the private health sector includes both for-profit and not-for-profit entities, this article pays particular attention to health actors with an underlying profit or social entrepreneurial motive, as this sector remains a relatively unexamined aspect of the global response to HIV. An effective private health sector can relieve existing bottlenecks in the public health sector, enabling governments to focus resources on those who cannot afford to pay for services. However, concerns about lack of regulation, quality of care, and affordability of private health services, if left unaddressed, could undermine health outcomes and social objectives.[5]

PRIVATE SECTOR ROLE IN HEALTH AND THE HIV RESPONSE—RECENT FINDINGS

The private health sector in many developing and emerging economies provides >50% of personal health care services,[6] and >60% of the health care in Africa is financed privately and paid for out of pocket.[4] Private health sector actors including both for-profit and not-for profit organizations play an important role in the delivery of HIV prevention and increasingly are engaging in delivery of HIV care and treatment services. A multicountry analysis conducted by the Private Sector Partnership–*One* project, a project funded by the US Agency for International Development, found that between 3% and 45% of women and between 6% and 42% of men reported the private for-profit sector as the source of their most recent HIV test.[7] The Center for Health Market Innovations has profiled >186 programs by private sector providers involved in delivery of HIV services in low- and middle-income countries (Fig. 1).

Rosen et al[8] found that 21% of all patients receiving ART in 6 African countries were served by private sector providers in 2006, and this number has grown since then. Several corporate entities in lower-income countries fund HIV

From the *Office of HIV/AIDS, Bureau for Global Health, US Agency for International Development, Washington, DC; †Private Health Sector Program, Abt Associates, Addis Ababa, Ethiopia; ‡Results for Development Institute, Washington, DC; and §Strengthening Health Outcomes Through the Private Sector, Abt Associates, Bethesda, MD.

The views and opinions expressed in the article are solely those of the authors and do not necessarily reflect those of the US Agency for International Development, nor those of the US government.

The authors have no funding or conflicts of interest to disclose.

Correspondence to: Pamela Rao, MA, PGDBA, MPH, MIME, Office of HIV/AIDS, Bureau for Global Health, US Agency for International Development, 1201 Pennsylvania Avenue NW, Suite 300, Washington, DC 20005 (e-mail: prao@usaid.gov).

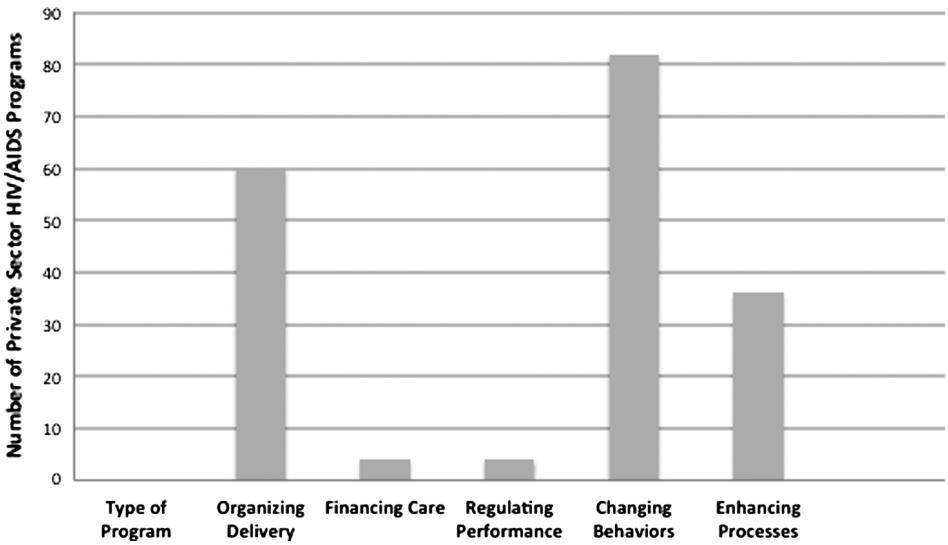

FIGURE 1. Private sector HIV/AIDS intervention, by types of services in LMIC. Source: Center for Health Market Innovations (2010), Washington, DC.

services for their employees and dependents. Health insurance companies in emerging economies are beginning to offer coverage for HIV services,[9] which has enabled patients to seek care in the private for-profit health sector, despite partial financial protection offered by insurance companies.

EXPANDING ACCESS TO HIV AND TB SERVICES THROUGH PRIVATE HEALTH SECTOR ENGAGEMENT IN ETHIOPIA

Ethiopia, the second most populous country in sub-Saharan Africa, has traditionally relied on the public health sector to meet the nation's health care demands. However, the public sector suffers from limited capacity: The total health expenditure is 4.9% of the gross domestic product, and the physician-to-population ratio is 1:37,209.[10,11] Key public health services—such as those for TB, HIV, and malaria—are largely supported by donors and provided free of charge to the public. Free provision of services created patient backlogs[12] in public health facilities, whereas available private sector facilities that charge a fee were not maximized. Over the past decade, the number of private health sector facilities and clinicians in Ethiopia has expanded rapidly and now exceeds that of the public sector (Table 1) in some urban and periurban areas.

The volume of TB and HIV cases in the public sector—totaling >2000 HIV-positive patients per physician in some areas[11]—has prompted the government of Ethiopia to further engage the private health sector. With an estimated 1.2 million people living with HIV and between 47% and 63% eligible for ART,[12] it is projected that it will take between 13.2 and 16.6 years for the public sector to provide treatment to all in need. However, if qualified private facilities, such as private hospitals and clinics, were to provide treatment, the required time would drop to between 4.2 and 5.2 years.[13] Table 2 describes the distribution of patients receiving HIV services in Addis Ababa, Ethiopia's capital city. Although 18% of adults and children enrolled in care and treatment are seen in the private sector, the proportion of those on ART is higher at private facilities (82.3% vs 59.6% at public facilities), and the private sector serves 25% of those on ART.

Private Health Sector Program–Ethiopia

Following a successful pilot program—the Public-Private Mix-Directly Observed Therapy Short-Course program for treatment of TB in Addis Ababa and Oromia regions,[14] piloted in 2006 and evaluated in 2007—Ethiopia's Federal Ministry of Health systematically engaged private health providers to scale up an HIV/AIDS and TB program. With the increase in demand for private sector services, the Public-Private Mix-Directly Observed Therapy Short-Course program was further expanded by the US Agency for International Development/Ethiopia as the Private Health Sector Program (PHSP) in 2008 to engage for-profit and not-for-profit providers in the delivery of key health services. Currently,

TABLE 1. Public and Private Health Care Capacity of 3 Urban Areas in Ethiopia (Addis Ababa, Dire Dawa, and Harar)

Health Facilities	Public (n)	Private (n)
Facilities		
Hospitals	12	30
Health centers	37	NA
Private clinics	NA	485
Staff*		
General practitioners	103	257
Internists	8	45
Pediatricians	11	29
OB-GYN	19	39
Nurses	1810	434

Source: Health and Health-Related Indicators, 2007/2008, Ministry of Health, Ethiopia.

*As in many other countries, public sector physicians in Ethiopia "moonlight" in private facilities. However, there is no double counting in data provided in Table 1. Data were obtained from the regional health bureau and validated by the facilities who keep counts segregated, that is, private practitioners and moonlighters.

NA, not applicable.

TABLE 2. Enrollment in HIV Care and ART at Public and Private Sector Health Facilities in Addis Ababa (July 2009 to June 2010)

Facility	No. Facilities	Patients Enrolled in HIV Care and Treatment*	Patients on ART, n (%)
Public			
Hospitals	9	3479	2741 (78.8)
Clinics	24	11,569	6228 (53.8)
Total	33	15,048	8969 (59.6)
Private			
Hospitals	16	2013	1855 (92.2)
Clinics	3	766	433 (56.5)
Total	19	2779	2288 (82.3)

*Includes pre-ART and ART patients.

TABLE 3. ART and Prevention of Mother-to-Child Transmission Quality-of-Care Indicators of Facilities in Addis Ababa

Patient Status	Public Sector Patients (%)	Private Sector Patients (%)
Enrolled in HIV care	80,276	11,852
Started on ART	46,460 (57.9)	9494 (80.1)
Dropouts	6677 (14.3)	1652 (17.4)
Stopped medications	271 (0.6)	19 (0.2)
Died	3179 (6.8)	287 (3.9)
ANC clients	130,136	112,548
ANC clients tested for HIV	39,246 (30.2)	17,233 (15.3)
ANC clients testing positive for HIV	1859 (4.7)	420 (2.4)
ANC clients testing negative for HIV	36,095 (91.2)	16,488 (95.7)
HIV-positive, received ARV	1437 (77.3)	329 (78.3)
HIV-exposed neonates received ARV	720	331
HIV-negative neonates	610	50
HIV-positive neonates	68	6

Source: Addis Ababa Health Bureau, 2009–2010, Facility Report.
ANC, acute natal care; ARV, antiretroviral.

181 PHSP-supported private hospitals and clinics are providing PPM-DOTS (T. G.-K., personal communication, January 2011) out of a total of 317 facilities, primarily in urban areas.[15] Although not-for-profit private facilities provide free treatment, patients pay out of pocket for health costs provided by for-profit facilities with the exception of antiretroviral drugs. An unpublished qualitative patient satisfaction survey conducted by the PHSP-Ethiopia in both public and private facilities suggests that the additional capacity to provide care has resulted in higher patient satisfaction and reduction in waiting time. PHSP is currently supporting the rollout of treatment for TB, HIV, family planning, sexually transmitted infections, and malaria through private health facilities in 7 regions of the country.

Staff in the private facilities supported by the PHSP initiative are trained on TB and HIV care, logistics, drug and reagent supply chain management, and monitoring and evaluation by PHSP-Ethiopia, but the government of Ethiopia provides free TB medications, rapid HIV test kits, and antiretroviral drugs. PHSP also provides supportive supervision and laboratory proficiency tests and external quality assessment. The effort to engage the private health sector has shown considerable success in the scale-up of HIV services (Table 3).

Within a context of enormous public health challenges, with crippling human resource shortages and overburdened public sector capacity, the government of Ethiopia has taken first steps, with the support of PHSP-Ethiopia, toward engaging the entire national health workforce and available health infrastructure in both sectors to meet the pressing demands for key public health priorities, such as HIV/AIDS and TB.

DISCUSSION

The benefits of engaging the private health sector to expand delivery of HIV and other essential public health services cannot be underestimated. Growing recognition of the importance of strong health systems provides an unprecedented opportunity to systematically include private health providers as an integral part of a country's health system strengthening strategy. Whether the private sector is systematically engaged by the public sector, evidence suggests that the private sector's role can and will grow to meet the increasing demand for health care services around the world. Ideally, private sector providers will follow national guidelines and adhere to quality standards and reporting guidelines—in the case of HIV, providing appropriate preventive and prophylactic care, approved antiretroviral regimens, appropriate clinical and laboratory monitoring, and the psychosocial support required for adherence and secondary prevention.

If unregulated, however, the growth of the private health sector could drain scarce human resources, exacerbate inequities, limit health outcomes, and undermine efforts to improve national health information systems; private sector growth may also jeopardize the economic well-being of clients seeking care in these facilities. Striking a balance between roles of steward, regulator, direct service provider, and financier is one of the most important challenges a government faces within the health sector.

National and local governments designing health sector reforms and health system strengthening initiatives tend to overlook the private health sector and are traditionally focused on the public health sector.[2] There is an urgent need to systematically include private sector actors in policy dialogue, planning, and implementation of public health programs if universal access is to be achieved and sustained. When so doing, it is important to distinguish between not-for-profit and for-profit providers because strategies to negotiate and define their health sector roles vary significantly. For example, in many countries, nonprofit organizations excel at reaching vulnerable populations, such as sex workers, but rely heavily on external aid to sustain their operations. In contrast, private, for-profit health facilities are financially sustainable but do not always serve the poorest or most vulnerable segments of the population.

Providing an enabling policy and regulatory environment, and creating appropriate market incentives for the commercial sector to engage in service provision in complement with public health initiatives are of paramount importance to achieving

health goals in an equitable manner. It is unrealistic to provide "health for all" and "universal access" at the current level of investment in low-income countries in sub-Saharan Africa, which spend only US$ 17.3 per capita on health care annually.[16] Moreover, a recent study showed that development assistance for health to governments of developing countries had a negative and significant effect on government spending on health, whereas development assistance for health had a positive and significant effect on domestic health spending when provided to the nongovernmental sector.[17] Recognizing the need for greater government involvement to leverage private health sector, the 63rd World Health Assembly passed the resolution "Strengthening the Capacity of Governments to Constructively Engage the Private Sector in Providing Essential Health-Care Services."[18] The resolution and the accompanying report acknowledge that private provision of services can lead to innovation and challenges and highlight the need to appropriately engage and regulate the private sector to contribute to providing services, financing goals, and ultimately improving a nation's health status.

ACKNOWLEDGMENTS

The authors acknowledge Gina Lagomarsino, Results for Development Institute, and Joep M. A. Lange, MD, PhD, Department of Global Health, Academic Medical Center, University of Amsterdam, for their input. They also thank the Addis Ababa Health Bureau for allowing them to use facility data; US Agency for International Development, Ethiopia Mission, for support to the PHSP-Ethiopia; and the organizers of the International AIDS Society preconference on HIV and HSS, Vienna, Austria, July 2010, for including the session on "Leveraging the Private Sector for Health" on which this article was based.

REFERENCES

1. American Public Health Association. Strengthening health systems in developing countries. Policy Number 20089. Washington, DC; 2008. Available at: http://www.apha.org/advocacy/policy/policysearch/default.htm?id=1375. Accessed November 19, 2010.
2. Arur A, Sulzbach S, Barnes J, et al. *Strengthening Health Systems by Engaging the Private Health Sector: Promising HIV/AIDS Partnerships*. Bethesda, MD: Strengthening Health Outcomes Through the Private Sector Project, Abt Associates, Inc; 2010.
3. Frenk J, Chen L, Bhutta ZA, et al. Health professionals for a new century: transforming education to strengthen health systems in an interdependent world. *Lancet*. 2010;376:1923–1958.
4. *The Business of Health in Africa: Partnering With the Private Sector to Improve People's Lives*. Washington, DC: International Finance Corporation; 2007.
5. Harding A, Preker A, eds. *Private Participation in Health Services*. Washington, DC: World Bank; 2003.
6. Lagomarsino G, Nachuk S, Kundra SS. *Public Stewardship of Private Providers in Mixed Health Systems: Synthesis Report From the Rockefeller Foundation–Sponsored Initiative on the Role of the Private Sector in Health Systems*. Washington, DC: Results for Development Institute; 2009.
7. Wang W, Sulzbach S, De S. Utilization of HIV-related services from the private health sector: a multi-country analysis. *Soc Sci Med*. 2011;72:216–223.
8. Rosen S, Feeley F, Connelly P, et al. The private sector and HIV/AIDS in Africa: taking stock of six years of applied research. *AIDS*. 2007;21(suppl 3):S41–S45.
9. McLeod HD, Achmat Z, Stein AM. Minimum benefits for HIV/AIDS in South African medical schemes. *SAAJ*. 2003;3:77–111.
10. Ethiopian Federal Ministry of Health. *Ethiopia's Fourth Health Accounts, 2007/2008*. Addis Ababa, Ethiopia: Ministry of Health; 2010.
11. Ethiopian Federal Ministry of Health. *Health and Health Related Indicators, 2007/2008*. Addis Ababa, Ethiopia: Ministry of Health; 2008.
12. Federal HIV/AIDS Prevention and Control Office. Monthly HIV care and ART update, February 2010. Available at: http://hapco.gov.et/index.php?option=com_remository&Itemid=97&func=fileinfo&id=284. Accessed January 26, 2011.
13. Ethiopian Federal Ministry of Health. *AIDS in Ethiopia 6th Report, Single Point HIV Prevalence Estimate*. Addis Ababa, Ethiopia: Ministry of Health; 2007.
14. Emmett W, Whalen C. *Final Evaluation: The Private Sector Program in Ethiopia: Assessing the Foundation for a Continuum Focused on Public-Private Health Sector Collaboration in Addressing HIV/AIDS and Tuberculosis in Ethiopia*. Washington, DC: Global Health Technical Assistance Project; 2008.
15. Health Promotion and Disease Prevention General Directorate, Tuberculosis Prevention and Control. *Annual Bulletin*, Vol. 2, No. 2. Addis Ababa, Ethiopia: Ministry of Health; March 24, 2010.
16. World Health Organization. *World Health Statistics 2008*. Geneva, Switzerland: World Health Organization; 2008. Available at: http://www.who.int/whosis/whostat/EN_WHS08_Full.pdf. Accessed January 27, 2011.
17. Lu C, Schneider MT, Gubbins P, et al. Public financing of health in developing countries: a cross-national systematic analysis. *Lancet*. 2010;375:1375–1387.
18. Strengthening the Capacity of Governments to Constructively Engage the Private Sector in Providing Essential Health-Care Services. Report by the Secretariat. Provisional Agenda Item 11.22. Geneva, Switzerland: World Health Organization; 2010. Available at: http://apps.who.int/gb/ebwha/pdf_files/WHA63/A63_25-en.pdf. Accessed February 24, 2011.