Private Sector Provision and Financing of AIDS Treatment in Africa: Current Developments

Frank Feeley, JD, Patrick Connelly, MPH, and Sydney Rosen, MPA

Corresponding author
Frank Feeley, JD
Center for International Health and Development, Boston
University School of Public Health, 85 E. Concord Street, 5th Floor, Boston, MA 02118, USA.
E-mail: ffeeley@bu.edu

Current Medicine Group LLC ISSN 1548-3568
Copyright © 2007 by Current Medicine Group LLC

Despite the rapid expansion of public sector highly active antiretroviral (ARV) treatment programs, the private sector continues to be an important source of services and financing for AIDS treatment in Africa. This article reviews currently available information on private sector initiatives, including recent innovations. Private sector providers continue to offer ARV treatment, although adherence problems resulting from high user fees indicate the need for employer, donor, or insurance support. Employer clinics have reported impressive results in patient recruitment and survival. Health insurers are removing AIDS exclusions and expanding AIDS coverage, in some cases with targeted lower cost policies. Public- or donor-funded ARVs have been used to leverage the expansion of populations treated at employer clinics, and attempts are underway to contract for private sector services using public and donor funds. With both funds and clinical resources stretched to meet AIDS treatment goals in countries with a high prevalence of HIV, further efforts are indicated to leverage private sector resources as part of a national treatment plan.

Introduction
Until the dramatic fall in prices of antiretroviral (ARV) drugs after the Thirteenth International AIDS Conference in 2000 and the advent of major donor funding for public ARV treatment programs, such as the President’s Emergency Plan for AIDS Relief (PEPFAR) and the Global Fund to Fight AIDS, Tuberculosis, and Malaria (Global Fund), the private sector was the only source of highly active ARV treatment (HAART) in most African countries. South African medical schemes reimbursed insureds for HAART dispensed by private practitioners. A few multinational companies (such as the DeBeers-affiliated diamond mines in Botswana and Namibia) offered HAART at workplace clinics, and the few Africans with HIV infection who could afford private treatment paid out of pocket. The total numbers on treatment were small.

Seven years later, the situation has changed greatly. The Joint United Nations Programme on HIV/AIDS estimated that, as of June 2006, more than 1 million patients were receiving HAART in Africa, although this is less than one quarter of the 4.6 million needing treatment [1]. Although public sector programs have expanded much more rapidly, the private sector also continues to treat patients for HIV/AIDS. Data on private sector treatment are difficult to obtain. Based on 2006 World Health Organization data, we estimated that roughly 21% of those receiving ARV therapy (ART) in December 2005 in six high-prevalence African countries (South Africa, Namibia, Botswana, Nigeria, Kenya, and Uganda) were being treated in the private sector [2]. With public programs heavily dependent on donor funds and rapidly reaching capacity limits, it is useful to ask what the private sector can contribute to sustainable treatment of AIDS in Africa. In this article, we review developments in private sector HIV/AIDS treatment and financing. Drawing on published reports and the personal experience of our research team, we attempt to draw conclusions about “what works” in private sector financing and provision of ART in Africa.

Background
Despite the existence of state-financed public health care systems, sub-Saharan Africa is heavily dependent on private funding and provision of medical care and drugs. Most private funding comes from patients themselves. Out-of-pocket payments comprise 50% or more of total health expenditures in most countries [3], and this is inadequate to meet needs. Because of the inadequacy of public facilities, some large, private sector employers run their
own clinics or hospitals. Other employers have traditionally offered a “medical allowance” to cover some costs incurred by their employees for private medical care.

Health insurance has had a limited impact on the financing of health care in sub-Saharan Africa outside South Africa, Namibia, and Zimbabwe. These three countries have a large medical scheme industry comprised of non-profit contributory health insurance plans managed by for-profit companies. The 10% to 20% who are insured are primarily higher income, formal sector workers who obtain coverage through their employer. Lower income workers generally cannot afford the “employee share” of the premium for the plans offered. Elsewhere in Africa, private insurers have covered only a small, urban elite.

Community health insurance plans have shown promise in improving access and reducing catastrophic health expenses [4], but they have been hard to expand to a national scale. Both community insurance and commercial plans were initially reluctant to offer an HIV/AIDS treatment benefit. Until recently, only the medical schemes in South Africa, Namibia, and Zimbabwe provided treatment for AIDS-related conditions and offered ART as a standard part of the benefit package.

Some of the first large-scale ART programs in Africa were introduced by major, multinational companies with large workforces and extensive on-site treatment capacity. Data on treatment uptake and survival from these employers are now appearing in the literature and offer an important indication of the long-term patient outcomes possible outside research settings.

Methodology/Data Sets
Rigorous analyses of the role of the private sector in treating AIDS are limited in number. Many reports simply describe a particular effort. The definition of the private sector is fluid, often encompassing mission hospitals that are heavily subsidized with government funds and often staffed with government-employed clinicians. In this analysis, we define the private sector in service provision to include physician offices, clinics, and hospitals not owned by any branch of government and dependent on employer payment, patient fees, or insurance for most or all of their income. Such facilities are usually “for-profit” but may include nonprofit organizations largely dependent on patient or insurance payments. The definition includes clinics run directly or on contract by employers to care for employees (and dependents). When we refer to private sector financing of AIDS care, we are referring to funding for health services which comes from direct (out of pocket) patient payment, private or community health insurance (but not social insurance), and direct or indirect employer support. We exclude providers that are primarily dependent on grants from domestic or international donors.

In order to develop a typology of private sector treatment and financing and to comment on the sustainability of these ventures, we draw on two sources. The first is a set of research activities conducted by the authors and colleagues at the Boston University Center for International Health and Development (CIHD) over the last 6 years and listed in Table 1. CIHD faculty and staff have been involved in the design, monitoring, and/or evaluation of private sector activities in eight African countries. Reports on these activities are posted on the CIHD website, and most that were not published in journals have been distributed by the organizations sponsoring the work. The web address is listed on the reference page to facilitate access to these reports [5,6].

The second source is a review of published literature, gray literature, and conference abstracts describing models of AIDS treatment financing and service delivery offered by the private sector to donors, employers, and individuals in Africa. The review was carried out by searching MEDLINE, Google Scholar, IRIN, and abstracts from the International AIDS Society’s International AIDS Conferences, as well as archived publications on the World Bank, World Economic Forum, and the Global Business Council websites. To identify the AIDS treatment models available, keywords from two categories were searched in combination. The first category included “AIDS treatment,” “ARVs,” and “HAART,” and the second included “private sector,” “employer,” “insurance,” “companies,” and “business.” An additional search term, “Africa,” was needed when searching Google Scholar to narrow the search geographically. The search was restricted to the English language, and only information made available since January 2004 was included. When references to new or innovative models did not provide information on current status, we attempted to contact the authors or sponsors directly.

Results
Based on the literature review and the experience described in Table 1, we developed the typology of AIDS treatment interventions presented in Table 2. There are three basic models, with some important internal variations.

Established Models
Fee for service providers
The fee for service (FFS) model is the most straightforward way in which the private sector pays for AIDS treatment. This model includes direct payments by individuals and employers for treatment services provided by general practitioners, clinics, hospitals, pharmacies, etc. Because of the wide variation in expertise and facilities available in Africa, quality of care and outcomes vary greatly. Some patients do well in private sector treatment; a FFS clinic in Uganda reported that 36% of patients initiating treatment were alive and in treatment at 1 year, 46% at 2 years, 40% at 3 years, and 35% at 4 years [7]. The advantage of this