Financing flows through private providers of HIV services in sub-Saharan Africa

Sean Callahan, Sharon Nakhimovsky
Abt Associates, Washington, DC, United States of America
Corresponding author: Sean Callahan, e-mail: sean_callahan@abtassoc.com

Over the past decade, the public health community has made significant strides in tackling the global HIV epidemic. Donor-funded programmes, including the President’s Emergency Plan for AIDS Relief (PEPFAR) and the Global Fund for AIDS, Tuberculosis and Malaria have marshalled unprecedented resources to combat the disease. Supplemeting domestic funding with this support, national HIV programmes helped 12.9 million people access life-saving antiretroviral therapy (ART) by the end of 2013. While the number of PLHIV increased from 32.1 million in 2005 to 35 million in 2013, rates of new infections and AIDS-related deaths have declined.1

Much remains to be done. The vast majority of PLHIV live in low- and middle-income countries, and almost two thirds face barriers to accessing ART services.1 Moreover, just as HIV funding needs rise with the number of PLHIV receiving routine care, donor funding has stagnated in many of these countries, forcing their governments to develop innovative ways to raise domestic financing and increase efficiency. Engaging private hospitals and clinics into the government’s HIV response can increase access to ART and other HIV services in a sustainable way. Private hospitals and clinics alone make up half of the health facilities in many sub-Saharan African countries and can be the preferred option for PLHIV receiving care for reasons concerning privacy and convenience, among others.2 Recognizing the potential for leveraging the resources private providers offer to increase access to HIV care, many sub-Saharan governments have pursued public-private partnership opportunities, for example, subcontracting out delivery of key services, strengthening referrals between public and private facilities, and using government funds to pay for care at private facilities.

In order to develop effective partnerships with private providers, governments must understand the role these facilities can play in the HIV response. However, in many countries governments have little information to foster such understanding. This article attempts to help address this knowledge gap by tracing the flow of spending on HIV from the sources of financing, through financing agents, and finally to private providers of HIV goods and services in four sub-Saharan African countries. By highlighting these flows, authors seek to demonstrate the scope and magnitude of the private sector’s contribution to the HIV response as well as identify potential ways donors and governments can better leverage resources these private providers offer.

Methodology

Data on past HIV spending can support efforts to understand the private sector’s role in the HIV response and improve the sustainability of HIV programmes.3 As part of the USAID-funded Strengthening Health Outcomes through the Private Sector (SHOPS) project, authors used HIV spending data compiled according to national health accounts (NHA) – the global standard for health resource tracking. National health accounts track the flow of health spending in a country. This flow begins with an entity that provides the funds (source), which may be the ministry of finance, employers (parastatals and private sector), an external partner or household, before moving to an agent (manager), such as the ministry of health, health insurance...
programmes, or a non-governmental organization (NGO). Managers spend the funds at health-care providers. National health accounts identify the amount of funds spent at each type of provider (public or private, health clinic or hospital), as well as the types of health goods and services consumed there. While the general NHA tracks total health spending, HIV subaccounts detail spending on HIV. Authors selected four sub-Saharan African countries (Côte d’Ivoire, Kenya, Malawi and Namibia) to include in this analysis because they have high quality NHA and HIV subaccounts data, represent a range of geographic regions, socioeconomic levels and have high numbers of PLHIV and HIV prevalence rates.

For this analysis, the private health sector includes for-profit and non-profit actors. Notwithstanding variation across countries, for-profit actors included private health insurance companies, privately owned medical facilities, companies with employee health programmes and private pharmacies. Non-profit actors included faith-based organizations, charities, NGOs, non-profit health facilities and community-based organizations.

Cross-country analysis was limited by some variability in data collection methods across the selected countries, most particularly in their approach to estimating out-of-pocket spending by PLHIV, as well as the limited number of quality NHA studies completed. Despite these limitations, these NHA data still offer the most accurate estimation of health expenditure flows in developing countries and provide valuable information to inform decisions about resource allocation and strategic planning, increase transparency, track progress toward spending goals, and strengthen civil society’s advocacy efforts.

Results
Côte d’Ivoire
In 2008, Côte d’Ivoire’s HIV response was highly dependent on international donors. Some 87% of the country’s HIV spending originated with donors — a ratio that is 74 percentage points higher than donors’ share of general health expenditures. In contrast, the Côte d’Ivoire Government provided only 7% of HIV funds. Households, private businesses and other private entities contributed the smallest proportion of HIV funds, amounting to 5% of HIV expenditure combined (Figure 1).

Only 5% of all HIV spending in 2008 went to for-profit providers. Donors allocated some funding for HIV to for-profit hospitals and clinics through NGOs. Although NGOs accounted for 99% of spending at for-profit facilities, this amount was only 2% of all NGO spending on HIV. No funding from the Côte d’Ivoire Government went to for-profit facilities.

While donor and government spending together effectively subsidized HIV care, findings suggest some gaps in financial coverage for PLHIV remain. At an aggregate level, PLHIV out-of-pocket expenditure accounted for only 3% of HIV spending — much lower than in the health sector overall, where 66% of expenditures were spent out-of-pocket. However, 74% of out-of-pocket spending on HIV occurred at private pharmacies and health facilities indicating that PLHIV still purchase HIV goods and services in the private sector despite the availability of free services in the public sector.

Table 1. Selection criteria for sample countries

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Côte d’Ivoire</th>
<th>Kenya</th>
<th>Malawi</th>
<th>Namibia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total population (2010)</td>
<td>19,378,000</td>
<td>40,513,000</td>
<td>15,370,000</td>
<td>2,283,000</td>
</tr>
<tr>
<td>Income group (World Bank)</td>
<td>Lower middle income</td>
<td>Low income</td>
<td>Low income</td>
<td>Upper middle income</td>
</tr>
<tr>
<td>Geographic location</td>
<td>West Africa</td>
<td>East Africa</td>
<td>Southeast Africa</td>
<td>Southern Africa</td>
</tr>
<tr>
<td>Adult HIV prevalence</td>
<td>2.7% 120,000</td>
<td>6% 690,000</td>
<td>10.3% 510,000</td>
<td>14.3% 120,000</td>
</tr>
<tr>
<td>No. of PLHIV on ART</td>
<td>2.7% 120,000</td>
<td>6% 690,000</td>
<td>10.3% 510,000</td>
<td>14.3% 120,000</td>
</tr>
</tbody>
</table>

Figure 1. Source and agents of HIV financing in Côte d’Ivoire (2008)
Kenya  

Between 2006 and 2010, Kenya’s HIV response became less dependent on donor funding and saw insurance coverage of HIV services increase. In 2010, donors accounted for 51% of HIV funding, proportionately greater than their share of general health funding (35%) but 19 percentage points lower than in 2006 (Figure 2). During the same period, insurance spending – including both private insurance companies and the National Hospital Insurance Fund (NHIF) – increased tenfold as coverage spread and HIV services were incorporated into insurance schemes’ benefit packages. Despite donor and government subsidies and increased risk pooling through insurance, out-of-pocket spending by PLHIV accounted for 19% of HIV spending in 2010.

About a quarter of all HIV spending went to private for-profit facilities in Kenya in 2010 – significantly more than in most sub-Saharan African countries. Financiers of this funding included the NHIF and private insurance, together accounting for a third of all HIV resources spent at these facilities (US$ 16.4 million). Insurance mechanisms spent an additional US$ 6.4 million for HIV services at not-for-profit facilities. As the Kenyan Government accounts for approximately 11% of funding managed by private health insurance, it is likely that government funds were spent at for-profit facilities. PLHIV were the main financier of HIV services at for-profit facilities in 2010, accounting for 71% of all facility resources. PLHIV spending at for-profit facilities also accounted for more than half (54%) of their out-of-pocket spending.

Malawi  

As in Côte d’Ivoire, Malawi’s HIV response is highly dependent on donors. In 2009, donors accounted for 83% of the US$ 181.5 million spent on HIV, which was 22 percentage points greater than their share of general health funding. Between 2003 and 2009, growth in donor spending on HIV increased at a much greater rate than growth in domestic financing. This increase exacerbated Malawi’s reliance on donor HIV funding yet effectively expanding the reach of the HIV response by funding more services for PLHIV. Even though increased donor funding along with government HIV funding kept out-of-pocket payments by PLHIV at 4% of HIV financing in 2009, the absolute amount of out-of-pocket payments by PLHIV increased by 300% between 2003 and 2009, even when accounting for inflation. Private actors only provided 3% of HIV spending in 2009, and managed about 7% (Figure 3) HIV spending at non-profit facilities increased from US$ 1.8 million in 2003 to US$ 17.2 million in 2009 and became increasingly reliant on donors. Some 76% of spending at facilities associated with the Christian Health Association of Malawi (CHAM) in 2009 came from donors, an increase of 48 percentage points since 2003. Donors channelled funding for HIV to non-profit (primarily CHAM) facilities through three different routes: public agencies, donors and international partners, and direct payments to CHAM. Between 2003 and 2009, spending on HIV at for-profit facilities increased from US$ 1.0 million to US$ 3.5 million. Very little of this funding originated with the Government of Malawi or donors. Despite donor and government subsidies, growth in HIV spending at for-profit facilities primarily came from PLHIV spending out-of-pocket. This trend shows that PLHIV purchased HIV goods and services at for-profit facilities despite the availability of subsidized and free care at public facilities and indicates that there is possibly a growing gap in financial coverage for PLHIV.

Figure 2. Source and agents of HIV financing in Kenya (2010)

Figure 3. Source and agents of HIV financing in Malawi (2009)
Namibia

A middle-income country with high prevalence of HIV, Namibia has a highly donor dependent HIV response in an otherwise domestic-funding driven health system. Specifically, in 2009, donors accounted for 51% of HIV funding in Namibia, 29 percentage points more than their share of general health spending (Figure 4). The Government of Namibia provided 45% of total HIV expenditures. Donor and government spending effectively subsidized health care, as indicated by low levels of out-of-pocket spending on health (6% of total health spending) and HIV (3% of total HIV spending). Private business spending at private health insurance companies accounted for less than 1% of HIV spending.

Of the US$ 130.9 million spent on HIV at all health facilities in 2009, the majority (88%) went to public facilities, while for-profit facilities only accounted for 7%. For-profit facility HIV funds came primarily from PLHIV (76%), public employee insurance (20%) and private insurance companies (4%). Public employee insurance, which is funded by the government (85%) and household contributions (15%), is also one of the main sources of funding at private pharmacies (51%). It is the only channel through which government money reaches private health facilities. Most HIV funds managed by private insurance companies were spent at for-profit facilities (65%) or private pharmacies (31%). Around 40% of out-of-pocket spending on HIV occurred at for-profit facilities, indicating that PLHIV still use private facilities despite the availability of free and subsidized services in the public sector. In contrast, NGOs, which were the second largest financing agent for HIV spending (29%), spent most of their HIV funding (94%) at public health programmes and providers of health-care administration.

Figure 4. Source and agents of HIV financing in Namibia (2009)

Discussion

Even though many governments have increased funding allocations for HIV programming, most of the countries in this analysis still rely heavily on donor funding. Across the board, all four countries saw donors contribute a greater portion of funding for HIV than for general health. In Kenya, even though public and private entities have increased their spending on HIV, donors still accounted for more than half of HIV funding in 2010. Donors provided 87% of Côte d’Ivoire’s HIV expenditures in 2008, but only 13% of general health spending. Between 2003 and 2009, HIV spending in Malawi increased by over 560%, largely resulting from increased focus on HIV by donors who provided 83% of HIV funds in 2009. Similarly, more than half of Namibia’s HIV funding came from donors in 2008.

Increased donor investment helped scale up prevention programmes and get more PLHIV on treatment. Donor dependency, however, undermines the sustainability of these programmes and leaves them vulnerable to changes in donor priorities. These findings highlight the importance for governments and donors to increase country ownership and link funding to long-term sustainability strategies for countries’ HIV programmes. PEPFAR,7 the Global Fund,6 the World Bank5 and other major donors have all identified private sector engagement and public-private partnerships as a key strategy to expand access to HIV services in a sustainable, country-driven way. Example efforts include engaging private companies for workplace programmes, contracting providers to deliver HIV services, and supporting the development of affordable, comprehensive prepaid health financing mechanisms. However, results of this analysis show that real support for private sector development may not match these stated intentions. For example, in Namibia very little donor money actually made it to private facilities; in Malawi a much larger percentage of donor funding reached private (mainly non-profit/CHAM) facilities. Going forward, donors should monitor how funding for HIV treatment is spent at the facility level to ensure that their
spending aligns with their stated strategic intentions.

Incorporating private providers and the HIV services they provide into public HIV programmes or insurance mechanisms may help donors and governments manage financial risk to households. In all four countries, out-of-pocket payments by PLHIV as a percentage of total HIV spending were lower than contributions of households for general health. These findings indicate that donor and government investments have helped reduced the burden on PLHIV to finance their HIV care but that more needs to be done, especially to protect poor PLHIV from financial hardship. Out-of-pocket payments tend to be highest at private-for-profit facilities, which are often clients’ preferred choice despite the availability of subsidized services in public sector facilities in all four countries. In Kenya, out-of-pocket spending by PLHIV at for-profit facilities decreased as a share of spending at for-profit facilities with increased spending by insurance mechanisms, but still accounted for the majority of HIV spending at these facilities. In Malawi, out-of-pocket spending by PLHIV for-profit facilities grew from 32 to 64% of the HIV expenditures at these facilities between 2003 and 2009.

Integration of private for-profit facilities comprehensively within government and donor-sponsored HIV programmes could ensure more consistent financial risk protection to PLHIV regardless of where they prefer to seek care. Namibia has already demonstrated one way to do this. In 2008, more than half of HIV spending by government employee insurance programmes occurred at for-profit facilities.

Another strategy is to promote health insurance coverage of HIV services, particularly in countries like Namibia and Kenya with a growing, vibrant health insurance market. NHA and insurance coverage data show the need for affordable health insurance products. Private insurance in Kenya managed more HIV spending than NHIF in 2010, but covered almost two million fewer people. Those covered are primarily formal sector workers, indicating that insurance-managed funding benefits a small, wealthy subset of the Kenyan population. To mitigate this inequity, health insurance companies can develop low-cost products that are affordable for a greater percentage of the population. Governments and donors may need to work together to promote risk-pooling mechanisms for PLHIV. Tracking how these new financing mechanisms decrease the financial burden on PLHIV will inform further reforms to improve coverage of PLHIV in insurance schemes. Stakeholders should also ensure that risk-pooling mechanisms are reliable and efficient to reduce administrative burdens on both payers and providers.

More regular and accurate estimates of HIV service use and spending at private facilities can inform strategies to engage the private sector. Key to developing effective strategies is accurate data. More high quality trend data in all countries can also strengthen the power of future analysis to track the development of HIV financing flows through private providers. Health sector stakeholders should make a concerted effort to systematically track resource flows through the private sector to more accurately measure its contribution to the HIV response and incorporate it into strategic planning.

Conclusions

Private providers of HIV services are important partners in national HIV responses. In many developing countries, their size and geographic spread can help reduce geographic barriers to accessing care, and PLHIV often prefer them given shorter wait times and perceived greater discretion. This study argues that greater integration of these partners into the government-led HIV responses in Côte d’Ivoire, Kenya, Malawi and Namibia can also strengthen the power of future analysis to track the development of HIV financing flows through private providers. Health sector stakeholders should make a concerted effort to systematically track resource flows through the private sector to more accurately measure its contribution to the HIV response and incorporate it into strategic planning.

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References

3. The methodology for conducting NHA was updated in 2011. The NHA data used in this analysis were generated before the update. 4. HIV/AIDS NHA subaccounts capture both health and non-health related HIV/AIDS spending. HIV spending estimates used in this analysis only include spending on activities that aim to improve, maintain or prevent deterioration of health. They do not include non-health programmes such as those focused on orphans and vulnerable children.