POLICY BRIEFS ON

ECONOMIC IMPACT OF HIV

15.

PUBLIC AND PRIVATE PROVISION OF HEALTH AND HIV SERVICES

Health Economics and Epidemiology Research Office
HE²RO
Wits Health Consortium
University of the Witwatersrand

WITS UNIVERSITY

BOSTON UNIVERSITY

UCL

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15.

PUBLIC AND PRIVATE PROVISION OF HEALTH AND HIV SERVICES

KEY POINTS

- **Private sector provision of health services – through for-profit, not-for-profit and informal providers – is widespread in low- and middle-income countries, and has played a role in the provision of HIV services.**
- **Empirical evidence on the role of private-sector service provision is hampered by the great heterogeneity of private health providers. Overall, private-sector providers appear roughly as effective in providing HIV-related services as public services, and they disproportionately serve wealthier populations.**
- **Public-private partnerships describe more evolved collaborations between the government, the private sector and, frequently, donors, and have played a role especially in capacity building and technology transfer.**
- **The potential to improve coverage, efficiency and equity of health services by complementing public services with private-sector involvement depends on local context and the nature of barriers to access.**

Private providers – comprising non-public entities, including for-profit, not-for-profit and informal providers, as well as traditional healers – play an important role in providing healthcare in low- and middle-income countries. This brief discusses the evident or potential contributions of private provision of health and HIV services, focusing on three questions: (1) What is the role and potential of private providers in extending coverage of health services? (2) What is the actual and potential role of private providers in improving equity in access to health services? (3) What is the efficiency of private vs public provision of health services, and where can involvement of private providers improve the efficiency of the health system in delivering specific services? We also consider more complex models of collaboration with the private sector in the form of public-private partnerships.

Coverage

With regard to the role of the private sector in extending coverage of HIV-related services, it is necessary to distinguish between an aggregate perspective and a focus on specific populations. As for health services in general, private providers play a role in delivering HIV services. These data may yield insights on the strengths and weaknesses of respective types of providers, but not so much on their contributions to coverage, as the counterfactual is not well defined. Patients with private providers may otherwise draw on the public sector and vice versa. Instead, provision of HIV services to key populations often relies on private providers

– typically non-governmental organisations (NGOs) or civil society organisation (CSOs) – as a tool for improving coverage where the public sector is considered less effective.

Private provision of health services is widespread in low- and middle-income countries. Data on private health spending (voluntary pre-paid and out-of-pocket) offer some indirect evidence (Figure 15.1) on the role of private provision, with the caveat that not all private spending goes to private providers. Overall, private spending plays a larger role in low-income countries (roughly, those countries with GDP per capita at US$1,000 or less in Figure 15.1) than in middle-income countries, with a large variation in its contribution across countries at similar income levels. For example, private spending accounts for between 30 percent and over 90 percent of health spending in low-income countries (WHO, 2020).

Direct data on the proportional provision of private vs public health services across countries are rare; most cross-country studies build on standardised data from Demographic and Health Surveys (DHS). Figure 15.2 illustrates such data, comparing the share of births (deliveries) taking place with the appropriate healthcare service with the share of those deliveries that take place in the private sector. Service coverage differs widely across sub-Saharan Africa (between 13 percent and 92 percent), as does the role of private-sector providers (with between 0 percent and 40 percent of all births receiving the appropriate service).

Overall, there is a (weak) negative correlation between overall service coverage of maternal health services and the share of private-sector provision. This means that the public sector played a relatively stronger role in countries attaining higher service coverage for maternal healthcare. This applies even though the picture is blurred by the presence of a small group of "outlier" countries (Chad, Ethiopia and Niger) where both indicators are very low (especially for overall service coverage, at below 20 percent in Figure 15.2), perhaps indicating the presence of factors which impede an effectively functioning health system and (even more so) private-sector development.

Figure 15.1: Private sector health funding

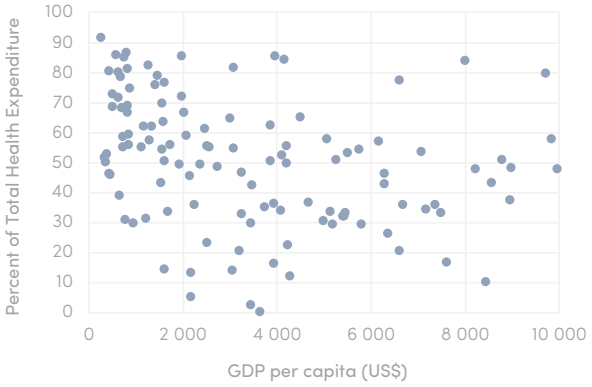
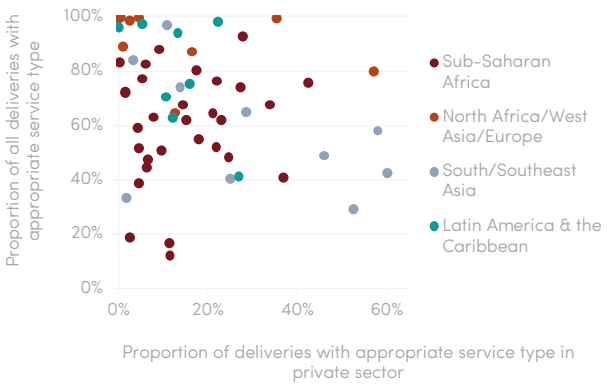


Figure 15.2: Deliveries with appropriate service type



Source: WHO (2020) for Figure 15.1, Benova et al. (2015, reprinted with permission) for Figure 15.2.

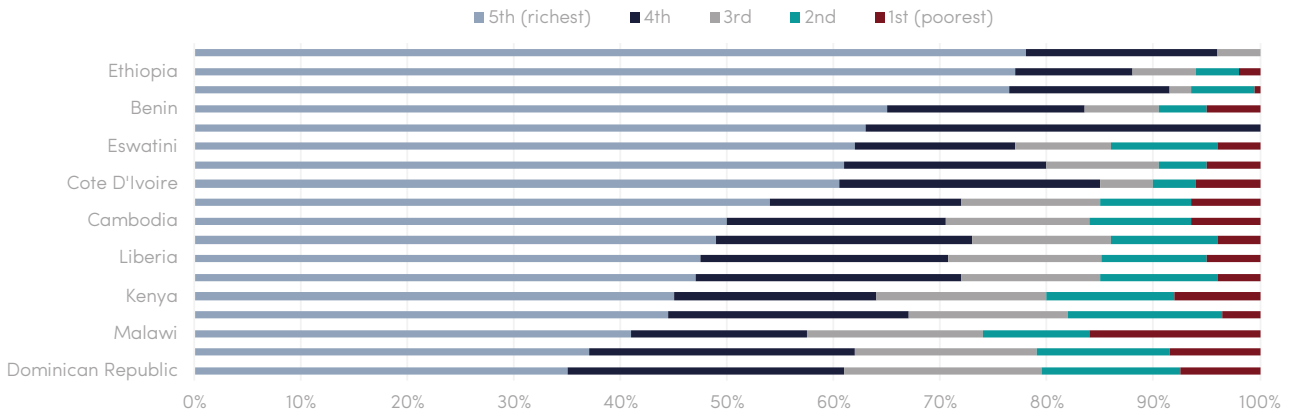
Meanwhile, the private sector (often through NGOs and CSOs) has been instrumental in extending access to HIV services to key populations, e.g., for HIV prevention and support services for sex workers or men who have sex with men, or harm reduction programmes for people who inject drugs. In these cases, non-state organisations complement public HIV services and are considered effective in overcoming barriers related to stigma and criminalisation, and in improving outcomes through peer education and support (Macdonald et al., 2019; also see Atuhaire et al. (2021) for a differentiated discussion on programmes targeting female sex workers).

Equity

The heterogeneity of the private health sector also makes it difficult to assess equity in access to private health services – differences in headcounts of services provided across population categories may not reflect the quality of those services. With this drawback in mind, the most substantial evidence on equity in access, as well as for service coverage overall, comes from DHS data. For example, data on antenatal and delivery care show that use of the private sector increases consistently with household wealth, while use of the public sector is fairly even across wealth quintiles (Benova et al., 2015). (In contrast, women in households with lower wealth are more likely to give birth without skilled birth attendance in either a public or private facility.)

Since antenatal care is an access point for HIV testing and treatment, the share of women who get tested for HIV and receive their tests through the private sector also increases strongly with household wealth (Johnson & Cheng, 2014). The implications of these gradients for the population groups served by private and public providers, respectively, can be dramatic: across 18 countries covered by Johnson & Cheng (2014, Figure 15.3), the share of patients receiving HIV tests in private-sector antenatal care who belonged to the top two wealth quintiles ranged from 58 percent to 100 percent (with a weighted average of 69 percent), while the share of patients from the lowest wealth quintile ranged from close to zero to 16 percent (weighted average: 7.6 percent).

Figure 15.3: Users of private health services by wealth quintile



Source: Johnson & Cheng (2014).

Efficiency and quality

Any assessment of the efficiency of public versus private services in general is hampered by the heterogeneity of the private sector. It is challenging to draw broad conclusions given the vast range of private providers, including formal-sector for-profit and not-for-profit providers, as well as informal providers and traditional healers.

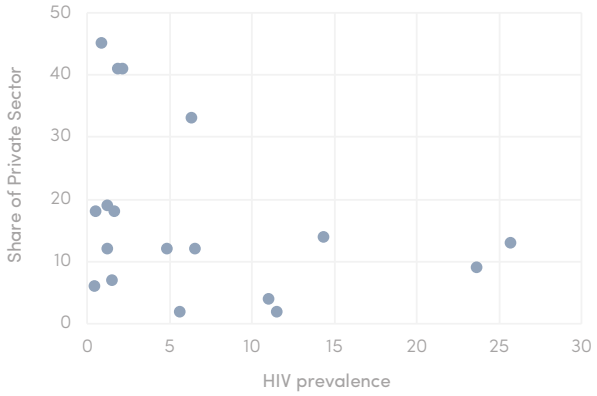
One systematic review, covering mostly studies comparing private-sector and public-sector entities across different types of health services in low- and middle-income countries, concludes that the "reported efficiency tended to be lower in the private than in the public sector, resulting in part from perverse incentives for unnecessary testing and treatment," whereas "public sector services experienced more limited availability of equipment, medications, and trained healthcare workers" (Basu et al., 2012).

For HIV and related services, Powell-Jackson et al. (2015) document superior performance of the private healthcare sector (both commercial and non-profit) compared with the public sector in terms of delivering a bundle of services during antenatal care. According to Johnson & Cheng (2014),

women are more likely to receive an HIV test during antenatal care at private health facilities than at public facilities, based on data from several DHS studies. This difference, though, disappears when controlling for patients' wealth – the result may therefore reflect that the private-sector facilities specialise in providing higher-quality care to wealthier patients, while private facilities perform only about as well as public-sector ones if they serve similar populations (a point that might also apply to the results by Powell-Jackson et al., 2015). A preliminary analysis from South Africa on provision of antiretroviral therapy for HIV patients (Long et al., 2020) suggests that private-sector clinics are similarly effective in terms of treatment outcomes as the public sector, and that the costs of service delivery are similar (but this relies on access to antiretroviral drugs procured through the public sector).

Looking ahead, the roles of private- vs public-sector provision are likely to shift where vertical HIV programmes (dominated by the public sector and various non-profit providers) are integrated into health systems in which private providers play a larger role, for two reasons. First, models of differentiated care offer opportunities for shifting some tasks from dedicated providers of HIV services to general providers – including community health workers, but also any private-sector facilities. Second, the lower costs of antiretroviral therapy (ART), reduced HIV incidence, and simplified delivery of ART have lowered the bar for including ART in medical-benefit plans offered by private providers and delivered through private facilities. Thus, there is an argument for increased provision of HIV-related services through private providers for patients paying privately (typically through private insurance) for higher-quality packages of care. Some cross-country data point to a role for the private sector both in expanding coverage and realising efficiency gains at the programme level. For example, the private sector contributed one-fifth of HIV tests in DHS data from 18 different countries (Johnson & Cheng, 2014). This role, though, differed widely across countries (Figure 15.4). Specifically, the role of the private sector was most pronounced (at least 40 percent of HIV tests conducted) in three countries with HIV prevalence below 2 percent, while it was less than 15 percent in countries where HIV prevalence exceeded 10 percent. This means that the private-sector providers are used more in countries where setting up dedicated HIV services could be less viable due to relatively lower demand. Relatedly, as countries attempted to reach the UNAIDS 90-90-90 targets by 2020, the surge in testing and treatment initiation over the last five years has favoured the public over the private sector in many countries, changing the distribution of services.

Figure 15.4: HIV prevalence and private sector share in HIV testing (percent)



Source: Johnson & Cheng (2014).

Public-private partnerships

Public-private partnerships (PPPs) describe more evolved collaborations – going beyond simple contractual arrangements for the delivery of services – between the government, the private sector and, frequently, donors, and often involve capacity building and technology transfer. These partnerships can serve different purposes: managing the transfer of resources when there is involvement by international funders, collaborating in the production of health goods and services, and setting up governance mechanisms to share risks and investments and accommodate different stakeholders (Fanelli et al., 2020).

With regard to the management of resource transfer, PPPs serve similar purposes as trust funds which are sometimes set up to manage largely externally funded programmes jointly between the government and donors (Haacker, 2015) – the difference being that here the bulk of services is delivered through the private sector, and private-sector representatives may also have a seat at the table in the governance of the programme. This aspect of PPPs is strongly linked to donor involvement (Palmer, 2006), while governments tend to adopt leaner contracting arrangements without some of the other elements mentioned above.

One of the most involved forms of PPPs regards responses to new and complex health challenges, such as Covid-19 and (earlier) HIV, in which private sector know-how is pulled in to rapidly and efficiently scale up health services or functioning of the health system in response to a pressing need, or the private sector collaborates with government agencies in research and development. At the global level, this approach has been used, for example, by the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) in partnerships with industry leaders from advanced countries to build drug-supply networks and laboratory infrastructure across sub-Saharan Africa in response to HIV (Sturchio & Cohen, 2012).

One example in the area of HIV is the African Comprehensive HIV/AIDS Partnership supporting the HIV response in Botswana, involving a private company, the Bill & Melinda Gates Foundation and the Government of Botswana, driven by the perception that effective support required not only financial resources or drug donations, but also "support for strengthening the health care infrastructure to assure that medicines are used effectively" (Ramiah & Reich, 2006). Shrivastava et al. (2019) document several other examples in which PPPs have contributed significantly to the scaling-up of national HIV viral-load testing programmes.

Can the private sector's potential to address priority health challenges be harnessed for better HIV care?

Looking ahead, what are the lessons for using the private sector's capacities to address pressing health challenges? The answer to this question depends in part on the existing health financing system in a given context. A comprehensive national insurance system with a strong public component, and with a mix of public and private providers, offers a means of aligning the private sector with urgent national health priorities. In this sense, universal health coverage is a method for "harnessing" the private sector's potential.

Within this system, or through specific arrangements, there is potential to pull in the private sector's capacities in response to health emergencies such as Covid-19, for example by leasing underused capacity like hospital beds from private providers. More generally, contracting the private sector could be an efficient way of expanding coverage, reaching populations which are not reached well by public services – considering operating costs, and the location and capacities of existing facilities. For example, if the treatment of some HIV patients is assigned to general practitioners or other private health providers, this frees up capacities in public facilities serving people living with HIV (Igumbor et al., 2014). The principle of differentiated care for people living with HIV who are receiving treatment offers opportunities to involve private providers to meet the needs of patients shifted into less intensive modes of care, depending on local demand for services and availability of providers. Whether the private sector provides a more effective and cost-effective mode of delivery, though, depends on the local context, and other considerations such as transaction costs, as well as the government's capacities for oversight, quality assurance, and regulation (Hanson et al., 2008; Rao et al., 2011).

Since evidence on the efficiency of private vs public health services is ambiguous, any potential for using private-sector capacities to improve the efficiency of health services overall rests on the local context and the type of services being delivered. Principal examples include the use of local private providers to improve population access to specific services, or the experience of PPPs in improving supply chains, in particular in drug delivery and laboratory systems (Shrivastava et al., 2019), although it is often unclear whether the PPP works as a means of capacity building or a sustainable business model. More generally, potential for efficiency gains through cooperation with private providers rests on the existence of capacity bottlenecks (or excess capacity) in some facilities, and the presence of economies of scale, for example in labs or distribution networks.

Arguments for using private providers to reach poor populations often rest on the weakness of public health services, for example as "a result of insufficient drugs supply, poor healthcare infrastructures, scarce resources and generally low quality of care" (Fanelli et al., 2019). However, it is often unclear whether investments in strengthening capacities of the public sector would not reach the desired outcomes more effectively or sustainably. The potential role of the private sector in overcoming barriers to access thus depends on the causes of such barriers (Hanson et al., 2008). Perhaps the most clear-cut example of private providers improving healthcare access of poor populations is the use of private providers (often non-profit organisations) where state capacities are weak, such as in a post-conflict situation. While there are studies on private providers contracted to extend health coverage to poor sub-populations, available reviews consider this evidence weak because the studies lack comparison with public-sector provision (Basu et al., 2012), or the schemes rely on substantial financial support from donors, the government or social health insurance schemes (Tung & Bennett, 2014).

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