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RESEARCH INSIGHTS

Lessons from South Africa in Contracting Out HIV Services

A study of three contracting models in South Africa found that private providers can partner with donors and governments to deliver HIV care, augment limited public health services, and maintain continuity of care. However, financing these services remains a challenge, particularly as subsidies decline.

Over the past decade, South Africa, in partnership with international donors and NGOs, has made enormous strides in tackling its HIV epidemic. Yet with 18 percent of adults and approximately 410,000 children living with the virus, the country continues to experience the world's greatest HIV burden.

This study documents the contracting and service delivery experience of Right to Care Health Services (RTCHS), a private company that manages HIV services on behalf of the United States Agency for International Development (USAID) under the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) and the 2012 PEPFAR partnership framework for South Africa's HIV and tuberculosis response, with the South African government, employers, and private health insurance plans (medical aid schemes).

Contracting out HIV services to private providers can improve access for patients.

Methods

To learn more about using private sector contracting mechanisms to deliver HIV services, the SHOPS project assessed three contracting models implemented by RTCHS over a 10-year period that delivered clinical and laboratory services for people living with HIV in South Africa (see Figure 1 on the next page).

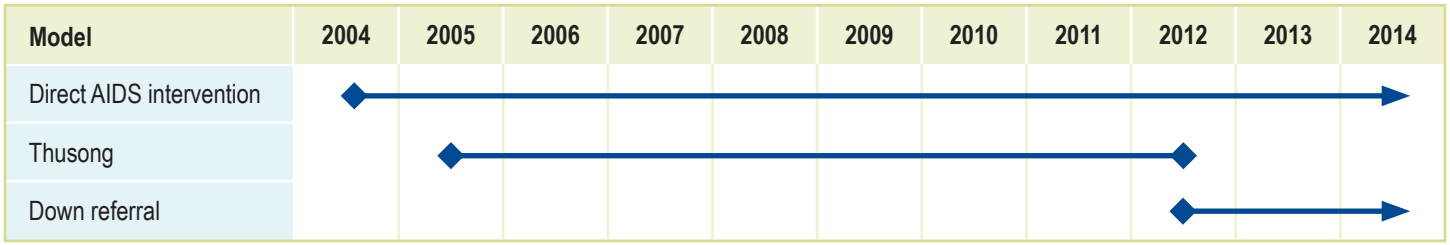
SHOPS interviewed representatives from the National and Gauteng provincial departments of health, USAID, and PEPFAR; RTCHS staff; RTCHS-affiliated general practitioners (GPs); laboratory service providers; and patients. A study of peer-reviewed publications and reports published by the South African government and RTCHS complemented patient demographic data collected for each model.

Key Findings

- Contracts with private providers can enable access to quality care for HIV.
- Social stigma, diverse demographics, and the complex nature of HIV care contribute to challenges in implementing service delivery contracts.
- Purchaser goals influence the delivery of care.
- Contracting out requires sustainable financing.

SHOPS
Strengthening Health Outcomes *through* the Private Sector

Figure 1. Timeline of Right to Care Health Services models



Findings

Contracts with private providers can enable access to quality care for HIV.
Private providers can deliver HIV services effectively and expand the often-limited reach of public facilities. Contracts with private health care providers improved geographic access for patients, shifted stable patients from crowded public care settings to private GPs, and leveraged existing private sector service delivery infrastructure for HIV treatment.

Patients were highly satisfied with care under the direct AIDS intervention model, but costs for purchasers are relatively higher (see table). The Thusong model demonstrated effective subsidized private sector care for low-income persons, but proved unsustainable without financing from the South African government when PEPFAR's subsidy waned. In contrast, the down referral model promotes sustainable public financing of more limited HIV care but raises concerns about the continuity of care and acceptance by patients and GPs.

Fees paid by purchasers to service providers

Model	Initial visit	Follow-up
Direct AIDS intervention	$58	$39
Thusong	$25	$21
Down referral	$25	$21

Social stigma, diverse demographics, and the complex nature of HIV care contribute to challenges in implementing service delivery contracts.
People living with HIV often require treatment of opportunistic infections and have wide-ranging health care needs influenced by factors such as lifestyle and socioeconomic status. The direct AIDS intervention and Thusong models demonstrated how—with adequate resources—workplace outreach, health promotion, call centers, nurse case managers, depots for pickup of antiretrovirals, enhanced drug supply monitoring, and GP training can help address challenges to delivering HIV care. When the more restrictive down referral model was introduced, patients lost access to some of these valued services, and their transition to public health care providers lacked effective coordination and disrupted continuity of care.

Contracting models

Direct AIDS intervention: Targets middle-class workers covered by medical aid schemes and employer-sponsored insurance with workplace-focused interventions; operates independently from PEPFAR and other donors.

Thusong: Similar to the direct AIDS intervention model, but with a more restrictive list of medications. Serves low-income people living with HIV who do not have insurance; financed by PEPFAR.

Down referral: A public-private partnership introduced in 2012 (during the phase-out of the Thusong model) to test cost-effectiveness of transferring stable* HIV patients from crowded public facilities to private sector GPs; financed by the South African government and PEPFAR.

*Stable patients met the following criteria:

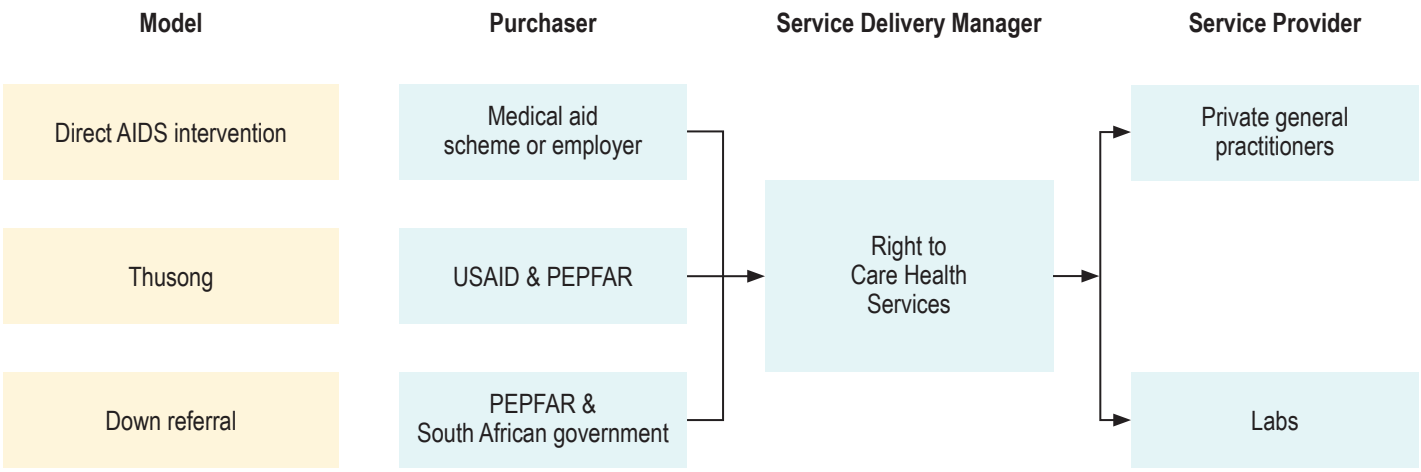
- CD4 count > 200 to 250 cell/mm^3
- Undetectable viral load
- Were not on Stavudine or second-line antiretrovirals
- No history of biological treatment failure
- No existing complications or comorbid conditions (e.g., tuberculosis) or secondary chronic illness (e.g., diabetes)

The down referral pilot
The more limited, lower-cost down referral model is sponsored by the government of South Africa to test the cost effectiveness of transferring 500 stable patients on antiretroviral therapy from a crowded public facility to 10 private sector GPs for maintenance care. In contrast to the fee-for-service arrangements found in other contracting models, PEPFAR pays RTCHS a capitation payment of $22 to 35 per patient per month to cover case management, administration, and patient care. RTCHS, at risk for the cost of services delivered, in turn pays GPs for allowed services on a fee-for-service basis. The public sector pays for and provides laboratory services and medicines. Only basic clinical assessments and an annual blood test are covered under the down referral model, leaving GPs with three options for non-covered care: (1) refer patients to public facilities, (2) charge patients, or (3) provide the care without compensation. Each of these options generated dissatisfaction among patients and GPs. While laboratory service delivery works well, it does not reduce the use of crowded public facilities. Pharmacy provision has been disrupted due to stockouts, common in the public sector. Insufficient communication, including use of informal agreements rather than written contracts in the early stages of the pilot, contributed to a lack of understanding by providers of what is covered and what is excluded.

Purchaser goals influence the delivery of care. Figure 2 illustrates key stakeholders and ensuing agreements for the three contracting models managed by RTCHS. Purchaser goals influenced the design and performance of each model with respect to patient demographics, services delivered, payment mechanism, cost, administrative complexity, and patient and provider satisfaction (see text box above).

Contracting out requires sustainable financing. The Thusong model began operating during the emergency response era of South Africa's AIDS epidemic, when humanitarian imperatives outweighed sustainability considerations. As PEPFAR's subsidy began to phase out in 2011, the South African government was expected to assume all or most of this subsidy. When this did not occur and patients were transferred back to the public sector for care, RTCHS administrators, staff, providers, and patients described adverse consequences, including refusal of service, limited consultation time with doctors, long waiting times for care (which, in one case, resulted in the loss of employment), long queues for medication, and confusion about drug regimens.

Figure 2. Contracting arrangements for HIV services



Program Implications

Contracting out services to private providers holds significant promise to expand the availability of essential health services for HIV care. Each of the three contracting models evaluated in this study and implemented by RTCHS supported the care and treatment of patients living with HIV in South Africa, but each also experienced challenges.

Examination of the design of each contract revealed that, although none of the models functioned perfectly, each offers lessons that may help program managers in other settings expand access to HIV services by contracting with the private health sector. For example, informal service delivery arrangements (in lieu of formal, written contracts) lack clarity and are difficult to scale up. Another lesson is that the purchaser's goals shape relationships and operations, including provider payment mechanisms and performance monitoring.

Contracting out requires sustainable financing. Subsidized programs for HIV service delivery can alleviate pressure on recipient governments to finance treatment and build on prior investments, including PEPFAR's. However, they must specify a process for phasing out and transitioning patients from the outset and then execute accordingly to avoid disruption. This process requires that the subsidy amount may be reasonably assumed by a country when it eventually takes on financial responsibility for HIV programs. In the case of South Africa, the government will need additional resources to finance service delivery that is available under private sector models such as down referral, or even the more costly direct AIDS intervention model, each of which has different funding requirements.

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Full Report

Tayag, Josef, James White, and Alejandra Mijares. 2014. *Extending the Reach: Contracting Out HIV Services to the Private Health Sector in Gauteng, South Africa*. Bethesda, Maryland: Strengthening Health Outcomes through the Private Sector Project, Abt Associates Inc.

Download this report at www.shopsproject.org.

This summary is based on research conducted by the SHOPS project. For more information, contact info@shopsproject.org.

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For more information about the SHOPS project, visit: www.shopsproject.org

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