Public-private sector partnerships as a means of development in Africa, in the context of HIV/AIDS

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Summary: Where and how the private sector can work in partnership with public agencies to improve human welfare is a wide ranging public debate. The broad issues, nonetheless, have been resolved; for example, the ‘Millennium Development Goals’ affirm the need for multi-sectoral, co-ordinated interventions and Corporate Social Responsibility is now an axiom of sound business practice. Indeed, private-public ‘partnerships’ are an accepted premiss for stimulating national development in the countries where there are HIV/AIDS epidemics. Where there is much debate, however, is over the details of where and how these partnerships can and do work effectively. Here, we focus on one ‘big’ question: how to promote development in the context of HIV/AIDS? We also focus on one set of issues, the role of the private sector in public health management in countries with HIV/AIDS epidemics.

Keywords: public-private partnerships, HIV/AIDS, treatment, health

"If health systems are to be considered the vehicle for the delivery of services and interventions to deal with HIV/AIDS, [the public health community] has over the last few years tended to neglect the vehicle". Much more attention has been paid to getting the passengers into the vehicle and determining where the vehicle is supposed to go, as opposed to trying to address the deficiencies of the vehicle itself." (McCoy)¹

The quote above by McCoy succinctly captures the widespread concerns, past and present, about the capability of public health services in Africa to confront the HIV/AIDS pandemic. A case in point is the ongoing, very public debate on the exodus of health professionals from Africa, their active recruitment by health services in the ‘north’, and subsequent government policy changes in some European and African countries to mitigate the problems created for the public health services in Africa.² Our contention is that McCoy’s observation also applies to the current state of private sector health-oriented interventions.

Today, there is little to contest over the capability of the private sector to play a critical role, particularly in developing countries, to reduce poverty and improve public health through independent and co-operative interventions.³ Indeed, private-public ‘partnerships’ are an accepted premiss for stimulating national development in the countries where there are HIV/AIDS epidemics. The International Labour Organization (ILO), the Global Fund, and other partners are working together to support expanding public-private partnerships in the world of work.

This includes community outreach where the employer covers the costs of antiretroviral drugs for permanent employees and the Global Fund or other donors extend access to these drugs to the families, contractors and the local community.³

Here, however, we draw attention to practical challenges facing the private sector, which exist irrespective of arguments about where and how companies can contribute to the public good in rolling back the pandemic and whether they can do more than they are doing. In other words, we ask what precisely are a ‘vehicle’s deficiencies’? We discuss this question in relation to the global effort to expand anti-retroviral treatment (ART) programmes and, specifically, to the evolution of workplace ‘wellness/health management’ programmes in South Africa. Our purpose is to illustrate policy-relevant issues that lie beneath debates about the

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¹ South Africa, for instance, entered into an agreement with the United Kingdom in 2003 which made allowances for health professionals of one country to work in another for a specified period.
need for, and possible forms of private-public sector partnerships.

Core challenges

Large multi-national corporations are providing a lead in South Africa on the design and implementation of health management programmes. We refer here to the impetus towards comprehensive health services which include multiple interventions (for example, education and awareness programmes; voluntary counselling and testing[VCT]; access to, or direct provision of ART – and nutritional supplements – to staff in need; extension of these services to workers’ spouses; and support of ‘community-based interventions’). These companies have an advantage over public health services on several grounds; for example, defined, concentrated populations and considerable financial resources to develop services. However, the results to date are disappointing: while many companies can boast high participation rates in education and awareness programmes and in VCT campaigns, few, if any can show high uptake rates of workers in ART programmes. Furthermore, workers who do enrol for treatment usually do so when they are too sick to work, thereby negating the fundamental purpose of a workplace programme, which is to keep workers healthy and productive.

At root, private sector health initiatives encounter two core challenges which confront all health systems in countries where there are HIV/AIDS epidemics. One is the lack of precedents on how to contain and manage HIV/AIDS; hence, the imperative for innovation in health systems delivery. The second is the quantum leap involved in conceiving and implementing comprehensive programmes which are effective in both preventing the transmission of the virus and treating those who are infected. There is little resemblance between standard occupational health programmes and ‘wellness’ programmes. The latter invokes the concept of the ‘continuum of care’ which, as we noted above, demands multiple interventions. Those interventions entail substantive investment in expertise either through ‘in-house’ employment of health professionals or payment to external service providers. The long term logic and scope of those investments inevitably raises consideration of collaboration with the public health sector, as at some point companies must confront issues such as drug procurement and enabling retrenched staff to migrate to public treatment programmes.

In turn, the lack of precedents demands experimentation which is reflected in South Africa, in the existence of different models of health care within the private sector. Likewise, there are standard protocols for health care in South Africa’s public health service but, in practice, there is huge variation from the norm and between different provincial and local health service departments and, indeed, between different hospitals and clinics. Our central argument, therefore, is that debates about, and policy-making on, public-private sector partnerships all too easily focus on form and satisfy political and ideological interests at the expense of appreciating the necessity of experimentation and innovation.

The situation in South Africa

In 2003 the South African government announced that it would begin providing treatment through the public health service. However, the roll out has been extra-ordinarily slow even though the public programme added greatly to the number of people who were accessing treatment via non-governmental organisation and private sector services. In 2006, the estimated total number of people needing treatment was 711,000. By 2007, approximately 306,000 people were receiving treatment, having risen from 280,000 in 2006 and from less than 50,000 in 2003. Currently (April 2008), South Africa’s public media is broadcasting that ‘2%’ of the population has tested for HIV.

Even allowing for a sizeable margin of error, these statistics show that South Africa has yet to achieve substantive success with regard to containing HIV and AIDS. Numerous reasons are put forward for this failure, ranging from a prevailing culture of stigma and discrimination to lack of political will. We have no reason to doubt the explanations nor, indeed, the possibility of significant inroads into the epidemic within the next few years as the manifold small and large scale interventions begin to have direct and indirect effects. However, ambitions for co-ordinated intervention with attendant multiplier effects, based on private-public sector partnerships, will not be achieved without consideration of the core challenges.

In the first instance there are structural constraints to consider. Sengwana and Veenstra, for instance, recorded that managers at all levels of the public health services spoke more readily of limited capacity to deliver services in health care facilities, than management capacity deficiencies. As a result, health workers shortages came across as a more pressing issue than capacity deficiencies resulting more specifically from the decentralisation of management functions. The shortage of health care workers was moreover not related to the number of posts, but was rather attributed to the limited number of health care workers trained, inadequate recruitment procedures, poor human resource management impacting on retention, and increasing deaths among nurses as they succumbed to HIV/AIDS.

Wadee and Khan highlighted the general shortage of health workers in South Africa. Very recently, the government reaffirmed its approach to tackling this problem. In reply to a question in parliament, the Minister of Health reported that her department had, in the six months period, since November 2006, appointed ‘507 doctors – predominantly from developing countries’ to public sector posts (Mercury newspaper, 28th March 2008).

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* A review of company websites will show that it is very difficult to find figures on actual numbers and proportion of staff on treatment and other success indicators such as treatment adherence rates and survival rates. This same is evident in the case of South Africa’s public health services at national, provincial and local levels.

** As revealed in a HEARD project establishing the cost effectiveness of different models of antiretroviral treatment programmes across clinical sites in KwaZulu Natal in urban and rural settings.

*** In a country with approximately 40-44 million inhabitants, this percentage suggests that approximately eight to nine hundred thousand people know their status, thereby intimating that those who do get tested are predominantly those who are both HIV positive and have sought treatment.
The shortage is exacerbated by the uneven distribution of health workers between the public and private health sectors. Table 1 shows the number of medical practitioners available to those served by the public and private sector respectively. Additionally, the retention of health workers appointed to rural posts is difficult and rural areas tend to have a lower ratio of health workers to population than urban areas.11

What these figures also allude to is the existence in South Africa of distinct parallel health services that are not mutually supportive. Simply put, the public health services serve, however imperfectly, the majority of the population and primarily the sub-population of HIV infected people, while the private sector serves a small minority of the national population and primarily those who are not infected (as attested by their success with VCT campaigns). Both sectors have limited reach. In the case of the public health services there are few facilities where individuals can get tested – the current government policy is for one facility per district. There are more facilities which provide treatment if necessary but they are not always the same as those which provide testing; hence people need to travel and make different arrangements to get access to treatment. Private sector employees access treatment through medical insurance or as a contract benefit if employed by companies that operate comprehensive workplace programmes. Furthermore stigma and discrimination are frequently cited by managers in both sectors and, indeed, by individuals as reasons for low levels of participation, be it for VCT or ART in any facility.4

Nonetheless, other more prosaic reasons are emerging. In the private sector, these include:13

- Lack of ‘buy-in’ from management; for example, when line managers and supervisors view interventions such as peer education and ‘know your status’ campaigns (VCT and company-wide sero-prevalence surveys) as factors that disrupt daily production demands and so they reluctantly support employee participation in them;
- Insufficient training, time or means given to peer educators to interact with employees;
- Disincentives such as when contract or casual employees see that they are entitled to VCT services but access to treatment is restricted to permanent employees;
- Workers not seeking treatment if they have not disclosed to their spouses and/or the latter do not have access to treatment;
- Interventions that ‘do not speak’ to the individual, taking into account factors such as age, gender, social circumstances and culture.

Yet, these problems along with those of stigma and discrimination are what stimulates innovation and experimentation by managers –in the public and private sector – to improve the reach and effectiveness of their HIV/AIDS services. In the public sector, the government began in 2004 to dismantle HIV/AIDS specific programmes and to integrate them into normal health service programmes and infrastructure. They also began to expand services such as looking for better ways to ensure adherence to treatment, establishing ‘youth-friendly’ clinics (where adolescents would not face moralistic injunctions from staff) and increasing the number of facilities that provide treatment.14

Changes to private sector workplace programmes in the mining industry and in the automotive industry illustrate the general direction of both the private and public sectors. Put schematically, the history of workplace programmes since 2000 reveals that companies often start with education and awareness programmes, proceed towards provision of ART, incorporate supplementary services such as food supplements and then are driven to expand further through providing access to services for workers’ spouses and/or supporting HIV/AIDS ‘supply chain’ initiatives (assisting companies that supply them with components or other services). Less discernable but in the same vein are initiatives within the public sector. A conference on ART services included many reports by clinicians and managers of public health service facilities that outlined how they had or were changing protocols and procedures and creating opportunities to collaborate with surrounding communities and businesses and NGOs in a quest to improve the effectiveness of both their prevention and treatment programmes.9 In some cases these innovations were being done with the approval of local health authorities (for example, Cape Town). In many cases, however, they were initiatives of frustrated clinic and hospital staff who were prepared to dispense with formally sanctioned protocols. These dynamics are significant for revealing not only the current experimentation within health programmes in South Africa but also for indicating the inevitable outcome: a diverse range of models, structures and partnerships; in short fragmented evolution of public and private health services.

Conclusion

We have outlined the expansion of health-related services in South Africa to illustrate the dynamic nature of private and public sector initiatives in contexts where there are rampant HIV/AIDS epidemics. Our purpose has been to qualify the long-standing interest in public-private sector partnerships as a means to combat HIV and AIDS and, more broadly, to enable development in the context of HIV/AIDS epidemics. Such partnerships may be desirable but, in practice, their form and content (hence the actual role of the private sector) cannot be prescribed in view of the experimentation and innovation that is occurring in the absence of effective solutions to curbing HIV/AIDS in developing countries. Nonetheless, we discern an opportunity in these circumstances for

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policies that support the drive towards private-public sector partnerships. The private sector has proved capability to achieve an essential first step in containing the transmission of HIV: widespread participation in VCT campaigns. It has not achieved substantive success in expanding access to treatment. However, it has demonstrated capability to systemic innovation; in short greater flexibility and commitment than the public sector to act upon experience and evidence. These are characteristics which support greater funding support from international agencies to companies specifically. Inevitably, companies come up against the same challenges as the public health services such as drug procurement and lack of health-care infrastructure. Providing support on the basis of their capability to systemic innovation is a required step towards making public-private sector partnerships an effective option.

REFERENCES