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# HIV and AIDS, STI and TB in the Private Sector

## Abstract

*This chapter reviews the delivery of HIV and AIDS, sexually transmitted infections and tuberculosis care within the private sector. The orientation and approach to these infectious diseases within the private sector is different to the public sector as each disease is treated vertically as a discreet episode and a client could consult three different service providers to obtain treatment and care for each of these diseases. This presents a major challenge in delivering continuity and quality of care. A clear limitation of this chapter is the focus on treatment and not prevention as this is the orientation of the private sector.*

*There are some 100 000 patients receiving HIV and AIDS care within disease management programmes in the private sector and approximately 67 600 are currently receiving Highly Active Antiretroviral Therapy. HIV and AIDS still remains stigmatised, resulting in the majority of clients enrolling late for treatment on disease management programmes. Treatment for sexually transmitted infections is known to be of poor and variable quality in the private sector with general practitioners not being sufficiently knowledgeable about the World Health Organization's syndromic management of sexually transmitted infections. However, there are examples of public-private partnerships which have proven to be cost effective in tuberculosis case management and these include employer-based private providers, private for-profit providers and private not-for-profit providers. Given the interrelatedness of these diseases, it would be important to model partnerships to deliver integrated comprehensive disease management programmes.*

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## Introduction

The HIV & AIDS and STI National Strategic Plan 2007-2011 (NSP) represents a broad consensus for an effective national response to these epidemics, including the particular challenge that tuberculosis presents.<sup>1</sup> This chapter reviews the delivery of HIV and AIDS, sexually transmitted infections (STIs) and tuberculosis (TB) care within the private sector. Aspects of the private sector response to each illness (particularly in relation to treatment) are reviewed as a discreet section, noting current trends, followed by a brief analysis.

## HIV and AIDS

Much of the focus of HIV and AIDS care in the private sector has been on providing Highly Active Antiretroviral Therapy (HAART) and the private sector has a longer history of providing this care than the public sector. Goal two of the NSP has called on the private sector to partner with other sectors in society to “reduce sexual transmission of HIV” and to “scale up prevention programmes for HIV positive people”.<sup>1</sup> Most of the partnerships articulated in the NSP concern ‘treatment care and support’, although the NSP also calls on the private sector to be a lead partner agency to “develop and integrate a package of sexual and reproductive health and HIV prevention services into all relevant health services”.<sup>1</sup> However, at present, there is limited collaboration between the public and private sectors.

Ease of access to HAART in the private sector is considerably better than that in the public sector.<sup>2</sup> The private sector comprises different groups and includes medical scheme beneficiaries (approximately 15% of the population), workplace treatment programmes, community treatment programmes (those funded by donors) and individuals paying for their own treatment.

Medical schemes are required in terms of the Medical Schemes Act (Act 131 of 1998) to provide at least the following Prescribed Minimum Benefits (PMBs) in relation to HIV infection.<sup>3</sup>

- HIV voluntary counselling and testing
- Co-trimoxazole as preventive therapy
- Screening and preventive therapy for TB
- Diagnosis and treatment of STIs
- Pain management in palliative care
- Treatment of opportunistic infections

- Prevention of mother-to-child transmission of HIV
- Post-exposure prophylaxis following occupational exposure or sexual assault
- Medical management and medication, including the provision of antiretroviral therapy (ART) and ongoing monitoring for medicine effectiveness and safety, to the extent provided for in the national guidelines applicable in the public sector

It is significant to note that contraception is not paid for as part of the PMBs within the private sector.

Medical schemes are prohibited by law from refusing admission to higher risk individuals or loading their premiums. In order to contain their exposure to financial risk and to meet their broader objectives of improvement of health care, medical schemes have increasingly focused on managing the health status of HIV-positive beneficiaries through disease management programmes (DMPs).<sup>a</sup>

In quantifying the growth of HAART by disease management and community treatment programmes, Johnson et al. identified approximately seventeen disease management companies and ten community treatment programmes and reviewed all treatment programmes to provide an estimate of patients on HAART by mid-2006.<sup>2</sup> They estimated that in mid-2006 a total of 55 900 patients were being treated through DMPs.<sup>2</sup> The DMP market is concentrated with 46 800 of this total being managed by the five largest programmes. The DMPs that account for the highest proportions are Aid for AIDS (36%), Lifesense (15%), Discovery Health (11%), Aurum Health (11%) and Qualsa (11%).

Community treatment programmes (Right to Care, The South Africa Catholics Bishops Conference and the Treatment Action Campaign) were treating approximately 11 600 patients with HAART by mid-2006. Together the DMPs and community treatment programmes total around 67 600 patients on HAART in the private sector. Johnson et al. estimate that the annual weighted year on year growth rate is 32% for all treatment programmes (26% for the five largest DMPs and some 62% for community treatment programmes).<sup>2</sup>

Aid for AIDS (AfA) is the longest running DMP in South Africa and has the largest number of people enrolled in the private sector. Accordingly, AfA is used as a case study in this review to illustrate the functioning of DMPs and to describe its expe-

<sup>a</sup> Personal communication, S Harrison, Council for Medical Schemes, 2007.

rience in HIV management. However, it is important to note that most of the large DMPs are competitive and would offer a similar service.

- Some 1 500 persons enrolled through a public-private partner initiative jointly managed with BroadReach Healthcare, which is donor funded

Figure 1 provides an illustration of how the AfA programme operates.

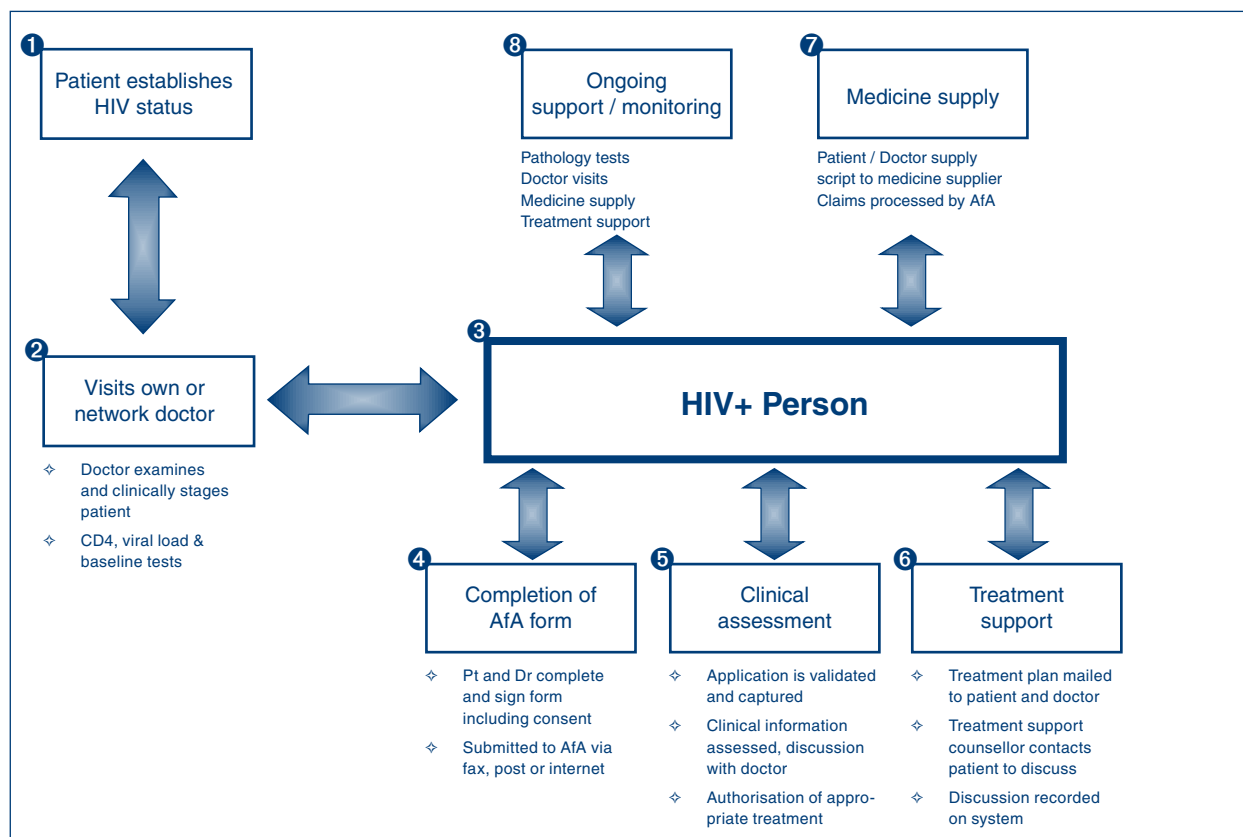
### Case Study – Aid for AIDS

The AfA programme has been in operation since mid-1998 and over 60 000 patients have been enrolled in the programme by approximately 4 000 private sector doctors.<sup>b</sup> At the time of writing this chapter, HAART was approved for 23 040 AfA patients.

The population of AfA comprises three groups and these include:

- Insured members of medical schemes contracted to AfA (the largest group)
- Corporate members who have been enrolled onto the programme by their companies as they are not on a medical scheme

Figure 1: The Aid for AIDS programme

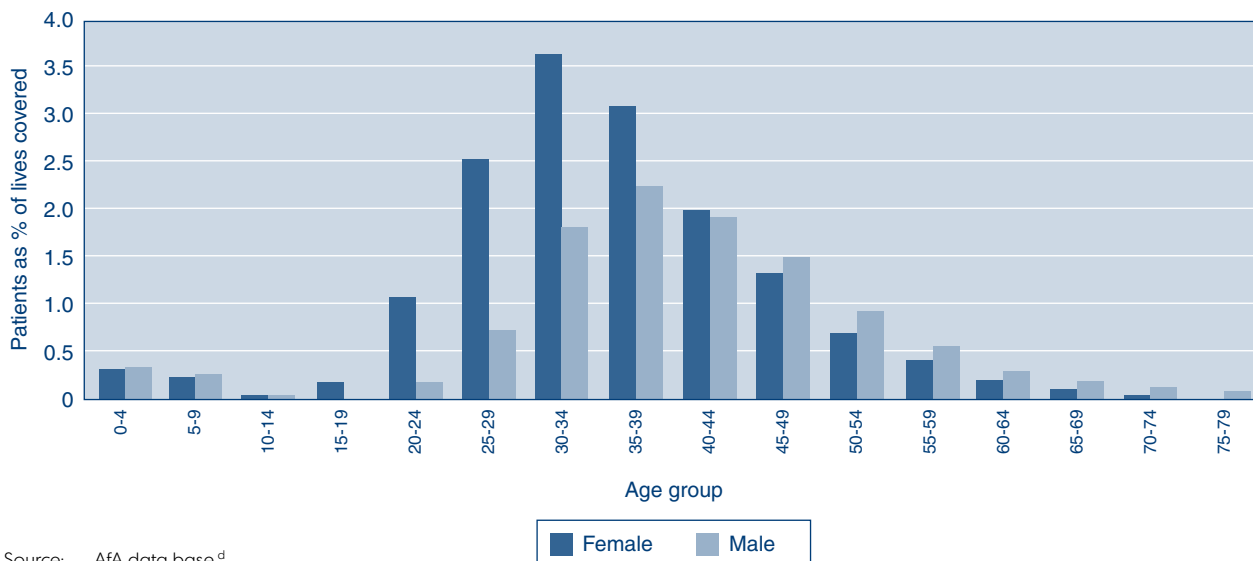


Source: AfA.<sup>c</sup>

<sup>b</sup> Data extracted from AfA data base.

<sup>c</sup> Personal communication, M Hislop, Aid for AIDS, May 2007.

**Figure 2: AfA enrolment by gender and age, 2006**



Source: AfA data base.<sup>d</sup>

A review of the demographics of the AfA client population, showed that enrolment is greatest between 25-45 years with 74% of patients in this age group (see Figure 2). The oldest patient enrolled is 83 years of age and to date 23% of patients have been pregnant at the time of registration.

Patients respond well to HAART with decreased viral loads following a few months of treatment. AfA has developed its own treatment guidelines in collaboration with a consultant advisory team and these guidelines are similar to those provided by the South African HIV Clinicians Society. Some 80% of patients are on first line regimens, about 15% on second line regimens and about 5% on a salvage regimen. Approximately 70% of patients are still on a first line regimen after two years of treatment and resistance has not yet become a significant problem.

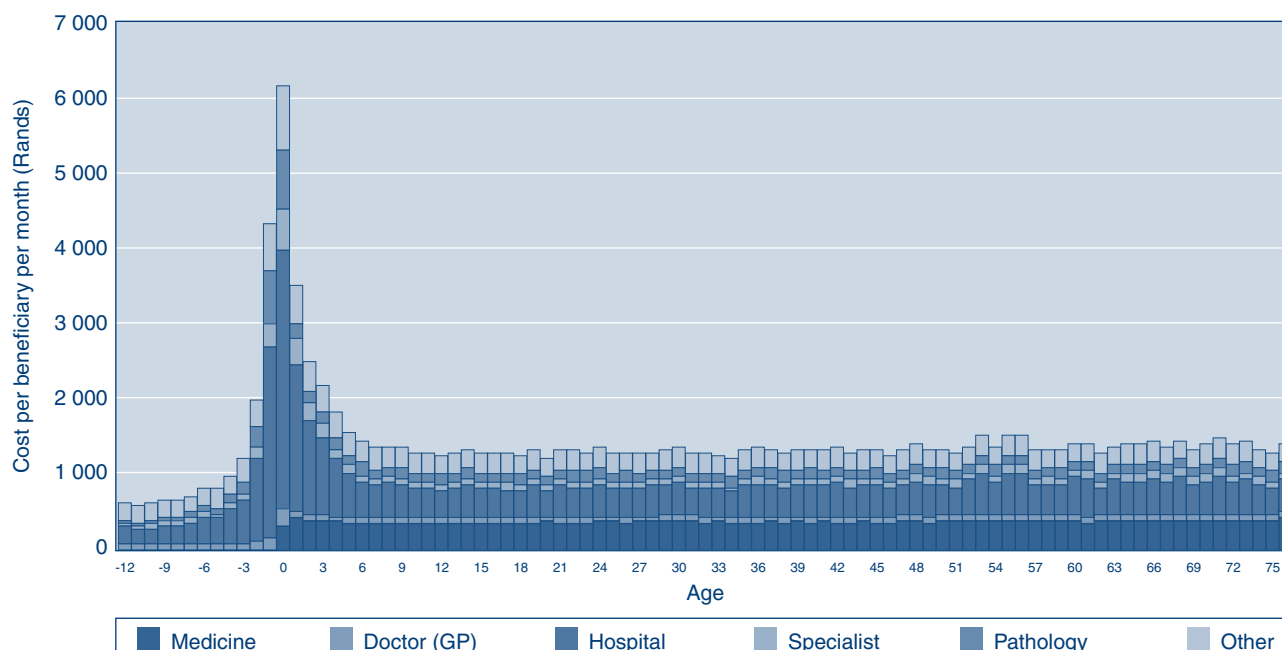
AfA monitors adherence to treatment by assessing pharmacy claims and generally, most patients (about 80%) have reasonable adherence to treatment. However, men tend to be less adherent than women.<sup>4</sup> Adherence remains a challenge as do drug side effects and the number of people requiring complex salvage therapy is increasing.

Treatment costs are high at entry into the programme because hospitalisation typically coincides with diagnosis or registration. Patients in a later stage of disease, in terms of a CD4 count, have somewhat higher entry costs than those at an earlier stage of disease. Significant hospital costs could therefore be avoided through earlier diagnosis and registration on the DMP. Treatment costs have been shown

to stabilise once a patient has enrolled and been stabilised on HAART (see Figure 3).

<sup>d</sup> Data obtained from the AfA data base, which contains information on enrollees on the programme from 1998 to 2007.

**Figure 3: Treatment costs relative to enrolment on AfA, 2002-2006**



Source: AfA data base.<sup>e</sup>

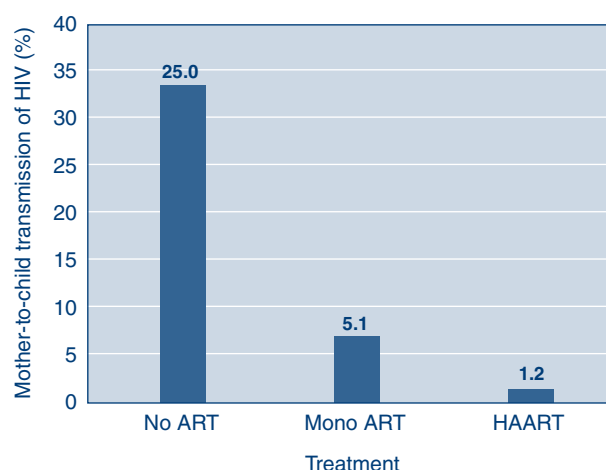
A critical issue relating to costs has been the fact that clients tend to enrol late in DMPs. AfA notes that there are more than 50% of people present with advanced disease with a CD4 count of less than 200. They argue that despite wide publicity about HIV and AIDS in the media, relatively few HIV-positive people are aware of their HIV status. Based on their tele-counselling service they report that denial, fear of disclosure, stigma and intolerance still persist.

Approximately 61% of enrollees on the treatment programme are women and about one quarter are pregnant. Women are counselled to utilise dual methods of contraception for purposes of both contraception and preventing re-infection. Thus condoms and a hormonal method or an Intra Uterine Device (IUD) is suggested. There is significant reliance on condom use as a major barrier method.

HIV positive pregnant women are actively managed once registered on the AfA programme. However, there are currently no procedures or guidelines in place for HIV-positive women wanting to have a child. Options are available for a HIV-positive pregnant woman wanting to have an abortion. However, AfA does not offer this as part of the continuum of HIV and AIDS care and this would need to be covered in terms of the routine benefits of a medical scheme.

There is also considerable focus on prevention of mother-to-child transmission (PMTCT) of HIV. Figure 4 shows the outcomes of the PMTCT programme which indicates a relatively low level of transmission of 1.2%. If indicated, the mother involved is offered HAART treatment.

**Figure 4: Outcomes of the AfA PMTCT programme, 2004**



Source: Hlatshwayo et al., 2004.<sup>5</sup>

Despite its successes, the experience of the AfA programme has highlighted various challenges impacting on the effectiveness of HIV and AIDS disease management programmes. Continuity of care is adversely affected by the ongoing problem of patients 'transferring out' of medical schemes,

<sup>e</sup> Data obtained from the AfA data base, which contains information on enrollees on the programme from 1998 to 2007. Personal communication, M Hislop, AfA, May 2007.

which makes it difficult to monitor and to track patients' progress.

TB co-infection, including extreme drug resistant TB (XDR-TB), is also reported by AfA to be a growing problem. An increasing challenge is that DMPs do not offer integrated programmes traversing the areas of TB, STIs and HIV and AIDS, and therefore the overall health care needs of individuals are not managed holistically.

## Sexually Transmitted Infections

The public sector has adopted the syndromic management approach advocated by the World Health Organization (WHO) for the management of STIs. Despite this sound approach to STI management and the fact that primary health care is free in the public sector, many clients who would ordinarily use public sector services consult general practitioners (GPs) for STI management. Schneider et al. estimated that half or more of STI episodes in the South African health sector are treated in the private sector.<sup>6</sup>

Palmer et al. noted that the high use of private health services is partly due to the inaccessibility of public health services, but in urban areas this might be because of perceptions of greater privacy, speed of services and quality of diagnosis, prescribing and counselling.<sup>7</sup> Chabikuli et al. also noted that GPs are widely available across the country and their surgeries are often open after hours when public facilities are closed. Compared to the public sector, communities also perceive GPs to be less judgemental towards people with stigmatising conditions such as STIs. When they suspect they have a STI, poor people prefer to pay for a consultation with a private GP where anonymity, confidentiality and dignity are more likely, than to receive free services in the public sector.<sup>8</sup>

Despite increasing perceptions of better quality care, the reality is that the quality of STI management in the private sector is highly variable.

Research on the review of prescriptions, found that GPs knowledge of recent developments in STI management was poor, with 58.5% who had not heard of syndromic management and only 32.3% who claimed to apply the syndromic approach in managing STI patients. Less than half of the GPs (43.1%) mentioned information, education, counselling or promotion of condom use as means of supporting patients to adopt sexual behaviour that reduces the risks of re-infection and transmission.<sup>9</sup>

GPs who qualified in the era of modern syndromic management of STIs (i.e. after 1993) were 3.5 times more likely to prescribe the correct treatment than those who qualified prior to 1993. The generational differences in the quality of treatment offered suggested that undergraduate education effectively sets patterns for future practice. Alternatively, younger GPs may have less fixed repertoires of prescribing, making them more receptive to new knowledge received through continued medical education than older GPs.<sup>10</sup>

A client's insurance status also influenced the quality of care. It was found that there was selective implementation of new knowledge in favour of medical scheme clients. More than half of the STI clients (53.4%) were cash paying and these clients received inferior prescriptions and care. STI clients with a medical scheme were 2.64 times more likely to receive effective treatment than cash clients.<sup>10</sup> Some 50.8% of GPs reported that they prescribed different drug combinations for insured and uninsured patients for at least one of the syndromes.<sup>10</sup>

The reason for this appears to be that for insured medical scheme clients, the costs of drugs are recouped from the medical scheme, whereas cash paying patients pay an all inclusive fee (for both the consultation and drugs). As a result there is a financial incentive for GPs to minimise costs by prescribing cheaper drugs and not adhering to syndromic management drug protocols.

The research by Chabikuli et al. suggests that the economic status of the patient and GP's perceptions of patients' ability to pay has a bearing on the reported care provided to insured and uninsured patients, in line with the incentives of the payment mechanism.<sup>9</sup> This suggests that GPs prescribing behaviour could be improved with financial incentives through targeted subsidies, such as the provision of STI drugs for cash clients.<sup>10</sup>

Clearly, this body of research points to significant limitations in the extent to which STI syndromic management has been implemented in the private sector. STI management does not appear to be a priority for GPs and this may be undermining national efforts to control STIs especially among the poor. This problem further underscores the importance of the NSP requirement for private sector providers and medical schemes to partner as lead agencies to *"increase access to quality STI service in the public and private sector offered by adequately trained staff utilising the updated syndromic management guidelines"*.<sup>1</sup>

Furthermore, the Centre for Health Policy and the London School of Hygiene and Tropical Medicine in collaboration with the Department of Health has developed a manual, 'Working with Private Providers on the Control of Sexually Transmitted Infections' for district programme managers. The introduction to this manual notes that private providers in workplaces, clinics, and private surgeries have a significant role to play in STI care in South Africa.

This is already occurring on a limited scale. For example, Right to Care (RtC), a non-governmental organisation (NGO) mostly funded by the President's Emergency Plan for AIDS Relief (PEPFAR), provides antiretroviral therapy (ART) through partnerships with government, NGOs and community-based organisations and with the private sector. The private sector programme is run with a financial services company where employers pay for their antiretrovirals (ARVs) and RtC funds private practitioners to see patients in different communities. There is evidence of integration of HIV management and STI care in this model.<sup>11</sup>

It is important for role players to adopt the recommended approach to STI management, including nationally formulated clinical guidelines. From the government's perspective, adherence to clinical guidelines in the private sector will not only ensure effective management of patients at all levels and sectors, but it will also delay the development of drug resistance and contribute to the control of STIs and the reduction of HIV transmission.

## Tuberculosis

A rapid increase in the detection of TB in a high HIV and AIDS environment and the emergence of multi-drug resistant TB (MDR-TB) has led the national and provincial governments to identify TB as a priority. The NSP clearly articulates within goal 6 and objective 6.3 the need for the private sector to partner as a lead agency with other stakeholders in "effective management of TB/HIV co-infection" and in intervening to "ensure implementation of the National TB control Plan".<sup>1</sup>

Whilst the public health sector is predominant in the provision of TB care across the country, there are private providers of TB treatment. These providers can be classified into three main groups:

1. Employer-based private providers (e.g. the mining industry TB services provided either in-house or contracted out to managed health care companies)
2. Private for-profit providers

3. Private not-for-profit providers (e.g. the NGOs providing community-based TB treatment)

Public-private partnerships involving some of the private providers are an important component of TB care and are discussed below.

### Employer-based private providers

There is a long history of provision of TB treatment in the mining industry. According to the Occupational Health and Safety Act (Act 85 of 1993) and the Mine Health and Safety Act (Act 29 of 1996) mining companies are responsible for ensuring TB surveillance, treatment and notification and in cases of possible chronic lung damage, the assessment of impairment and submission of cases for compensation.<sup>12,13</sup>

According to the provisions of the regulatory framework, employers are required to cover the cost of TB services for their employees. Some mining companies provide medical services (including TB services) in-house, whilst other companies contract these services out to managed care companies. The managed care companies are paid on a capitation basis by the employer to provide a comprehensive service to lower income groups of employees. Higher income employees contribute to medical schemes and can choose health care providers. Like the majority of employer-based health services, mining companies generally do not provide health care services for the wider community (i.e. people other than the companies' employees and their dependents).

### Private for-profit providers

South Africa has a long history of contracting chronic clinical care to private for-profit providers. Clinical contracts awarded for hospital TB services are provided by Lifecare Group Holdings (Lifecare). The contract with Lifecare uses the per-diem payment method, requiring the government to reimburse Lifecare retrospectively for the number of annual patient days delivered. A study on the relative efficiency of contracting out versus direct provision of hospital services in South Africa found that for contracting out to generate efficiency gains the necessary conditions for an efficient contract must be in place.<sup>14</sup> These conditions include strong government capacity to negotiate, implement and monitor contracts; adequate information on government's own production costs, as well as those of competitors; and the presence of actual or at least potential competition. Most of these conditions are not present in the contract with Lifecare.

The Medical Scheme Act, effective from January 2000, regulates medical scheme coverage for certain defined conditions in terms of the PMBs. The aim of this legislation is to prevent schemes that did not provide these minimum requirements from abandoning members to the public sector, thereby exhausting public hospital facilities. The minimum benefits may be covered by one network of hospitals, which includes public sector hospitals.<sup>15</sup> The PMBs for TB are part of the PMBs for the treatment and management of opportunistic infections in HIV and AIDS patients.<sup>16</sup> In the private practitioners' setting, patients diagnosed with TB are referred to the nearest public clinic for treatment. The main reasons for referring TB patients are: medical schemes do not cover TB treatment in an ambulatory setting; TB treatment in the private sector is costly for the patient; and private practitioners do not have the necessary training in managing TB.

### Private not-for-profit providers

The NGO sector also plays a vital role in TB treatment at the community level, where community health workers, who are usually volunteers, are increasingly being used as directly observed treatment, short course (DOTS) supporters. The government has recognised that NGOs have a crucial role to play in the National TB Control Programme (NTCP) as they add value by making treatment more accessible to TB patients through various strategies and programmes, including community-based DOTS. In addition to service delivery, NGOs provide an important link between the formal public health services and the community. The Western Cape has been particularly active in implementing community-based TB treatment and initiating the training of DOTS supporters by local NGOs in the early 1990s. The DOTS supporters are actively involved in most of the public health facilities in the Western Cape and their services are firmly linked to the health services.

### Public-private partnerships

A public-private partnership (PPP) is a formal or informal collaboration among two or more organisations engaged in a joint initiative to achieve common objectives.<sup>17</sup> At least one partner is from the public sector, and at least one is from the private sector. PPPs are a relatively new phenomenon in South Africa, and are seen as one component of the public sector's overall strategy for improving the provision of public services. Public-private arrangements for the provision of TB treatment that exist in South Africa range from formal

contracts with for-profit hospitals to informal, historical partnerships with employer-based service providers and formal / informal arrangements with NGOs. Small-scale partnerships with private practitioners / hospitals and traditional healers are gradually emerging.

Effective involvement of the private sector in the provision of TB treatment requires an understanding of the motivation of private providers, their capacity and the existing institutional and organisational capacity to support interactions. What motivates private providers to provide health care services that are in the public interest and what are the most appropriate incentives in a PPP for delivering TB treatment at the right cost and quality?

Evidence shows that private providers in existing and potential partnerships have both financial and non-financial motivation for participation in the partnership for the provision of TB treatment.<sup>18</sup> The main financial motivation for the for-profit and non-profit private providers is profit-maximising and cost-savings respectively. Training, controlling the TB epidemic and good relationships with the government are the main non-financial motivations for participation in partnership for the provision of TB treatment.

Whilst incentives in the existing partnerships range from free drugs to training, incentives that may be required to support development of broader PPPs in the provision of TB treatment include access to use public sector diagnostic facilities and drugs and in the case of private for-profit providers, a set fee per patient treated. Training on the national TB treatment guidelines and a good working relationship with the government are also important. A range of incentives, therefore, could be used to encourage private sector participation in partnership with the government for the provision of TB treatment. While recognising that 'getting incentives right' is important in any principal-agent relationship, monitoring and evaluation of the partnerships, however, may not always be simple and other factors, such as levels of trust and perceptions of relative risks, may potentially play an essential role in underpinning efficient PPPs.

The two main existing models of partnerships for TB treatment in South Africa are the public-private workplace partnership (PWPP) model, and the public-private non-government partnership (PNP) model. The PWPP model represents a partnership between provincial TB programmes and mining companies where the employers' occupational health services are either reimbursed per patient day or the employer receives free drugs for each TB patient treated in their clinic. The type of reimbursement depends on provincial regulations.

The PNP model is a partnership between provincial TB control programmes and NGOs providing community-based DOT in which NGOs are paid a monthly amount per patient to manage community-based TB programmes. In this model, patients are diagnosed and monitored in public clinics for the first 10 days and subsequent treatment is directly observed by community health workers (i.e. treatment supporters) in the community. In return for payments from provincial TB programmes both private partners are required to:

- ▶ follow national TB treatment guidelines;
- ▶ complete and submit standardised quarterly reports to district TB coordinators; and
- ▶ liaise with district public health facilities.

Different models of PPPs are suited to differential target populations. Employer-based TB treatment is appropriate in companies that employ a large number of people and / or where occupational health clinics exist. The NGO model is well-suited to areas of high unemployment and where geographical access to health facilities for patients is poor.

There are also various other models of PPPs in operation. For example, many occupational health services in the Western Cape have agreements with their local authority TB services to provide directly observed TB treatment in the workplace. According to this agreement, the public clinic is responsible for TB investigation and the issuing of drugs and the occupational health nurse supervises TB treatment daily at the workplace. The cost of TB treatment is therefore split – while the cost of the occupational nurse is borne by the employer, the government covers the cost of the drugs and investigations. A private occupational physician has a contract with the employer to provide primary care and occupational health at the factory clinic twice a week.

Although private practitioners tend to refer their TB patients to the public sector, there are examples where private practitioners are involved in the provision of TB treatment in a partnership with the district health services. In the Free State, the provincial TB programme has trained 293 private practitioners on the NTCP guidelines over the last four years. The district TB coordinators generally have a very good relationship with private practitioners. For example, in some cases, TB patients diagnosed in the private sector prefer to take their medication at home. In such cases, the patient gets a monthly supply of drugs from the public clinic, and the private practitioner takes responsibility for following the patient throughout the treatment cycle according to the national guidelines. The private practitioner is requested to monitor

and report the outcome of the treatment programme to the district TB coordinator.

Traditional healers have considerable status with a high degree of acceptance by the majority of the South African population. They generally reside within their communities which make them more easily available and accessible to the communities they serve. Although there is entrenched historical bias towards western / allopathic health care, the government has committed itself to the involvement of traditional healers in the provision of health care services.

In order to cope with the increasing numbers of TB patients, the TB control programme in the North West has developed good working relationships with around 1 000 traditional healers in the province. Traditional healers are integrated into the existing community-based TB DOTS programmes, where options for treatment supervision include the local health clinic, community health workers, and traditional healers.

A study conducted on aspects of the quality of care provided in the two main partnership models discussed above (the PWP model and the PNP model) showed that the quality of care is superior in both models of PPP when compared to the purely public sector model of delivery.<sup>19</sup> The PWP sites had the highest score in all three aspects of quality of care namely, structure, process and outcome. In terms of process quality, the sites achieved similar scores, reflecting a very good knowledge of the treatment guidelines for both private and public providers. TB patients supervised in public clinics generally had lower treatment completion rates than those supervised in occupational health clinics in the workplace and in the community.<sup>19</sup>

This study further found that both PPP models could reduce costs incurred to the patient. In particular the PNP model was more cost-effective than either the purely public or the PWP delivery model. In addition, TB care provided through these PPP models is more accessible and convenient to patients.

PPPs in the area of TB show that there is a strong economic case for expanding and scaling up the involvement of the private sector in TB treatment. The cost per new patient treated to government could be reduced by enhanced partnerships between the private and public sectors. Expansion of PPPs may require increased investment in partnerships. As discussed, PPPs seem to be capable of delivering important improvements in the affordability and efficiency of TB treatment and improving the South African health system's capacity to cope with the impact of the HIV

and AIDS epidemic. In addition, increased collaboration with private providers through partnerships could potentially improve the quality of care and increase access to care.

## Conclusions

The NSP reflects opportunities for the private sector to respond to South Africa's leading epidemics (including the case management of TB). Key recommendations of the NSP in relation to these epidemics include the need to *"consolidate and build existing partnerships, especially concentrating on increasing the contribution of the private sector"*.<sup>1</sup>

PPPs are not necessarily the preferred option for improving the efficiency of services, but are one of a range of possible service delivery options available to the government. PPPs remain a relatively new phenomenon in South Africa and are seen as one component of the public sector's overall strategy for the provision of public services. The evidence presented has suggested that PPPs have made an important contribution particularly in the field of TB care and management.

A key challenge of the private sector's response to these leading epidemics is the vertical nature of service provision and the lack of integrated comprehensive programming. For example, no comprehensive approach to sexual and reproductive health care exists within the private sector. This situation is not peculiar to South Africa but has been well documented in a review of international policy and programmes.<sup>20</sup>

The private sector has also had a curative agenda and as such has not concentrated on prevention in the areas of TB and STIs, including HIV and AIDS. Even in relation to curative services, there appears to be insufficient financial incentives among private sector providers to motivate uniformly high standards in provision of care for these priority health conditions, as was seen in the discussion around STI care.

Given the magnitude of these epidemics it is important to expand on the lessons learnt from the various treatment care and support programmes and to take these forward. Due to interrelatedness of these diseases and the reality that clients in the public or private sector are 'mobile,' it is imperative to model partnerships to deliver comprehensive integrated DMPs.

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