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The role of the private sector in HIV treatment and care in the attainment of the 90-90-90 case and universal health coverage: A case analysis for Kenya

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Introduction: The UNAIDS Global 90-90-90 target requires a change in strategy for achievement. A key strategy is the involvement of the private sector in HIV care and treatment, then includes private hospitals/clinics, laboratories both affiliated to hospitals and independent. The costs of care and treatment in the various institutions include traditional access to care and related costs. Kenya is transitioning from a Low Income Country (LIC) to a Low and Medium Developed Country (LMIC) hence over dependency from donor support should be reduced hence increasing domestic resource mobilization; where private sector becomes a key player. Kenya has also joined the global interest to achieve SGDs and declared Universal Health Coverage (UHC) as its priority agenda thus increasing the demand for financing. Currently, Kenya's unmet funding need for HIV, TB, and Malaria would total USD. 840 million annually between 2019–2022 excluding health provider and infrastructure costs already funded by the Government. Approximately 90% (USD.750 million) is already available from Global Fund, US Government and other donors, thus reducing the burden of the three diseases from the total costs of Universal Health Coverage. However, Kenya requires USD. 850 million annually to cover the estimated 1.6 million living positives within the SDGs "leave no one behind". There is, therefore, need to understand the cost of service delivery both from government and private sector; the efficiency gains for service delivery and alternative models to raise these resources.

Methodology: National Estimates were undertaken and analyzed to establish probabilities of new infections and related costs of care. Additionally, Clinical and cost data for the year 2015 was collected using population-based data from the KNBS. The costing data was collected using manual questionnaires. Data estimates included the national population, county prevalence rates and current costs of treatment. Data collected from questionnaires included fixed assets, medical equipment, time, staffing, total workload (utilization), and HIV care services specific workload. Analysis of the data included Multi-stage model and Activity Based Costing (ABC) model to the cost of treatment (2017-2060), an estimate of current and future money cost of care and treatment as an ingredient-based approach to provide a service to one patient/client at a facility. To determine these costs for HIV treatment was collected from 5 major towns while estimates from national prevalence's were considered in the study.

Conclusions: Inflation remains

a key risk in the achievement of 90-90-90, more than double HIV infection across the period. The private sector has the opportunity to bring in the efficiencies and help achieve the 90-90-90. Dispensing costs of ARVs across the pharmacies revealed a range similar to dispensing costs in Tier 2 clinics and Tier 3 hospitals; Tier 4 hospitals' dispensing costs were twice that of independent pharmacies. Independent laboratories also conducted HIV-related tests. Some of the Tier 3 hospitals outsourced laboratory services from the independent laboratories. Overall, the average costs of diagnostic tests in independent laboratories were comparable to those of Tier 2 clinics. Further, Alternative models for domestic Resource mobilization can contribute immensely towards UHC achievement coupled with high levels of efficiency in service delivery.

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