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PRESIDENT'S EMERGENCY PLAN FOR AIDS RELIEF

Per-Patient Costs Have Declined Substantially, but Better Cost Data Would Help Efforts to Expand Treatment

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Highlights

Highlights of GAO-13-345, a report to congressional requesters

Why GAO Did This Study

Through PEPFAR—first authorized in 2003—the United States has supported major advances in HIV/AIDS treatment, care, and prevention in more than 30 countries, including directly supporting treatment for almost 5.1 million people. However, millions more people still need treatment. Congress reauthorized PEPFAR in 2008—authorizing up to $48 billion over 5 years—making it a major policy goal to help partner countries develop independent, sustainable HIV programs. Congress also set spending and treatment targets. OGAC leads PEPFAR by allocating funding and providing guidance to implementing agencies. As requested GAO reviewed PEPFAR-supported treatment programs. GAO examined (1) how per-patient treatment costs have changed and affected program implementation, (2) how PEPFAR cost information supports efforts to expand treatment, and (3) how PEPFAR has met a legislated treatment spending requirement. GAO reviewed cost analyses and reports and analyzed ARV drug data relating to fiscal years 2005 through 2011; conducted fieldwork in three countries selected on the basis of program size and other factors; and interviewed PEPFAR officials and implementing partners.

What GAO Recommends

GAO recommends that State develop a plan for (1) expanding the use of in-depth cost studies to additional countries and sites, where appropriate, and (2) broadening expenditure analysis to include non-PEPFAR costs, as feasible. State generally agreed with the report's recommendations.

View GAO-13-345. For more information, contact David Gootnick at (202) 512-3149 or gootnickd@gao.gov, or contact Marcia Crosse at (202) 512-7114 or crossem@gao.gov.

What GAO Found

The Department of State's (State) Office of the U.S. Global AIDS Coordinator (OGAC) has reported that per-patient treatment costs declined from about $1,053 to $339 from 2005 to 2011. Purchasing generic antiretroviral (ARV) drugs, together with declining drug prices, has led to substantial savings. OGAC estimates that the President's Emergency Plan for AIDS Relief (PEPFAR) has saved $934 million since fiscal year 2005 by buying generic instead of branded products. PEPFAR's analyses of data from eight country treatment-cost studies indicate that per-patient costs also declined as programs realized economies of scale while taking on new patients. Furthermore, the analyses suggest that costs decreased as countries' treatment programs matured, particularly in the first year after programs expanded, and reduced one-time investments. Per-patient cost savings have facilitated substantial increases in the number of people on ARV treatment. In September 2012, an estimated 8 million were on treatment in low- and middle-income countries, of which PEPFAR directly supported 5.1 million—an increase of 125 percent since 2008, the year the program was reauthorized.

Despite substantial declines in per-patient treatment costs, it is important that countries continue to improve the efficiency of their programs to expand to meet the needs of the estimated 23 million people eligible for ARV treatment under recent international guidelines. PEPFAR's cost estimation and expenditure analysis approaches provide complementary information that can help partner countries expand treatment and identify potential cost savings. However, as currently applied, these approaches do not capture the full costs of treatment. Cost estimation provides in-depth information, but data are limited because detailed cost studies have been done in only eight partner countries, at a small number of sites. Moreover, although treatment programs are changing rapidly, key data for most of the studies are no longer timely, since they were collected in 2006 and 2007. PEPFAR does not have a plan for systematically conducting or repeating cost studies in partner countries. Data from expenditure analyses, while more timely, are limited because they do not include non-PEPFAR costs. Without more timely and comprehensive information on treatment costs, PEFPAR may be missing opportunities to identify potential savings, which are critical for expanding HIV treatment programs to those in need.

Using an OGAC-developed budgetary formula, PEPFAR has met the legislative requirement that more than half of its funds be spent each year to provide specific treatment and care services for people living with HIV. From fiscal year 2008 to fiscal year 2012, PEPFAR funds allocated to capacity building—to strengthen health systems, laboratory capacity, and strategic information systems—increased from 15 percent to 21 percent of PEPFAR's total funds to support country programs. However, the current formula does not include the capacity building funds. These funds—which support PEPFAR country teams' efforts to meet another legislative goal of promoting sustainable country-owned programs—and other PEPFAR activities also contribute to HIV treatment and care services. PEPFAR does not currently have a methodology to account for those contributions. Without such a methodology, it is not possible to determine the full amount of PEPFAR funds that are allocated to support the HIV treatment and care services identified in the spending requirement. However, the treatment spending requirement expires at the end of September 2013.