Private partners can lift public health

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WHEN an election is held amid widespread poverty and inequality, it is to be expected that the National Health Insurance (NHI) will be a talking point. On paper it makes sense: as Health Minister Aaron Motsoaledi put it, the idea is to make healthcare available to all based on need rather than socioeconomic status.

No one can deny that many South Africans live in dire need, and the poorest citizens have the least access to quality healthcare. Add to this the burden of HIV, tuberculosis, and the rising tide of non-communicable diseases — including cancer — and you have a perfect storm brewing.

If one factor in a host of broken systems contributing to healthcare — poor transport, education, administration, and drug stock-outs — creates a challenge for a patient, the size of the problem quadruples.

Motsoaledi emphasises that 80% of medical specialists in SA service only a fifth of the population. Although SA spends about 10% of its GDP on health — India spends 1% and China 3% — the allocation of funds is a challenge.

Inequality poses an appreciable problem for the government and the healthcare industry, including funders.

The NHI has been punted as a means to assist the under-resourced, but funding hurdles need to be overcome. Even in the UK, where the employed subsidise the unemployed fairly successfully, the funding of a national health system is still problematic. In SA, where the unemployment rate has reached a 12-year high, the pool of potential subsidisers is simply too small.

A possible part of the solution lies in more efficient partnerships between funders and healthcare service providers, and between the private and public sectors.

The Independent Clinical Oncology Network has managed to bridge the gap between funders, patients, and clinicians. On some levels it is seeking to do the impossible; to expand the number of patients being treated by private healthcare, thereby reducing the burden on the state — one way to improve outcomes for both patients and providers.

BY REDUCING private healthcare costs, it has succeeded in bringing an estimated 20% more oncology patients into private care. One of the ways it does this is by limiting the variation in clinical treatment

protocols, ensuring greater consistency in prescriptions, lower costs, and better patient outcomes overall.

The network negotiates with stakeholders to arrange drug imports where necessary. The result is more productive relationships and lower costs to the funder of care. This model can work in other areas of medicine. The Independent Clinical Oncology Network's approach has been widely praised. At the 2015 World Innovation Summit for Health in Qatar, it was featured in a report on how cancer care can be made more affordable without compromising on quality.

The network also illustrates the value of multidisciplinary partnerships. Public-private partnerships are a viable option. In Kenya, this has worked particularly well.

"Public-private partnerships combine the skills and resources of both the public and private sectors in new ways, through sharing of risks and responsibilities," the Kenya Healthcare Federation says. "This enables governments to benefit from the expertise of the private sector and allows them to focus more on policy, planning, and regulation."

A study by Evanson Kiambati Minjire on the performance of public-private partnerships in healthcare notes that it is a growing phenomenon, particularly in the developing world. Policy makers do not have a repository of best practices to draw on, but Minjire notes that major factors influencing the success of such partnerships are, first and foremost, accountability and the regulatory environment, followed by project funding.

The advantages of a public-private partnership, notes the World Bank, are normally rooted in the need to improve the operation of public health services and facilities, and to expand access to higher quality services. They can leverage private investment to benefit public services and have the potential to formalise arrangements with nonprofit partners that play important roles in public services.

These partnerships also provide state resources with more potential partners as the private healthcare sector matures, the World Bank says.

The public-private partnership model has been used in Southern Africa: Lesotho's Queen Mamohato Memorial Hospital and clinics were financed, constructed, and operated privately, and its clinical and non-clinical services were provided privately. Lesotho's government reimbursed the operator for capital and recurrent costs, and provided the buildings.

Public-private partnerships are not privatisation. They are a joining of forces for the benefit of healthcare. While the Queen Mamohato hospital project was questioned in an Oxfam report for its long-term cost, it consistently produces better patient outcomes than its predecessors. Its directors

slammed Oxfam for inflating estimated costs in its report, and Lesotho's budget speech for 2014-15 backed them up.

SOCIAL impact bonds have also been used to some effect, not only in healthcare. Last year the £1.65m Ways to Wellness programme was launched by Bridges in the UK, providing upfront funding for preventive interventions by specialist providers, and aiming to improve health outcomes for about 11,000 people.

The Western Cape departments of health and social development have set aside R25m to invest in three social impact bonds in partnership with the Bertha Centre for Social Innovation and Entrepreneurship at the University of Cape Town. The aim is to improve the health, nutrition, and developmental status of pregnant women and young children living in low-income communities.

The healthcare system cannot be tackled in isolation. It is also necessary to examine the health of patients holistically, factoring in community support, transport, the availability of field workers, and issues that may influence patient compliance, such as the temptation to sell medications.

Medication deliveries may ease the burden of administration on hospitals and the burden of time, cost, and transport on patients — increasing compliance and decreasing the costs of medical care for all. There is no need for resistance to seeking more innovative approaches to healthcare — including public-private partnerships. Renewable energy is an outstanding example of the potential success of the model, and healthcare innovation needs to be tackled urgently.

The NHI should not be regarded as the only solution: it may be complemented by additional initiatives. The advantages of combining state infrastructure and private resources are glaringly obvious. It is not, at present, a perfect system. But the only way to arrive at perfect is to get started.

by Jacques Snyman in Business Day

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