Is private medical practice a hindrance to universal healthcare in sub-Saharan Africa?

Dr. Joe Aluoch observes the difficult relationship between the work of private practioners and the ideals of universal health care. Can they realign? Unlikely within the current healthcare model?

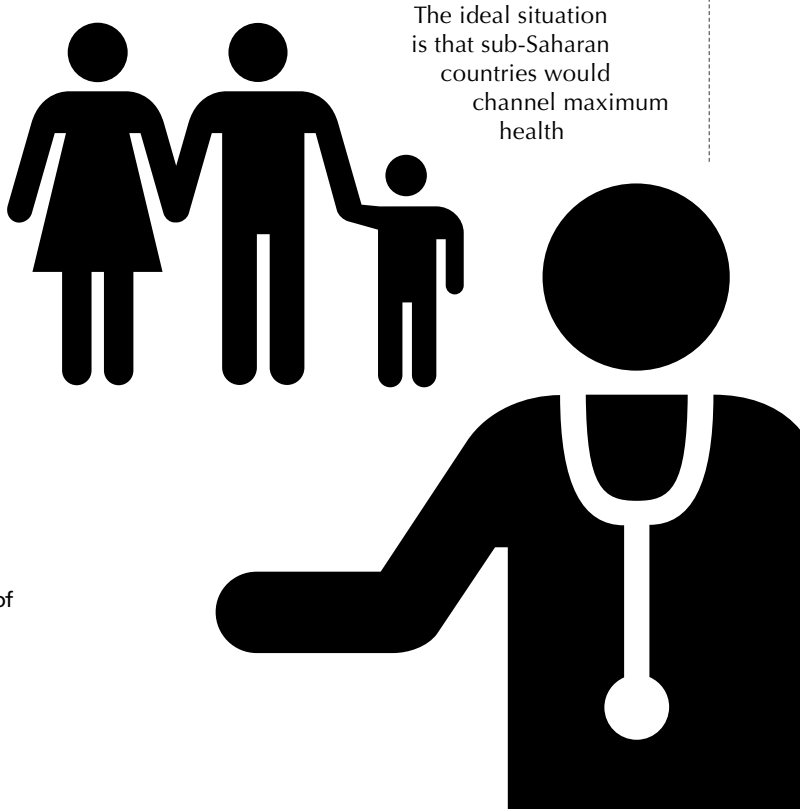
Achievement of internationally adopted goals of universal healthcare (UH) in Africa requires effective use of all available health resources in every country. Important among these resources is the supply of Physicians, not only because of the services the doctors can directly provide, but because of the leadership they can give in healthcare teams and the network of health services delivery in a country. Since physicians are always in limited supply in sub-Saharan countries; the allocation of their time and services in relation to the needs of the national population is of paramount importance. Unfortunately, a large percentage of the physician's time in sub-Saharan Africa is allocated to a minority of the population, leaving the majority ill served.

Private for-profit healthcare and concern over its failure to deliver social benefit remains a challenge in achieving a well-functioning healthcare system. A properly functioning healthcare system can be regarded as one that assures quality delivery of services in response not only to health needs but also to private demand, and guarantees provision of care to both rich and poor people. Although in principle a well functioning health system can encompass both private and public medical centres, private healthcare providers tend to do rather poorly on some parameters, for instance market skimming through padding of fees especially by medical specialists, often unnecessary diagnostic tests, purveying of 'false medicine' and large gaps in coverage.

Unlike in most other social service domains, health service providers in the public sector must compete with others in private practice. Not surprisingly, especially in sub-Saharan Africa, the market for private medical services is increasing as the public medical facilities become over-stretched due to high demand. The achievement of UH, which remains a major goal across the entire region, depends on improvement of both individual and community behaviors and includes several other factors, including improved environmental conditions and other economic factors. Medical care alone cannot be expected to achieve universal health in the continent. Moreover, the health of the population must be considered not only as a final aim, but also as a vital instrument for economic development.

One defining characteristic of private medical care is that it is not regulated by public need; rather it follows the impersonal and uncaring dictates of the marketplace. In that way, therefore, private healthcare service may constitute a veritable obstacle to UH. For instance, private medical practice as a profit-making enterprise is hardly likely to become involved in the implementation of preventive measures. Doctors in private practice often give freedom to citizens to choose what kind of care they need and can afford. By frequent hospital admission, their professional fees, expensive diagnostic procedures and therapy, doctors in private medical practice generate a high percentage of the total health bills of any nation. Doctors' private practice may often be wasteful in regards to excessive investigations, prescription of expensive drugs and frequent and prolonged stay in hospital. In reality, doctors in private practice often carry out diagnostic procedures more often than strictly necessary, make too much use of intensive care unit facilities and perform some surgeries more often than warranted by clear clinical indication. Private doctors are interested more in medical care than healthcare and more orientated to the curative than the preventative. This situation often places severe demand on resource allocation for health service in these low-income countries.

The ideal situation is that sub-Saharan countries would channel maximum health



Dr. Joe Aluoch, FRCP, is one of Kenya's most senior doctors. He is a former Chair of the Kenya Medical Association, President of the Kenya Association of Physicians, and Chair of the National Health Insurance Fund. He still practices.
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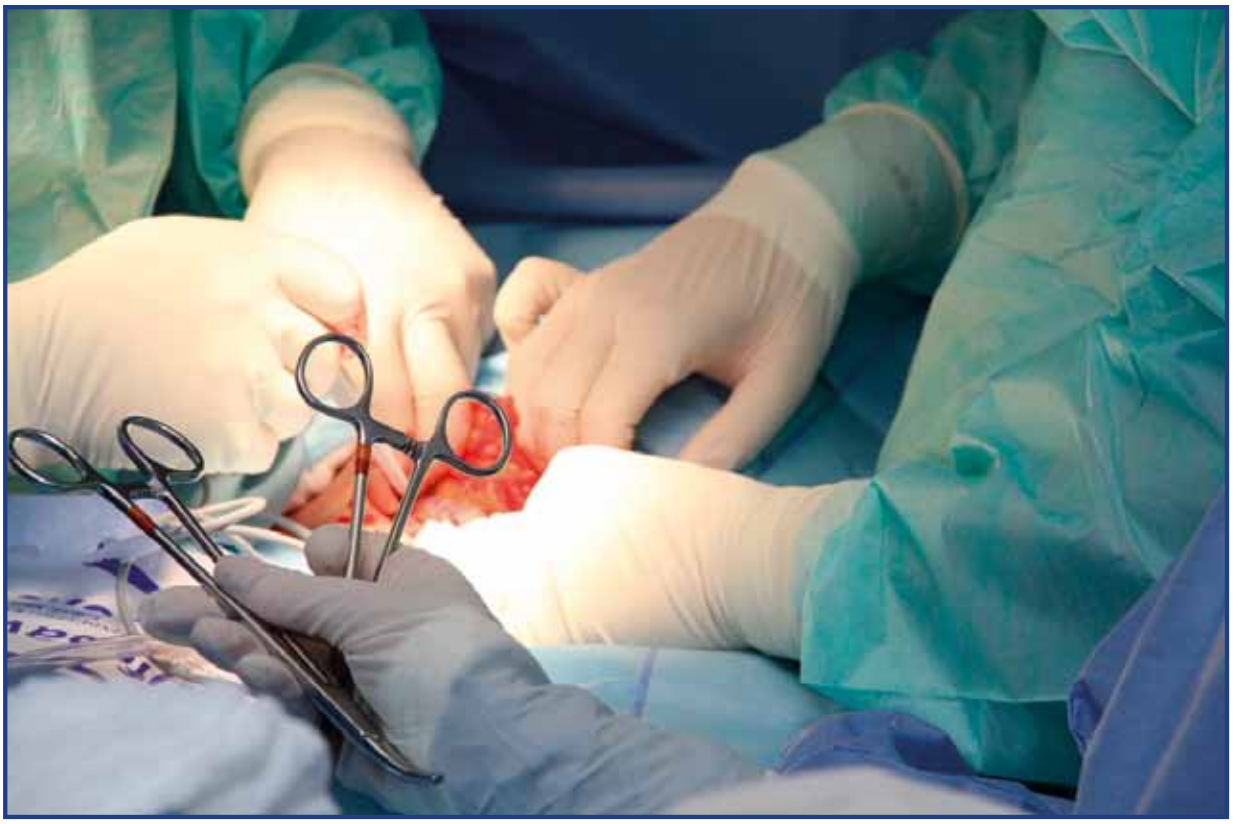

expenditure into public services to achieve universal healthcare (UHC). Achieving good public health services would make the demand for private medical practice decline spontaneously. In fact, the key to achieving UHC in sub-Saharan Africa would be to develop an effective task quality which will transform the current relatively large private health expenditure in these countries to public expenditure. This would be ideal, but bringing it to pass is no walk in the park, not least because of systematic distortions and powerful vested interests in the private sector. In consideration, therefore, achieving UHC in sub-Saharan Africa remains a distant goal into the foreseeable future.

The majority of highly trained doctors in sub-Saharan Africa are in full time or part-time private practice, depriving the public service of their contribution to UH. This concentration of highly trained physicians in private medical practice deprives the national public healthcare system of much-needed support, including in the training of healthcare personnel, qualified participation in health promotion and disease prevention for the majority of the population. Most importantly, it denies the public health system critical expertise needed in research to expand knowledge in the health sciences.

An inescapable evil of private healthcare is that doctors' fees may be too high and thus require supplementation from the patients' pockets. Thus, inadvertently or not, the well-to-do will be favoured over the under-privileged. In addition, private healthcare often lays far greater emphasis on treatment rather than prevention, and specialist practice is favoured over general practice. Concomitantly, the concentration of services is to be found in the urban areas where the populace typically enjoys a higher purchasing power.

In light of some of these challenges, what can developing countries seeking to achieve UH do?

There is no doubt that the remuneration of doctors in keeping with their expected standard of living may be a driving force for most of the specialists opting for private practice. This situation accepts inequalities as inevitable and implicitly assumes that the possibility of achieving UH is slim indeed. It is such assumptions that bedevil all attempts at achieving UH, cynicism quickly setting in to turn otherwise well-meaning initiatives into a mockery. Thus, any serious attempt must first and foremost tackle these underlying assumptions and philosophies, improve public healthcare provision, improve the lot of medical personnel in the public health system, incentivize preventative medical education, and involve citizens and all stakeholders in a comprehensive healthcare approach.

14TH

ANNUAL SCIENTIFIC CONFERENCE

Date: 27th—30th September 2017||Venue: Pride Inn Paradise, Shanzu

THEME:

Towards Excellence in Renal Care and Education in Developing Countries

SUB-THEMES

1. Clinical Guidelines Nephrology
2. Curricula in Renal Training
3. Acute Kidney Injury
4. Hypertension in Chronic Kidney Disease
5. Kidney Transplantation
6. Pediatric Nephrology
7. Diabetic Nephropathy
8. Glomerular Diseases
9. Haemodialysis
10. Peritoneal Dialysis
11. Tropical Nephropathy
12. Anaemia in CKD
13. Acid Base Balance
14. Electrolyte Disturbances
15. Cancer and the Kidney
16. Original Research Papers
17. HIV and the Kidney
18. Mineral and Bone Disease

CALL FOR PAPERS

The committee will accept only a limited number of papers that meet the criteria of originality, presentation quality and topic relevance. The structured abstracts should be between **250 - 300** words.

The **deadline** for abstract submission is **30th June 2017** and abstracts should be submitted by email only to *wambugumaranga@yahoo.co.uk* cc *info@kenyarenal.org*

Registration fee	Before 30th June 2017	After 30th June 2017
KRA Members	Ksh. 12,000	Kshs. 14,000
Nurses/Registrars	Ksh. 10,000	Kshs. 10,000
EA delegates Non- Members	Ksh. 14,000	Kshs. 16,000
International Delegates	$250	$250

Conference Organizing Committee:

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Co-developing a new kind of partnership to improve the quality of health services in Africa

Lopa Basu and colleagues report on a special USA/Africa initiative to champion patient safety

The partnership-based approach between hospitals is a proven mechanism to strengthen relationships, promote bi-directional learning, and provide a sustainable platform for co-development of ideas and implementation approaches to improve healthcare. One example of a successful partnership is the World Health Organization (WHO) African Partnerships for Patient Safety (APPS) programme that has been implemented in over 20 African countries since 2009. APPS is based on hospital twinning partnerships, whereby a hospital in a high resource setting is partnered with a hospital in a limited resource setting with the goal of improving patient safety and quality. APPS advocates for patient safety as a precondition of healthcare delivery and catalyzes a range of actions to strengthen health systems, builds local capacity, helps reduce medical errors and prevents patient harm. The programme acts as a conduit for patient safety improvements that can spread across countries, uniting patient safety efforts through bi-directional learning through partnership exchange visits and virtual communication through regular phone calls.

The Johns Hopkins Medicine Armstrong Institute for Patient Safety and Quality (AI) launched an AI-APPS partnership in 2014 with three hospitals in Africa: 1) Jackson F Doe Hospital, Liberia, 2) Kiir Mayardit Hospital, South Sudan, and 3) Kiwoko Hospital, Ugandan Protestant Medical Bureau (UPMB), Uganda. AI-APPS kicked off its partnerships during a three-day meeting in Baltimore, USA, with the fundamental belief that co-development of solutions is critical for the success and sustainability of any initiative. Attended by staff from three African hospitals, WHO Service Delivery & Safety Department and AI, the partners worked together to define the principles of their partnership and co-developed a partnership plan focusing on key patient safety action areas of interest to the African partner hospitals, including hand hygiene, healthcare waste management, infection prevention, safe surgery, and medication safety.

AI's mission of partnering with patients and loved ones from a place of respect and humility to end patient harm, improve patient outcomes and eliminate waste from the system provided an environment of continual learning. In this setting, validated quality improvement tools that have been widely used in the US were adapted for use in local African hospital settings. Through technical exchange visits and phone meetings, the AI-APPS partnership has highlighted three key learnings:

1) Local patient safety hospital champions are the primary agents for implementation and change;
2) Local innovations for quality improvement has the potential for sustainability and regional spread;
3) South-to-South learning is essential for sustainability. AI's principle of doing things 'with people' instead of 'to people' has shaped the collaborative nature of the relationship, and this principle is the cornerstone of the partnership.

Local patient safety champions are critical in generating ideas, getting buy-in from frontline staff and creating innovative approaches to fit local context. Dr. James Nyontinyo from Kiwoko Hospital in the AI-APPS Uganda partnership is an example of one such champion. A chief surgeon who is well-respected by patients, hospital staff and national level stakeholders, he has promoted the implementation of hand hygiene, health care waste management activities and the Comprehensive Unit-based Safety Programme (CUSP). CUSP was developed at AI and is a systematic approach that has been shown to reduce hospital-acquired infections in the US. Recognising the success of the CUSP trainings for healthcare providers, the AI-APPS team launched the first African CUSP training at Kiwoko hospital that focused on using multidisciplinary teams to understand the science of safety and identify system-level defects to avoid patient harm. Noting that this type of training needs to be adapted to fit the local context, CUSP was adapted in several ways including utilising local vocabulary in the training materials and

Lopa Basu, Nancy Edwards-Molello, and Albert Wu are from the Johns Hopkins Medicine Armstrong Institute for Patient Safety and Quality.

The 25th Kenya Ear Nose and Throat Society (KENTS) Annual Scientific Conference
&
1st African Head and Neck Society Annual Scientific Conference

Date: 25th to 27th May 2017 Venue: Pride Inn Hotel, Mombasa

Theme:

Strides in Head and Neck Surgery in Africa

Conference Fees

Registration	Before 31st March	After 31st March
Full Members	Kshs 15,000	Kshs 20,000
Associate Members	Kshs 10,000	Kshs 12,000
East Africa Region delegates	Kshs 20,000	Kshs 25,000
International Delegates	$250	$300

Pre-conference Workshop: Head & Neck Surgery			
Venue: **Nairobi Surgical Skills Centre, Nairobi**			Dates: **21st - 23rd May 2017**
Course Fee:		**Full Course**	**Lectures Only**
	Consultants	Kshs 20,000	Kshs. 10,000
	Residents	Kshs 10,000	Kshs. 7,500

CALL FOR ABSTRACTS

Oral papers and poster presentations will be accepted provided they meet the criteria of originality, quality of presentation and topic relevance. The structured abstracts should ***not exceed 300 words****.*
The deadline for abstract submission is ***31st March 2017*** *and abstracts should be submitted by email to Dr. Karuga email -* ***drkaruga@prodigykenya.com*** *cc* ***draipatel.patel55@gmail.com***

Conference Organising Committee:
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Event Organizer

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P.O Box 29727 - 00202, Nairobi, Kenya Cell: 0726 830 732
E-mail: info@mmskenya.co.ke, www.mmskenya.co.ke

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extending standard one day of training to two-days to permit more group learning and dialogue. Champions such as Dr. James and lead nursing staff at Kiwoko hospital played a key role in promoting the CUSP model by directly participating in the training and modeling the approaches described in CUSP. Dr. James explained the impact at his hospital: 'Before CUSP there was a sense of despair-knowing what was unsafe but feeling disempowered to speak up and save the day. During the introduction of CUSP it was very difficult to comprehend the concept though we felt we needed a solution to our challenges regarding patient safety. It feels more comfortable to be motivated by patient safety than by fear for litigation. Slowly the hierarchal culture is crumbling and some of the most feared doctors are beginning to embrace and ask for alternative to getting things done mentioning if CUSP could help. During some challenges faced I have heard some staff say 'CUSP will help solve that'.'

Similarly, Dr. Lawrence Sherman from the APPS-AI Liberia partnership is the CEO & Medical Director at Jackson F. Doe (JFD) Hospital in Tappita, Liberia is another local champion. He has engaged with national stakeholders on quality improvement activities and findings from JFD will be shared with other APPS partner hospitals in Liberia, including other APPS Liberian hospitals and their partners including Nagasaki University in Japan and ESTHER France. Dr. Sherman explains: 'The regional spread of information and knowledge within Liberia and other APPS Network has been invaluable, not because it provides information on the methods of how others have achieved sustainable and quality healthcare in their own setting, but because it provides us with an opportunity to participate and design our healthcare practices to conform to the dynamics in our own locale. The APPS Network will continue to be the platform for sharing rather than one of imposition of ideas and realities that may be solely alien and not applicable in all settings.'

In addition to partnership exchange visits with AI team members to JFD, exchange visits have also included national and subnational level stakeholders and other APPS partners working with hospitals in Liberia. The next phase of engagement will include a cross learning session between APPS partners including Nagasaki University staff with AI staff on specific tools and trainings used by each partner group. This engagement will serve to enhance each of the twinning partnerships. National level stakeholders from the Liberia Ministry of Health have been committed to this partnership-based approach and understand the critical need for regional coordination and shared learnings on facility level quality improvement efforts. Continued engagement with national level stakeholders in Liberia and twinning partners in Liberia including ESTHER France are promoting sustainable mechanisms for shared learning both nationally and globally.

In an effort to enhance technical capacity for local patient champions, the APPS-AI team has learned that sharing stories from local context including challenges and successes for quality improvement approaches is a key opportunity. With a focus on hand hygiene for infection prevention, the Kiwoko hospital pharmacist travelled to Kisiizi hospital in another region in Uganda to learn how to produce local alcohol based handrub (ABHR) using the WHO Guide to Local ABHR Production. Kisiizi hospital was one of the first wave APPS partners in 2009 and was well-experienced in producing local ABHR and after the APPS-AI programme launched, the opportunity to have the Kiwoko hospital pharmacist learn from a local Uganda pharmacist on how to produce the ABHR promoted shared learning and also helped to strengthen relationships across the Ugandan Protestant Medical Bureau (UPMB) network, where both Kiwoko and Kisiizi hospitals are partners. Furthermore, due to the security challenges for Hopkins AI staff to travel to South Sudan, Kiir Mayardit hospital staff traveled to Kampala, Uganda twice for in-person patient safety trainings which included hand hygiene, patient safety culture and healthcare waste management. Kiir Mayardit physician and local patient safety champion, Dr. Nyok Bol explains: 'This partnership, with inclusion of South-South learning, builds the capacity of the health care providers in South Sudan and allows us to catch-up and be updated with the dynamic changes that are happening in the field.'

The AI-APPS programme has built a strong foundation of bi-directional learning as a platform for facility-level quality improvement. Engaging with local patient safety champions and promoting technical capacity building training programmes through South-South learning are critical factors in the co-creation of a successful partnership. Solutions that have been adapted to the local context and creating mechanisms both virtual and in-person to strengthen relationships between people have continued to promote knowledge generation on quality improvement efforts at the facility level. This programme is a concrete example of how to reach the Sustainable Development Goal 17 to revitalise global partnerships and can be a model to improve quality health services in Africa and beyond.

African Partnerships for Patient Safety (APPS) was established in 2009 in response to the political commitment on patient safety emanating from the WHO AFRO Region. The programme engages closely with WHO Member States and frontline healthcare professionals in an area of the world where advancing safety and quality of care has been very difficult. APPS has had a recent name change to Twinning Partnerships for Improvement (TPI) as hospital partnerships have expanded beyond the African region.

Please visit the following link to learn more and register for APPS: http://www.who.int/patientsafety/implementation/apps/en/

And to learn more about TPI please visit: http://www.who.int/csr/resources/publications/ebola/twinning-partnerships-package/en/

Reference

http://www.who.int/gpsc/5may/Guide_to_Local_Production.pdf

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11th
ANNUAL SCIENTIFIC CONFERENCE

21ST - 23RD JUNE 2017 || VENUE: PRIDE INN PARADISE, SHANZU

THEME:

Role of Orthopaedics in Achieving the UN Sustainable Development Goals

PRE CONFERENCE - DATE: 21ST JUNE 2017

Spine Workshop *Shoulder Workshop: A-Z of the shoulder

Registration Fees	Early (Before 31st Mar 2017)	Late (After 1st April 2017)
Members	Kshs. 19,000	Kshs.21,000
Associate/ Registrars/ Nurses/ MedicalStudents	Kshs. 10,000	Kshs. 12,000
Non-Members	Kshs. 25,000	Kshs.25,000
International Delegates	300 USD	300 USD

Call for Abstracts

All abstracts should not be more than 250 words and should be submitted by email only to **abstracts2017@koa.or.ke** by 31st December 2016

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Chair Scientific Committee -Dr. James Kigera
Chair Finance Committee -Dr. Akil Fazal

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Cell: 0726830732 || Email: info@mmskenya.co.ke, www.mmskenya.co.ke

News Update

Africa last? Or is the order changing?

Early talk was of major cuts to The United States Agency for International Development (USAID) spending in Africa, but Congress has shelved many of President Bush's proposals, so whilst the situation is serious it might not be as bad as first anticipated.

Nothing is confirmed as yet, but Congress has stood strong against President Trump's initial efforts to slash the foreign aid budget. The indications are that funding to the Global Fund and The President's Emergency Plan For AIDS Relief (PEPFAR) may after all be sustained, though rarely have we had an administration that flips and flops quite so much over policy from one day to the next. What is certain so far is that anything to do with climate change is going to be slashed, and the UN is going to lose something like US$640 million from the $10 billion that the USA currently pays in.

But Trump and his team say that they still wish to trim foreign aid spending by a little over 30% so having been rebuffed on one hand, it will be interesting to see how they respond.

The budget proposals they had put forward had eliminated all funding through the development assistance account in all the countries in the region, a vote that had benefited education and water projects. But according to data from Foreign Assistance, a US government agency that tracks its development aid, the effect might have been mitigated by the fact that in recent years, USAID has actually been spending less than it had budgeted. For instance, this year, Washington had planned to spend $3.06 billion in the East African region, a drop from $3.75 billion two years ago, though what it is actually on course to spend much less. Kenya's health sector was set to be the biggest beneficiary in the aid spending, with a planned spending of more than $1.68 billion in the past three years, but it looks as if it will actually only receive $530 million. So the real effect of a cut of projected spend might not be quite as significant a change as it might otherwise have appeared to be.

However, Uganda and Ethiopia may still be majorly affected by the phasing out of the development assistance window that had been an important source of funding. Prior to Congress's intervention it looked as if Ethiopia would suffer the biggest cut at $132.1 million followed by Uganda at $67.8 million. Rwanda and Tanzania at $50.7 million each while Kenya would lose $11.78 million, South Sudan $10.6 million and Burundi $9.4 million. Only Somalia came out better off with a net increase of around $36 million. However economic aid will continue as before, totaling some $201 million, except for the African Union and Burundi to whom the Trump administration proposed a complete axeing of support.

The US uses the economic assistance fund to promote economic and political stability where it has strategic interests. The fund has been used in anti-extremism funding, improvements to judicial processes and training to the private sector in economic development.

There is still a lot to play for. Trump had called for an additional eye-watering $54 billion for defence spending. Now Congress seems inclined to provide him with a figure approaching only half of this, and no one is quite sure how he will react.

Meanwhile Africa's cash-strapped health sector will remain with fingers crossed. The impact of PEPFAR in supporting the primary care salary bill across the continent is of critical importance. A slashing of support would have a huge impact on services to millions of people. Congress appears to understand this, but if President Trump is to achieve his ambition of dramatically reducing the USA's government spend, and realigning policy to suit home needs, then we have to conclude that there is still quite a long way for this particular debate to go before we can be sure of the final outcome.