

BroadReach
healthcare

Care into action.

Impact of HIV/AIDS on Labour Productivity: Pan African Ports Public-Private Solutions

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Presentation Outline

- Overview of BroadReach Healthcare
- HIV/AIDS and Workplace Productivity
- Reasons for Limited Success of Workplace Programs to Date
- Supply and demand-Side Challenges to Scale-Up of Workplace HIV/AIDS Prevention, Treatment and Care
- A Pan African Ports “Systems Approach” to tackling HIV/AIDS
- Parting Thoughts
- Back-up slides

Overview of BroadReach

- Global healthcare solutions company focused on developing new healthcare markets, delivery systems, and comprehensive healthcare capacity
- Identifying and implementing innovative models for rapid scale-up of HIV/AIDS treatment delivery
- Deploying innovative technologies to overcome capacity barriers e.g. rapid tests (HIV & CD4) , satellite communications, telemedicine
- Key Focus = “private sector” approach to “public sector” issues
- View HIV/AIDS as an enabler to broader health systems development

Our Experience

- Led the implementation and management of Botswana's National Antiretroviral Programme (Masa) for last 4 years
 - Under leadership of Botswana MOH, Bill and Melinda Gates Foundation, & Merck
 - One of the largest public sector ARV programs in Africa
- Currently implementing large scale US PEPFAR funded treatment program in South Africa
 - Matching over 4000 private sector doctors with public sector patients
 - 5 year capacity to treat 150,000 to 350,000 patients
- Provided strategic consulting on HIV/AIDS treatment to governments of China, Ethiopia, Mozambique, Vietnam, Caribbean, etc
- Providing management support to Government of Ethiopia for National Antiretroviral rollout

HIV/AIDS Decreases Workplace Productivity

- Decreased individual performance
- Absenteeism
 - Direct illness
 - Support for sick relatives & funeral attendance
- Increased direct and passed on cost
 - Recruitment
 - Training
 - Medical fees
- Critical irreplaceable loss of skills

Limited Workplace Program Success to Date

CURRENT WORKPLACE REALITY:

- Lack of adequate and/or enforced protective policies
- Lack of effective HIV workplace education & awareness programs
- Fear of testing
- Stigma & fear of stigma
- Lack of adequate general health coverage
- Incentive to minimize responsibility for benefits



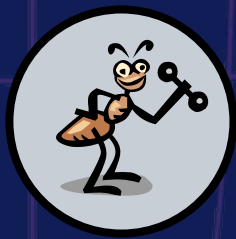
RESULTING IN:

- Low testing uptake (“invisible” enemy)
- Unwillingness to access HIV services in the workplace
- Persistence of status quo
 - Risky behavior and new infections
 - Loss of productivity
- Lack of services

Why HIV is Difficult to Address in Workplace

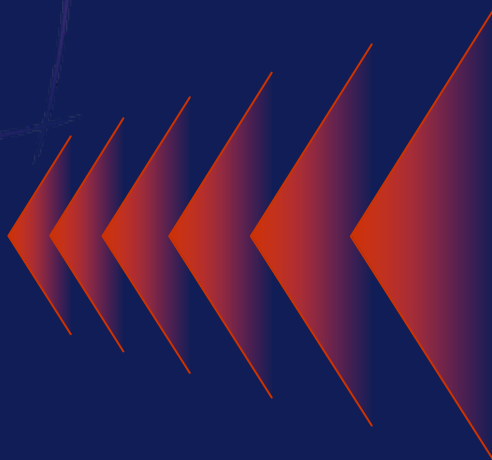


SMALL SCALE INDIVIDUAL RESPONSES

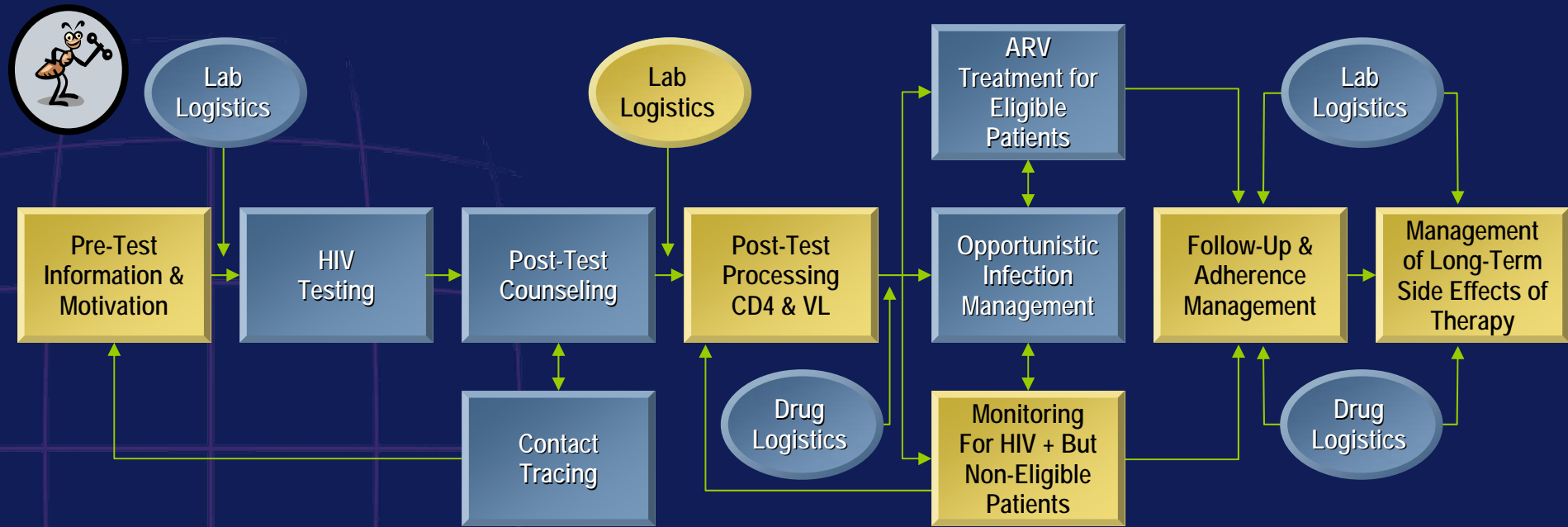


SUPPLY-SIDE

DEMAND-SIDE



Key Systems for Implementing a National ARV Program



CROSS-CUTTING/SUPPORT SYSTEMS

- Program Development, Management & Logistics
- IEC & Community Mobilization
- Staff Recruitment & Retention
- Training
- Data & Financial Management
- Referral
- Psychosocial & Wellness Support
- Procurement of Space & Equipment
- Monitoring, Evaluation (M&E) and Operational Research
- Accountability Enforcement

Additional Supply-Side Challenges



- Limited health infrastructure in the workplace
- Limited general health coverage for staff, often none for dependents
- Dependence on overburdened government services to treat workers
- Lack of care systems to support “well” workers and dependents requiring impeccable “lifetime” follow-up in the community

Demand-Side Challenges

- Large “invisible” burden of disease in workplace
- Wide diversity of home origins of staff
 - Migrant workers, often from other countries
 - Families of workers widely distributed geographically
- Wide diversity in definition of term “employee” and span of responsibility (especially across borders)
- Environmental & social, cultural & economic challenges limiting access and reach into rural areas
- Challenging special risk groups (e.g. children, truck drivers, sailors, migrant workers)



How Do We Address These Challenges?

Think Differently...



... The scale of the solution must match the scale of the problem from the outset.

PAN AFRICAN PORTS “PPP” MANAGED CARE MODEL TO:

- **Prevent** new infections
- **Test** those who do not already know their status
- **Treat** employees and extend benefits to dependents
- **Support** “well” employees and dependents in the community

A Pan African Ports PPP Co-operation Solution

MAIN ISSUES TO BE ADDRESSED:

- Financing (prevention, treatment & care)
- Policy and creation of enabling supportive environments
- Provision of supply-side factors for prevention, treatment and support
- Elegantly tackle key demand-side challenges (e.g. migrant workers, care for dependents)
- Managing and coordinating a Pan African Ports Public-Private program

Financing Prevention, Treatment and Care

- Pool financial resources from Pan African Ports Authorities and other supply chain Small and Medium Enterprises (SMEs) to fund employees
- Match funding from large external sources anxiously looking to fund large scale public private models
 - PEPFAR (US Government)- for dependents
 - Global Fund (Multilateral)- for dependents
 - Bilateral Sources- for dependents
 - National Governments
 - Large private corporations
- Risk pooling insurance models (all contribute small amounts when well to treat the smaller number of sick)

Policy and Enabling Environment

- Numerous best practices exist that can be adapted to create **ONE** Pan African ports cooperative workplace policy
- Solid leadership commitment from Ports Authority management in each country
- Each Port Authority implements and enforces protective workplace policies (decrease fear, stigma)
- Each Port Authority drives 100% testing and patient uptake programs at all levels

Providing Prevention, Treatment and Care

- Develop a single Pan African Ports Prevention, Treatment and Care health plan for workers and dependents in the community
- Pan African Ports “pool” supply-side resources and share across all participating members
- Form Public private partnerships (PPPs) in each country to provide necessary expanded capacity base
- Each port authority drives 100% prevention, treatment and care programs (including primary care)

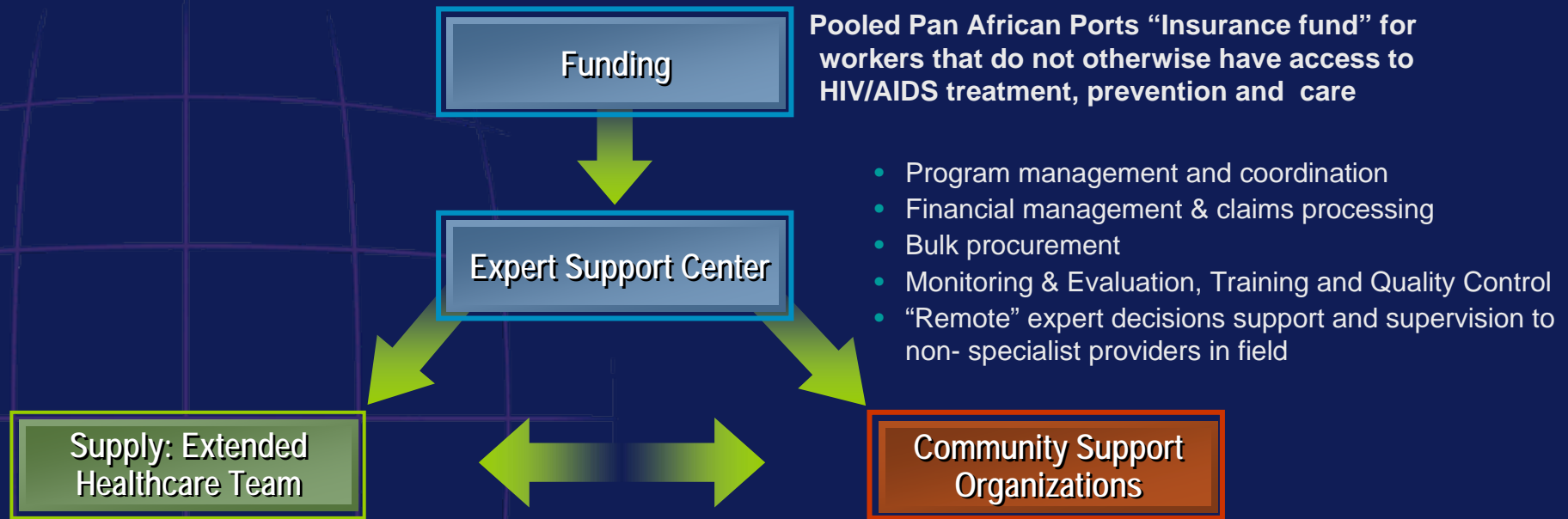
Tackling Demand Side Challenges

- Pan African Public-Private Co-operative Model creates many “win win” scenarios
 - Allows a consistent program to be offered across borders
 - Same service package can “follow” a migrant worker
 - Provides services for dependents regardless of which country they are in (landlocked or otherwise)
 - Allows for 100% coverage on a continent-wide basis
 - Allows workers to receive comprehensive services away from the workplace

Managing and Coordinating a Pan African Program

- Deploy a large scale health management and insurance model with regional hubs
- Distribute specialty services from central location through telemedicine
- Centralize all critical backroom functions that would be wasteful to replicate in each country
 - Management functions, policy and planning
 - Claims management
 - Deep clinical expertise
 - Bulk procurement and distribution of health supplies
 - Monitoring, evaluation and operational research

A Pan African Ports Authority Public Private Partnership



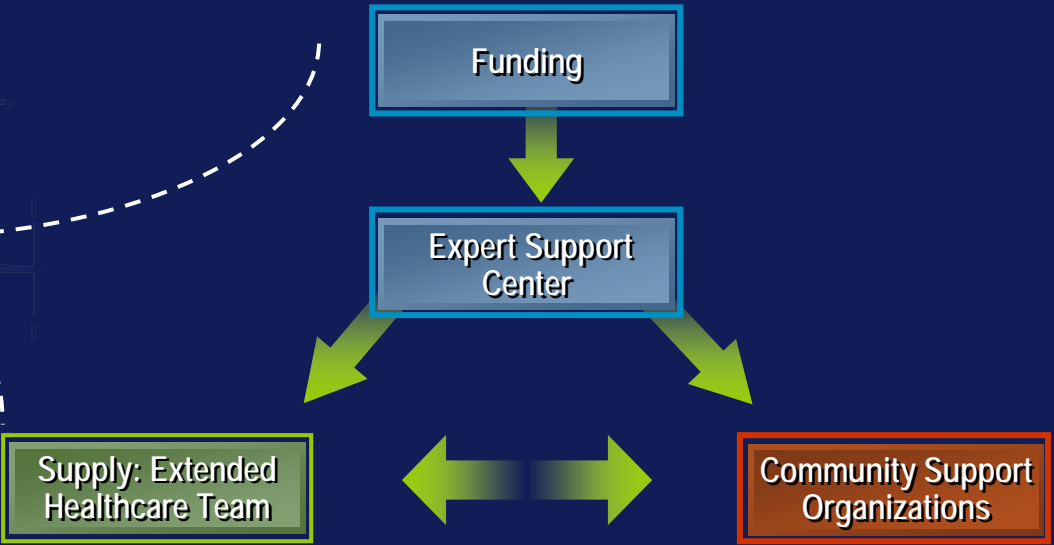
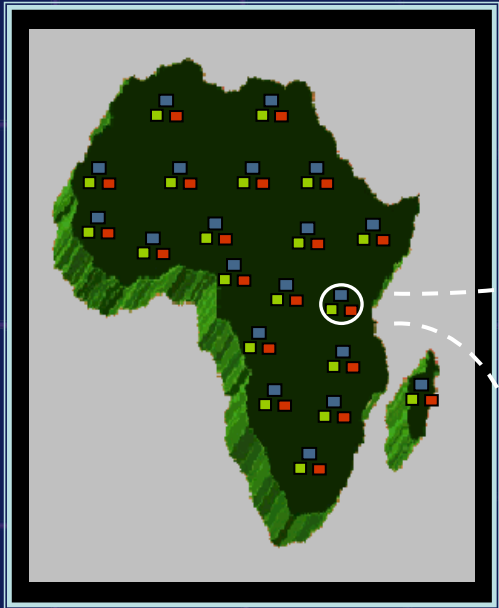
Nationwide Public, Private, NGO, FBO & Community Providers of Supply Chain Services:

- General practitioner doctors and nurses
- Allied health professionals and auxiliary health staff
- New cadres of Community Health Workers
- Management and other special skilled staff (local and international)
- Pharmacies and drug distributors
- Laboratories
- Commodities and consumables suppliers

Any Setting Where Workers and Dependents Can Be Accessed in a Consistent Repetitive Manner (Naturally “Captive” Populations):

- Ports Authority Workplace & Health facilities
- Suppliers Workplaces (small and large enterprises)
- PLWHA Networks
- Institutions (religious, academic, military etc)
- Villages
- Any other definable structured communities
- Families
- Individuals

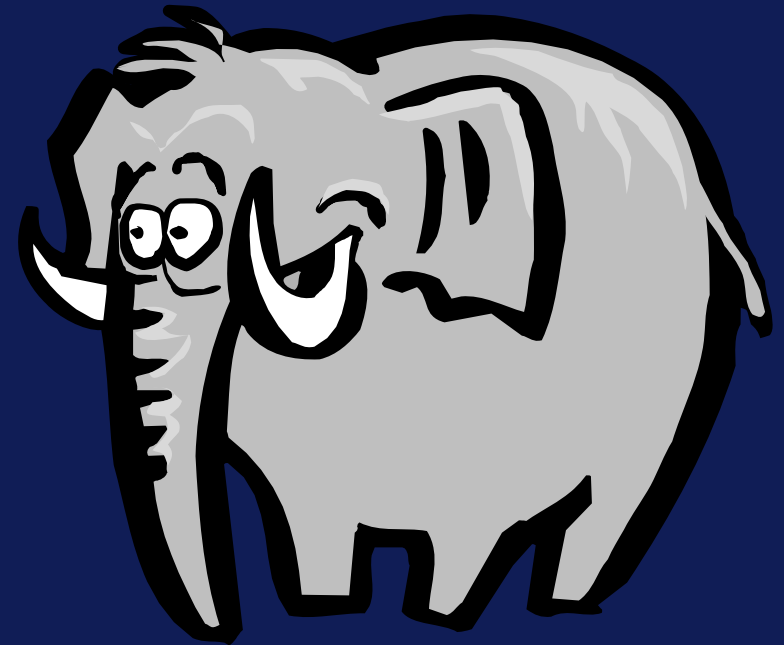
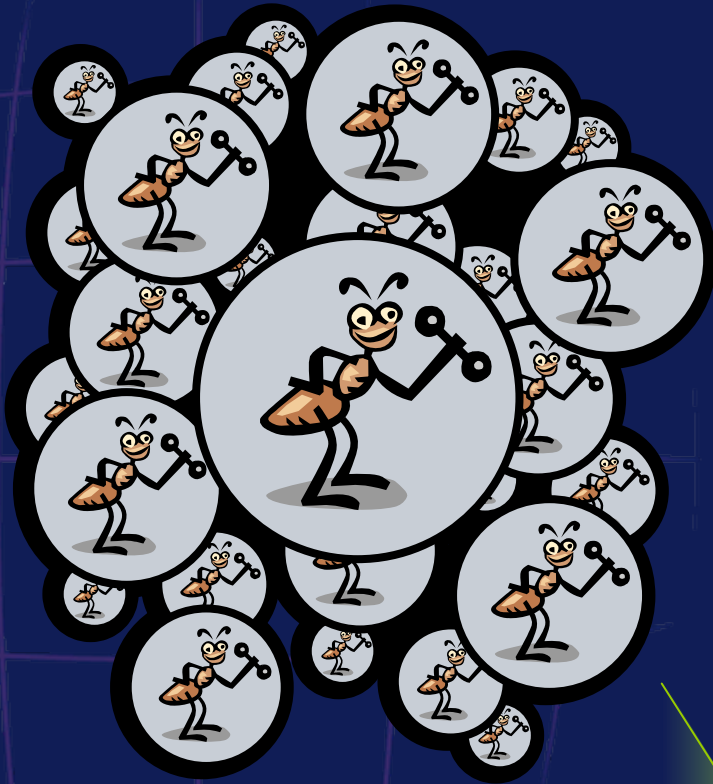
Expanded Vision of Public Private Capacity Maximization



Source: BroadReach Healthcare Implementation and Assessment Strategy.

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By Working Together.....



SUPPLY-SIDE

DEMAND-SIDE

Parting Thoughts

- The core of a successful ART program is not physical infrastructure, rather it's systems and processes which allow patients to take drugs on a prescribed and consistent basis
- Emphasis must be on early identification and maintaining wellness- a significant paradigm shift from current health delivery models
- We must avoid re-inventing the wheel and use “winning” models, existing expertise and multi-sectoral capacity
- We must have the courage to cross boundaries and join hands in the spirit of true jointly **accountable** partnerships where every stakeholder down to the individual has a distinct, enforced and monitored role



Thank You!



BroadReach

healthcare

Care into action.

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Best Practice Workplace Programs

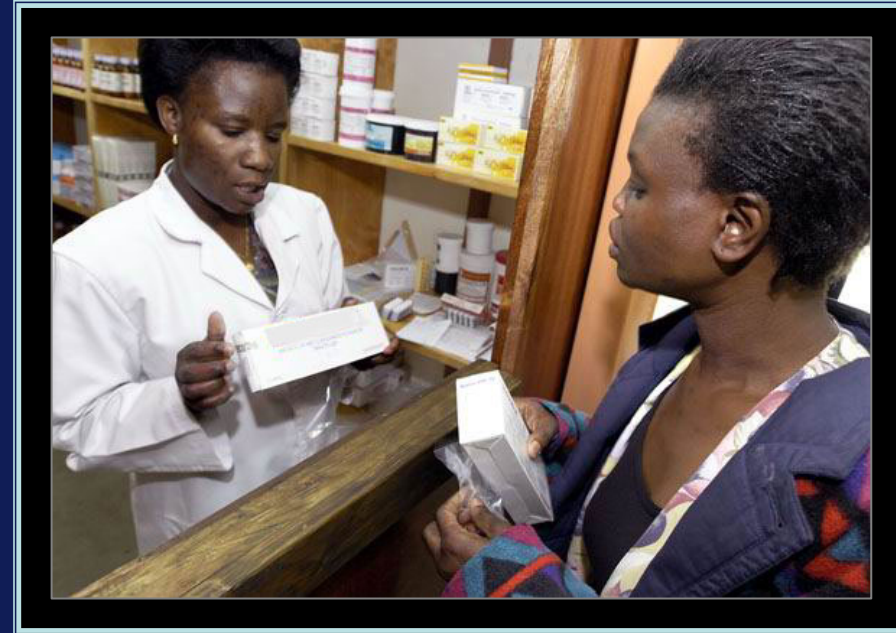


- Notable workplace programs exist that demonstrate success is possible:
 - BMW South Africa: Prevention, Treatment and Care (employees and dependents)
 - Anglo American South Africa: Treatment and care for employees
 - Debswana Botswana: Treatment and Care for Employees public private partnership with telemedicine
 - Daimler Chrysler South Africa: Treatment and care
 - Guinness/Diageo: Treatment program for bottlers
 - Coca cola Africa: Treatment program for bottlers
 - Shell: Comprehensive community programs (health, education, social welfare)
 - Exxon Mobil: Treatment and care programs for employees

Best Practice In Increasing Testing Rates



- In Botswana testing success improved from below 20% to above 90% with introduction for routine opt-out testing in health facilities
- In Uganda there is significant testing success with door to door testing campaign in the communities (>90% uptake)



Best Practice in Overcoming Human Resource Challenges

In South Africa private sector models have shown it is possible to spread the expertise of a few specialists over thousands of generalist community based providers



PROVIDER FOCUSED SUPPORT

- Initial and Ongoing Provider Training
- Clinical Guidelines Enforcement and Oversight
- Provider Clinical Questions Call in
- Case-by-Case Clinical Decision Support
- Difficult Case Review
- Comprehensive Results Monitoring (Human and Electronic)
- Financial Claims Management for Provider Payments



Remote Expert
Center

PATIENT FOCUSED SUPPORT

- Registering Patients
- Patient Education/Treatment Literacy
- Monitoring (labs, visits, adverse events, adherence)
- Ongoing Patient Education and Awareness
- Ongoing Patient Telephonic Counseling and Support

Ratios of 1 specialist
to over 13,000
patients achieved

Outcomes equivalent
or better than
Western Countries

Best Practice Harnessing Cross-Sectoral Skills and Capacity



- Botswana has shown that public private partnerships can catalyze implementation and avail many non-traditional skill sets:
 - Management and planning skills
 - Social marketing
 - Financial skills
 - Recruitment and HR Management
 - Actuarial risk assessments
 - Computers and data management
 - Telecommunications
 - Logistics and supply chain
 - Transportation and delivery services
 - Insurance and claims management



Over 60% of eligible patients treated in <48 months

Best Practice Using Community Workers as Health Providers



- Experience in Haiti has shown success with supervised community health workers models of HAART provision
 - Adherence rates >90%
 - Reduced hospitalizations & length of stay
- Community based programs South Africa (Kayelitsha) have demonstrated
 - >90% adherence rates
 - >90% with optimal viral suppression at 6 months
 - >70% reduction in OIs

