

# Public-Private Interactions in the South African Health Sector: Experience and Perspectives from National, Provincial and Local Levels

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## EXECUTIVE SUMMARY

### Public-Private Interactions in the South African Health Sector

This report is an introductory analysis and overview of Public-Private Interactions (PPIs) in the South African health system. It forms part of a broader programme of work looking at decentralisation and health.

Section 5 provides an overview of the evolution of health PPIs in South Africa. PPIs are not new to the country, which has a long history of interactions with the private sector for both clinical and non-clinical service delivery. However, as this report outlines, PPI development has been given impetus since 1994 by a set of three parallel policy processes. Various initiatives at provincial level in the late 1990s led to the development of the National Department of Health (NDOH) public-private partnership (PPP) policy guidelines towards the end of 1999. These were published just after the promulgation of the National Treasury PPP guidelines, that establish specific procedures for provincial departments to follow in developing and implementing PPPs as defined by them. The Treasury guidelines are not health-specific and effectively exclude some of the forms of interactions occurring within the health sector as well as giving primacy to efficiency and affordability as PPP goals. The broader concerns of the NDOH led it, finally, to develop a policy document around public private *interactions* in 2000, that covers both Treasury-defined PPIs and other forms of interactions, as well as emphasising the specific importance of equity as a health sector goal. Importantly, as local government falls outside the jurisdiction of national and provincial government neither of these policy processes can directly influence PPI development in this sphere – although there are already a considerable number of local government health PPIs.

Drawing on data from a postal questionnaire, key informant interviews and a media analysis, Section 6 of this report provides a mapping of the current range of health sector PPIs being implemented or developed in the country.

The first set of interactions that are currently taking place are those central to managing the relationships between the public and private sectors that lead to and support the development and implementation of PPIs. These include formal/informal dialogue, policy and patient transfer protocols/procedures. The second set are those PPIs supporting service delivery. These include purchased services, outsourced non-clinical services, joint ventures and private finance initiatives (PFI). Purchased services refer to the public sector purchase of private clinical services with both profit and non-profit organisations and/or individuals. Outsourced non-clinical services emerged as a key PPI. Joint-ventures refer to sharing of resources predominantly on a lease or service basis. Examples include hospital co-location or sharing under-used public or private resources. The PFI refers to projects involving the raising of finance on private money markets mainly for infrastructure development of hospitals and both medical/non-medical technology. Other PPIs identified are asset swap, subsidies to employers providing medical aid coverage to employees and PPIs concerned with drug affordability and

accessibility. The range of PPIs unfolding in the health sector shows that many PPIs do not fit neatly into the traditional PPP model provided by National Treasury. For instance a PFI may need to follow Treasury guidelines, whereas purchasing renal treatment or employing session doctors from the private sector are not included in the Treasury framework. In addition PPIs may have differing objectives. Co-location may enhance efficient resource use, whereas PFI may be driven by the need to address infrastructure backlogs.

In terms of identifying where PPIs are underway and being developed there is a wide range of experience between and within spheres of government. Local Government is more amenable to purchased services than provinces, as local government runs few or no hospitals. Provinces, on the other hand, have extensive experience with outsourced non-clinical services. Joint ventures are more common at the provincial and facility level, with PFIs playing a prominent role in both national and provincial level discussions. However, there is uneven implementation of PPIs between and within spheres of government. For instance, even though PFI is discussed at provincial level, some provinces are opposed to the PFI model. Likewise, hospital co-location is being considered in provinces such as the Free State, Eastern Cape and Kwazulu Natal, whilst Gauteng has not adopted the co-location model.

A final analysis presented here highlights the enormous complexity of PPIs. On the one hand, every PPI involves a blurred set of relationships between the two sectors around a set of core functions. On the other hand, the same basic form of PPI can be implemented through different sets of public-private relationships around these functions. For instance, in the case of purchased services such as session doctors or contracting renal treatment the public-private relationships differ markedly. With session doctors capital and recurrent financing is public with capital ownership essentially public. The healthcare provider is unclear in that it is a private individual providing a service in a public facility and is thus viewed more as public than private. However, in the case of contracting renal treatment the capital financing and ownership is private, the recurrent is public in that the public sector purchases a service from a private healthcare provider. In both instances demand is driven by the public sector purchasing clinical care on behalf of public beneficiaries from private healthcare providers.

Finally, Section 7 explores the underlying rationales for PPIs showing the differences between actors. For instance NDOH is concerned with strengthening the health system, improving equity and containing costs, whereas National Treasury is concerned with addressing infrastructure backlogs, value-for-money and shifting risk to the private sector. The public sector is more generally concerned with improving equity, whilst private hospitals and funders are primarily concerned with profit. Differences between actors have the potential to allow PPIs to generate negative impacts on the health system. These negative impacts include mistrust between the public and private sectors and further fragmentation of the health system. Key informant interviews also identified a range of potential pitfalls in PPI development. The most importance of these is the lack of public sector

capacity to manage the PPI process as well as to manage relationships with private sector agents. As there is also a lack of evidence on the impacts of PPIs, PPIs are also being developed and implemented with an inadequate evidence-base to guide and support implementation.

Overall, therefore, this report concludes that the NDOH should play the central role in co-ordinating future PPI development and implementation across the sector and across spheres of governance. This strong central role is important given the complexity of PPIs and the current differences in PPI experiences across spheres of governance and geographic areas. The goal of the NDOH should be to ensure that a unified vision and co-ordinated action for PPI development and implementation is fostered, so as to strengthen the health system as a whole. In addition the NDOH needs to provide technical support and training opportunities to all spheres of government so as to strengthen the capacity needed to implement PPIs without undermining the health system. Finally, evidence is needed on the impacts of PPI implementation in South Africa so as to allow policy-makers and managers to constantly evaluate whether or not PPIs can improve and strengthen the South African health system.

# 1. INTRODUCTION

Historically, within many countries, the responsibility for social service delivery has rested primarily within the realm of government. However, the private sector is playing an increasingly important role in the delivery of services even in countries with dominant public sectors, and so governments have begun to explore ways in which to involve the private sector in health service delivery without compromising public interest (Bennett et al, 1997).

The South African health system comprises a strong private sector, serving less than one-fifth of the population and financed through voluntary health insurance and out-of-pocket payments. The public sector, which serves the rest of the population, is funded primarily through taxation. South Africa also has a long history of public-private interactions (PPIs) within the health system. This includes contracts with both profit and non-profit providers supporting the delivery of tuberculosis, psychiatric and secondary level hospital care for public patients. However, although South Africa currently has high total healthcare spending (8.5% of GDP), its health status ranks poorly with respect to countries spending as much and even less on healthcare (McIntyre et al, 1995; McIntyre and Gilson, 2002). One explanation for this poor performance is the inefficiency within the health system associated with its segmentation between public and private sectors (McIntyre and Gilson, 2002). There is therefore a need to understand whether, and if so, how, the public and private sectors can work together more effectively in the future in order to improve overall health system performance. An environment of constrained public sector resources and limitations on further private sector market expansion only add to the pressure to increase the levels of interaction between the sectors.

In South Africa the National Treasury has developed guidelines on Public-Private Partnerships or PPPs (National Treasury, 2000) providing a framework for the development and implementation of PPPs by all national and provincial government departments. According to National Treasury (2001: 5) a PPP is a contractual agreement in which a private party delivers a service or performs a function for the public sector with the private sector assuming the risks associated with the delivery or function. Policymakers are starting to come to grips with the notion of PPPs especially with the more complex relationships that have developed in other sectors. PPPs are, therefore, currently being developed in many sectors ranging from transport to public works to the health sector. Parallel to this process has been the development, by the National Department of Health (NDOH), of guidelines on what are called Public-Private Interaction (PPIs) (NDOH, 2001). PPIs refer to engagements that include not only PPPs as defined by the National Treasury guidelines but also a range of other interactions that may support service delivery directly or indirectly. However, the differences between these terms and between specific types of PPIs, as well as whether or not to engage with the private sector, are not well understood by South African health sector public managers. The research reported here is, therefore, intended to assist these managers in addressing the challenges posed by PPIs, by providing

insights into the emerging policy and experience around PPIs within the country. The primary objectives of the study were to:

1. review the international experience with PPIs;
2. develop a conceptual framework for describing and monitoring PPIs;
3. outline the policy environment regarding PPIs in South Africa;
4. map the extent and nature of current and planned PPI initiatives in the health sector.

The review of international PPI experience feeds into the development of a conceptual framework, as well as providing some context for understanding the landscape in which PPIs are taking place in South Africa. The development of a conceptual framework is important for the task of mapping and categorising PPIs within the health sector, in terms that speak to the management challenges associated with them. Similarly, outlining the policy environment is useful for managers because it highlights the key factors influencing the development and implementation of PPIs, such as specific driving forces and key stakeholders, and so supports consideration of why PPIs are emerging and what they are intended to achieve. Finally, mapping the current spectrum of PPIs gives a sense of the diverse experiences within the country. Overall, this analysis seeks to provide a basis for the further management action, including monitoring and evaluation, required to ensure that PPI development contributes to health system goals.

Although this project was undertaken within the programme of work of the Local Government and Health (LGH) consortium, it looks at experience across all spheres of government rather than primarily at the local government sphere. Placing the local government experience within the broader policy environment is important as national health policy and guidelines around PPIs are relevant across all tiers of government, and because health sector experience in this field is still very limited. This report, thus, provides an overview of that environment and broader health sector experience with PPIs as well as highlighting key aspects of the local government experience.

The report contains 6 further sections that outline:

- the research methods used in this study;
- the conceptual framework for mapping PPIs, developed from consideration of international experience;
- key South African policy developments;
- the range of PPIs that currently exist;
- the key stakeholders and drivers underlying PPI development;
- Finally, some key recommendations are presented.

## 2. METHODS

Table 1 provides an overview of the full range of data sources and data collection methods used in this study. The postal questionnaire was specifically conducted in order to gather information on planned and implemented PPIs. Unfortunately the response rate was too low to generate wide information. Key problems were:

- lack of success in obtaining information from provincial respondents (not one provincial response was received, despite support from the NDOH); Two provinces, however, provided detailed information on facility-level contracts for clinical and non-clinical services.
- lack of capacity and knowledge in some newly created municipalities, particularly C level municipalities;
- complexity of survey questionnaire.

Nonetheless, the questionnaire returns from some local government authorities did provide useful information that is discussed in the PPI mapping presented in section 6.

**Table 1: Details of Data Collection Methods**

<b>Data Source</b>	<b>Details</b>	<b>Use</b>
1. Literature Review	Health policy, health economics, business management, public management and administration, privatisation literature.	<ul style="list-style-type: none"> <li>• To review international and national experience of PPIs.</li> <li>• To develop conceptual framework to describe and monitor health sector PPIs.</li> </ul>
2. Document Review	<ul style="list-style-type: none"> <li>• 19 Documents Reviewed</li> <li>• National health (4)</li> <li>• Provinces (3)</li> <li>• National Treasury (2)</li> <li>• Constitutional Development (1)</li> <li>• Local Government (2)</li> <li>• Trade Unions (3)</li> <li>• DBSA (2)</li> <li>• SAHR2001 (1)</li> <li>• Private Funding Association (1)</li> </ul>	<ul style="list-style-type: none"> <li>• To map the extent and nature of health sector PPIs.</li> <li>• To outline the policy environment.</li> <li>• To understand the key PPI drivers</li> <li>• To validate other data sources.</li> </ul>
3. Key-Informant Interviews	19 in-depth interviews: <ul style="list-style-type: none"> <li>• 1 from NDOH</li> <li>• 1 from National Treasury</li> <li>• 7 from Provincial Health Departments</li> <li>• 3 from Local Government</li> <li>• 2 central hospital CEOs</li> <li>• 3 senior private sector representatives</li> <li>• 1 with a trade union federation</li> <li>• 1 researcher</li> </ul>	<ul style="list-style-type: none"> <li>• to map the extent and nature of current health sector PPIs</li> <li>• to outline the policy environment</li> <li>• to undertake a stakeholder analysis vis-à-vis opposition/support of PPIs</li> <li>• to understand the key PPI drivers</li> <li>• to validate other data sources</li> </ul>
4. National Postal Survey	<ul style="list-style-type: none"> <li>• 9 provinces</li> <li>• all the A municipalities</li> <li>• major B municipalities</li> <li>• C municipalities</li> </ul>	<ul style="list-style-type: none"> <li>• To map the extent and nature of health sector PPIs</li> <li>• To outline the policy environment</li> <li>• To understand the key PPI drivers</li> <li>• To validate other data sources</li> </ul>
5. Media Analysis	Review of independent print media (October 2000-October 2002)	<ul style="list-style-type: none"> <li>• To map the extent and nature of health sector PPIs.</li> <li>• To outline the policy environment.</li> <li>• To understand the key PPI drivers</li> <li>• To validate other data sources.</li> </ul>

### 3. PUTTING PPIs INTO PERSPECTIVE – AN INTERNATIONAL OVERVIEW

This relationship between the public and private sectors with respect to service delivery is traditionally viewed by health economists in terms of two key functions, that of *financing* and *provision* (Donaldson and Gerard, 1993; Bennett et al, 1997) by which the responsibilities of the public and private sectors are delineated. Figure 1 is useful in highlighting some of the possible sets of relationships that may exist between the public and private sectors. It illuminates possible relationships in which there is a clear role for each sector with respect to financing and/or provision. For instance, the public sector contracting of clinical services provided by the private sector is captured under public financing and private provision, whilst private financing and public provision may refer to insurance schemes purchasing care provided in public hospitals.

**Figure 1: Public and Private Roles in Financing and Provision (adapted from Bennett and Ngalande-Banda, 1994:3)**

		FINANCING		
		PUBLIC	PRIVATE	
P R O V I S I O N		(public financing & public provision – traditional public sector role)	(private financing & public provision)	P U B L I C
		(Public financing & private provision)	(Private financing & private provision)	P R I V A T E

Thus, one is able to use this framework to understand PPIs with respect to the financing and provision of clinical and non-clinical services. Internationally, the most documented form of PPI is that of contracting out of clinical and non-clinical services (Robinson, 1994; Jackson, 1994; Ngalande-Banda, 1996; Bennett et al 1997; Jeffers 1997; Mills, 1997; Buse and Walt 2000; Palmer, 2000). For instance Bhatia and Mills (1997) provide a review of the range of varying functions that may occur in the contracting of catering – a support service. These range from services provided by private firms within public facilities to those using private infrastructure outside public facilities. With non-clinical contracting, clinical services remain the responsibility of the public

sector and non-clinical services in support of service delivery are provided by the private sector. These services may include catering, portering, security, gardening and laundry services.

The experience of contracting out clinical services in the developing world is limited. Interesting examples are the experiences in Thailand (Tangcharoansathien et al 1997) and Lebanon (Smith et al, 2001). In Thailand public sector hospitals have contracts with the private sector to provide and maintain expensive medical technology. Public clinicians use the technology, and the private firm is paid a proportion of the user charges paid by patients to the public hospital. In Lebanon the government contracts with private hospitals to set aside space for public patients (Smith et al, 2001). This relationship follows a simple public-purchaser/private provider model, but has led to escalating costs and increasing demands by the private sector for greater investment in the sector. However, evidence of contracting with the for-profit sector for clinical service delivery in the developing world is limited.

The health sector in developing countries has greater PPI experience with Non-Governmental Organisations (NGOs) than with the for-profit private sector. In developing countries there is vast experience of simple contracting between governments and NGOs often in relation to providing district level services (Smith et al, 2001). The vast majority of experience is in Sub-Saharan Africa, but it is not confined to this region. Cambodia, for instance, has started piloting the contracting out of district level services to NGOs (Smith et al 2001). NGO activity ranges from direct service provision to welfare activities to training support to the supply of drugs (Gilson et al, 1994). Although NGOs may receive international support from private foundations, churches, multi- and bi-lateral agencies, governments provide support through subsidies, drug and equipment donations and staff secondment (Gilson et al, 1994). One should note that health care provision by NGOs is not unique to the developing world. For instance, in the United Kingdom, according to Jackson (1994) voluntary and charitable hospitals may be increasingly expected to engage in ventures with the National Health Service (NHS).

Contracting of clinical services is more common in high-income countries where capacity exists in the public sector to monitor performance and outputs of clinical care contracts. Another important factor is that of the public sector's ability to finance the private provision of clinical care. For instance, several developed countries like the United Kingdom (Le Grand 1993; Berman 1995, Jackson 1994), New Zealand (Howden-Chapman et al 2000; Hopkins et al 2001) and Sweden (Harrison et al, 2000) contract private providers to provide primary health care. With payment to private providers there is a clear separation between purchasing and provision of services. In the federal system of the United States state governments may contract with private providers and Health Maintenance Organisations (HMOs) as primary care providers. It is not unusual to contract selected services as does Atlantic City for TB, STD and food-borne diseases (Wall, 1998).

Contracting out falls under the umbrella of Public Private Partnerships (PPPs) and is the simplest form of partnership. *Public-Private Partnerships* (PPPs)

entail clear guidelines on the procedures to follow that govern the relationships between the public and private sectors (Ott et al, 1991; Robinson, 1994). These include PPPs such the *Private Finance Initiative* (PFI). In the health sector PFI or *joint capital projects* (Jackson, 1994) are increasingly common in some countries. The most cited experience is that of the United Kingdom with the National Health Service's (NHS) attempts to upgrade and build facilities (Gaffney et al, 1999). The PFI is a type of concession agreement in which the private sector is allowed to build, upgrade and equip NHS hospitals and primary health care facilities. These arrangements are referred to as *design, build and finance* (DBF) or *design, build, finance and operate* (DBFO) schemes (Ruane, 2000). The latter scheme includes the provision of services like maintenance, portering, cleaning and catering. The government, however, has retained its role in providing clinical services. What makes the PFI different from a *concession* in the true sense is that the public sector has a management contract with the private institution in which the government pays the private institution a fee. With a *concession* the private party delivers a service and collects revenue through user charges. It is important to note the language of concessions is more common in the non-health sector. With PFI the private party delivers a service and raises revenue from payment by the public sector.

Emerging from the language of concessions is the concept of *LOO* (lease, own and operate). *LOO* schemes are linked to the notion of leasing existing spare public sector capacity to the private sector. An example of a *LOO* scheme is that of the private sector leasing wards in public sector hospitals, in which the private sector 'adopts' (Sharma et al, 2001) wards. The private sector owns the ward and operates it by providing services to private patients. Costs are recovered by charging users, whilst paying the public sector to allow it to render its private service. Although this form of interaction raises possibilities for PPIs the experience of this PPI type is limited internationally.

Finally, there are always relationships between the public sector and the private individual seeking healthcare. These interactions occur on a daily basis with private patients paying user charges for publicly provided or publicly subsidised private health care delivery.

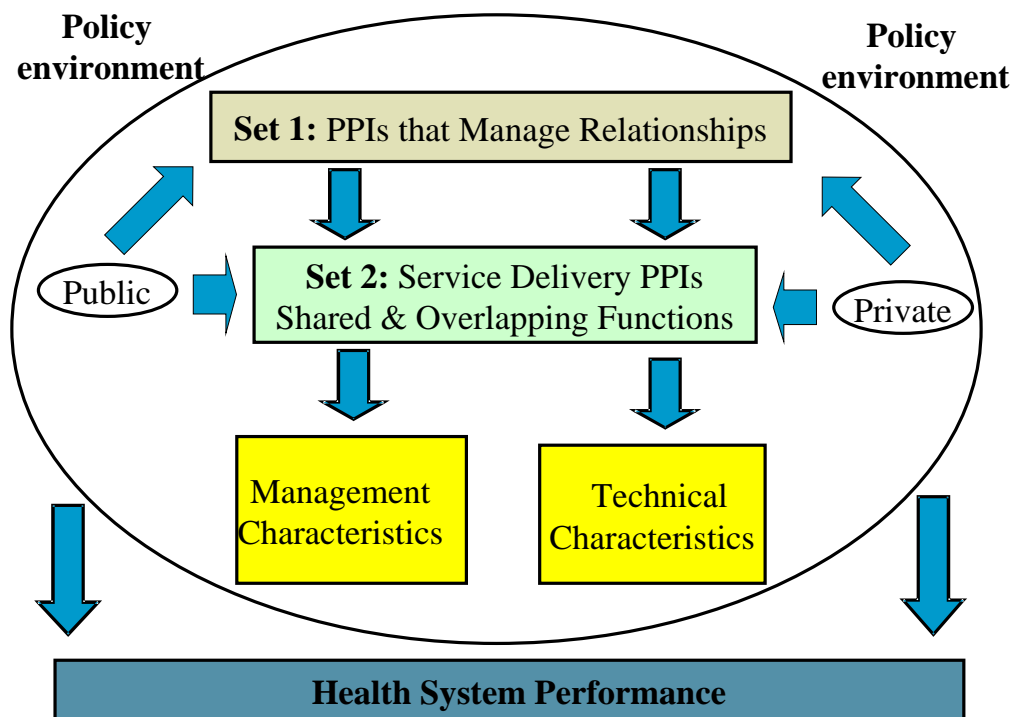
#### 4. A CONCEPTUAL FRAMEWORK FOR UNDERSTANDING PPIs IN SOUTH AFRICA

The public-private/financing-provision framework (Figure 1) used in assessing public and private roles with respect to financing and provision has its clear strengths. It provides a simple means of capturing the respective functions of the public and private sectors by locating these functions within a defined set of alternatives. Nonetheless, the framework does have its limitations.

Figure 1 does not allow one to capture the full complexity of relationships between the public and private sectors, which involve the overlapping and sharing of functions with respect to financing and provision. By studying the functioning of PPIs in South Africa it has emerged that there may be relationships in which the financing function cannot be solely attributable to one or the other sector. The private sector may raise capital financing to meet infrastructure requirements, whilst the public sector runs an operational budget to provide clinical services. Likewise, with provision all or a few clinical and support services may be provided by either sector. For instance management and catering may be provided by the public sector whilst security and laundry services are provided by the private sector. Furthermore figure 1 does not fully consider the notion of *ownership*, a notion fundamental to property rights. Property rights are those rights to use an asset, derive income there from and to transfer resources or assets to another party (Foss, 1995). Private ownership may have an intrinsic effect by providing appropriate incentives to the service providers. Whereas the lack of property rights in the public sector leads to inadequate incentives for efficient behaviour (Bennett et al, 1997). For the private sector, the legal proprietorship that comes with ownership creates an environment attractive to potential private investors, as it creates revenue-generating possibilities and ensures greater control whilst reducing the uncertainty associated with non-ownership. For the public sector ownership provides the state with the assets required to ensure that the benefits of asset control are transferred to the beneficiaries or public sector dependants, whilst reducing uncertainty in the public sector's ability to provide services efficiently and equitably.

Figure 2 therefore attempts to provide an expanded framework to consider the complexity of the relationships that may exist between the public and private sectors. It builds on figure 1 by considering the *policy environment* in which PPIs are taking place. Figure 2 attempts to go beyond the relationships of financing and provision by considering those relationships that may facilitate financing and provision relationships between the sectors. Furthermore it considers the blurred boundaries that may exist between both financing and provision by the public and private sectors.

**Figure 2: Functions of the public and private sectors in relation to health sector service delivery**



It is useful to provide an overview of each of the components of figure 2.

- The *policy environment considers*: the context in which PPIs are taking place; the key stakeholders, the role they play and what their objectives may be in relation to each other; the evolution of PPI development internationally and nationally as well as the processes that allow for PPI policy development.
- There are two different sets of PPIs that have been identified and highlighted within the framework – *PPIs that manage relationships* and *service delivery PPIs*.
- *PPIs that manage relationships* consider both the formal and informal dialogue that exists in facilitating the development and implementation of PPIs.
- *Service delivery PPIs* allow one to capture the overlapping of functions with respect to both financing and provision, whilst unpacking the complex nature of shared functions. This is achieved by distinguishing between the *management* and the *technical characteristics* of PPIs.
- The *management characteristics* consider the level of management, the service of focus and the private sector agent. For an overview of the management characteristics see Table 2.

**Table 2: Management Characteristics of PPIs**

<b>Management Characteristics</b>	<b>Key Features</b>
Level of management	National, provincial, local and facility
Service of focus	Clinical and/or non-clinical; Hospital and/or clinic service.
Private agent	Private funder, hospital group, non-clinical service provider, private clinician.

- The *technical characteristics* assist in identifying respective functions with respect to capital/recurrent financing, capital ownership, healthcare provider and the demand decision-maker<sup>1</sup>. For an overview of these characteristics see Table 3.

**Table 3: Technical Characteristics of PPIs**

<b>Technical Characteristics</b>	<b>Key Features</b>
Capital/Recurrent Financing	These functions are often not clear-cut and boundaries between functions are often blurred, with overlapping and/or sharing of financing between the sectors.
Capital Ownership	Boundaries of ownership may be blurred, with overlapping and/or sharing of ownership between sectors
Healthcare Provider	May be public and/or private
Demand Decision-Maker	The agent/individual responsible for purchasing clinical care. Could be government, individual payer or insurance/medical aid scheme.

Figure 2 also allows one to understand the complexity of risk transfer by highlighting the potential for risk transfer between the sectors. For instance, when upgrading facilities in the public health sector the government may wish to transfer the risk of raising capital finance for upgrading facilities to the private sector. The public sector may also want the private sector to bear the risk of maintaining the upgraded structures, whilst the public sector bears the risks associated with providing clinical services. That is, the public sector remains accountable to the population served should quality of care deteriorate for instance.

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<sup>1</sup> The phrase demand decision-maker has been used to explore public-private relations in health care in the United Kingdom. It has been used in a recent King's Fund publication (Keen et al, 2001)

## 5. WHAT'S HAPPENING ON PPIS IN SOUTH AFRICA?

Table 4: The South African Policy Context – Key milestones

Date	National Health	National Treasury	Provincial Health	Local Government	Other developments
Pre-1994	<ul style="list-style-type: none"> <li>1940s: Expansion of mission hospitals</li> <li>1970s: nationalisation of 'homeland' mission hospitals-</li> <li>recent decades: State-Aided Hospitals, SANTA, LIFECARE</li> <li>contracting of non-clinical services varied</li> </ul>		<ul style="list-style-type: none"> <li>recent decades: State-Aided Hospitals, SANTA, LIFECARE</li> <li>Part-time District Surgeons</li> <li>contracting of non-clinical services varied</li> </ul>	<ul style="list-style-type: none"> <li>contracting of non-clinical services varied</li> </ul>	<ul style="list-style-type: none"> <li>1992: Queenstown water &amp; sanitation</li> <li>1992: Benoni Fire and Emergency services</li> <li>1993: Springs bus service</li> </ul>
1994	<ul style="list-style-type: none"> <li>May: ANC Health Plan Published</li> </ul>				<ul style="list-style-type: none"> <li>April: General Elections</li> </ul>
1995	<ul style="list-style-type: none"> <li>Jan: Committee of Inquiry into SHI</li> </ul>		<ul style="list-style-type: none"> <li>Public-Private Forum set up in Free State</li> </ul>	<ul style="list-style-type: none"> <li>Nov: LG elections</li> </ul>	
1996	<ul style="list-style-type: none"> <li>Medical Schemes Working Group established</li> </ul>	<ul style="list-style-type: none"> <li>June: GEAR Published</li> </ul>	<ul style="list-style-type: none"> <li>April: Uitenhague hospital PPP (EC)</li> </ul>	<ul style="list-style-type: none"> <li>May: LG elections in WC and KZN</li> </ul>	<ul style="list-style-type: none"> <li>May: Final Constitution</li> <li>December: N4 toll road concession awarded</li> </ul>
1997	<ul style="list-style-type: none"> <li>April: Health White Paper</li> <li>Medical Schemes Working Group discussion concluded</li> </ul>		<ul style="list-style-type: none"> <li>June: Northern Province PPP policy document</li> </ul>		
1998	<ul style="list-style-type: none"> <li>Medical Schemes Regulation Act promulgated</li> <li>June – PPP conference in Eastern Cape organised by <i>The Equity Project (Management Sciences for Health)</i></li> </ul>		<ul style="list-style-type: none"> <li>April: EC PPP policy document</li> <li>August: WC PPP policy document</li> </ul>	<ul style="list-style-type: none"> <li>March; White Paper on Local Government</li> <li>Dec: LG Municipal Structures Act</li> </ul>	

1999	<ul style="list-style-type: none"> <li>• NDOH PPP task team established.</li> <li>• April: Draft National PPP policy document</li> <li>• November: National PPP conference</li> </ul>	<ul style="list-style-type: none"> <li>• March: PFMA</li> <li>• December: PPP strategic framework endorsed by cabinet</li> </ul>		<ul style="list-style-type: none"> <li>• May: Green Paper on Municipal Service Partnerships</li> </ul>	<ul style="list-style-type: none"> <li>• Dolphin Coast water services contract signed</li> <li>• KZN)Nelspruit water services contract</li> <li>• May: N3 toll road concession awarded</li> </ul>
2000	<ul style="list-style-type: none"> <li>• November: Final National PPP policy document</li> </ul>	<ul style="list-style-type: none"> <li>• April: PFMA regulations, chapter 16 on PPPs (strategic framework and general guidelines)</li> <li>• July: PPP Unit set up</li> <li>• Sept: PPP detailed guidelines</li> </ul>	<ul style="list-style-type: none"> <li>• June: PPP Forum set up in WC.</li> </ul>	<ul style="list-style-type: none"> <li>• April: White Paper on Municipal Service Partnerships</li> <li>• July: Municipal Finance Management Bill</li> <li>• Nov: LG Municipal Systems Act</li> <li>• Dec: LG elections</li> </ul>	<ul style="list-style-type: none"> <li>• March: Bloemfontein prison concession</li> <li>• May: Commercialisation programme of SA National Parks Announced</li> <li>• August: Louis Trichardt prison concession</li> </ul>
2001	<ul style="list-style-type: none"> <li>• National PPI Working Group established</li> <li>• November: Summit PPI document</li> <li>• National Health Bill gazetted</li> <li>• November: National Health Summit – PPI session</li> </ul>	<ul style="list-style-type: none"> <li>• January: PPP manual volume 1</li> <li>• May: PPP manual volume 2</li> </ul>	<ul style="list-style-type: none"> <li>• Jan: RFP for Nkosi Albert Luthuli (KZN)</li> <li>• Feb: RFP for Universitas &amp; Pelonomi co-location (FS)</li> <li>• FS PPP forum re-established.</li> <li>• Hospital co-location feasibility studies (EC and WC)</li> <li>• Dec: Nkosi Albert Luthuli contract signed</li> </ul>		<ul style="list-style-type: none"> <li>• November: Fleet management contract signed (NC)</li> <li>• Dec: ecotourism project contract signed (Limpopo)</li> </ul>
2002	<ul style="list-style-type: none"> <li>• PPI Lekgotla</li> <li>• September: Health Bill referred to State law advisors</li> </ul>	<ul style="list-style-type: none"> <li>• May: Revisions to PPP regulations</li> </ul>	<ul style="list-style-type: none"> <li>• July: Co-location contract signed (FS)</li> </ul>		

## 5.1 Key Milestones in National and Provincial Government

PPIs are not something new to South Africa. As far back as the 1940s there was an expansion of mission hospitals, and by the 1970s the former-homeland mission hospitals were nationalised. The South African public sector also has contracts with non-profit or state-aided hospitals, which received the bulk of their recurrent budget from public authorities (Broomberg et al, 1997). In recent decades there have been long-standing arrangements with both the for-profit and non-Governmental sectors. There have been state-aided hospitals, arrangements with the South African National Tuberculosis Association (SANTA) and contracts with for-profit providers such as Lifecare for Psychiatric, Tuberculosis and acute hospital care. Provincial Health Departments also entered into primary care PPIs through the Part-Time District Surgeon (PDS) System. There has also been extensive yet varying experience with outsourcing non-core services such as security in public sector health facilities. With this backdrop a useful starting point for engaging with PPI development in the South African health sector is April 1994, a key turning point in the South African political and health-system landscape.

Shortly after the April 1994 democratic elections in South Africa attempts were already underway to rebuild the health system. This culminated in the ANC Health Plan (ANC, 1994) a month later. The Health Plan envisioned a role for both private funders and providers with a vision of a National Health Insurance (NHI) fund, with medical schemes forming the basis of the fund (Gilson et al, 1999). This vision implicitly planted the seeds for PPI debates with a single-payer being the primary factor enabling greater interaction between the sectors with respect to service delivery. Despite many NHI/SHI debates no immediate conclusion was reached, and in January 1995 a Committee of Inquiry into Social Health Insurance (SHI) was established. The contracting of private practitioners was mentioned in the Committee of Inquiry report.

In 1997 *The White Paper on the Transformation of the Public Health System* (South Africa, 1997) was published. Although it failed to present a clear strategy on dealing with the private sector it did envisage a health system in which public and private (for-profit and non-profit) could be co-ordinated (Gilson et al, 1999). It was only 2 years later that the National Health Department would attempt to develop a coherent policy towards the private sector aimed at forging partnerships between the sectors. The National Health Department did not develop Public-Private Partnerships within a vacuum. It was influenced to an extent by developments happening at the provincial level. As far back as June 1997 the Northern Province had developed a policy document with respect to the private sector. This was followed in April 1998 by the Eastern Cape, and after a PPP conference in the Eastern Cape, by the Western Cape in August 1998. These documents influenced the thinking that emerged within the National Department, and by April 1999 a first draft of policy guidelines was drafted by a PPP task-team. The final version was only accepted in November 2000, over a year and a half later, by the Provincial Health Restructuring Committee (NDoH, 2000).

A key milestone occurred in March 1999 when National Treasury published the Public Finance Management Act (PFMA), which sought to improve public sector efficiency. This Act would prove to be important as it set forth the guidelines that managers had to follow with respect to financial accountability and enhanced efficiency. It was the PFMA that led to the development in December 1999 of a PPP strategic framework that was endorsed by cabinet. Within four months - by April 2000 - in line with PFMA regulations, PPPs were included along with both a strategic framework as well as general guidelines, which provincial departments had to adhere to with respect to PPPs. A few months later, in June 2000, a PPP unit was established in National Treasury to facilitate the process by supporting and approving provincial departments' PPP endeavours. Detailed PPP guidelines were drafted by September 2000 and the following year in January and June two PPP manuals had been published. The central elements of National Treasury PPP guidelines are the transfer of risk to the private sector, affordability and demonstrated value-for-money. By 2000 two prison concessions were awarded, one in the Free State and the other in Limpopo Province. The following year the Northern Cape signed a fleet management PPP and in Limpopo an ecotourism PPP was signed.

Although the National Health Department had drafted a PPP document 8 months before Treasury's PPP Strategic Framework reached cabinet approval, the final version accepted by PHRC came two months after Treasury's detailed guidelines. Although it may appear to be a short lapse it proved crucial as many of the proposals outlined in the National Health PPP document did not fit neatly with the guidelines laid out by Treasury. Furthermore, within less than 3 months of the Health PPP document approval by PHRC, the Kwazulu-Natal (KZN) and Free State (FS) health departments were already initiating PPPs adhering to the procedures set-up by Treasury's PPP guidelines. The KZN health department was initiating a Private Finance Initiative (PFI) to equip Nkosi Albert Luthuli Hospital in January 2001, and the FS health department embarked on a co-location programme for Universitas and Pelonomi Hospitals in Bloemfontein. The National Health Department PPP document did cover these sorts of arrangements, but fell short in that it failed to stipulate the clear procedural guidelines that provinces need to follow to bring PPPs to fruition. The Treasury guidelines filled this gap and the National Health Department had to try to develop a means of improving interactions with the private sector without limiting these to PPPs as outlined by Treasury. A strategy was therefore needed to incorporate the PHRC accepted framework with that of Treasury whilst at the same time including debate and investigation of other possible interactions that could not be limited to PPPs alone.

The limitations of the NDOH PPP document coupled with the low rating of the South African health system in the World Health Report (WHO, 2000) fast-tracked the establishment of a PPI Working Group in early 2001. By November 2001, at the National Health Summit, a PPI document drafted by the PPI Working Group was presented laying out the vision for the health sector. At the Summit PPIs were identified as a priority area leading to the

July 2002 PPI Lekgotla in which all the major stakeholders participated in a forum dedicated solely to PPIs. The Lekgotla included representation from National Health, National Treasury, Provincial Health Departments, local municipalities, private healthcare funders and private hospitals. Private funders had already made some ground in preparing for PPIs, a subject discussed at the Board of Healthcare Funders Conference 2 months prior to the Lekgotla.

## **5.2 Key Milestones in Local Government**

The Final Constitution was promulgated in May 1996 in which three spheres of government were officially recognised – National, Provincial and Local/Municipal. Local Governments have a lot more autonomy than provincial departments in that – apart from grants from the provinces – they are able to raise revenue through local property taxes. Local government is also responsible for collecting revenue for electricity, water and sanitation services from their constituency. Local government however has also been subject to regulatory guidance from National Government with respect to the Department of Provincial and Local Government as well as the Department of Constitutional Affairs. Local Government, it seems, appeared to be more proactive than provincial departments vis-à-vis public private partnerships. By 1997 the Municipal PPP pilot programme was initiated. In March the following year the Municipal Infrastructure Investment Unit (MIIU) was established. Early in 1999 two landmark water privatisation contracts were signed – one in Dolphin Coast and the other in Nelspruit.

Parallel legislative processes were underway in 1998. In March the White Paper on Local Government was gazetted followed in December by the Municipal Structures Act. The Municipal Structures Act was complemented by an agreement on municipal restructuring between the South African Local Government Association (SALGA) and municipal unions. By May 1999 the Green paper on municipal service partnerships was published and under a year later, in April 2000, became a White Paper. In July the local government version of the PFMA - the Municipal Finance Bill - was published. By November 2000 the Municipal Systems Act was promulgated. These legislative processes are vital to local government PPPs as they endorse partnerships with the private sector in order to meet infrastructure backlogs as well as to improve service delivery.

In terms of local government health services the Municipal Systems Act paved the way for the creation of three types of municipalities – A, B and C municipalities. A municipalities are the large metros and include Johannesburg, Cape Town and Durban. The B municipalities are those servicing larger towns such as East London and Bloemfontein. The C municipalities are called district municipalities, and many were newly-created with new boundaries. With respect to health services it is predominantly the A and B municipalities that were already providing some basic primary health care and environmental health services. The C municipalities are mainly responsible for environmental health services yet many have as yet not been able to establish health departments. The Municipal Systems Act therefore

provides the framework in which PPPs can take place at the local government level. It does not speak directly to health services, but health services can consider the role the private sector is to play in service delivery, either through financing or actual service provision. Unlike the PPI developments that are emerging at the National and Provincial level, the Municipal Systems Act has influenced interactions at the municipal or local government level. There has not been a unified approach by local government with respect to health-specific PPIs.

Table 5 summarises some basic information drawn from policy documents, using a categorisation of PPIs derived from the national DOH PPP Task Team document, dated 2000. The details of each broad category are discussed further in section 6.

In comparing different sets of policy documents, the Table highlights four key points:

- joint ventures and purchased services are PPI categories only discussed and promoted within the health sector, although partnerships with NGOs are also identified in general local government policy;
- the explicitly stated broad rationales of joint ventures and purchased services highlight the health sector's key focus on equity (covering community benefit in relation to joint ventures and greater access in relation to purchased services) as a guiding policy principle, and as distinct from the central efficiency and sustainability concerns of the Treasury guidelines (e.g. value for money, affordability);
- outsourcing of non-clinical services is widely discussed and promoted in health and broader policy development, and with similar rationales;
- whilst PFI arrangements (or Treasury PPPs) are recognized in health sector policy documentation it is perhaps more widely identified outside the health sector.

**Table 5: Categories of PPIs derived from the document review**

<b>Category</b>	<b>Broad rationale (for health derived from NDOH 2000)</b>	<b>Documents in which discussed</b>
<p><b>1) JOINT VENTURES</b> Includes co-location, sharing of under-used resources (in either public or private sector), leasing spare capacity to private sector as well as using private health finance to support public sector delivery, e.g. preferred provider contracts with medical aid schemes, also associated with differentiated amenities</p>	<p>Develop to secure higher quality services or lower costs, public sector revenue and 'community benefit' e.g. better access for disadvantaged, personnel retention, new models of customer service</p>	<p><u>Health:</u> NDOH 2000; NDOH 2001; ECDOH 1998; DOH Health Sector Strategic Framework 1999-2004 Moorman 2001</p>
<p><b>2) PURCHASED SERVICES</b> includes outsourcing clinical services, establishing contracts with Independent Practitioner Associations, promoting private provision of priority public health services, partnerships with NGOs and CBOs</p>	<p>Develop with NGOs/ CBOs either because government does not have capacity to provide service or because leads to greater access or quality of care; Develop with private provider for specialized service when no alternative available</p>	<p><u>Health:</u> NDOH PPP task team 2000 NDOH 2001 ECDOH 1998 Moorman 2001</p> <p><u>Non-Health:</u> White Paper on Local Government (NGO partnerships only)</p>
<p><b>3) OUTSOURCING NON-CLINICAL SERVICES</b> (of various types)</p> <p>Including, non-health: Operations &amp; maintenance contracts (3-5 years) Operations &amp; maintenance contracts with renting of assets (8-15 years)</p>	<p><u>Health:</u> Develop to secure reduced cost or improved access/quality of care</p> <p><u>Non-health: e.g.</u> To get economies of scale and efficient use of specialist expertise and experience, but need to maintain quality through tender and monitoring procedures (Local Government White Paper)</p>	<p><u>Health:</u> NDOH PPP task team 2000 DOH Health Sector Strategic Framework 1999-2004 ECDOH 1998 NDOH 2001</p> <p><u>Non-Health:</u> Dept Constitutional Development DBSA 2000 White paper on Local Govt</p>
<p><b>4) PRIVATE FINANCE INITIATIVE/PPPs</b></p> <p>Including leases and concessions</p>	<p><u>Health:</u> develop to provide capital funding that public sector cannot afford, with (following Treasury guidelines) clear benefits to patients, value for money, affordability, savings to health care purchasers, good management (risk central to these arrangements)</p> <p><u>Non-health: e.g.</u> To exploit economies of scale and improve coordination at point of service delivery; and, for large scale capital investment, to transfer risk in return for responsibility for revenue generation (Local Government White Paper)</p>	<p><u>Health:</u> NDOH 2000 NDOH 2001 NDOH Health Sector Strategic Framework 1999-2004</p> <p><u>Non-Health:</u> Treasury Regulations 1999 White Paper on Local Govt Dept Constitutional Development DBSA 2000</p>
<p><b>5) OTHER</b> e.g. Public subsidisation of private services e.g. Ownership transfer</p>		<p><u>Health:</u> NDOH 2001 <u>Non-Health:</u> White paper on Local Govt</p>

## 6. MAPPING PPIs

In mapping health sector PPIs the conceptual framework (figure 2) highlighting shared functions and key agent will be applied. This framework will be used to provide a qualitative exploration of the range of South African health sector PPIs. It therefore seeks to map the types of PPIs that are underway and emerging, without actually providing a head-count of the numbers of PPIs. It will therefore attempt to unravel the complex nature of health sector PPIs. Interview analysis, documentary review, and the national survey have provided a means with which to categorise PPIs using a qualitative approach. The national survey aimed at providing a comprehensive mapping of PPIs in the country, but due to a low response rate it was only possible to undertake a qualitative analysis of the data collected. Different survey designs were used for provinces and local government and samples of the Provincial and A Municipality questionnaires are provided in Annex 1.

There are two broad sets of PPIs that have emerged from the analysis. The first set deals with PPIs that facilitate dialogue between the public and private sectors, and this set is referred to as “managing relationships”. Within “managing relationships” key categories that have been identified are:

- Formal dialogue
- Informal dialogue
- Policy
- Patient transfer protocols/procedures

The second set “PPIs supporting service delivery” touches more closely on those PPIs that pertain directly to actual delivery of health services. The key categories emerging have been:

- Purchased Services
- Outsourced Non-Clinical Services
- Joint Ventures
- Private Finance Initiatives (PFIs)
- Public-Private Partnerships (PPPs)
- Other

Table 6 provides an overview of the objectives of health sector PPIs by category, drawn from interview, survey and documentary data.

**Table 6: Overview of health sector PPI objectives**

<b>Category</b>	<b>Objective/s</b>	<b>Sources</b>
<i>Set 1: PPIs that manage relationships</i>		
Formal dialogue	<ul style="list-style-type: none"> <li>Facilitating discussion between the sectors</li> <li>Building trust</li> <li>Initiating service delivery PPIs</li> </ul>	<ul style="list-style-type: none"> <li>Interview data</li> </ul>
Informal dialogue	<ul style="list-style-type: none"> <li>Facilitating discussion between the sectors</li> <li>Building trust</li> <li>Initiating service delivery PPIs</li> </ul>	<ul style="list-style-type: none"> <li>Interview data</li> </ul>
Policy	<ul style="list-style-type: none"> <li>Facilitating discussion between the sectors</li> </ul>	<ul style="list-style-type: none"> <li>Interview data</li> </ul>
Patient transfer policy/protocols	<ul style="list-style-type: none"> <li>Avoiding conflict of interest between the sectors</li> </ul>	<ul style="list-style-type: none"> <li>Interview data</li> </ul>
<i>Set 2: Service delivery PPIs</i>		
Purchased services	<ul style="list-style-type: none"> <li>Improve access</li> <li>Improve quality of care</li> <li>Improve service delivery in areas of need</li> <li>Promote public health role of private practitioners.</li> <li>Tapping into external expertise</li> </ul>	NDOH (2000), NDOH (2001), ECDOH (1998), Moorman (2001), White Paper on Local Government, interview data, survey data.
Outsourced Non-Clinical Services	<ul style="list-style-type: none"> <li>Reduce costs</li> <li>Improved access</li> <li>Improved quality of care</li> <li>Shifting risk of capital investment to private sector.</li> </ul>	NDOH(1999), NDOH (2000), NDOH (2001), ECDOH, Dept of Constitutional Development (??), DBSA (2000), White Paper on Local Government, Interview data, survey data.
Joint-Ventures	<ul style="list-style-type: none"> <li>Higher quality services</li> <li>Lower costs</li> <li>Revenue generation</li> <li>Improved access</li> <li>Improved efficiency via improved resource use</li> </ul>	NDOH (1999), NDOH (2000), NDOH (2001), ECDOH (1998), Moorman (2001), Interview data, survey data.
PFI's	<ul style="list-style-type: none"> <li>Access to private sector finance and expertise</li> <li>Value-for-money</li> <li>Affordability</li> <li>Savings to health care purchasers</li> <li>Improved management</li> <li>Addressing infrastructure backlogs</li> </ul>	NDOH (1999), NDOH (2000), NDOH (2001), National Treasury (1999), interview data.
PPPs	<ul style="list-style-type: none"> <li>Risk transfer to private sector</li> <li>Affordability</li> <li>Value-for-money</li> <li>Improved economies of scale</li> <li>Improved service delivery</li> </ul>	National Treasury (1999), White Paper on Local Government, Department of Constitutional Development (?), DBSA (2000), Interview data.
Other <ul style="list-style-type: none"> <li>Tax relief and Asset Swap</li> </ul>	<ul style="list-style-type: none"> <li>Improve access</li> <li>Addressing infrastructure backlogs</li> </ul>	NDOH (2001), White Paper on Local Government

## **6.1. Set 1: Managing Relationships**

### **Formal dialogue**

Across the interviews the largest number of examples raised about PPIs for managing relationships spoke to mechanisms of formal dialogue raised by both sectors. The most notable one is that of the Public-Private Forums that have evolved in the Free State and the Western Cape. Out of the PPI Lekgotla the Western Cape was seen positively as an example other provinces could follow. These forums involve regular meetings between key stakeholders in the provincial public and private health sectors in which issues are brought onto the table and discussed. These issues can often be specific such as discussion on transfer protocols or information sharing, whereas at times it can be diverse with the odd presentation by an external speaker about work undertaken. For instance in once WC Forum a University of Stellenbosch researcher presented work on a comparative costing study between public and private facilities (interview material). Another important aspect of formal dialogue is that which takes place at national level. The PPI Working Group also provides a formal platform for actors to discuss pertinent PPI issues and to get involved closely in supporting the NDOH in finalising policy around PPIs. The PPI Working Group was set up by the NDOH and includes interested stakeholders. It is important to note that the PPI Working Group fed into and supported both the Health Summit and PPI Lekgotla processes. Although not a truly representative body, it continues to have discussion after the National Health Summit.

### **Informal Dialogue**

The role of informal dialogue was raised in a number of interviews in both sectors. These refer to the odd telephone call or request by one or the other party for assistance or information.

### **Policy**

Policy debates around SHI, Uniform Patient Fee Schedule (UPFS), pharmaceutical pricing, organ transplants and RWOPS are among the various policies cited that enable interaction between the public and private sectors.

### **Patient Transfer Protocols/Procedures**

Another area of managing relationships is that of 'patient transfer protocols/procedures. These are seen as an important mechanism for managing relationships between the sectors. Gauteng, KZN and WC have been quite proactive in ensuring that these protocols be put in place and effectively administered so as to avoid conflict of interest between the sectors with respect to insured patients whose benefits have run-out in a private facility (interview data).

### **Caveat**

*The categories used to capture PPIs that manage relationships are not mutually exclusive. For instance, informal dialogue is partly a product of the relationships built on in the formal dialogue. For instance, a private hospital representative has been able to interact more informally with senior health officials as a result of the formal processes like the PPI Working Group and the Lekgotla. These formal processes have thus facilitated the ease with which key actors can engage in fruitful informal dialogue. Through formal processes for instance, the private hospital representatives as well as the private funders have been able to engage more freely with senior health policymakers around information and perhaps collaborating more formally on a comparative costing study. In other words the formal dialogue feeds into the informal and vice-versa.*

## **6.2. Set 2: PPIs Supporting Service Delivery**

### **6.2.1 Purchased Services**

“Purchased services’ is used to refer to the public sector purchase of private clinical services. These ‘purchased services’ were the major PPIs identified in interview and documentary data. Purchased services can take the form of outsourcing clinical care with both for-profit and non-profit organisations and/or individuals. Contracts with for-profit firms such as Lifecare for Psychiatric and Tuberculosis care and with private individuals such as the PDS system fall into this category. Further examples include radiology/pathology with renal treatment emerging as a possible option (Moorman, 2001). Private hospital representatives specifically raised the potential for contracting out of acute care management within public hospitals, as well as the provision of specific interventions such as hip replacements (Interview data).

Another interesting example is the involvement of the private sector in areas identified as major public health priorities. These areas may include STI management, family planning and immunisation (NDOH, 2001) This is followed by various arrangements with NGOs, and includes contracts with NGOs such as SANTA as well as those NGOs providing home-based care for AIDS treatment. Arrangements with NGOs have been identified at both the provincial and local government level, although with local government it is more common amongst the “A” municipalities, that is, the metros. Although some informants have noted long-running contracts with state-aided hospitals, this did not emerge as a key category identified across interviews (interview data). The third most common form of purchased services is those interactions with private practitioners – doctors and nurses – contracted on a session basis. This also applies to those private providers who are able to render a service in the absence of specialist services in the public sector (NDOH, 2000). These arrangements do take place at the provincial level, but have been identified as an important component of service delivery by local municipalities. Local government is also more amenable to outsourcing

clinical services than non-clinical services than the province, as local government runs few or no hospitals.

### **6.2.2. Outsourced non-clinical services**

After “purchased services” this form of PPI was raised as a key issue across interview and documentary data. As mentioned earlier local government supports few non-core outsourcing activities as it runs little or no hospitals or clinics. Provinces, however, have extensive experience with the outsourcing of non-core services. There is no uniform policy across the country, and what provinces seek to outsource differs from province to province. For instance KZN has made a concerted attempt to outsource catering across around the province (interview material) whereas in Gauteng there is a mix of in-house and outsourced catering.

Another potential form of outsourcing is the actual outsourcing of the entire management to a private agent. Although debated in the Eastern Cape this has taken the form of a management contract in which private management consultants provide mentoring support to public sector management (interview data). What is emerging though is the employment of ‘transaction advisors’ to manage the PPP process between provinces, National Treasury and the private financiers and/or providers. This form of management contract is likely to gain momentum as more provinces embark on PPPs requiring Treasury approval.

Another important emerging example of outsourcing is that of operations and maintenance contracts. These interactions involve contracting a private agent to provide maintenance support for facilities and equipment. These can take on two dimensions. The first dimension is a contract linked to the lease of equipment from a private agent. The second is a contract linked to a specialist private (not necessarily the agent from which the equipment is leased or purchased) agent with the sole aim of maintaining equipment/facilities as and when needed. This is somewhat different from conventional outsourcing, as it bears directly on clinical outcomes. These contracts often involve the maintenance of hi-tech expensive medical equipment and information technology systems. Important dimensions include facilities maintenance, but these can sometimes overlap with the non-core services such as catering, portering, security, ground maintenance and laundry as is the case of the Nkosi Albert Luthuli PFI. The PFI will be discussed later as the way in which it is financed is somewhat different from the traditional management contract.

### **6.2.3. Joint Ventures**

Joint ventures refer to arrangements in which the public and private sectors share resources predominantly on a lease or service basis (NDOH, 2000). With the lease model the state leases space to the private sector or vice versa. With the service model space and/or services are provided for private patients but serviced by the public sector. Likewise the private sector may be

entitled to use public sector space and equipment for private patients, in return providing services to public patients. Typical emerging arrangements are those like hospital co-location, with the potential thereof being explored in the Eastern Cape, Western Cape and the Free State. Co-location can refer either to the leasing of spare capacity to the private sector (NDOH, 2001) or sharing under-used public or private resources. This can materialise by allowing private doctors, for instance, to use public capacity to treat private patients in return for free sessions, perhaps even in return for a facility upgrade (ECDOH, 1998). Another example of sharing resources is that of a private radiology group using state facilities in return for payment of variable costs as well as the provision of a radiographer to serve public patients (ECDOH, 1998). Another such example is that of the clothing industry clinics in the Western Cape using public facilities for X-rays and laboratory tests in return for payment of variable costs (personal communication, industry clinic doctor). Another form of potential joint venture is that between public providers and private financing. Examples include preferred provider contracts with medical aid schemes (NDOH, 2001), drawing private finance to support public service delivery through Social Health Insurance (SHI) and differentiated amenities. Differentiated amenities is an interesting case in point in that it seeks to raise revenue for the public sector through the creation of hotel facilities to attract predominantly medical aid patients as well as, to a limited extent, private individuals who are able to pay for fees. Differentiated amenities seeks to address the emerging debates and discussions with private funders keen to market low-cost health insurance packages, for quality public sector hospital services. Another example of the private sector purchasing public sector services is that of specialist care in tertiary hospitals (Moorman, 2001), for instance transplants, procedures that are too costly in the private sector. This type of joint venture is essentially the service model with private funding purchasing a publicly-provided service.

Joint ventures, however, need not always refer to areas of clinical service delivery. They could also refer to areas involving human resource development and human resource policy especially with respect to the retention of skilled staff in the public sector. Such arrangements refer to 'Remunerated Work Outside the Public Sector' (RWOPS), which provide guidelines allowing public providers the opportunity to earn additional income, hence strengthening the incentive to remain with the public sector. This form of PPI lays the foundation for the human resource needs for arrangements such as differentiated amenities in which specialist skills can be retained within the public sector. This is essentially a twist on the service model of 'joint venture', in that by remaining within the public sector specialists are allowed then to treat private patients in public differentiated amenities. Therefore instead of using public facilities to render services to private patients and providing additional services to the public sector in return, the core function is providing services to public patients and hence being allowed, in addition, to see private patients in public facilities.

#### **6.2.4. Private Finance Initiatives (PFIs)**

The Private Finance Initiative (PFI) has become quite prominent in both national and provincial level discussions, and to a limited extent in local government (survey data). Being a different sphere of government, beyond the jurisdiction of National Treasury, local government is not compelled to follow Treasury's PPP guidelines when embarking on a PFI. The evidence is limited, but preliminary data suggests that local government perspectives of what PFI is differs markedly from that espoused by Treasury. From the survey data the local government planning on embarking on a PFI is actually embarking on a project that involves no contract with a private agent over a lengthy time period. It merely refers to raising capital through private donations to build a facility. PFI, on the other hand, involves raising capital on private money markets. Nkosi Albert Luthuli Hospital in KZN has embarked on the first health-PFI in the country, and subsequently the KZN health department is planning to embark on a few more (interview data). PFI has also been planned by the Gauteng Health Department to revitalise Chris Hani Baragwanath, and has featured in policymaker and management thinking at both the province and facility level (interview data). National DOH has also raised PFI as a means of addressing infrastructure requirements (NDOH, 2000), as does National Treasury (1999). PFI can essentially take on 2 dimensions. It can be used to build new facilities or revitalise existing ones, and it can also be used to equip facilities with the latest high-tech medical and non-medical technology. In the case of the Nkosi Albert Luthuli PFI it is the latter, whereas the former has featured in thinking in both Gauteng and KZN to revitalise and rebuild facilities such as Chris Hani Baragwanath and King Edward respectively.

#### **6.2.5. Other**

A PPI that is being planned and discussed is unfolding in the Western Cape, and essentially involves the private non-health sector. This involves an interaction referred to as "asset swap" in which private investors – not necessarily health-related – are offered prime property owned by the province. In return investors are required to build, upgrade and equip facilities in areas where there is a perceived need for services (interview material). Unlike the PFI where the public sector enters into a contract with a private agent for a 15-30 year period, the swap is once-off and does not require the public sector to lay out capital expenditure immediately or deferred over the contract period.

Another interaction that is not new, but one identified in interview and documentary data is that of public subsidies to the private. This usually manifests itself in terms of tax breaks to employers providing medical-aid coverage to employees in both the private and public sectors.

The media analysis was not included in the overall mapping analysis, as the media analysis uncovered PPIs that were not identified in the interview, documentary and survey data. The media analysis highlighted predominantly debates around the impact of the HIV/AIDS epidemic and the addressing

questions around the affordability, distribution and provision of antiretrovirals. PPIs dealing with these issue are mainly concerned with making drugs more affordable and broadening access, making HIV test kits available and developing partnerships around counselling. These PPIs range from PPIs managing relationships to actual service delivery PPIs such as 'joint-ventures' with respect to reduced prices for anti-retrovirals and HIV test kits.

### 6.3. Analysing the complexity of PPIs

In order to analyse the complex nature of PPIs it is useful to analyse them according to the *management* and *technical* characteristics. This allows one to better understand how the respective roles of the public and private sectors unfold, providing an insight into the nature of the interaction/s shaping the range of relationships that may exist and/or that may unfold.

#### 6.3.1 Analysis of PPIs by management characteristics

Table 7 uses a set of 'management characteristics' to map the range of PPIs identified through interviews and questionnaires. The PPIs identified through the media analysis are excluded from this table because there was inadequate information with which to categorise them. The PPIs are listed in the table using the broad PPI categories of the 2000 NDOH PPP Task Team document.

The table shows that the **local government** is primarily involved in the management of purchased service arrangements, as well as undertaking some non-clinical outsourcing (with more planned). It has little involvement in joint ventures or PFIs (although some are planned). The *purchased services* being managed by local government are, primarily, linked to individual providers, clinical support services (radiology, pathology) and home based palliative care, and so involve interaction with a range of for-profit specialist clinical providers as well as NGOs. In terms of *non-clinical outsourcing*, local government are involved in a diverse set of PPIs interacting with specialist companies but tends to focus on non-clinical services linked to primary care as it does not have responsibility for hospital care.

**Provincial DOHs and facility management** are also involved in purchased service arrangements and, unlike local government, have some contracts with private hospital companies to support hospital level clinical care. These management levels also engage in a wide range of non-clinical outsourcing contracts. They are the dominant groups involved in *joint ventures*, which cover a wide range of services but are mostly linked to hospital care. The private agents involved in these PPIs are quite diverse, including hospital companies, private funders and specialist companies. *PFIs* are also managed at the PDOH/facility level, although with considerable national back-up, focus exclusively on non-clinical services (and currently include only a few construction projects) and involve interaction with specialist companies.

Overall, therefore, despite limited consideration within current national (Health and Treasury) policy frameworks, local government is involved in quite a wide range of PPIs with a diverse range of private agents. The PDOH and facility management levels are the dominant managers of joint ventures, PFIs and other PPIs. Finally, it appears that most PPPs identified focus on1y on hospital and specialist care, with little consideration of primary care.

**Table 7: Mapping PPIs by management characteristics**

	<i>Management level</i>	<i>Service of focus</i>	<i>Private agent</i>
<b>Purchased services</b>			
Outsourcing clinical care	Most local government; some facility	hospital level (beds/wards); individual providers (specialist, hospital level); radiology & pathology services	Hospital/clinical companies; providers; specialist support companies
NGO arrangements	Most local government	Most focused on palliative HIV care	NGOs
Session doctors	Most local government	Providers	Private providers
Contracts with state aided hospitals	Local government	Unclear	State-aided hospitals
Clinical service contracts	PDOH	total facility clinical & non-clinical	Hospital companies
<b>Outsourcing non-clinical care</b>			
Outsourcing non-clinical care	Most are facility or local government; with some province links	buildings, management, security, laundry, maintenance, kitchens	Specialist companies
Transaction advisers	PDOH/facility	PFIs	Specialist individuals/ Companies
<b>Joint venture</b>			
Co-location	Most PDOH/facility	most are at hospital level; one for primary care	Private hospital companies
Sharing resources	Most facility; one local government	Most around equipment; one around primary care provision	Private hospital/clinical companies
Selling services to private sector	Facility	High tech care/services	Private hospital companies; Funders
Human resource (HR) development	Various	Various forms of HR	Private hospital companies plus other various
Differentiated amenities	PDOH/Facility	Beds/wards	n/a?
Co-operative framework with Universities	PDOH	HR	Universities
<b>PFIs</b>			
Various	Most PDOH/ facility, with national back-up; 2 local government	Nkosi Albert Luthuli; more building & equipment; some equipment & non-clinical	Specialist building & equipment companies
<b>Other</b>			
e.g. Asset swap/property transactions	PDOH	Property	Commercial developers
e.g. vaccine production	National	Vaccines	Pharmaceutical companies

### 6.3.2. Analysis of PPIs by technical characteristics

The boundaries between public and private sector functions are often blurred, and even within PPI categories complexity exists. With *capital financing* the boundaries may be blurred depending on who purchases capital inputs should they be for facilities or equipment. For instance, the public sector may finance the building of a new facility, whilst the private sector finances the equipment, as is the case of the Nkosi Albert Luthuli PFI. With *recurrent financing* the public source of funding is predominantly through general taxation or from revenue collected through user charges. The private sector may be liable for *recurrent financing* in particular forms of PPIs, meeting these costs through user-charges or even through payments made by the public sector, as is the case of 'purchased services'. There is potential for blurred boundaries with respect to *recurrent financing* and *capital financing*. For instance, in the case of the PFI the private sector finances the capital investment upfront but this, capital cost is included in the public sector's recurrent financing of the contract with the private consortium. Box 1 applies *technical characteristics* analysis to highlight the nature and complexity of PFI in greater detail.

*Capital ownership* determines relationships vis-à-vis capital financing, but can also speak to recurrent financing in the case of leasing facilities and/or equipment. The boundaries become blurred when different capital inputs are shared and/or owned by the public and private sectors. For instance, with hospital co-location the facility is owned by the public sector, but the private sector may own the equipment used within the space leased from the public sector. In addition, the public sector also owns equipment in that section of the facility operated by the public sector. The complexity emerges when equipment is shared between the public and the private with provision of services being potentially private, but with publicly owned equipment and vice versa.

In the case of the planned co-location in the WC at Hermanus the private sector builds new public and private wards on government property, and is allowed to use the private wards without license for a period of time before transferring the ownership of the private ward to the public sector. In this instance, *capital financing* is private, *recurrent financing* a combination of public and private, as public and private wards co-exist in one facility, and *capital ownership* is private until the wards are reverted to public control and ownership. The *healthcare provider* and *demand decision-maker* refer specifically to clinical service delivery, the former speaking to healthcare supply whilst the latter addresses that of healthcare demand. Boundaries are more clearly defined with respect to *healthcare provider*, but there may be instances when these boundaries are blurred, as is the case with *session workers*. Session workers are privately contracted to provide care in a public facility to public sector beneficiaries. In the case of session workers the care provided is often seen as public, when in fact is jointly public-private. With the *demand decision-maker* the boundaries are for the most part clearly-defined. Even in the case of hospital co-location it is clear that both private and public agents are responsible for purchasing services, the former in the private sector wards, and the latter in the public sector facility.

Table 8 uses the set of technical characteristics to highlight the complex nature of PPIs, by focusing on a few examples within each category. Table 8 demonstrates that even within the same categories there may be different relationships between the sectors with respect to the key function of financing, ownership and provision.

**Table 8: Applying the technical characteristics in highlighting the complexity of PPIs**

	<i>Capital Financing</i>	<i>Recurrent Financing</i>	<i>Capital Ownership</i>	<i>Healthcare Provider</i>	<i>Demand Decision-maker</i>
<b>Purchased Services</b>					
Session Doctors	Public	Public (collective tax)	Public	Private/ Public (blurred)	Public
Renal Treatment	Private	Public (collective tax)	Private	Private	Public
<b>Outsourcing Non-Clinical Services</b>					
Outsourcing Management	Public	Public (collective tax)	Public	N/A	N/A
Outsourcing transport	Private	Public (collective tax)	Private	N/A	N/A
<b>Joint-Venture</b>					
FS Hospital co-location	Public & Private	Public & Private	Public & Private	Public & Private	Public & Private (individual)
WC Co-location	Private	Public	Private reverting to public	Public & Private	Public & Private (individual)
Differentiated Amenities	Public	Public (collective tax)	Public	Public	Private (individual)
<b>PFI</b>					
Nkosi Albert Luthuli	Private (equipment) & Public (facility)	Public (collective tax)	Public	Public	N/A
<b>Other</b>					
Asset Swap	Private	Public	Public	Public	Public

### **Box 1: Analysis of Private Finance Initiatives (PFIs) by Technical Characteristics**

#### **Analysis of Private Finance Initiatives (PFIs) by Technical Characteristics**

With the PFI in terms of delineating the financing functions it is not cut-and-dry. For instance, with respect to capital financing it is the private sector that bears the risk of raising the capital on money markets to provide the technology and infrastructure requirements. Depending on the nature of the PFI it may be a lot more clear-cut. For instance with Nkosi Albert Luthuli the province had the hospital built by the Department of Public Works. The capital cost function is therefore clearly evident in this regard. However, for equipment, that is when the PFI comes to play. However, as part of the management contract this cost is deferred over the duration of the contract and included in the management fee. What makes it all the more confusing is that in some provinces the PFI is to be funded out of the capital budget (Gauteng Budget Vote, 2003/4). Therefore the distinction between recurrent and capital financing becomes blurred and the functions of the public and private parties may not be that easy to identify at first glance. What makes it confusing is the distinction between the purchasing of equipment and the revitalising or building of facilities versus the actual operations and maintenance contracts that will go hand-in-hand with the capital investment.

With respect to *capital ownership* at the onset of the interaction it is the private consortium that owns the facility and/or equipment that is has financed. With the Nkosi Albert Luthuli PFI the private consortium owns the equipment and the facility is owned by the province. It was the province that had the facility built by public works. However, at the end of the contract the province may resume ownership of the technology, but would still need to extend the maintenance contract to either the same private agent or to another. With respect to capital ownership in terms of the PFI there may be a change of ownership was the contract period has ended, unless of course the contract is re-negotiated to extend the contract duration. The healthcare provider is the public sector, as the interaction is concerned primarily with the provision of equipment and/or facilities. The concept of demand-decision maker is not applicable, unless off course the PFI involves the provision of clinical services by the private sector.

## **7. WHY ARE PPIS BEING DEVELOPED WITHIN THE SOUTH AFRICAN HEALTH SECTOR?**

### **7.1 Actor objectives and rationales**

Earlier sections provide some basic information about the specific goals of different forms of PPI. However, additional material from the in-depth interviews and media analysis provides a clearer sense of why actors from both the public and private sectors are developing PPIs. Understanding the intentions and rationales of key actors is crucial in considering what potential PPIs have to contribute to the health system over time.

The main public sector actors considered in the table are the NDOH, Provincial Departments of Health (PDOH), Local Government Health Departments and National Treasury. The information obtained on local government views was, however, quite limited. The main private sector actors considered are the private funders (namely health insurance and medical aid schemes), private hospital companies and other private providers (the latter solely from the perspective of other actors). The Trade Union perspective is also briefly considered. Table 9 presents these actors' stated objectives for entering into PPIs as well as the key drivers (broader contextual factors) underlying their interest in PPIs.

**Table 9: Key actors, objectives and drivers vis-à-vis PPI development and implementation<sup>a</sup>**

<b>Actors</b>	<b>Objectives</b>	<b>Drivers</b>
<b>Public Sector Actors</b>		
National Department of Health	<ol style="list-style-type: none"> <li>1. Strengthening the health system</li> <li>2. Cost containment in the health sector</li> <li>3. Revenue Generation</li> <li>4. Improving equity of financing and access</li> <li>5. Improving efficiency</li> </ol>	<ol style="list-style-type: none"> <li>1. Fragmented health system</li> <li>2. Cost-escalation in the private sector</li> <li>3. Budgetary constraints</li> <li>4. Mal-distribution of resources across public/private sector relative to population served, leading to poor coverage and access for poorest income groups; as well as poor value for money of South African health system (as shown by low rating in World Health Report 2001)</li> <li>5. Budgetary constraints; under-utilised resources within the system.</li> </ol>
Provincial Departments of Health	<ol style="list-style-type: none"> <li>1. Improving efficiency</li> <li>2. Improving equity</li> <li>3. Improving quality of care</li> <li>4. Strengthening the health system</li> <li>5. Revenue generation</li> <li>6. Capacity building</li> <li>7. Staff retention</li> </ol>	<ol style="list-style-type: none"> <li>1. Budgetary constraints, need to improve service delivery, under-utilised resources within the system</li> <li>2. Need to improve access</li> <li>3. Low morale, public expectations</li> <li>4. Fragmented health system</li> <li>5. Budgetary constraints and need to improve service delivery</li> <li>6. Capacity constraints</li> <li>7. Staff exodus abroad and to private sector</li> </ol>
Local Government Health Departments	<ol style="list-style-type: none"> <li>1. Meet infrastructure requirements</li> <li>2. Reduce costs</li> <li>3. Capacity building</li> <li>4. Enhance efficiency</li> <li>5. Equity</li> </ol>	<ol style="list-style-type: none"> <li>1. Infrastructure backlogs</li> <li>2. Budgetary constraints</li> <li>3. Capacity constraints</li> <li>4. Budgetary constraints, need to improve service delivery, under-utilised resources within the system</li> <li>5. Improving access.</li> </ol>
National Treasury	<ol style="list-style-type: none"> <li>1. Shifting risk to the private sector</li> <li>2. Value-for-Money</li> <li>3. Addressing infrastructure backlogs</li> </ol>	<ol style="list-style-type: none"> <li>1. Budgetary constraints</li> <li>2. Budgetary constraints</li> <li>3. Infrastructure backlogs</li> </ol>
<b>Private Sector Actors</b>		
Private Funders	<ol style="list-style-type: none"> <li>1. Reduce costs</li> <li>2. Improve access</li> <li>3. Improve efficiency</li> <li>4. Strengthening the health system</li> </ol>	<ol style="list-style-type: none"> <li>1. Cost escalation in private sector</li> <li>2. Lack of access to medical insurance and private healthcare; declining market; market saturation</li> <li>3. Under-utilised resources within system</li> </ol>

<b>Actors</b>	<b>Objectives</b>	<b>Drivers</b>
	<ul style="list-style-type: none"> <li>5. Profit</li> <li>6. Enhancing trust between the public and private sectors</li> </ul>	<ul style="list-style-type: none"> <li>4. Fragmented health system</li> <li>5. Declining market; market saturation</li> <li>6. Lack of trust between the sectors</li> </ul>
Private Hospital Companies	<ul style="list-style-type: none"> <li>1. Enhanced efficiency</li> <li>2. Improved perceptions of the private sector</li> <li>3. Profit</li> <li>4. Staff retention</li> <li>5. Enhancing trust between the public and private sectors</li> </ul>	<ul style="list-style-type: none"> <li>1. Duplication in health system</li> <li>2. Negative perceptions of private sector by government</li> <li>3. Declining market; market saturation</li> <li>4. Personnel exodus abroad</li> <li>5. Lack of trust between the sectors</li> </ul>
Other Private Providers	<ul style="list-style-type: none"> <li>1. Profit</li> <li>2. Strengthening the health system</li> </ul>	<ul style="list-style-type: none"> <li>1. Declining market; market saturation</li> <li>2. Fragmented health system</li> </ul>
<b>Social Actors</b>		
Trade Unions	<ul style="list-style-type: none"> <li>1. Strengthening the public sector</li> <li>2. Improving equity</li> <li>3. Protecting workers</li> </ul>	<ul style="list-style-type: none"> <li>1. Declining budgets, deteriorating public sector</li> <li>2. Lack of access to healthcare</li> <li>3. Fear of job losses and job insecurity with PPIs.</li> </ul>
<p>Note: (a) The numbering of the objectives and the drivers indicates the linkages between them (i.e. objective 1 for any actor is underlain by driver 1)  Source: interview data, document review and media review</p>		

A frequently stated and common objective for PPIs across actors is the intention to raise *efficiency*. However, there are different perspectives about how PPIs will achieve this objective. For the public health sector, the key efficiency objective appears to be the potential to maximise the use of existing resources through PPIs, in the face both of public sector budget constraints and the perception, within and beyond government, that public service delivery is inefficient. The particular PDOH concern to improve *quality of care* also seems to be linked to concern with the perceived problems of current provision. Public sector inefficiencies are also highlighted by the national Treasury as a general issue of relevance to PPI discussions, and ensuring value for money (a way of defining efficiency) is one of its key criteria for deciding whether to implement any PPI. However, Treasury is not necessarily convinced that clinical care contracts (purchased services) can, in particular, truly promote efficiency. In contrast to the public sector, the efficiency concerns of private health care actors largely focus on the need to curtail the costs of private care provision in the face of market saturation (providers) and falling insurance coverage levels (funders). From this different starting point, private sector actors nonetheless agree with the public health sector that there is a need to avoid duplication of resources, especially in relation to health technology and facilities, and to make better use of existing, under-utilised resources across sectors.

*Revenue generation* is another important objective for many public sector actors, and one that is, in part, linked to improving efficiency. These actors also commonly link this objective to that of improving quality of care (and even access), and concern for it is generally seen as driven by current public sector budget constraints. In contrast, *profit* is, of course, a central objective and driver of private health care actors' support for PPIs.

A key difference between public and private actors is the public sector concern for *equity*, which is identified as at least as important as efficiency and revenue generation as a PPI objective. This concern is expressed, variously, as the need to improve access to public services, to tackle public sector infrastructural backlogs and to address the mal-distribution of resources between the public and private health sectors. The NDOH perspective specifically emphasises the need to address the inequities resulting from the segmented nature of the health system. In contrast, the key equity objective for the National Treasury appears to be concern for both the total costs of, and mal-distribution between areas of, infrastructural backlogs. This objective is, in turn, driven by awareness both of the limits on the level of capital investment government can afford and of the problems of the current capital budgeting process. Interestingly, although private health care actors do not raise equity as an objective for PPIs, they, like Trade Unions, do raise some concerns about the potential impact on equity of PPIs that involve service delivery tiering within public hospitals (e.g. differentiated amenities or preferred provider contracts).

*Strengthening the health system* is a further important objective for all actors. From all perspectives, this concern was underlain by the need to address fragmentation and segmentation in service delivery. It was linked by private

health care actors to the need to *build trust* between the sectors in order to allow constructive dialogue about how to strengthen the health system. Building trust, therefore, seems to be not so much an objective of PPIs as a means of strengthening the health system by improving relationships between the sectors. Tackling *human resource problems* was also noted by both public and private actors as an objective for PPIs, in terms of retaining skills within the health system. All actors are concerned with the emigration of health staff overseas, and the public sector is also concerned with the exodus of staff to the private sector. The PPIs identified as mechanisms of tackling this problem range from those focussed on managing relationships (formal dialogue to a unified strategy for overcoming the loss to the country) to those offering incentives to retain staff within the public sector. Some actors specifically note the need to retain within the public sector the specialist staff necessary to train future specialists for both sectors. More generally, some hope that, by improving infrastructure, equipment and so on, PPIs will provide non-financial incentives to retain trained personnel in the public sector. A few forms of PPI were also identified as a capacity building mechanism for the development of public sector management.

Finally, the Trade Union perspective supports some of the concerns raised by public sector actors in discussion of PPIs, and even affirms some of the objectives raised by these actors. However, the perspective also includes strong reservations about the role and potential impacts of PPIs. For example, Unions worry that PPIs will lead to inequitable tiering within the public sector rather than tackling existing inequities.

## **7.2 Processes encouraging PPI development**

Actors' interests in PPIs are also driven by a series of policy development and implementation processes. Table 10 summarises the key processes identified by actors as important to PPI development.

**Table 10: Processes facilitating PPI development and implementation**

<b>Actor</b>	<b>Driving Process</b>
NDOH	PPI Working Group National Health Summit PPI Lekgotla Provincial developments around specific treasury-approved PPPs
National Treasury	PPP Unit PPP guidelines PPI Working Group
Provincial Departments of Health	National Health Summit PPI Lekgotla Treasury PPP Guidelines Treasury PPP training courses Provincial Public-Private Forums Solicited and unsolicited bids
Local Government Health Departments	Solicited and unsolicited bids
Private Funders	PPI Working Group National Health Summit PPI Lekgotla Provincial Public-Private Forums SHI development debates
Private Hospital Groups	PPI Working Group National Health Summit PPI Lekgotla Provincial Public-Private Forums SHI development debates
Other Private Providers	Provincial Public-Private Forums Solicited and unsolicited bids SHI development debates
Trade Unions	Anti-privatisation debates Provincial PPP development Facility-level PPIs

The main driving processes for the *NDOH* have been the PPI Working Group, the National Health Summit and the PPI Lekgotla. These processes have been instrumental in allowing the NDOH to work towards developing a unified vision for the health sector. They have involved the provinces, National Treasury and, although to a quite limited extent, local government. At the same time, however, provincial developments and activities associated with specific Treasury-approved PPPs have also driven some NDOH activities.

*National Treasury's* creation of a PPP unit to facilitate the development and implementation of PPPs across sectors in provinces around the country has given it significant influence over other public sector actors. Through the PPP unit National Treasury has, therefore, played key roles in discussions around health-sector PPPs planned and implemented by provincial health departments. However, this experience and expertise has also been taken on-board within the PPI Working Group and subsequent National Health Summit/PPI Lekgotla processes.

*Provincial DOHs* have mostly been influenced by the National Treasury's PPP Unit and PPP guidelines. The National Treasury influence has come not only from supporting health PPPs within provinces, but also through attendance by senior provincial health officials on the PPP training courses it runs. Another driving process that has evolved in provinces such as the Western Cape and the Free State has been the development of public-private forums. Such forums are themselves PPIs that manage relationships between the sectors in a formal manner and aiding the building of trust between the sectors. The NDOH has also had some influence over provinces through its processes and support to provinces. Finally, solicited and unsolicited bids from the private sector have required some provincial responses.

*Local government* has not really been involved in either the National Treasury-led PPP, or NDOH-led PPI, processes. Local government, for example, falls outside the jurisdiction of National Treasury and is therefore not obliged to seek Treasury approval and assistance with respect to PPPs. Only a few local government officials were present at the PPI Lekgotla. Instead, the key driving process for local government appears to have been dealing with solicited and unsolicited bids from the private sector with respect to various elements of service delivery and infrastructure investment.

The PPI Working Group, National Health Summit, PPI Lekgotla and provincial public-private forums have all involved *private sector actors*, and so have facilitated dialogue between the sectors. Private providers have also participated in the public-private forums. A further process driving private sector interest in PPIs are the continuing discussions about social health insurance (SHI). Funders and providers are anxious that the design of a scheme may undermine their market shares, and also see roles for themselves within such a scheme.

*Trade unions*, finally, have been only partially engaged in some of the PPI policy processes. Some Union representatives were presented at the National Legkotla, and there has also been Union involvement in some provincial-led PPPs. However, the key processes driving Unions engagement in PPI debates is likely to have been the anti-privatisation drive the Union movement has spearheaded as well as, in the health sector, piece-meal engagement in the development of specific PPIs.

### **7.3 Actors' views of the problems and pitfalls of PPIs**

Discussions with interviewees identified a range of current concerns about the development of PPIs.

For public sector actors, the key issues included:

- The need for a legislative framework, supplemented by national direction and guidance for use by provincial health departments in negotiations
- The need for strong and specific technical capacity within the public sector and at all levels to manage the laborious process of negotiations

around large-scale PPIs e.g. PFIs (and particularly around risk transfer) and to ensure that the private sector does not take advantage of the public sector in either the contract negotiations or in implementation in ways that have negative long-term consequences for the public sector

- The difficulties of establishing measurable outcomes for inclusion in contracts
- The need for adequate resources to support the necessary development of skills and systems
- The need to manage public perceptions around PPIs to avoid them undercutting support for the public sector

For private sector actors, the key issues included:

- Lack of trust between sectors – making the negotiations process difficult and suggesting the need for specific trust-building activities (such as the National Legkotla);
- Lack of clarity or transparency around government decision-making procedures, and personnel turnover in government
- The lack of national coordination in decision-making around PPIs, requiring engagement with each province;
- Government reluctance to take on any risks, which undermines value of entering into PPIs for private sector
- Problems with government procedures, such as timely payment
- Quality of care problems in public sector, including personnel shortages
- Trade Union (COSATU) stance on privatisation.

Finally, Trade Unions specifically identified concerns such as:

- PPIs will lead to tiering within the public sector;
- government does not have the capacity to analyse fully potential PPIs;
- the private sector has no incentive to serve the poor.

## 8. LESSONS FOR THE FUTURE?

### Conclusions

Three main and inter-linked conclusions can be drawn from this overall analysis of the emerging experience of PPIs in the South African health sector:

1. Managing PPIs is complex and challenging – on the one hand, every PPI embodies a complex set of relationships between diverse public and private actors, and public sector managers (at facility or geographical levels) frequently manage a series of PPIs, and on the other hand, specifying and monitoring contracts around health activities is always difficult.

*This is shown by, the:*

- analysis of the different characteristics of, and actors involved in, different forms of PPI;
- mapping of the range of PPIs currently under development around the country;
- views of key South African actors currently involved in PPI development.

2. There is a lack of clarity or vision around the potential and pitfalls of PPI development within the health sector, and between and within spheres of government, leading to diverse PPI understandings, objectives and developments across the country;

*This is shown by, the:*

- limited understanding among actors of the terminology surrounding PPPs/PPIs;
- wide range of PPIs under development, across and between provinces, and across and between spheres of government;
- lack of overarching legislative frameworks and operational guidelines acting as guides across all spheres of government;
- many and varying objectives established for different forms of PPI as well as identified by different actors;
- lack of an evidence-base on experience with PPI development, including data on the impacts of PPIs on key health sector goals.

3. There is a need for strong capacity development to manage more effectively the process of PPI development within the health sector in order to ensure health policy goals are realised, and not undermined, by PPIs.

*This is shown by, the:*

- currently limited coordination across and between spheres of government of the process of health sector PPI development;
- clear complexity of any PPI and of managing several PPIs at the same time;

- views of key South African actors currently involved in PPI development.

## Proposals

The key dangers of uncoordinated action around PPIs are that it runs the risks both of further fragmenting the health system and of generating additional costs and burdens for the public sector. The current lack of evidence on the range of PPIs being developed across the health sector and on the cost and benefits, to the health sector, of existing, new and planned PPIs is of particular concern. Without such information, future system development cannot build on the lessons of the past. International experience strongly highlights the need for hard data about whether or not PPIs achieve the gains expected of them, and about the factors that influence their successes and failures.

The necessary starting point for coordination around PPIs is a coherent and widely accepted vision and framework. The national PPI document (as discussed at the 2000 National Summit) provides such a vision, as well as a set of principles to guide PPI development in the health sector. However, it is neither well-understood at the operational level nor has been widely distributed at provincial or local government levels. It is also not complemented by guidelines on how to apply its criteria. In contrast, although influential at provincial level, the Treasury approach to developing PPPs has only limited applicability to the wide range of PPIs being considered in the health sector, and to the diverse range of objectives being pursued by health actors.

**Therefore, the central recommendation drawn from this analysis is that there is a need to implement the vision outlined in the 2000 National Summit PPI document by strengthening the organisational capacity<sup>2</sup> of the public sector to develop and implement PPIs – including the capacity to choose not to implement PPIs. This recommendation is targeted primarily at the NDOH on the understanding that the very complex nature of PPIs, and their peculiar demands, requires a strong central role that can enable coordinated action across the health system (as evidenced by the national Treasury PPP unit). Implementation of PPIs will, however, clearly continue to be a task of provincial and local government levels, and facility managers.**

**Eleven specific proposals are incorporated within this overarching recommendation. They are:**

1. Develop a PPI unit within the NDOH that is tasked with, amongst other things:

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<sup>2</sup> This understanding of organisational capacity is derived from Hilderbrand and Grindle (1994), and has previously been used within the South African context (Brijlal et al. 1997).

- communicating the health vision for PPIs (e.g. as summarised in the 2000 national health summit document) across the health sector (including to all spheres of government as well as to private actors);
  - developing health specific frameworks and guidelines for use in management;
  - coordinating health PPI development with national Treasury and the national Department of Local government and xxx;
  - supporting the development of mechanisms to enable dialogue and exchange between the public and private sectors;
  - coordinating the development of 'national' PPIs (that are implemented across provincial/municipality boundaries);
  - providing operational support to provincial and local government managers as requested;
  - offering relevant training to provincial and local government managers;
  - coordinating the monitoring and evaluation of PPI experience within the country;
2. Secure people and funding to allow the national PPI unit to function effectively.

Once established, this national PPI unit should then itself:

3. Consider with provincial DOHs whether or not to establish dedicated provincial PPI units, or to allocate this responsibility to an existing position or officer within the PDOH;
4. Develop operational guidelines to support the development and implementation of specific PPIs by hospital, provincial and local government health managers;
5. Provide guidance to local government health managers on the tasks and functions associated with PPI management, and skills required;
6. Develop programmes for training hospital, provincial and local government health managers in PPI contract development, negotiation and management;
7. Establish a functioning coordinating mechanism at national level (perhaps building on existing structures) to allow exchange of experiences around PPI management between key hospital managers, and provincial and local government health managers;
8. Establish national level opportunities for engagement between public and private sector actors on specific PPI-related matters;
9. Promote the establishment of provincial forums where public (including local government actors) and private sector actors can interact in discussing and sharing ideas on specific operational issues;
10. Develop guidelines for tracking the growth of PPIs across the country, including some routine monitoring and evaluation of their performance, and support the collection of relevant data at provincial, local government and hospital levels (these guidelines could draw lessons from this project's problems in gathering information about PPIs);
11. Commission external assessments of the impacts of the first wave of PPIs, to feed into future policy development.

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# ANNEX 1: SURVEY OF PUBLIC-PRIVATE INTERACTIONS IN THE HEALTH SECTOR PROVINCIAL QUESTIONNAIRE

## INSTRUCTIONS FOR COMPLETION

Please Read Carefully!

This survey is a follow up to the discussions on Public-Private Interactions (PPIs) held at the Health Summit in November 2001. **The aim of the survey is to collect information on ALL current and planned interactions between the Department of Health and the private sector.**

For the purposes of this survey, a **PPI refers to ANY relationship or arrangement with a private sector entity in order to provide or support health service delivery.** It is important to note that this definition encompasses, but is broader than, the traditional definition of public-private partnerships (PPPs). Therefore, PPIs include arrangements such as the following:

- The employment of individual health workers on a sessional basis to provide general or specialised clinical care;
- Contracts with private hospitals, clinics or agencies to provide general or specialised clinical care;
- Contracts with state-aided hospitals, SANTA etc;
- Out-sourcing of clinical support services such as pathology or radiology services;
- Home-based care projects;
- Contracting-out of non-clinical services such as laundry, catering, security or transport services;
- Contracts for the provision of management services or support;
- Employment of private consultants;
- Leasing-out of public facilities or equipment, the establishment of private wards, and other co-location projects;
- Private financing initiatives (PFIs); and
- Preferred provider arrangements with private medical schemes.

Questionnaires have been sent to the National Department of Health as well as all Provincial Health Departments. For Local Government, questionnaires have been sent to all Category A Municipalities, all Category C Municipalities, and selected Category B Municipalities.

This questionnaire should be completed from the perspective of the *Provincial Department of Health*. It aims to identify ALL health sector PPIs at the *Provincial* level as well as *Provincial* policies and structures with regard to PPIs. When completing the questionnaire, please focus on ALL the PPIs which fall under your Department's direct sphere of influence. For example, this questionnaire should cover PPIs at the provincial head office as well as regional offices, provincial hospitals and provincial clinics, but should not include PPIs at municipal offices or clinics.

The questionnaire has generally been addressed to the Head of Department or an individual suggested by National Department. Nevertheless, please identify the most appropriate person/persons in your Department to complete the questionnaire in order to ensure that the results are as comprehensive and accurate as possible. Please ensure that ALL sections of the questionnaire are completed, particularly Sections E and F.

Please complete the questionnaire by the 28 June 2002 and return it by Post (using the enclosed envelope) or Fax to:

Haroon Wadee  
Centre for Health Policy  
PO Box 1038, Johannesburg, 2000

Fax: (011) 489-9900

For any questions or help with the completion of this questionnaire, please contact either:

Haroon Wadee                      Tel: (011) 489-9942

Duane Blaauw                        Tel: (011) 489-9932 / 082-295-7377

**THANK YOU FOR YOUR TIME !**

## **SECTION A: HEALTH DEPARTMENT INFORMATION**

Province

Head of Department

Questionnaire completed by:

Name	Position	Tel (W)	Tel (Cell)

*Include all persons who participated in the completion of this questionnaire*

## **SECTION B: OVERVIEW OF ALL CURRENT AND PLANNED PPIs**

Identify **ALL** the PPIs in which the *Provincial Health Department* is currently involved or planning to get involved (see definition of PPIs on the front page). Be sure to identify PPIs at **ALL** levels of the *Provincial Health Department* including the head office, regions and provincial facilities (hospitals and clinics).

1. Is the *Provincial Health Department* currently engaged in any PPIs ?

Yes
No

Is the *Provincial Health Department* considering getting involved in any PPIs ?

Yes
No

If Yes Why? What are the main objectives of developing PPIs ?

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If No Why not ?

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2. The Table below provides a categorisation of different types of PPIs. Please fill in the **total number** of initiatives in each category as accurately as possible. In the case of PPIs at regional or facility level, count each region and facility involved as a separate PPI. Also count each separate service agreement as a separate PPI.

					NUMBER OF PPIs	
Type of PPI Arrangement		Private Sector Partner	Examples	Code	Current	Being Planned
Service agreements	General or Specialised Clinical care	Private practitioners	<i>Employment of sessional workers, district surgeons</i>	a		
		Private entity (for-profit)	<i>Contracts with private hospitals, clinics or agencies for clinical care</i>	b		
		Private entity (not-for-profit)	<i>Contracts with state-aided hospitals, SANTA</i>	c		
	Clinical support services	Any private entity	<i>Outsourced pathology, radiology services</i>	d		
	Community based care	NGO or CBO	<i>Home-based care projects</i>	e		
	Non-clinical services	Any private entity	<i>Outsourced laundry, catering, security, transport services</i>	f		
	Management services	Any private entity	<i>Private management of public facility, management contracts</i>	g		
	Consultancy services	Any private entity	<i>Employment of private consultants</i>	h		
Agreements whereby private entity makes use of public sector facilities or resources		Any private entity	<i>Leasing of wards or equipment, establishment of private wards in public hospitals, co-location projects</i>	i		
Partnerships on infrastructure development or other capital projects		Any private entity	<i>Private finance initiatives (PFIs)</i>	j		
Preferred provider arrangements		Private medical scheme	<i>Arrangements with private medical scheme</i>	k		
Any other				l		

TOTAL 

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*Provide brief information on EACH of the PPIs enumerated in this table by completing SECTION E*

3. Describe briefly the current status of the following initiatives in your province:

Remunerative work  
outside the public  
sector (RWOPS)

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Certificate of need

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Uniform provider fee  
system (UPFS)

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4. List any other types of interactions that the *Provincial Health Department* has with private sector entities that you think should be included in the categorisation of PPIs.

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5. Has the *Provincial Health Department* received any requests from the private sector for the development of PPIs ?

Yes
No

If Yes What was the total number of requests received in each of the following years ?

2000	
2001	
2002	

*Provide brief information on EACH of the requests received in 2001 and 2002 by completing SECTION F*







## **SECTION E: DETAILS OF CURRENT AND PLANNED PPIs**

Complete the information below for each of the PPIs enumerated in the Table in Q2 on Page 51 .

The total number of PPIs listed here should be the same as the total of the Table.

*Please use additional sheets if required.*

No	Description	Type of PPI (Use code below)	Public partner / Site	Private partner	Status		Duration (Years)	Total budget	Written contract (Y/N)	Contact person
					Current	Being planned				
1.										
2.										
3.										
4.										
5.										
6.										
7.										
8.										
9.										
10.										
11.										
12.										
13.										
14.										
15.										

**Code for Types of PPIs**

a: Private practitioner provides clinical services  
 b: Private entity (for-profit) provides clinical services  
 c: Private entity (not-for-profit) provides clinical services

d: NGO or CBO provides community based services  
 e: Private entity provides clinical support services  
 f: Private entity provides non-clinical services

g: Private entity provides management services  
 h: Private entity provides consultancy services  
 i: Private entity makes use of public facilities or resources

j: Partnership with private entity on capital project  
 k: Preferred provider arrangement with private entity  
 l: Other

**SECTION E: DETAILS OF CURRENT AND PLANNED PPIs (Continued)**

Complete the information below for each of the PPIs enumerated in the Table in Q2 on Page 51 .  
 The total number of PPIs listed here should be the same as the total of the Table.

*Please use additional sheets if required.*

No	Description	Type of PPI (Use code below)	Public partner / Site	Private partner	Status		Duration (Years)	Total budget	Written contract (Y/N)	Contact person
					Current	Being planned				
16.										
17.										
18.										
19.										
20.										
21.										
22.										
23.										
24.										
25.										
26.										
27.										
28.										
29.										
30.										

**Code for Types of PPIs**

a: Private practitioner provides clinical services  
 b: Private entity (for-profit) provides clinical services  
 c: Private entity (not-for-profit) provides clinical services

d: NGO or CBO provides community based services  
 e: Private entity provides clinical support services  
 f: Private entity provides non-clinical services

g: Private entity provides management services  
 h: Private entity provides consultancy services  
 i: Private entity makes use of public facilities or resources

j: Partnership with private entity on capital project  
 k: Preferred provider arrangement with private entity  
 l: Other

## **SECTION E: DETAILS OF CURRENT AND PLANNED PPIs (Continued)**

Complete the information below for each of the PPIs enumerated in the Table in Q2 on Page 51 .  
The total number of PPIs listed here should be the same as the total of the Table.

*Please use additional sheets if required.*

No	Description	Type of PPI (Use code below)	Public partner / Site	Private partner	Status		Duration (Years)	Total budget	Written contract (Y/N)	Contact person
					Current	Being planned				
31.										
32.										
33.										
34.										
35.										
36.										
37.										
38.										
39.										
40.										
41.										
42.										
43.										
44.										
45.										

**Code for Types of PPIs**

a: Private practitioner provides clinical services  
b: Private entity (for-profit) provides clinical services  
c: Private entity (not-for-profit) provides clinical services

d: NGO or CBO provides community based services  
e: Private entity provides clinical support services  
f: Private entity provides non-clinical services

g: Private entity provides management services  
h: Private entity provides consultancy services  
i: Private entity makes use of public facilities or resources

j: Partnership with private entity on capital project  
k: Preferred provider arrangement with private entity  
l: Other

## **SECTION F: DETAILS OF REQUESTS FROM THE PRIVATE SECTOR FOR THE DEVELOPMENT OF PPIs**

Complete the information below for each of the requests received from the private sector in 2001 and 2002 (Q5 on Page 52).

The total number of requests listed here should be the same as the total for 2001 and 2002.

*Please use additional sheets if required.*

No	Description	Private Partner	Date Received (Month / Year)	Outcome
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				
13.				
14.				
15.				

**SECTION F: DETAILS OF REQUESTS FROM THE PRIVATE SECTOR FOR THE DEVELOPMENT OF PPIs  
(Continued)**

Complete the information below for each of the requests received from the private sector in 2001 and 2002 (Q5 on Page 52).

The total number of requests listed here should be the same as the total for 2001 and 2002.

*Please use additional sheets if required.*

No	Description	Private Partner	Date Received (Month / Year)	Outcome
16.				
17.				
18.				
19.				
20.				
21.				
22.				
23.				
24.				
25.				
26.				
27.				
28.				
29.				
30.				

*THANK YOU FOR YOUR TIME !*

**SURVEY OF PUBLIC-PRIVATE INTERACTIONS IN THE HEALTH SECTOR  
LOCAL GOVERNMENT QUESTIONNAIRE –  
CATEGORY A MUNICIPALITIES (METROPOLITAN COUNCILS)**

**INSTRUCTIONS FOR COMPLETION**

Please Read Carefully!

This survey is a follow up to the discussions on Public-Private Interactions (PPIs) held at the Health Summit in November 2001. **The aim of the survey is to collect information on ALL current and planned interactions between the Department of Health and the private sector.**

For the purposes of this survey, **a PPI refers to ANY relationship or arrangement with a private sector entity in order to provide or support health service delivery.** It is important to note that this definition encompasses, but is broader than, the traditional definition of public-private partnerships (PPPs). Therefore, PPIs include arrangements such as the following:

- The employment of individual health workers on a sessional basis to provide general or specialised clinical care;
- Contracts with private hospitals, clinics or agencies to provide general or specialised clinical care;
- Contracts with state-aided hospitals, SANTA etc;
- Out-sourcing of clinical support services such as pathology or radiology services;
- Home-based care projects;
- Contracting-out of non-clinical services such as laundry, catering, security or transport services;
- Contracts for the provision of management services or support;
- Employment of private consultants;
- Leasing-out of public facilities or equipment, the establishment of private wards, and other co-location projects;
- Private financing initiatives (PFIs); and
- Preferred provider arrangements with private medical schemes.

Questionnaires have been sent to the National Department of Health as well as all Provincial Health Departments. For Local Government, questionnaires have been sent to all Category A Municipalities, all Category C Municipalities, and selected Category B Municipalities.

This questionnaire should be completed from the perspective of the *Metropolitan Council Department of Health*. It aims to identify ALL health sector PPIs at the *Metropolitan Council* level as well as *Metropolitan Council* policies and structures with regard to PPIs. When completing the questionnaire, please focus on ALL the PPIs which fall under your Department's direct sphere of influence. For example, this questionnaire should cover PPIs at the Metropolitan central office as well as an Metro sub-structures and Metro clinics, but should not include PPIs at provincial offices, hospitals and clinics.

The questionnaire has generally been addressed to the Head of Department or an individual suggested by National Department. Nevertheless, please identify the most appropriate person/persons in your Department to complete the questionnaire in order to ensure that the results are as comprehensive and accurate as possible. Please ensure that ALL sections of the questionnaire are completed, particularly Sections E and F.

Please complete the questionnaire by the 28 June 2002 and return it by Post (using the enclosed envelope) or Fax to:

Haroon Wadee  
Centre for Health Policy  
PO Box 1038  
Johannesburg  
2000  
Fax: (011) 489-9900

For any questions or help with the completion of this questionnaire, please contact either:

Haroon Wadee                      Tel: (011) 489-9942  
Duane Blaauw                        Tel: (011) 489-9932 / 082-295-7377

**THANK YOU FOR YOUR TIME !**

**SECTION A: HEALTH DEPARTMENT INFORMATION**

Municipality Name

Municipal Manager   
 Head of Municipal Health Department

Questionnaire completed by:

Name	Position	Tel (W)	Tel (Cell)

*Include all persons who participated in the completion of this questionnaire*

**SECTION B: OVERVIEW OF ALL CURRENT AND PLANNED PPIs**

Identify **ALL** the PPIs in which the *Metropolitan Council Health Department* is currently involved or planning to get involved (see definition of PPIs on the front page). Be sure to identify PPIs at **ALL** levels of the *Metropolitan Council Health Department* including the central office, any sub-structures, and municipal clinics.

6. Is the *Metropolitan Council Health Department* currently engaged in any PPIs ?  Yes  No

Is the *Metropolitan Council Health Department* considering getting involved in any PPIs ?  Yes  No

If Yes Why? What are the main objectives of developing PPIs ?

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If No Why not ?

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7. The Table below provides a categorisation of different types of PPIs. Please fill in the **total number** of initiatives in each category as accurately as possible. In the case of PPIs at sub-structure or clinic level, count each sub-structure and clinic involved as a separate PPI. Also count each separate service agreement as a separate PPI.

				NUMBER OF PPIs		
Type of PPI Arrangement		Private Sector Partner	Examples	Code	Current	Being Planned
Service agreements	General or Specialised Clinical care	Private practitioners	<i>Employment of sessional workers, district surgeons</i>	m		
		Private entity (for-profit)	<i>Contracts with private hospitals, clinics or agencies for clinical care</i>	n		
		Private entity (not-for-profit)	<i>Contracts with state-aided hospitals, SANTA</i>	o		
	Clinical support services	Any private entity	<i>Outsourced pathology, radiology services</i>	p		
	Community based care	NGO or CBO	<i>Home-based care projects</i>	q		
	Non-clinical services	Any private entity	<i>Outsourced laundry, catering, security, transport services</i>	r		
	Management services	Any private entity	<i>Private management of public facility, management contracts</i>	s		
	Consultancy services	Any private entity	<i>Employment of private consultants</i>	t		
Agreements whereby private entity makes use of public sector facilities or resources		Any private entity	<i>Leasing of wards or equipment, establishment of private wards in public hospitals, co-location projects</i>	u		
Partnerships on infrastructure development or other capital projects		Any private entity	<i>Private finance initiatives (PFIs)</i>	v		
Preferred provider arrangements		Private medical scheme	<i>Arrangements with private medical scheme</i>	w		
Any other				x		

TOTAL 

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Provide brief information on EACH of the PPIs enumerated in this table by completing SECTION E



## SECTION C: PPI POLICIES AND STRUCTURES

12. Does the *Metropolitan Council Health Department* have its own written policy on PPPs / PPIs ?

Yes
No

If Yes, please include copies of all relevant documents

13. Does the *Metropolitan Council* have its own written policy on PPPs / PPIs ?

Yes
No

If Yes, please include copies of all relevant documents

14. Does the *Metropolitan Council Health Department* have a dedicated PPP / PPI unit or department ?

Yes
No

If Yes Name of Manager

Position

Tel

If No Who deals with policy on PPPs / PPIs ?

Name of Manager

Position

Tel

15. Does the *Metropolitan Council* have a dedicated PPP / PPI unit or department ?

Yes
No

If Yes Name of Manager

Position

Tel

16. Does anyone from the *Metropolitan Council Health Department* attend the National PPP meetings ?

Yes
No

If Yes Name

Position

17. Has anyone from the *Metropolitan Council Health Department* attended the National Treasury PPP workshops?

Yes
No

If Yes Name

Position

18. List any other PPP / PPI processes or activities (policy development, training courses etc) in which the *Metropolitan Council Health Department* has been involved?

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## SECTION E: DETAILS OF CURRENT AND PLANNED PPIs

Complete the information below for each of the PPIs enumerated in the Table in Q2 on Page 51 .

The total number of PPIs listed here should be the same as the total of the Table.

*Please use additional sheets if required.*

No	Description	Type of PPI (Use code below)	Public partner / Site	Private partner	Status		Duration (Years)	Total budget	Written contract (Y/N)	Contact person
					Current	Being planned				
46.										
47.										
48.										
49.										
50.										
51.										
52.										
53.										
54.										
55.										
56.										
57.										
58.										
59.										
60.										

### Code for Types of PPIs

a: Private practitioner provides clinical services  
 b: Private entity (for-profit) provides clinical services  
 c: Private entity (not-for-profit) provides clinical services

d: NGO or CBO provides community based services  
 e: Private entity provides clinical support services  
 f: Private entity provides non-clinical services

g: Private entity provides management services  
 h: Private entity provides consultancy services  
 i: Private entity makes use of public facilities or resources

j: Partnership with private entity on capital project  
 k: Preferred provider arrangement with private entity  
 l: Other

## SECTION E: DETAILS OF CURRENT AND PLANNED PPIs (Continued)

Complete the information below for each of the PPIs enumerated in the Table in Q2 on Page 51 .  
 The total number of PPIs listed here should be the same as the total of the Table.

*Please use additional sheets if required.*

No	Description	Type of PPI (Use code below)	Public partner / Site	Private partner	Status		Duration (Years)	Total budget	Written contract (Y/N)	Contact person
					Current	Being planned				
61.										
62.										
63.										
64.										
65.										
66.										
67.										
68.										
69.										
70.										
71.										
72.										
73.										
74.										
75.										

**Code for Types of PPIs**

a: Private practitioner provides clinical services  
 b: Private entity (for-profit) provides clinical services  
 c: Private entity (not-for-profit) provides clinical services

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 f: Private entity provides non-clinical services

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 h: Private entity provides consultancy services  
 i: Private entity makes use of public facilities or resources

j: Partnership with private entity on capital project  
 k: Preferred provider arrangement with private entity  
 l: Other

## SECTION E: DETAILS OF CURRENT AND PLANNED PPIs (Continued)

Complete the information below for each of the PPIs enumerated in the Table in Q2 on Page 51 .  
 The total number of PPIs listed here should be the same as the total of the Table.

*Please use additional sheets if required.*

No	Description	Type of PPI (Use code below)	Public partner / Site	Private partner	Status		Duration (Years)	Total budget	Written contract (Y/N)	Contact person
					Current	Being planned				
76.										
77.										
78.										
79.										
80.										
81.										
82.										
83.										
84.										
85.										
86.										
87.										
88.										
89.										
90.										

**Code for Types of PPIs**

a: Private practitioner provides clinical services  
 b: Private entity (for-profit) provides clinical services  
 c: Private entity (not-for-profit) provides clinical services

d: NGO or CBO provides community based services  
 e: Private entity provides clinical support services  
 f: Private entity provides non-clinical services

g: Private entity provides management services  
 h: Private entity provides consultancy services  
 i: Private entity makes use of public facilities or resources

j: Partnership with private entity on capital project  
 k: Preferred provider arrangement with private entity  
 l: Other

## **SECTION F: DETAILS OF REQUESTS FROM THE PRIVATE SECTOR FOR THE DEVELOPMENT OF PPIs**

Complete the information below for each of the requests received from the private sector in 2001 and 2002 (Q5 on Page 52).

The total number of requests listed here should be the same as the total for 2001 and 2002.

*Please use additional sheets if*

*required.*

No	Description	Private Partner	Date Received (Month / Year)	Outcome
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
0.				

**SECTION F: DETAILS OF REQUESTS FROM THE PRIVATE SECTOR FOR THE DEVELOPMENT OF PPIs  
(Continued)**

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Complete the information below for each of the requests received from the private sector in 2001 and 2002 (Q5 on Page 52).

The total number of requests listed here should be the same as the total for 2001 and 2002.

*Please use additional sheets if required.*

No	Description	Private Partner	Date Received (Month / Year)	Outcome
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

**THANK YOU FOR YOUR TIME !**