

CHAPTER 8: CONCLUSIONS AND RECOMMENDATIONS

...We are all against concessions because they tend to evolve into monopolies... (Picazo, 2005).

... But it is difficult to do it country-wide because then you go to monopoly situations. The other problem is: companies are normally quite keen to do PPPs in areas where there are high concentrations of rich people because rich people have money... You won't find somebody wanting to do PPPs in Timbuktu. The only people who go there are the NGOs and invariably you just fund them totally which means you may just as well provide the service yourself (Muller, 2005).

There are the partnerships with NGOs. That's where the NGO will draft a business plan and the NGO will come to the department who will then fund the business plan. The NGO will take the funding from the department and provide services.....but I believe that our NGO sector still needs to develop quite a bit before they become more successful... but there is a nice start to the process (Muller, 2005).

8.1 Introduction

A summary of the main results derived under each of the five objectives provides an introduction to this chapter. The results areas are measured against efficiency, effectiveness, economy and equity as this has become the main drivers in achieving sustainable and quality service outcomes in health care interventions.

Governments are finding it more and more difficult to raise finances to support the growing needs of the communities they serve. As the growth of inequities, especially in the local spheres (between rural and urban development) worsened, the challenges the government faced to create stability became determining factors in the creation of social advancement. Health, education, housing and social security nets became the pivotal point for success. The complexities associated with budgeting processes and a preoccupation with strategic issues led to the neglect of issues surrounding the raising and spending of public finance (allocation and distribution policies) in particular to health care. Finding alternative ways to strengthen the strategic and operational outcomes through effective allocation and distributional policies, not only in health care but in

synergy with the overall budget, became a major challenge. Accelerated growth and expected increase in productivity not only improved the country's competitive advantage in the global society but offered the government increased revenue to be used to stimulate further economic growth. Balancing the expenditure/GDP ratio through the utilisation of PPP leads to subsequent increases in tax revenue and forms an important instrument in reducing inequities. Public-private partnerships are about the raising of private finance. PPPs are seen as a more sustainable form of privatisation and offer the government a long-term solution for financing public sector activities, while interest rates remain stable and inflationary behaviour are managed. It also involves the private and non-governmental sectors as partners in public activities in that they share the responsibility and risks of service delivery in which market forces steered quality through its supply- and demand factors.

Trends in public management emphasised business and market orientations. Managerialism led the government to introduce a more classical style of business management with its central focus on the internal functioning and capacity-building. These trends encouraged a movement towards partnerships. Meeting the needs in service delivery, especially in health care, involved various types of partnerships in which often more than five partners were tied to a specific health care outcome. This meant that alignments became more complex, fluid and the boundaries shifted continuously creating complex networks between the sectors. The concept of policy networks for problem-solving and societal governance provided an alternative in reaction to the limits of governance by proclaiming a strategic retreat by means of privatising, deregulating and decentralisation. The ideas of the NPM which have been dominant for the past ten years were challenged as network management became a form of steering aimed at promoting joint problem-solving within policy development.

8.2 A summary of the main results

Three main interventions (political, economic and social interventions) steered external and internal decision-making processes and influenced the role government took as enabler, facilitator and regulator to strengthen policy implementation and thereby improving the quality of its service delivery outcomes. Neo-liberal ideologies and political authority framed the government's approach to find the most fair and just distribution

policies in a social developmental approach as this played a determining role in how allocation policies were put together.

Political decisions and the strong influence of advocacy groups, medical associations and transnational organisations such as the pharmaceutical companies shaped distribution and allocation policies in health care and determined the role and function government played in the economic and the social policy. It directed the methods of state interference and determined how public finances were raised. The emphasis that the government placed on value-creating strategies shifted the overarching mission towards a vision and outcomes focus in which the priorities of the budgeting process weigh stronger towards operational planning (90%) instead of the strategic issues (10%) (Kaplan & Norton, 2001:289). In contrast, health care reforms focused on strategic issues instead of operational aspects of budgeting. While global organisations pushed for greater private investments that offered them new markets and a greater share of future earnings created by the HIV/Aids epidemic, governments had to find ways to provide health care to all sectors of society in the most equitable, effective, economic and efficient way. Societies' claims of entitlement to health care services complicated health care as this defines their experiences of the state and underlines their place in the broader democratic society. Health care enforces values and norms through different aspects of its operation. HIV/Aids challenges norms and values and its links between political ideologies, economic and social structures and supporting health care structures.

Distributional justice determines the role government plays in providing goods and services equitably to communities. The distributive goals encourage outcomes that improved access, opportunity and security needs. Social interventions impact on public finance as it is vulnerable to fluctuations within the economic cycle, rising figures in unemployment and poverty, and increases in life-threatening illnesses and poor health. Achieving positive outcomes through the political, economic and social interventions depended on the resources available and the structures the government used to reach the desired outcomes. Therefore, a major issue in policy-making for health interventions is based on the distribution and allocation policies as they relate directly to the GDP and impact on the facilitation and stimulation of the market (economic growth and labour issues).

The government's ability to find a balance between the relative sizes of the public and private sectors within a mixed economy steered by the demands- (benefits) and supply function (costs) is a key issue in managing the inequities in health care. The inflationary behaviour of the supply-side (costs of services and goods) impacts on allocation policies and economic growth. Raising costs increases the government's revenue but also increase the social budget as poverty levels increase. Managing the inflationary behaviour and interest rates becomes a critical aspect of wealth-creating strategies and improved productivity.

Initially PPPs was seen as mechanisms in the macroeconomic plan that manipulated the functioning of the market together with its fiscal structures and enhanced the outcomes of the operational budget through infrastructure delivery. The focus of PPP as a mechanism in the macroeconomic plan has shifted towards integrating the short-term objectives. This means that the generic PPP model had to adjust its focus and strategic initiatives to fit in with the operational objectives in achieving value-for-money outcomes. PPP is seen as a mechanism that provided the government with ways to add to its resources in a fiscal responsible way.

However, a strong resistance in the DOH against the use of PPPs shifted the strategic and operational focus towards the development of an alternative model which they felt met the needs of the department the best. The PPIs were used to procure clinical services separate from the PPP model. Also, the establishment of a PPP unit in DOH failed mainly because of the perceived complexities associated with PPP procurement and the absence of skilled staff to manage the processes. The complex processes prescribed in the generic PPP model did not fit into the needs for service delivery in health care. The BOT schemes were not flexible enough and the benefits of utilising BOT schemes propagated by the PPP unit became those aspects that formed major constraints in the implementation of the health care policy. One of the most important benefits of BOT schemes was described as the ability to combine infrastructure and service delivery through the same private financiers. It was argued that by bringing the two services together, efficiency is increased in the design of the facilities and costs were reduced. Combining the infrastructure and service delivery meant that the financiers were responsible for providing quality clinical services and encouraging WTP

in customer relationships. Added constraints to this system were the inability to get private funders interested in providing services in the rural and under-developed areas.

Utilising PPPs in health care meant that instead of building capacity and strengthening the health care system it had the opposite effect. PPPs increased inequities in health care and did not meet the needs of service delivery in poverty-stricken areas. Taking into consideration that HIV/Aids affected the poor, youth and young adults between twenty and thirty years of age in impoverished communities the most, health care services providing for these needs were placed under constant strain as services were in high demand. HIV/Aids requires intricate internal processes that supports extensive long-term treatments and periods of hospitalisation and well-designed follow-up and monitoring systems.

This means that human capacity became the main cost drivers for health care expenditure in the PHC and DHC system, followed by organisational and information capital investments. The inability of customers to provide out of pocket payments or become part of private insurance schemes placed the full responsibility for service delivery at government (public health) who supported health initiatives through increased social expenditures and social security networks. Taking a balanced approach to the management of PPPs was thus necessary. Acknowledging the weaknesses and strengths of utilising PPPs in the health environment ensured that strategic interventions targeted those internal processes where the benefits of PPPs increased value-for-money outcomes. Where the utilisation of PPPs increased the weaknesses in the health care system, it became critical to find alternative approaches that managed finance relationships and supported human capital investments. In presenting a best practice model, alternative options are given to solve problems that allow the government to make decisions and choices in a fiscal responsible manner.

8.3 Recommendations for the development of a “best practice model” in the HIV/Aids policy strategies

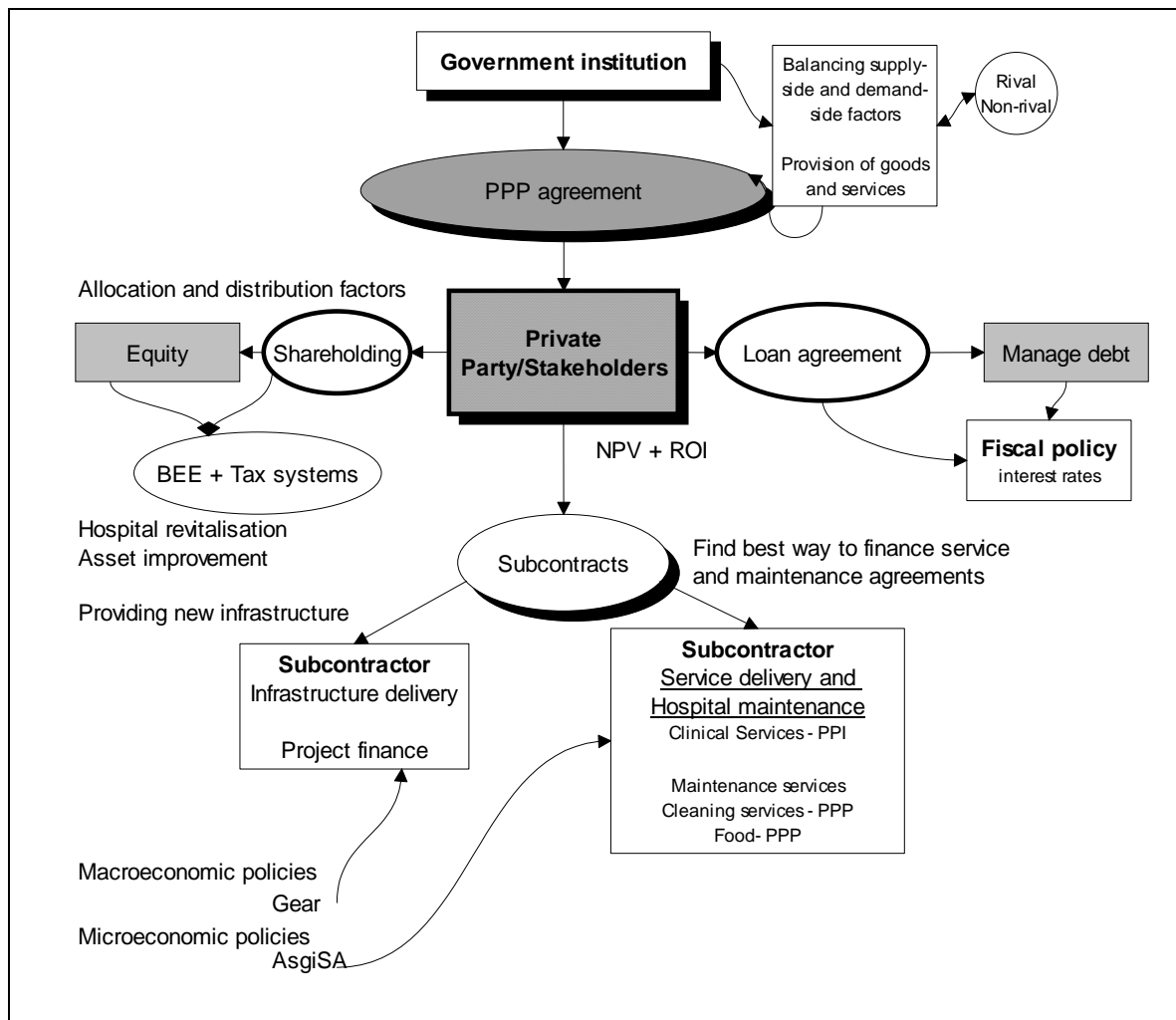
In short, the advantages of utilising PPPs in health care have shown both strengths and weaknesses. Focusing only on the negative outcomes, thereby resisting the use of PPP, is short-sighted as it does not enforce fiscal responsible mechanisms in health care interventions. Similarly, refusing to look at the strengths and weaknesses of PPI and enforcing PPPs as the only way does not benefit health care in the long run. The main

difference between the PPP model and the PPI model is based on its focus and how it utilises the budgeting and procurement mechanisms to enhance government expenditure through its management of risks (technical, operational and financial risk). PPP focuses on infrastructure development and the use of private funding where risk becomes the core issue, while PPI focuses on purchasing human capital within the clinical field and utilising the NGO sector and private sector to achieve value-for-money outcomes, retaining the risk by outsourcing the actual service.

The economic and social concepts applied in the both the PPP and PPI model are sound. Using different service providers and funding schemes instead of placing the responsibility for both infrastructure and clinical service delivery in the hand of one provider seems to become a key constraint when the PPP model is employed in health care. The overall framework for health care thus demands a flexible model in which various funding combinations are to be built to suit the needs as required.

Figure 8.1 makes use of the generic PPP model and explores how PPI can become an integral part of the model. This means that the key categories within the PPI environment must be integrated in the existing PPP regulatory framework and generic finance model as well as the definition of PPP as set out in Regulation 16 of the PFMA, 1999. PPIs must be accepted as an option that provides alternative choices in purchasing clinical care, structuring capital ownership, financing and setting up agreements for clinical services in an aim to go beyond the relationship prescribed for financing and provision. Shifting the emphasis of supply-side dynamics supported in the PPP generic model towards that of a demand-side focus, meant that decision-makers who purchase clinical care (consumers) now become the key issue to be taken into consideration when strategic interventions are designed. A “best practice model” is presented in Figure 8.1 and provides recommendations that support practices in health care which will strengthen policy capacity towards an integrated approach of supply- and demand-side dimensions, thereby resulting in improved quality of service delivery.

Figure 8.1: An alternative approach to achieve efficient service delivery: adapted PPP model



Source: Adapted from PPP Unit (2004a:6); National Treasury (2003).

In a social developmental approach the government uses public finance to foster national prosperity through its investment in physical and human capital. This is reflected in Figure 8.1 where the short-term opportunity cost offsets greater private sector income and wealth for the future. Utilising public, NGO and private expenditures are seen as complementary mechanisms in stimulating the economy. Through its budgeting processes the government creates an enabling environment in which public expenditure is used to procure infrastructures and human capital necessary for market systems to work efficiently. However, injudicious use of public finances where allocation and distribution policies have the opposite effect on wealth creation, leads to the crowding out especially where generous out-of-work social security benefits deter economic

activity as it replaces private expenditures through taxation. The budget of 2006 recognises the need to reinforce modernisation and competitiveness as well as its capacity constraints that limit the ability to spend effectively. Figure 8.1 is designed to increase private and public investment and encourage economic growth. By increasing the real expenditure, government is able to realise its social and economic objectives.

The expansionary trend of the budget was introduced because the unemployment rate in the country has been high. By introducing the expansionary budget, the government increased spending and decreased particular forms of taxes. These actions were supported in Gear in which the generic PPP model became a mechanism to enhance economic growth and employment. As the government shifted its focus to quality improvements in all sectors, the constraints and weaknesses in the systems demanded sector-specific strategies in which the emphasis is now placed on microeconomic policies that underline quality management and human capital. However, the PPP model does not shift its focus to include AsgiSA as it overtook from Gear early in 2006. Figure 8.1 therefore recommends that by integrating the PPI into the generic PPP model, better policy co-ordination is achieved within the microeconomic policies.

The growth in inequities in health care is a major challenge. Section 217 of the Constitution of the Republic of South Africa, 1996 and Regulation 16.7 Section 67(4) of the PFMA, 1999 prescribe procurement practices in government and for PPP agreements. Through the application of the procurement practices that comply with the “Code of Good Practice for BEE in PPPs”, inequalities are dealt with. BEE applied in PPI and PPP is in line with the Strategy for Broad-based Black Economic Empowerment Act, 2003 (BBBEE Strategy). The BEE policy is interwoven in the Draft Health and Finance Charters. Currently tax relief provisions are in conflict with equity and shareholder requirements as set out in the Charters. This results in tax obstacles discouraging more widespread ownership of employees. The government must therefore align its BEE initiatives with the tax legislation, particularly if the disposal of assets is required to settle part of the loan obligations.

8.3.1 Policy implications

The strengths of Figure 8.1 thus lie in its ability to meet inequities and provide additionality through increased investments in both public and private domains by

transferring risk and affordability. The emphasis on risk transfer is described as a key performance indicator for the PPP model. A shift in focus towards expenditure management and value for money propositions occurred in which performance management determines outcomes for affordability, sustainability, and accessibility which are key issues in service delivery management.

Poor performance and an inability to deliver infrastructure are associated with high costs for government. By transferring these costs to the private sector, affordability is improved and value for money is achieved. Similarly, risks structures surrounding the purchasing of human capital are tied to supply- and demand value chains which are strongly influenced by performance management risks. Still, the management of service delivery does not differ much from infrastructure development initiatives as a partnership development plan becomes an essential vehicle in managing both infrastructure delivery and human capital delivery. The partnership development plan describes governance structures, co-ordination, trust, communication, partnership assessment and provides guidelines for dispute resolution. The success of the partnership model utilised, depends on how risks are managed throughout the partnership agreement.

This model requires a gradual shift from a system that is driven by national targets towards an integrated and intertwined approach for HIV/Aids in the national health care system in which the role of PPP and PPI become mechanisms for quality improvement. By integrating the models a greater emphasis is placed on primary health care and intersectoral alignments. Policy outcomes in health care are multidimensional and triangulated in social developmental issues. This means that the internal processes administered in health care interventions have the greatest impact on strategy and demand continuous performance improvement to support value propositions.

8.3.2 Alternative options

It is concluded from this study that the utilisation of a PPP provides an effective development tool in the achievement of sustainable outcomes in fiscal policy in that it allows the government to share the risks of service delivery through partnerships, thereby creating 4Es in service outcomes. However, due to gaps in the system and the emphasis that the generic PPP model places on infrastructure development, means that the utilisation of PPPs in health care as a mechanism for fiscal responsibility, is not

successfully achieved. This also means that PPPs are not used in a fiscal responsible manner in HIV/Aids intervention strategies. The impact of this on the roll-out plans for HIV/Aids is substantial as strategies do not strengthen the strategic intent supported through value-creating initiatives within the long-term and medium-term strategies (MTBPS). This increases the emerging gap between the demands made on the government to provide services and its capacity to do the job.

The success of health care interventions is based on the strategic alignment of organisational, human and information capital. The absence of critical elements such as leadership, teamwork and service co-ordination between bureaucracies makes the utilisation of partnerships a complex tool in providing affordable services (effective, efficient, economic and equitable) as these elements have a direct bearing on performance management as well as risk management.

8.4 Future research

Future research studies need to investigate the following issues related to outcomes established from this study:

- The government's role as enabler, facilitator and regulator in creating sustainable outcomes in NHS.
- Managing the impact of supply- (costs) and demand-side (benefits) factors in health care policy: reducing the growing inequities in service delivery outcomes.
- Balancing the relative size of the public and private health sector and its impact on accountability and responsiveness in service delivery.
- Policy implications of introducing alternative approaches (joint ventures, purchased services and outsourcing) into the PPP model and procurement structures supported in the PFMA, 1999.
- Alignment of BEE initiatives with tax legislation and settlement of loan obligations: Determining allocation and distribution policies in health care.

8.5 Conclusion

The impacts of policy-making on HIV/Aids are intricate as the policy outcomes are multidimensional and triangulated in the outcomes of social development and economic policies as well as the outcomes of the macro- and micro fiscal policies that are shaped by ideologies and preferences of the political authorities. The research question formed the pivotal point on which the study explored the extent to which strategies impacted on

the roll-out plans for HIV/Aids policies in South Africa in an aim to put forward recommendations for best practices that result in enhanced fiscal responsibility.

Trends in health care and public finance required governments to consider the utilisation of PPPs. This qualitative study provided an in-depth probe into literature, supported by interviews with experts and roleplayers in the field to evaluate if PPP offered fiscal responsible mechanisms to HIV/Aids intervention strategies. Accepted business tools contributed to systematic analysis of the data and allowed both for an inductive and logical approach throughout the study.

The study concluded that the concepts behind the utilisation of PPP are sound but offer health care reforms a highly complex procurement tool to solve its resource and capacity-building problems. Unfortunately, this mechanism is not applicable in all situations and should therefore be used with skill. Recommendations for best practices identified trends and patterns of behaviour that impacted on strategic, technical, legal and operational issues in health care. Evidence showed that HIV/Aids must be considered an integral part of health care for policies to become effective in meeting the needs of society. Only by resolving the key issues that prevent effective, efficient, economic and equitable outcomes in health care, can the threats that HIV/Aids pose for health care and public finance be minimised holistically and successfully.