CHAPTER 2: STRATEGY FORMULATION AND THE EXTERNAL ENVIRONMENT OF GOVERNMENT

The essence of strategy formulation is coping with competition (Pearce & Robertson, 2002:85).

2.1 Introduction

Formulating strategies that optimise opportunities and overcome threats depict the complex necessities involved in achieving successful opportunities as well as accentuate the interrelationship between strategic intent, social responsibility and operational environments. Strategy formulation in health care is influenced by international and global trends. Chapter 2 discusses how various trends influence and shape policy-making in the HIV/Aids environment. Moreover, trends influence growth rates (efficiency) which directly impact on the living standards of citizens and the ability of government to provide effective and efficient social security networks that enhance conditions necessary to promote health.

Partnerships with multi- and transnational organisations dominate the HIV/Aids domain. These organisations are powerful voices in that they direct decision-making and strategies for health care reforms which impact on the manner in which HIV/Aids-related problems are solved by governments. Free trade promotes the welfare of countries. Free trade means that all countries can have a comparative advantage in those markets or industries that they are relatively or comparatively the best at. The European Union, United States and Japan do not only prescribe conditions for trade but the multi- and transnational pharmaceutical companies are based in each of these countries. Protectionism through the trade-related aspects of intellectual property rights (TRIPS) has a significant impact on providing more affordable treatments for developing countries therefore Protectionism enjoys political support in the developed countries by enhancing a comparative advantage in a global economy that is fast becoming more interconnected. Assessing the issues of HIV/Aids and how trends influence health care reforms, becomes a pivotal point in understanding the symbiotic relationship between the economic environment, political systems, legal and cultural environments. This relationship is illustrated in an international study of the remote environment of the developed and developing countries which provide insight into the health care systems supported by different ideologies and how HIV/Aids strategies developed.

Macroeconomic policies focus on aggregate income while microeconomic policies look at the individual markets (health care sector), firms (hospitals and medical services) and households. Balancing the distributional and allocation policies relates to economic efficiency and growth and depends on efficient budget management. Government is responsible for allocating scarce resources and building policies that drive the process in health care towards distribution of services thereby increasing and supporting wealth and physical well-being. A government cannot limit the functioning of the market systems in favour of its own allocation and distribution policies, but has to take into consideration the nature and degree of competition and its effect on resource deployment and environmental interactions.

This chapter concludes by highlighting the key issues that impact on strategies in the developed and developing countries. It further shows a shift from state-centric politics towards more complex forms of governance that centre on value-for-money approaches guiding decision-making in public finance, health care reforms and sustainable development. International trade moved in the direction of multilateralism helping developing countries to liberalise and expand in world trade. Sustained growth in the world's gross domestic product is based on the creation and expansion of new markets. This argument forms the key leverage point on which global governance and political ideologies support linkages between the state, society and the economy and public-private partnerships.

2.2 The remote environment

Trends or patterns of world trade influence and direct the way in which business is conducted in government (public sector) and the private sectors (Hough & Neuland, 2000:6; *cf.* Miles & Scott, 2005:169). Some of the international mega trends include technological renewal, rediscovery of capitalism, shifts from manufacturing to service delivery, the development of trading regional blocks and internationalisation of business. Internationalisation is measured in terms of trade, exports, imports cross-border investment flows, international alliances and partnerships with foreign firms. These have significant bearing on how business treats the entire world as its domain in terms of meeting the supply and demand requirements (Hough & Neuland, 2000:3, 6). Internationalisation facilitates new markets and increases competition. The formation of

regional trading blocks such as the European Union (EU) and the North American Free Trade Agreement (NAFTA) has influenced the proportional value of international trade for which individual countries are responsible. Strategic trade policies allowed governments to pursue an economic strategy of earning high profits on foreign markets. Monopolies and oligopolies earn higher profits than firms in competitive markets, challenging governments to regulate relationships carefully. Strategic trade policies allow governments to take measures to ensure that domestic firms win a larger market share (Tayeb, 2000:32). The enactment of policies concerning trade and investment must be consistent with the development of the industrial base and stimulate economic growth as well as attract direct investment into the country. This protects the welfare of the nation (Tayeb, 2000:275).

The regional trading blocks have a direct effect on the growth rate and living standards of citizens (Hough & Neuland, 2000:7). The economic situation, political influence, social life, family relations, health and well-being culminate in migration patterns that have structural effects on the economy (Haour-Knipe & Rector, 1996:20). The concept of migration theory have push (unemployment, lack of democracy, poverty) and pull factors (availability of employment and opportunities) (Haour-Knipe & Rector, 1996:22). Migration, as a potential positive force for development is not reflected in national policies while health status is often used as a means to define who should be allowed to immigrate. In countries where immigrants are perceived as culturally and economically threatening, the immigration and related health policies do not recognise the positive role or special needs of immigrants (xenophobia). Haour-Knipe and Rector (1996:40) further note that health and social problems are created when people are socially marginalised and rejected. This brings about added burdens on health care systems.

The remote environment comprises factors that originate beyond any single organisation's operating situation (Pearce & Robertson, 2000:71). The political, economic, social, technological, legislative and environmental (PESTLE) factors present organisations with opportunities, threats and constraints. While trade agreements that result from improved relations between the developed and developing countries also impact on wages and productivity, trade has substantial distributional implications for a country (Miles & Scott, 2005:184). Hence, government's tend to engage in restrictive trade policies in order to outperform rival nations in certain key high-value-added

activities. Health care and pharmaceutical products are seen as high-value-added activities because in the HIV/Aids environment the supply of drugs and service provision are key issues towards answering the health-related problems (Lee, Buse & Fustukian, 2002:91; *cf.* Lethbridge, 2002b:4). To achieve high-value-added outcomes in health care, government has to balance trade imperatives with health priorities. The supply and production of drugs for HIV/Aids are highly controversial. Trade imperatives versus health priorities lead to conflicting values that question profitability of markets against the delivery of affordable medicines in an aim to reduce poverty (O'Manique, 2004:84). This becomes difficult as these relationships move towards "control and power relationships" versus "conflict of interest" between governments and the pharmaceutical industries in the developed countries. At the centre of the relationship lies the political ideology government supports as this determines the type of government structures built to support its role as provider or enabler. Ideologies and political philosophy also shape government's attitude towards multi- and transnational companies and how its economic policies work together to support the interests of these companies.

Pharmaceutical industries in the developed countries are amongst the most profitable economic activities after tourism and finance. Pharmaceutical industries are global enterprises consisting of six multinational organisations that dominate the global HIV/Aids environment (Siplon, 2002:128; *cf.* Health Committee, 2005:5). Trends of overuse of medicines and overprescribing known as "medicalisation" placed unsustainable demands on the developed countries' NHSs. Health policies provided a confused vision of how "well-being" is maintained in that it simultaneously emphasised the failure of preventative public health measures. Conflicting values and interests influenced the effectiveness of the NHSs. Government health systems are simultaneously faced with the responsibility to promote the interest of the public health system as well as the interest of the pharmaceutical industry. Prioritising and balancing the interest of the patients and public health over the interest of the pharmaceutical industry led by its market forces became extremely difficult. The growth in PPPs exacerbated the conflicting issues. In solving the conflict of interest in health care in the UK, policy analysts proposed that the sponsorship of the pharmaceutical industry be passed from the Department of Health to the Department of Trade and Industry, thereby channelling the functions to the government department which would be the most effective to deal with the related interests (Health Committee, 2005:5).

Miles and Scott (2005:185) state that competitiveness comprises two distinct notions: that of economic growth and comparative advantage or absolute and relative productiveness. Comparative advantage implies that all countries gain from trade which also implies that all countries lose from trade barriers. Therefore, trade should not be viewed as a competition in which a country has to outperform its rivals. As generic drugs have come to play a major role in containing the NHS drug expenditure in the developed and developing countries, more aggressive arguments emanated from the multi- and transnational pharmaceutical companies enforcing patents protection in a bid to safeguard investments and future earnings, as well as profits from their products (Siplon, 2002:134; *cf.* O'Manique, 2004:17,84).

The establishment of service delivery and manufacturing by these multi- and transnational organisations in other countries brought with it a multitude of problems, i.e. the movement of multinational corporations to low-wage nations in a quest to increase profits which harmed unskilled and semi-skilled markets and showed the negative consequence of globalisation. Movement of multinational corporations is complicated when local governments impose high tariffs or quotas on the import of certain goods and services. Companies then choose various methods such as contract manufacturing, licensing or direct investment in the manufacturing facility to introduce and develop new markets (Hough & Neuwland, 2000:18). Compulsory licensing enforced by government enables organisations other than the patent holder to copy patented or copyright products and processes. This allows competitors and generic drug manufacturers to produce the product under government licence without fear of prosecution. Compulsory licences can be issued because of high prices charged by the major pharmaceutical companies for their products (AVERT.ORG, 2005:3).

TRIPS regulations have had a significant impact on providing more affordable treatments for developing countries through "generics". The WTO invited members that were unable to produce pharmaceuticals at home and who suffered serious health crises to import generics from other nations under compulsory licences (Lethbridge, 2002a:10; *cf.* O'Manique, 2004:88; *cf.* AVERT, 2005b:2). However, many of the countries that were in need of compulsory licences received significant amounts of aid from donors. In the fear of losing their supply of international aid and investment, countries were reluctant to

apply for the compulsory licences (Lethbridge, 2002a:10; *cf.* AVERT, 2005b:3). Major pharmaceutical companies bypassed the TRIPS system to make it easier for their drugs to be produced generically by issuing voluntary licences. In South Africa, GlaxoSmithKline issued a voluntary licence to Aspen, a major producer of generics which allowed them to share the rights to their drugs, namely AZT, 3TC and the combination of Combivir (AVERT, 2005b:4). Aspen offered to give 30% of their net sales to one or more NGO fighting HIV/Aids in South Africa (AVERT, 2005b:4).

As generic drug companies invested more in research and development, the countries that produced low-cost medicines were able to come up with original low-cost medicines themselves which competed with existing products. This was evident in both India (Cipla and Ranbaxy) and Brazil where companies that produced generics were able to develop one-day, easy-to-take fixed dose combinations that would be difficult to manufacture in developed countries (Siplon, 2002:135; *cf.* AVERT, 2005a:5; *cf.* AVERT, 2005b:2). Brazil, became the centre of political arguments that highlighted the difference in the USA's waiting list to supply medicine to the poor. Brazil, rated as a poor country, achieved the same levels of compliance to the strict medical regiment despite the fact that it has poor health care infrastructures (Siplon, 2002:135).

The growing position of the private sector working alongside and in the public sector threatened the power of the public health care sector in determining the direction and role of public health care for the future. As profitability and patent protection became the basis on which service delivery outcomes are measured, governments find it more difficult to give effect to the *Ottawa Charter for Health Promotion* and the *Health-for-all policy for the twenty-first century* (Siplon, 2002:134; *cf.* O'Manique, 2004:78).

2.2.1 The global environment

Rich developed nations have the resources available to cope with the increased demands that HIV/Aids place on their health care systems. Turning it from a fatal diagnosis to a chronic condition demanded an intricate network of supporting health care systems (Siplon, 2002:115; *cf.* Labonte, Schrecker, Sanders & Meeus, 2004:40). The increased demands placed on health care systems also impact on government budgets and expenditures. Worldwide the continued rise in health care costs forced governments not only to introduce cost-control mechanisms, but to analyse the conditions that

contributed to increased inflation. The main shift of cost control moved away from the pharmaceutical industry towards the control of other expenses such as salaries and fee structures. Governments focused on the design of intervention strategies and capacity-building initiatives that influenced the supply- and demand-side factors in health care because it offered more equitable outcomes in health care (Economist, 2005b:109).

Lucrative health markets are created in health care through PPP agreements that underscore profit motives as the driving factor in their strategies (Sen, 2003:5). Health care markets are becoming of central importance in health care provision. The growing interrelationship between the private (for-profit and not-for-profit sectors) and public sectors gradually moved the state into the position of enabler and regulator by privatising funding and provision of public services through the General Agreement on Trade in Service (GATS). GATS is used as a facilitator for global governance for privatisation and competition, turning health care into health markets (Lethbridge, 2002a:10; *cf.* Sen, 2003:37; *cf.* Labonte et al, 2004:66). O'Manique (2004:82) states that in theory all countries have a say in trade negotiations. This however, was not the case in the development and application of General Agreement on Tariffs and Trade and World Trade Organisation (GATT/WTO) rules which were strongly influenced by specific industries and the commercial interests of multinational firms (US) in the adoption of the TRIPS agreement.

Although the pharmaceutical companies have become major players in PPP and play a valuable part in health care reforms, drug costs are only about 20% of the overall health care spending and are not seen as the main contributing force in the rise of health care costs (Economist, 2005b:109). Currently, multi-national and transnational corporations are lobbying and competing with Indian, Chinese and Brazilian generic producers to capture large segments of the gross domestic products (GDP) governments spend on public health services (Lethbridge, 2002a:10; *cf.* Economist, 2005b:109). The lower costs of generic producers become increasingly more appealing to governments in their drive towards cost containment and value-for-money approaches. Rather, it is believed that the generic industry will have a slow-down effect on the growth and the value of the pharmaceutical markets (Economist, 2005b:109; *cf.* Muller, 2005). Still, the more lucrative the health markets become, the more difficult it becomes for governments to

regulate accountable and responsible fiscal structures that determine health care outcomes in an equitable manner.

2.2.2 Health care reforms, public finance and partnerships

The developed and developing countries face large demands on already overstretched health care services. The HIV/Aids crisis is stated to be the most severe in southern Africa and is home to 30% of people living with HIV/Aids worldwide. Six countries (Botswana, Namibia, South Africa, Swaziland, Zambia and Zimbabwe) form the global epicentre of the HIV/Aids pandemic (Bauer & Taylor, 2005:278). The scale of the HIV/Aids pandemic makes it the most threatening issue confronting the region as it has become far more than a health crisis. HIV/Aids transcends economic, political and social boundaries and issues and has become a human, social and economic disaster that highlights disparities and inequities in health care (Deaton, 2003:113; *cf.* World Health Organisation, 2004b:8; *cf.* Bauer & Taylor, 2005:278).

Increases in HIV/Aids, TB, malaria and non-communicable diseases have exacerbated access to health care services in African and Asian countries (Gwatkin, 2002:4, 6; *cf.* Deaton, 2003:113). Added to this is the bilateral donor' influence on health care systems as they finance over 50% of health expenditure in most African countries (Uganda, 58%) (Lethbridge, 2002b:7). The increased demand on health services and pressure on governmental resources led to the trend of involving the private sector through a series of mechanisms with the aim of improving efficiency and effectiveness in health care (Gwatkin, 2002:30; Lethbridge, 2002a:5; *cf.* Lethbridge, 2002b:7). Health care reforms were implemented to cope with the changing demands. The approaches taken by the developed and developing countries centred on a public-private mix in health care as opposed to development and the individual's right to health care. Issues revolved around the benefits of options available, choices made and the impact of reforms (McPake & Mills, 2000:8).

The *World Development Report* of 1993 recommended that governments in developing countries shift elements of service provision from the public to the private for-profit health sector if they wanted to cope with the increased demands of HIV/Aids on their health systems (Lee, Buse & Fustukian, 2002:44). The justification for this was the belief that the private sector was technically more efficient in the delivery of health services (Lee et

al., 2002:42; *cf.* Lethbridge, 2002b:4). These arguments were based on the assumption that competition improved quality and drove costs down. United Nation agencies actively supported actions that promoted partnerships between themself and the corporate sector (Richter, 2004:44). For governments to successfully achieve the Millennium Development Goals (MDG), required massive investment in health sectors, budget allocations and official development aid (Freedman, 2005:19). MDG required that governments should foster competition and diversity in the supply of health services and inputs, particularly in the provision of drugs (Lethbridge, 2002b:3; *cf.* Freedman, 2005:20). Through the millennium declaration the health sector is recognised as a central part of the wider development agenda as both the health policy and health sector become the leading wedge in forging equitable and democratic societies set out in the MDG (Freedman, 2005:20).

The value of partnerships and the pursuit of PPP became an integral part of international financing institutions such as WHO, World Bank and United Nations Children's Fund (UNICEF) provided a framework for partnership and action. They emphasised the value of public-private partnerships as an integral part of development planning (Lee et al., 2002:41; *cf.* Lethbridge, 2002a:27; *cf.* World Health Organisation 2004b:26; *cf.* Richter, 2004:43; *cf.* Freedman, 2005:19). Lethbridge (2002a:27) revealed that the influence of each of the United Nations (UN) organisations on health care has been extensive as they promoted two main types of policy to influence service delivery in the health care sector:

- Policies were related to structural adjustments and encouraged economic growth, debt, trade and public sector reforms.
- Policies specifically targeted private sector investment and health sector reform programmes that influenced accessibility.

However, none of these policies have proved that they strengthened health services mainly because health systems are not mechanical structures to deliver technical interventions. Health systems must be seen as core social institutions (Freedman, 2005:21). Over the past 20 years health care systems in developing countries experienced the impact of structural adjustment policies and health sector reforms as advocated and guided by the policy reforms of UN organisations (Lethbridge, 2002b:4; *cf.* Freedman, 2005:21). Corporatisation was seen as the first step in moving health care towards privatisation, implementing more business-like approaches in management (Lee

et al., 2002:45; *cf.* Lethbridge, 2002a:8; *cf.* Lethbridge, 2002b:4). Efficiency improvements in the health sector were based on competitive markets in which government capacity regulated and managed the market (Lee et al., 2002:42). It also recognised that the scaling up of health interventions depended largely on strengthening the overall health system. A range of trends in public administration influenced the approaches governments took towards the type of health care intervention they used and could afford. The trends included deregulation, delayering, decentralisation, re-engineering, privatisation, accountability enhancements and technological developments (Cooper, Brady, Hidalgo-Hardeman, Hyde, Naff, Ott & White, 1998:389). Strengthening the overall health system demanded value propositions through value-creating strategies. This meant taking into consideration the serious problems experienced in human resource shortages. The essence of strategy lies in its activities and internal processes (value chain) (Kaplan & Norton, 2001:90; *cf.* Freedman, 2005:20).

Public-private partnerships are presented as an innovative approach of the new millennium with no other acceptable alternative (Richter, 2004:45). PPPs allowed governments to draw the private sector into operating with the public sector. These partnerships covered a range of relationships and became the preferred choice for interventions in the health sector. Formalising links and partnerships between organisations in different sectors is a major challenge, as one needs to understand the driving force that guides the strategic intent and the value propositions in each sector.

2.3 How competitive forces shape strategy

International financial markets are important to governments, multinational firms and investors as these markets consist of foreign exchange, derivatives, debt relief and equity management. The international financial markets assist government and central banks to finance fiscal and current account deficits and maintain their exchange rates in order to keep their products profitable and competitive (Tayeb, 2000:43). An increase in inflation rates reduces the countries' competitive advantage and directly impacts on economic growth.

Competitive forces influenced the way organisations in each sector shape their strategies. Strategies are determined by each organisation's perceived threat of new entrants, the bargaining power they offer to customers and suppliers, and how

threatened they are by alternative or new services or products and the jockeying amongst contestants. Each one of these five forces identified by Pearce and Robertson (2003:86) and Porter (1990:69) is a crucial element that determines if public, private and NGO sectors face the need to change rapidly for survival (Verzuh, 2003:20). No sector stands separate from these forces and even though governments are not driven by increased profit margins for shareholders, they still have to understand how economic, social and political decisions are intertwined and impact on each sector as this has a significant bearing on allocation and distributional structures, economic stability and inflation (Moffat, 2005; *cf.* Muller, 2005).

More aggressive growth goals demonstrate effectiveness, efficiency, customer satisfaction and whether new initiatives can be taken on. Strategic competencies and risk management alters the opportunity-versus-risk equation as it leads to early problem recognition, more accurate cost forecasts and provides better performance outcomes. Health care in the developed countries support supply-side economics in which the bargaining power of suppliers are underscored by competitive pressures which provide the groundwork for strategic actions (Tayeb, 2000:31, 37; *cf.* Pearce & Robertson, 2003:86; *cf.* Verzuh, 2003:21; *cf.* Abedian et al., 2003:185).

2.4 Contending forces and HIV/Aids

The writings of Adam Smith (1723-1790) describe the virtues of market decisions. Personal beneficial market decisions are, according to Adam Smith, also socially beneficial. The social benefit can be identified as efficiency (Hillman, 2003:3). Efficiency in the competitive market is linked to the supply- and demand-side factors. Efficiency achieved through markets requires that markets must be competitive. Markets often fail to achieve efficiency and it then becomes the responsibility of government to correct the inefficiencies. These inefficiencies occur when spending benefits the collective interests of a number of people at the same time. Markets alone do not ensure efficiency, especially when individual market decisions affect the outcomes of each other. Therefore, economic reasons alone do not determine why some goods or services are provided exclusively by private or public sector organisations (Farnhan & Horton, 1996:28; *cf.* Hillman, 2003:10).

Although the main argument on which these decisions are based is that the bottomline for business is profits while the bottomline for government is described as power and politics, the ultimate choice in the public sector reflects political choices and priorities at a given time instead of only economic reasons. The strongest competitive force in the private sector is determined by profitability that becomes a driver in strategy formulation (Pearce & Robertson, 2003:86; *cf.* Greene, 2005:318). Therefore, different forces take prominence in shaping competition in each industry. In health care, the key force is the suppliers. One has to keep in mind that every industry has an underlying structure formed by a set of fundamental economic and technical characteristics that give rise to competitive forces. In order to strategise and understand the factors that influence the health care environment, it becomes imperative to identify the characteristics that are critical to the strength of each competitive force and how it links with the public, private and NGO sectors (Pearce & Robertson, 2003:84-87).

2.5 The global environment and strategic considerations for multi- and transnational organisations

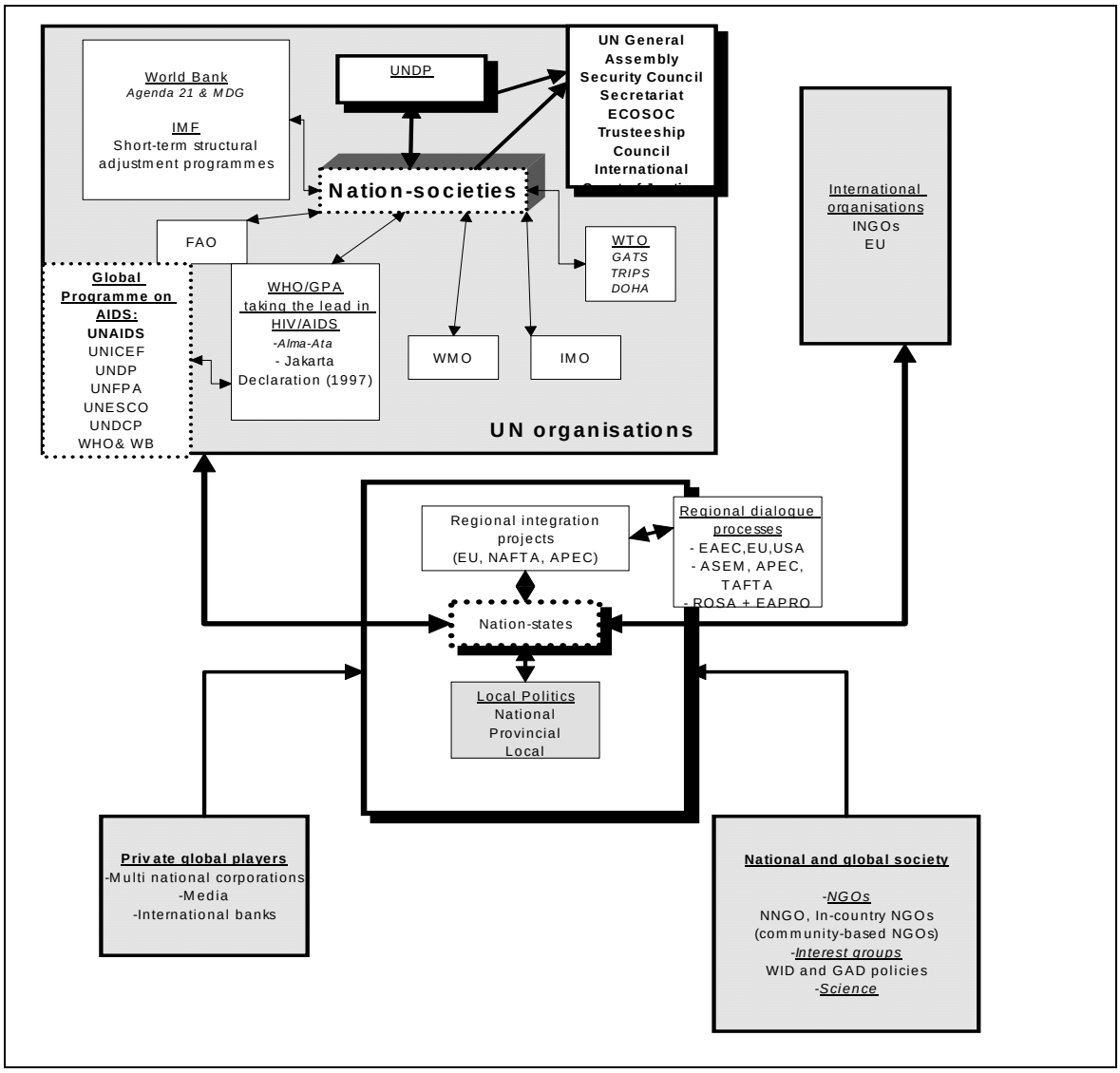
Global trends in global structures identify transnational interaction, concatenated interdependencies and a variety of border-crossing integration processes (Kennedy, Messner & Nuscheler, 2002:30). The impact of the transnational interaction is becoming a determining factor in the policy environment and how development initiatives were put together.

During the 1990s, the promotion of health care became an active part of the global governance system through global public-private partnerships (GPPPs) that were formed between the health sector and the UN agencies (Lee et al., 2002:45). The sectors encouraged global trends that mainly consisted of the contracting out of clinical, diagnostic and support services. These global trends resulted in the expansion of the private sector and massive investments in high-technology equipment and treatment. The supply-side factors drove the private health care sector through policy reforms. The policy reforms were influenced by the trends UN agencies prescribed through their theories on development (Lee et al., 2002:48; *cf.* Lethbridge, 2002a:47). Globalised health markets pushed market forces forward and used a three-category classification of health GPPP which is developed for product-based (drugs), product development-based (initiated by public sector in research) and issues and systems-based partnerships (strategic consistency). The industry used these classifications as a basis to embark on

a multipronged strategy to gain access to and influence multilateral and UN decision-making (Lee et al., 2002:48). The promotion of growth within the private sector has been so successful that current private health care systems show monopolistic signs, indirectly weakening the public sector health systems worldwide.

In a schematic layout, the roleplayers in global governance and their role in determining development outcomes for nation-states to nation-societies are presented. Nation-societies remain the main actors in international politics providing the framework for global governance (Kennedy et al., 2002:122, 134). Global governance is not deemed viable without the networks between state, society and economy. Public-private partnerships become the link between state, society and economy which means that the state co-operates with social groups in which they work out joint solutions for common problems (Kennedy et al., 2002:162). Participation thus occurs in a bottom-up decision-making procedure instead of the traditional top-down approach.

Figure 2.1: Global Governance and development



Source: Adapted from Kennedy, Messner, Nusheler (2002:122, 143); Spiegel, Taw, Wehling, Williams (2004:610).

Figure 2.1 shows the increased number of social subsystems developing beyond the national boundaries which are all tied to regulatory systems. The six principal bodies of the United Nations focus on specific issues and are vehicles for administering universal norms, global security, and humanitarian assistance, and facilitate debates (Krasno, 2004:4). The most significant development has been the establishment of the WTO in 1995 which acts as the platform for national governments and transnational corporations (TNC) in newly established markets of the service sector (Hoekman & Martin, 2001:75; *cf.* Sen, 2003:5). The General Agreement on Trade in Services (GATS) is an integral

part of the WTO arrangements and covers health, education, public utilities, social welfare, financial services and transport. GATS encourages trade and regulates tender procedures in the service industries between government and the private sector (Hoekman & Martin, 2001:75, 85; *cf.* Sen, 2003:37).

The WTO is pushing PPP forward making way for the multinational and transnational corporations to capture some part of the gross domestic product that governments spend on public health services (Lee et al., 2002:48; *cf.* Sen, 2003:45). WHO has moved health systems towards the concept of "new universalism" which means supplying quality essential services defined by cost-effectiveness criteria to the population as a whole (Sen, 2003:68). With this new system, it is argued that the private market is able to respond more effectively to the complex health problems. However, as Sen (2003:42) points out, revising GATS would reduce access to health care and undermine mechanisms for containing costs. Therefore, international law and rules governing profits and shares must be implemented so that they do not have adverse health, social and environmental impacts. With this in mind, many governments are restructuring their public services and GATS is seen as a mechanism for locking in existing commercial practices (Sen, 2003:45).

2.5.1 The influence of global environments on strategy and HIV/Aids interventions

The effects of globalisation and regionalisation add a new dimension to arguments as they influenced development theories and ideologies. Furthermore, these new dimensions influenced agenda-setting, framing of priorities, building coalitions and justifying policies which determine the role of the state as a development agent (Labonte et al., 2004:1). Labonte et al. (2004:2) define *globalisation* as: "… a constellation of a process by which nations, business and people are becoming more connected and interdependent across the globe through increased economic integration and communication exchange, cultural diffusion (especially of Western culture) and travel".

Buse and Walt (in Lee et al., 2002:43) state that globalisation forced a shift from state-centric politics to more complex forms of multicentred governance and provided a new set of challenges to the existing multilateral systems. The new set of challenges changed the key notions of the sovereign state. The nation-state is giving way to a transition from industrialised societies to knowledge and information societies (Korten, 1990:29; *cf.*

Kennedy et al., 2002:9). Globalisation and regionalisation are overtaking the standard unit of development from the conventional agent - the state, with the international institutions and market forces now setting the tone for development (Pieterse, 2001:1). Global trends are pushing development trends in the direction of a world society (Kennedy et al., 2002:27; *cf.* Lee et al., 2002:43). These changes bring new challenges as they impact on all spheres of life. Kennedy et al. (2002:27) portray the new world society as an increased involvement of non-statal actors in transboundary interactions. They also illustrate this as the multiplication and networking of political, economic and social levels of action.

Scheil-Adlung (2001:114) points out that the health care markets are becoming of central importance for health care provision. This process started with the Alma-Ata Conference in September 1978 when a plea was made for a system of primary health care (Van der Velden, Van Ginneken, Velema, De Walle & Van Wijnen, 1995:21; *cf.* Szirmai, 1997:141). The United Nations' Assembly endorsed the Alma-Ata in 1979 and the WHO adopted it in its *Global Strategy for Health for All by the Year 2000* (WHO, 1981). Primary health care was seen as a basic human right that must be accessible, affordable and socially relevant (Van der Velden et al., 1995:25; *cf.* Szirmai, 1997:141).

With the Jakarta Declaration (1997), the World Health Organisation member states made commitments to a global strategy for *Health for All* (WHO and Education and Communication, 1997; *cf.* Promotion, 2004). It was concluded that comprehensive approaches to health development were the most effective, and new responses were needed. The *Ottawa Charter for Health Promotion* formed the guideline for health promotion. The Jakarta Declaration (1997) emphasised the role of the World Health Organisation in taking the lead towards building global health initiatives. This was accomplished by the formation of partnerships between governments, NGOs, development banks, UN agencies and the private sector (WHO and Education and Communication, 1997; *cf.* Promotion, 2004). These goals were strengthened in May 1998 with the World Health Organisation's declaration *Health-for-all policy for the twenty-first century* which discussed the issues of reducing social and economic inequities.

The Millennium Development Goals became an instrument of sustainable development in which governance structures were put together to reduce social and economic

inequities. The strategies for reaching these goals were based on health promotion, health education, disease prevention cure and care (Van der Velden et al., 1995:19). In addition, equity in the distribution of health systems became a core determinant in establishing the effectiveness of strategies (Van der Velden et al., 1995:19; *cf.* Maxwell, 2005:3). Priorities for public expenditure were based on the improvement of infrastructure for productive sectors of which accessibility to clean water became a major issue. Health and education improves growth and reduces poverty. Social protection is based on the heart of poverty-reduction strategies as it provides safeguards for health and nutrition (Maxwell, 2005:6).

The fifth Global Health Promotion Conference (2000) held in Mexico City focused on the social determinants of health and its impact on the economic sector. By signing the Mexican ministerial statement on health promotion *From Ideas to Actions*, the sustainability of local, national and international actions in health were drawn into plans of action to monitor and promote health care (Promotion, 2004). One can conclude that the Alma-Ata conference shaped health policies and strategies worldwide (Szirmai, 1997:143). Various authors argue that with the implementation of Alma-Ata the focus was taken away from a curative care approach and directed towards a primary health care approach which emphasised the reallocation of medical funds to improve accessibility and participation in local health care centres (Van der Velden et al., 1995:21; *cf.* Szirmai, 1997:143). The primary health care concept has dominated both (inter)national policy-making and programme development for the past two decades and continues to do so (Van der Velden et al., 1995:21).

2.5.2 Factors that influence strategic decisions in health care

Development is concerned with the improvement of living conditions and the elimination of poverty (Kingsbury, Remenyi, McKay & Hunt, 2004:1). Development is seen as the world's most critical problem as it incorporates the most pressing issues that involve history, material resources, economic infrastructure, trading links, political systems, conflict and the environment. Even though the terminology of development has changed, development continues to challenge sustainable reduction of poverty on a global scale through participation, empowerment and investments that achieve sectoral reforms. Some countries that were previously regarded as Third World and who are generally classified as "developing countries" have managed to improve their position with the right

mix of policies combined with honest and competent governments (Kingsbury al., 2004:9).

The gap between the developing countries and developed countries increased in an environment in which the international economic and ideological order demanded greater focus on the accountability and transparency of decision-makers, more attention on governance issues that supported pro-poor policies, fairer international economic relations in free market capitalism for the control of the development agenda. The relationship between health and development and poverty reduction became a core factor in that it defined quality of life and well-being (Freedman, 2005:20).

The belief that the wealthier developed countries could assist the poorer developing countries, originated after the Second World War. This belief continued to shape international development targets of the UN agencies and motives for co-operation in the light of globalisation. In 1996, the Organisation for Economic Cooperation and Development (OECD)'s Development Assistance Committee placed emphasis on effective partnerships and locally owned development strategies (Lee et al., 2002:43; *cf.* Kingsbury et al., 2004:81). Underlying the global growth in health care markets are trends that bring long-term structural changes in health care (Scheiler-Adlung, 2001:115). These changes are underlined by global trends in governance. This process of global change does not only involve governments or international organisations as instruments of the world states but calls for more state-organised multilateralism and co-operation of government and non-government organisations from the local to the global level (Kennedy et al. 2002:161; *cf.* Sen, 2003:37). The NGOs have gained an influential voice in shaping policy in soft policy areas such as environment, human rights and gender issues. This move influenced and changed the traditional approaches taken in health care in that it involved the private sector of donor countries in playing an active part in development co-operation(Kennedy et al., 2002:162).

Various factors influenced the approaches taken to health care. These factors, as indicated in Table 2.1 are identified within the literature study and formed the framework for the assessment of the international case studies.

Table 2.1: Factors taken into consideration in analysing the international health care environment

Political	o The ideology and "class structures" that shape the role of the state through: o Constitution o Democracy and participation o State intervention o Building state capacity in health care: o Reforms o Electoral processes o Role of executive and policy o International relations and global governance structures o Regional trading blocks o International aid
Economical (Enabler and facilitator)	o Market outcomes and government interventions o Government fiscal policies: macro and micro policies o Economic systems and supporting economic policies o Implications for the public sector and public finance o Socio-economic arrangement and its impact on employment o Influence of religion and culture upon social policy o HIV/Aids impact on: • Employment, economic systems and growth • Influence of religion and culture • government fiscal structures • private sector
Social (Distribution of goods and services)	o Role of the state o Intervention - approach to social development and poverty: social justice o Main determinants of social policy • Predominantly internal factors ▪ Demographic factors ▪ Political factor ▪ Institutional evaluation factor ▪ Economic factors (rate of growth per capital) ▪ Influence of interest/pressure groups ▪ Social psychological factor

	Political factor = sum total of demographic + economic + social psychological factors. This means social security is a political problem • Predominant external factors ▪ Cultural diffusion ▪ Technical development ▪ International standardisation and co-operation o Health care markets and HIV/Aids interventions o Health care reform and policies: link between health, social welfare and poverty • Privatisation: Health care markets: Public-private partnerships • HIV/Aids intervention strategies ▪ Costs ▪ Constraints in system ▪ Assumptions ▪ Policies o Employment and ill health/ HIV/Aids • Government income and budgeting • Impact of New Public Management on service delivery and financial management • PPPs and HIV/Aids
Technological	o IT, development and health care reforms o Financial information systems a key element in organisational planning and decision-making o Administrative structures and IT support
Legislative	o Role of government o Health care policies and its impact on HIV/Aids intervention o HIV/Aids policies and fiscal structures
Health Environment: (global, regional and national)	o Millennium Declaration and environmental policies for HIV/Aids: developed and developing countries o Poverty and social inequities: urbanisation, rural (cultural environment) o Infrastructure o Migration

Source: Own framework (2006).

Each of the factors set out in Table 2.1 explores the relationship between the political, social and economic environments in the developed and developing countries. Evidence

from the study showed that the resources and skills available in the developed and developing countries determine how health systems are constructed. It showed how various strategies combine within the ideological framework which a country supports in order to cope with the changing and growing demands made on health care. Annexure A presents a study of the health care systems and its impact on HIV/Aids strategies for the developed countries (Case Study 1 and Case Study 2).

Annexure B investigates the health care systems of the developing countries and how policy decisions for HIV/Aids are influenced by the ideological perspectives of the developed countries. Annexure B illustrates that in the marketisation and emergence of global health markets many of the low and middle-income countries saw substantial changes in their health sectors. These changes included public sector dominance of health care provision and financing to one where there are substantial levels of private sector activity (Lee et al., 2002:78). The relative size of the outcomes of the market system reflects the relative power of various stakeholders. This is emphasised by the trade-off power of sellers to maximise profits and the ability of the consumers of health care to constrain them. Too many problems (inequities) in the private market called for a shift from government orientation towards that of a more regulatory role in health care (Lee et al, 2002:81).

Distilling the key issues from the developed and developing countries (Annexure A and Annexure B) offer insight into those factors in the remote environment that influenced health care reforms and impacted on strategies for HIV/Aids. The key issues that have the greatest impact on determining strategies are discussed in the political, economical, social, technological, legislative and HIV/Aids environment as follows:

2.5.2.1 Political factors

Politically, the developed nations play a determining role in global policy-making and the global structure. The global structures provide a framework for decision-making strategies and determine the type of role government takes in intervention strategies. The ideological orientation of the developing countries is strongly influenced by various patterns of colonialism and imperialism that shaped attitudes and development approaches. These attitudes are being influenced by western political thought, namely classic liberalism, socialism and conservatism. Democratic ideologies such as

contemporary liberalism remain an ideal American enterprise and influence development thinking as it seeks to extend democracy and capitalism thereby enhancing the role of government through the introduction of the Breton-Wood agencies.

Globalisation and regionalisation has changed the standard unit of development, “the nation state” into a “world society”. Transnational interaction determined development initiatives especially as international institutions and market forces set the tone for development. Therefore, it became imperative that leaders had to be actively involved in regional development and economic integration in order to strengthen their economies. None of the countries investigated had similar ideological orientations and the final policy choice and the type of strategy selected to solve health-related problems were strongly influenced by the political institutional structures and previous experiences that shaped their political preferences. Added to this, electoral processes framed by the ideological approach in which different political views in society coexist and compete for the political power, played a significant role in deciding which policies were priorities and in need of funding. The power balance between citizens and public sector determined the type of state interference, the degree of empowerment and values utilised towards decision-making and accessibility of services.

The constitution is central to democracy and the creation of well-being. The constitution determines how governance structures, power relationships, accountability and administrative systems underscore political ideologies and provides the rules for democracy and participation achieved through decentralisation and the devolution of powers, as well as the development of strong local government structures that support service delivery between local and national spheres. Intervention is encouraged through market-orientated reforms in which the state assumes control over the allocation of resources and incentive structures for investment through sustained economic growth. Partnerships between health departments, local authorities, voluntary sector and service users are viewed as a key success factor in the mobilisation of economic and social development. PPP becomes a link between the state, society and the economy. Participation occurrs in a bottom-up decentralised manner which takes decision-making away from a system that was driven by national targets towards a system that is driven by the needs of society (within the local spheres). A bottom-up approach allows for micro reforms. Competitive tendering encourages democratic values through value-for-money

approaches within an equal and social just system. Building state capacity in NHS is encouraged through partnerships in infrastructure development and modernisation of services in order to improve quality service outcomes. Improved quality service outcomes leads to the strengthening of policy implementation capacity, thereby delivering services efficiently, effectively, economically and equitably (4Es).

International co-operation is provided by the developed countries who contribute loans and funds through intricate networks of international organisations for development initiatives in the developing countries to raise living standards, reduce inequalities in health care organisations and to provide loans for upliftment and development of communities. The World Bank supported by the International Finance Corporation (IFC) stimulates technical initiatives towards PPPs and infrastructure development. In service delivery, built-operate-transfer (BOT) schemes are the preferred option, especially in education and health. The World Bank takes a strong position against concessions because they easily evolve into monopolies (Picazo, 2005). No model for BOT was known to exist that provides for HIV/Aids and a whole range of services or there was no single focus on HIV/Aids. The Global Fund was created to be a unique PPP in assisting HIV/Aids responses (PEPFAR and the supply-chain management systems (SCMS)).

2.5.2.2 Economic factors

The market outcomes and the role government plays in stimulating the economic environment are determined by the constitution of each country investigated. The neo-liberal approach is the most popular method of state intervention in the developing countries in that it promotes the highest degree of spiritual and material well-being. The core task of government is to focus on well-being and the difference in class structures thereby reducing poverty. Growth and sustainability in government is achieved through sustained investment in public goods such as health care and depends on economic efficiency and social justice. A growing economy will improve well-being. Fiscal policies as well as the government budget have important supply-side effects and are used to fight unemployment by cutting debt and public expenditure. The way government manages its own finances constitutes a large part of the GDP. Health care spending in the developed countries is much higher than in the developing countries. Governments encourage consumer spending and the growth of the private sector by promoting

competition and efficiency which leads to efficiency and growth. Monetary policies focus on the supply of money and impacts on the demand-side of macro economic policies.

Market-based approaches changed budgeting and allocative processes towards public expenditure management and linked expenditure with measurable results tied to value-for-money approaches. Separating the effects of public finance from public policy and social justice is impossible as each outcome is intertwined with choices, trade-offs and political promises. Raising and spending of public funds is influenced and determined by political philosophies and ideologies that underpins the citizen-state (electoral) relationships. Market-orientated economies (mixed markets) provide the best solutions in a democratic society. The principles of supply and demand in a mixed economy are based on equitability in distribution and allocation of health care by providing accessible services and improving opportunities and securities. Economic systems and supporting economic policies are devoted to pro-growth policies and free markets.

The monopolistic behaviour of transnational corporations through the manipulation of intellectual property rights (TRIPS), influenced political and policy decisions in the HIV/Aids environment. Strong health markets developed, resulting in conflict of interests between the public and private health sectors which impacted on equities, costs and accessibility of services.

Partnerships between the public, private and NGO sectors demanded a shift towards horisontal and broader-based policies which moved governments into the role of enabler and facilitator coordinating multisectoral responses between all sectors. These sectors became an integral part of the budgeting process as the supply and demand burden of high costs are shared on all levels, reducing public finance for goods and services and making it possible to continue health and social service deliveries.

The wide gaps in literacy rates between male and female, cultural beliefs and practices based on strong hierarchical caste systems and the rights of women exacerbated HIV/Aids and impacted negatively on growth and revenue-gathering structures. These negative trends are strengthened by poor infrastructure, fragmented services and absence of skills and resources. This is clearly visible in the rural areas where an

absence of skills and resources led to increased demands made on governments fiscal structures.

2.5.2.3 Social factors

Governments in the developing countries prefer to utilise a developmental approach to social and health reforms. Partnerships form the core of service delivery and production of goods in which the government enables, facilitates and regulates conditions that enhance social redistribution, social provision and empowerment. Policy decisions are influenced by the link between poverty, health and well-being. HIV/Aids becomes an integral part of the NHS and is not seen in isolation. Health programmes are framed in the social model that supports primary health care (PHC) and local delivery planning by integrating health services with wider economic and social development and encourages participation.

Responses to HIV/Aids were placed within the broader macroeconomic framework which centred on institutional and structural reforms (capacity building). A minimalist approach to welfare and health care propagated by UN agencies predominated and influenced policy decisions in the developing countries as international aid conditions enforced specific views. These views preferred voluntary and private sector partnerships to manage health care initiatives in HIV/Aids that are guided by “abstinence policies” or a separate act to define and regulate aid in HIV/Aids and provide guidelines to metropolitan areas to strengthen PHC.

Worldwide, governments moved away from expensive curative care (medical model) towards palliative care, support mechanisms and prevention (affordability, value for money and risk transfers). The developing countries showed low health spending compared to the developed countries. This influenced the impact of HIV/Aids on social and health care systems. The absence of resources compounded the effect of HIV/Aids case loads in the developing countries. The growth of “health markets” in developing countries showed increased profits and shareholding for the private sector. Unfortunately, it also showed a negative increase of the net effects in public health due to an absence of explicit policies to manage and regulate the growth of the private health markets which led to an uneven growth and imbalance between the private and public

sector. This has a negative impact on service delivery to the poor and the quality of outcomes.

Governments encouraged the process of privatisation and corporatisation through tax exemptions, subsidies and liberal lending from public financial institutions. Resources in private health care moved towards acute and high-technology care with fewer resources to PHC in rural areas which reduced accessibility and the quality of care. The private sector is not interested in providing free and accessible care, but focuses on the enforcement of intellectual property; particularly in the pharmaceutical sector.

Government strategies provided a foundation for public-private partnerships by strengthening community-based programmes and by implementing prevention programmes through behavioural change, information and awareness, strengthening PHCS and infrastructure to support service delivery; improve quality of service delivery, surveillance and research (specific focus on reseach and development (R&D)) and placing an increased focus on information and awareness through education.

A parallel shift in health care policy occurred in which governments moved away from a system that is mainly driven by national targets. This changed the approaches taken to HIV/Aids strategies as it integrated and intertwined HIV/Aids in the NHS towards a focus that determined standards which formed the main drivers for quality services (minimum service outcomes are specified). Fewer national targets with more emphasis on local priority plans developed in partnership with NHS. Financial systems that support a “payment by result” approach (outcomes-based) formed the basis for intervention strategies. Emphasis is placed on demand-side factors (instead of the traditional supply-side factors) where patient and choices with quality form the main drivers for service delivery. This is supported by service modernisation, ITC and capacity-building through partnership agreements strengthening NHS in service delivery.

2.5.2.4 Technical factors

Information restructured the economy from the manufacturing of products towards the production of knowledge. This trend had a significant impact on science and technology (R&D) as this is a critical element of wealth creation and public goods. The United States reduced its R&D investment and is gradually losing its position as world leader. The

disputes between the developed and developing countries on intellectual property (patent rights) and generics, form critical issues in R&D debates and HIV/Aids. CARE Ware, an electronic medical record and reporting system developed for HIV patients, is currently tested as part of the PEPFAR initiative.

The modernisation and improvement of NHS required greater investment in information technology. Telemedicine and ITC brought a paradigm shift in health care as it brought treatment to remote areas through technology. Case Study 3 is taking all possible steps to become a global information technological superpower. High-tech manufacturing is the fastest growing sector driven by Asian economies. The digital divide between the developed and developing countries reduced the developing countries' competitive advantage which had a major impact on infrastructure and service delivery.

Internet has increased and spread the influence of Aids activists. They challenged the ownership of Aids issues by medical and academic experts and shifted the ownership of policy issues to the people who are affected by the disease. The Aids activists and NGO sectors have become powerful voices in the policy-making process.

2.5.2.5 Legislative factors

The International lawmakers approached HIV/Aids issues by emphasising "the right to health care" (health rights). However, even though they provided guidelines, these had to be seen as recommendations that are not legally binding. This meant that enforcement mechanisms had to be adapted to suit local situations in accordance with UN Resolution No. 1995/44 passed by the Commission on Human Rights. It is thus the responsibility of each country to enforce the international law in accordance with the UN Resolutions.

Legislation takes an integrationist approach (informed consent and confidentiality) towards HIV/Aids and health care policies. The patient is central to the strategy in combating HIV/Aids. Governments must review legislation and practices to ensure privacy and integrity. No specific legislation measures for HIV/Aids have been adopted on the statute books of the developing countries. Issues are resolved through their health policy and a policy for public-private partnerships in health that combines health-sector strategic plans.

Regulatory and sectoral laws must resolve power relationships amongst the few entities participating in competitive tendering and stipulate conditions to form a consortium of a minimum number of private sector parties to avoid collusion in partnership projects and the formation of monopolies. It is all about containing competitive tensions. Very little legislation exists on PPP because it is interwoven in existing laws. It is important to provide primary legislation to give banks and contracting parties' legal powers when long-term contracts are negotiated so that each party can get their money when things go wrong, and know that there are ways out for all parties involved. Both the developed and developing countries make use of PPP units that supports government treasuries in their role as enabler, facilitator and regulator whereby the unit provides technical support to government departments. The units are responsible for PPP implementation.

2.5.2.6 HIV/Aids environmental factors

The sustainable development strategy is framed by the MDG, the Doha Development Agenda of the WTO, the Monterey Consensus on Finance Development and the World Summit on Sustainable Development (WSSD), 2002. The MDG focuses on poverty eradication and sees it as a major component in solving HIV/Aids-related problems. Women are the hardest hit by HIV/Aids in the developing countries because HIV/Aids is intertwined in the cultural practices. HIV/Aids shows the highest infection rates in urban areas where cultural practices dominate relationships in communities.

NHS (public and private sectors) demands higher dependency on complex infrastructure that engages in the global networks. Worldwide, large demands are made on overstretched health care services thereby increasing the demands on social spending and public finance structures. Local authorities are faced with a need to provide more services and infrastructure but do not have the funds to support this. GDP spending of government is increased by HIV/Aids. PPP is a mechanism in the local sphere of government that improves service backlogs. PPP is a viable option when ROI is maximised and risks minimised. The key success factor of PPP is based in management and initiatives associated with balancing risks throughout the project cycle. PPP procurement is a movement away from the traditional procurement tool. It is a complex mechanism that demands a high level of skills in both the public and private sector in order to provide successful outcomes. The history of PPPs abounds with failed projects

but when used with skill it becomes a highly effective mechanism. No known models for PPP in the HIV/Aids environment exist as such. PPPs are not effective in all sectors. Health and education at the moment are seen as the areas in which it shows the best outcomes.

The developed countries formed partnerships through the G8 (France, US, UK, Germany, Italy, Canada, Japan, EU) with the developing countries to provide collective management of the world economy and reconciliation of globalised tensions between G8 members and generating global political leadership. NEPAD was welcomed in the *G8 Africa Action Plan*. The NEPAD document is a merger of the Millennium Africa Recovery Plan (MAP) which focused on economic policies stimulating sustainable economic growth and the OMEGA Plan which focused on infrastructure development. Migrant labour influenced economic development and caused societal disruption at multiple levels. The growing movements of migrants impact on trade routes (economy), health care systems and social security systems of the developed and developing countries.

2.6 Conclusion

Strategy formulation is about exploiting the opportunities that are available by selecting critical environmental variables and identifying the factors that influence strategies. The strategic key issues (economy, society and demographics, politics and technology) in the remote environment provide strategic forecasting issues by identifying the trends in this environment that have significant impact on effective and efficient health care delivery. The strategic key issues play a determining role in shaping HIV/Aids interventions.

The next chapter investigates the global impact of HIV/Aids on health care and public finance structures. Although HIV/Aids is a syndrome, in this study the term *disease* will be used to describe it. The study provides a short introduction to the “disease” and its epidemiology. HIV/Aids is strictly speaking not a disease but a collection of many different conditions that manifest in the body, showing different manifestations and timelines. This increases the unpredictable nature of the disease, uncertainty and risk factors regarding HIV transmission.