CHAPTER 7: DEVELOPING ALTERNATIVE HEALTH POLICY OPTIONS

Health care is extremely difficult in South Africa because it is one of the most highly inflationary medical systems in the world probably equal the US. I haven't seen any system…so a word of caution to do PPP on an extremely large scale because if it were less inflationary like in other countries then you would not have the problem. But since it is, can you imagine the cost of caring for HIV positive person if you do it through a PPP? (Picazo, 2005).

You know the more I think about it, we are making something of HIV/Aids, something that it is not supposed to be. In my opinion HIV/Aids is by now a normal condition and you cannot in my opinion divorce HIV/Aids from the rest of the provision of medical services…… You must just say HIV/Aids is a primary health function and it must happen there. An HIV/Aids program and patient will cost you on the long run a lot more. But a lot of the treatment which the patient will require will be antibiotic, cough medicine… the ARV part only comes in towards the end when full blown Aids is diagnosed (Muller,2005).

The accessibility of clinics depends on the community. It doesn't matter if it is in the rural areas or in urban areas (Pienaar, Venter & Maluleka, 2005).

7.1 Introduction

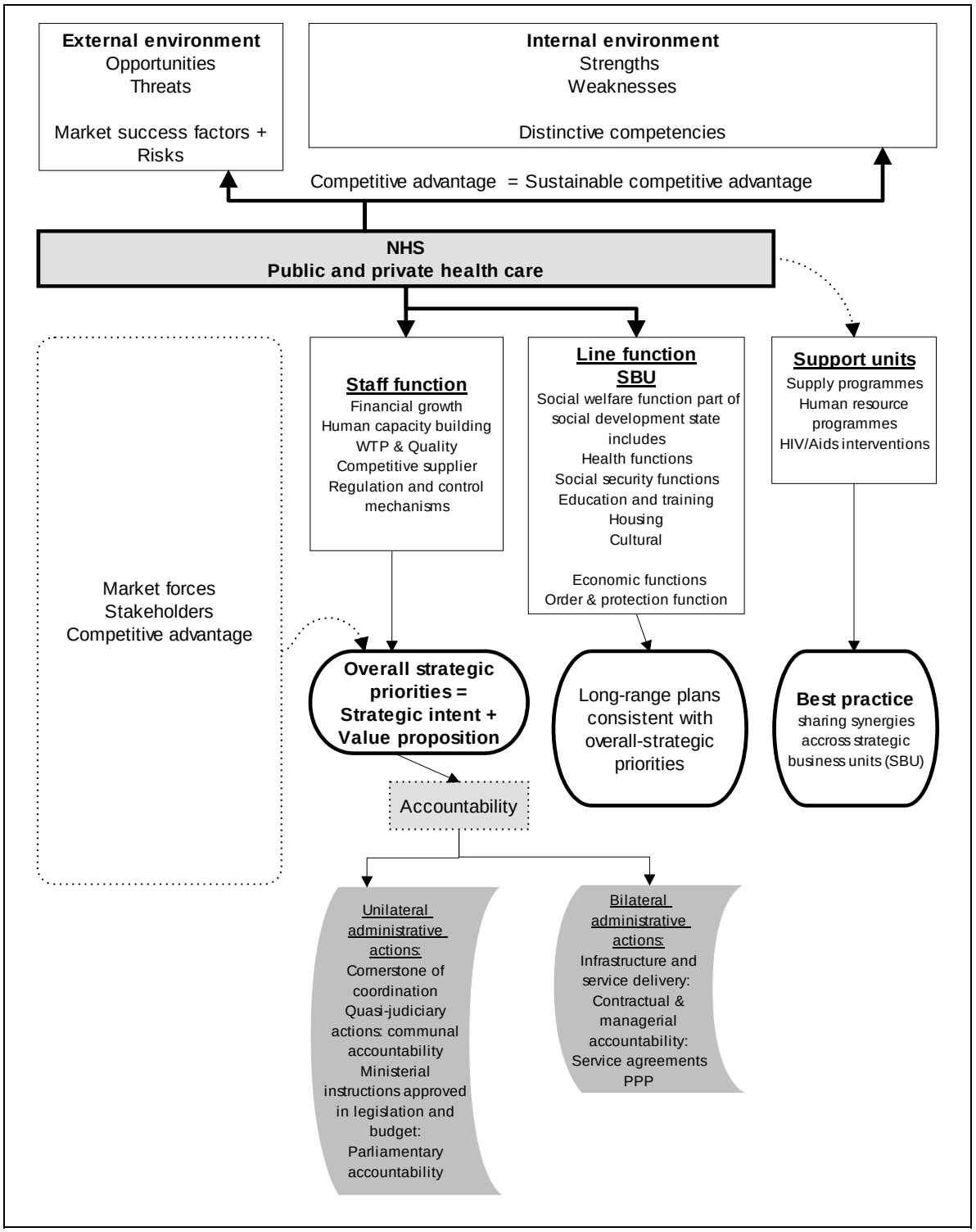
The main issues, trends and patterns in the data with reference to the research question are broadly discussed in this chapter. Options are therefore linked to trends and patterns to provide for new and alternative approaches that solve the problem statement by questioning the extent to which the overall strategic objectives have impacted on the roll-out plan for HIV/Aids policies in South Africa.

On account of high uncertainties and risks that surround HIV/Aids, policy implementation has increased the demands made on management's ability to frame clear and well-defined strategic, operational and technical objectives. The strategic outcomes are further complicated by changing perspectives in public management. The NPM movement reshaped thinking and approaches taken in public policy-making and public management which has significant consequences for public finance. With the NPM an

increased emphasis is placed on utilising public-private partnerships as a mechanism for fiscal responsibility. Utilising public-private partnerships transforms the nature of government functions and the role government plays in establishing quality service outcomes. Gildenhuys (1997:46) recognises the importance of first coming to understand different ideologies and how this influences the nature of government functions before rational decisions can be made on recommending the best strategic outcome and policy directives. This rationale formed the core determinant in overcoming the threat that HIV/Aids posed for public finance and health care delivery in this study. Literature indicates that by strengthening health policy capacity the government improved its ability to deliver services more effectively, efficiently, economically and equitably (4Es). Strengthening and building state capacity leads to improved implementation of health care interventions in the national health care system. It therefore requires increased investment in infrastructure development as well as the provision of clinical and administrative systems. By considering the above actions, it is believed that the government will be able to cope more effectively with the increased demands placed on its health finance structures.

Value-for-money approaches support policies that are easily administered and take account of the short-, medium- and long-term interests by enabling and providing opportunities for sustained developmental issues. Figure 7.1 forms a template for the following discussion of results on which the factors within the external and internal environments were linked with concurrent government functions and overall strategies to achieve best practice outcomes for NHS and HIV/Aids interventions.

Figure 7.1: Linking health and concurrent functions of government with overall strategic outcomes in the NHS



Source: Adapted from Kaplan and Norton (2001:48); Roux, Brynard, Botes, Fourie (1997:338); Gildenhuys (1997:24).

7.2 Discussion of international results (external remote environments)

Worldwide, health care reforms and the approaches taken towards HIV/Aids interventions are strongly influenced by political institutional structures and market forces that are driven by two global roleplayers, the United States and the United Kingdom. The political ideologies of these two global roleplayers are a dominant force in the power relationships that steer the process of globalisation and regional development. They direct the positions that developing countries take within the world society and determine the global trends that push development and transnational interaction which became a determining factor in policy and how development initiatives are put together (Kennedy et al., 2002:27). Their strategies guided by development theories are mainly influenced by political preferences and ideologies which regulate outcomes of global and regional economies. The impact of the power relationship between the developed and the developing countries has a profound effect on the revenue structures of developing countries, their available resources and the ability to cope with the increased demands made on health care systems as well as the effect of spiralling health costs on their budgets and their direct ability to cope with HIV/Aids.

Schumpeter stresses that competition is profoundly dynamic in character as the nature of economic position is not in equilibrium but is driven by a motion of continuous change (Porter, 1990:70). The importance of countries keeping their competitive advantage in an industry such as “health markets” is thus centred on finding new markets and identifying a need for new technology (Porter, 1990: 71; *cf.* Pearce & Robertson, 2003:85). At the core of establishing competitive markets are international organisations and health markets which set the tone for development (Lee et al., 2002:48; *cf*. Sen, 2003:45; *cf.* Labonte et al, 2004:1). It is widely recognised that in economies of scale, technological leads and the differentiation of products create positive conditions for trade that offer advantages in exports and sustained development (Porter, 1990:33,70). Technological superiority and the ability to produce more differentiated and higher-quality products are key issues in the creation of health markets and in keeping the competitive advantage in an industry. It is critical to understand that transnational organisations compete in international markets and that it is these firms that create and sustain the competitive advantage and explain the role the nation plays within the process (Porter, 1990:33; *cf.* Hough & Neuland, 2000:34). Patent rights and intellectual property (TRIPS), profiteering and shareholding place the developed countries in a bargaining position and provided

them with a competitive advantage which determined the costs associated with HIV/Aids interventions (Lethbridge, 2002a:10; *cf.* Siplon, 2002:115; *cf.* AVERT, 2005a; *cf.* AVERT, 2005b). Developed countries have adequate financial resources to develop new treatments as well as adjust their health systems to cope with the increased demands made on their budgets, infrastructure and support systems, taking HIV/Aids from a fatal to a chronic condition. In contrast, the developing countries (low- to middle-income countries) have inadequate resources, poorly developed public and private health care sectors and 90% of HIV/Aids patients in need of care (Barnett & Whiteside, 2002:195; *cf.* Siplon, 2002:134).

This meant that HIV/Aids has come to challenge traditional health care and economic systems in both the developed and developing countries because even though the developed countries have less patients, the costs and inabilities of the developing countries to cope with HIV/Aids and health care have a carry-through effect on their economies and health care systems. HIV/Aids emphasises the inadequacies and differences between “rich (have) and poor (have not)”. Worldwide, it forced governments into accepting responsibility for reducing poverty and all its social-related problems. The Millennium Development Goals (MDG) became an instrument of sustainable development for the developing countries in that it supported governance structures which reduced social and economic inequities.

Literature indicates that efficiency improvements in health care are based on competitive markets in which government capacity is regulated and the market is managed. Scaling up of health interventions depends on strengthening the overall health care system. A key success factor in answering health-related problems thus lies in service delivery and the supply of goods. Currently, all health interventions in the developed countries are built on and steered by supply-side economics which favours the wealthy in that the fiscal policy encourages lower taxes and minimises the government’s presence in the economy by putting the supply of money in the hands of business. Likewise, the supply-side character encourages expensive technology-driven and curative treatments in which the bottomline is profits.

By forcing governments to take on more social responsibilities governments had to reassess their role and the impact that ideologies and political preferences had on

budgeting processes and service delivery outcomes. This meant a shift away from the supply-side economies towards the inclusion and balancing of demand-side factors. How the supply and demand-side economies are utilised influences all government functions as they are affected by the way revenue is raised and how public money is spent. Distribution and allocation policies are executed through government budgets. Creating a balance between the economic and social policy is critical for wealth creation and physical well-being which are the underlying factors that determine successful outcomes for HIV/Aids strategies. While the demand-side theory puts the cash in the hands of the patient who is responsible to negotiate for more efficient treatment interventions, the supply and demand functions set the boundaries for efficiency, competition and value-for-money approaches. It should also be noted that policies implemented without considering how they influence the entire system undermine the country's competitive advantage and have severe effects on economic growth and economic efficiency.

Public budgeting is about public policy. Fiscal policy involves the macroeconomic theory and the achievement of economic growth by reducing and managing inflationary behaviour. The inflationary behaviour of health care has a significant impact on the development and design of organisational structures in health care, as well as the growth of the private sector versus public sector.

Through the background study (Annexure A and Annexure B) it became apparent that various governments coped differently with the burden that HIV/Aids placed on their budgets (distribution and allocation) and expenditure pattern. Allocative efficiency (efficiency in product mix) impacts on the capacity of the budget system to distribute resources. The resources available for distribution are determined by government priorities and the choice of intervention programmes in health care systems, social security networks and economic sectors and how these interact with each other. No fixed pattern or template is available as allocative efficiency, productive efficiency, efficiency in consumption as well as administrative efficiency in health care differ in all case studies investigated.

Comparing the intervention strategies and applying a timeline to the actions showed that developing countries applied a similar type of policy interventions for HIV/Aids, as their strategies were steered by the economic and political impacts of the developed countries

on the developing world. However, developed countries used extensive international funding to solve HIV/Aids-related problems. Acceptance of these funds (UN organisations) came with specific demands and requirements for policy structures which could explain why similar trends in solving HIV/Aids-related problems were used in the developing countries. Strategic interventions showed particular problems which included the failure to integrate health services with the wider economic and social development environment. However, all case studies experienced poor participation in their local spheres. This could be contributed to the development of health care and planning according to national targets that did not take cognisance of the local priorities, needs and desires.

Available resources and capacity-building initiatives stood out as determining factors in the design of effective strategies in each of the four countries investigated. By comparing the intervention strategies that were used to develop roll-out plans for HIV/Aids policy and health care systems, one saw that the strategic interventions and roll-out plans for controlling the impact of HIV/Aids in the developing countries started much earlier than in the developed countries. This happened mainly because HIV/Aids affected the economies and available resources of the developing countries at a much earlier stage. The approach to strategic interventions was initially based on improving the institutional capacity based on the views of the WHO who considered HIV/Aids solely as a medical problem. Later, a movement towards structural development (SAP) propagated by the World Bank moved the developing countries towards strategic interventions that recognised the socioeconomic impact of HIV/Aids on the economy and society. Pro-growth policies emphasised strategic actions that encouraged good governance and partnerships within the HIV/Aids environment. It highlighted the impact that individual policies had in different contexts and called to attention the need for good governance and accountability practices (McPake & Mills, 2000:813).

PPP became the dominant slogan of ideologies supported by contemporary conservatism (libertarians) and propagated by the developed countries for improved governance and development. Each case study was influenced by trends that shaped health care interventions and how government perceived its role as enabler, facilitator and regulator. The trends such as deregulation, delayering, decentralisation, re-engineering, privatisation, accountability enhancements and technological developments

determined how governance and accountability practices were put together (Cooper et al., 1998:29). The trends were further influenced by the relationship between the citizen and state which determined how much emphasis was placed on the common good of its citizens, the culture and religious practices which contributed to the characteristics of government, the type of role the state selected to play in achieving well-being and how government constructed its judicial and legislative measures.

Each of these trends were swayed by hidden assumptions that framed preconceived ideas and ascertained how problems related to HIV/Aids were framed, the type of strategies they supported in designing health care systems and governments' operational definition of health care needs for its citizens. Improved health care and education strategies dominated the political landscape within a model of constitutional democracy. The competitive economic markets overruled and even steered political philosophy and thinking. Hence, finding new and innovative ways to support governments in putting together funding mechanisms that are able to cope with the increased costs of service delivery shared by all sectors, is mostly driven by competitive and economic market forces hinged on consumerism. The NPM movement encouraged this trend by moving governments towards applying businesslike approaches in their day-to-day practices.

Health care reforms became an integral part of the events and decisions that occur within the political, economical and social fields. All health activities are intertwined in some way with the outcomes and strategies applied to well-being in each of these fields. In order for health care strategies to be successful, it became imperative that the strategies had to identify the market success factors and strategic risks that influenced its ability to provide sustainable and effective outcomes in service delivery. Risk management is an integrative function of strategic management and requires that strategic risk drivers (technical and programmatic issues) and strategic risk indicators (cost and time schedules) have to be identified in order to be operationally effective and efficient. The high levels of uncertainty and risk that surround HIV/Aids policy decisions require that health and finance structures must be built to environments that can change and adapt to the needs of the communities it serves. Health care becomes an important instrument in achieving social development and a driver in realising sustainable outcomes. Evidence from all four case studies showed that health care cannot stand on

its own as a separate entity. Well-being and "common good" are interwoven into all aspects of life, and are determined by political philosophies and ideologies; economic growth; empowerment and employment issues such as migration; the security needs and gender issues, poverty and social dimensions of cultural practices and its influence on savings and security needs of individuals and families; technological aspects; legislative issues and human rights; and environmental issues such as agriculture and nutritional needs and quality life expectancy (Qualy). Poverty is perceived as the greatest threat to well-being. The MDG advises that poverty must be halved by 2015 which means that massive investments in the health sector are necessary to realise each of these goals.

7.2.1 Developed countries

Political ideologies shaped the role of the state as well as the economic market and this determined how welfare and health care reforms were approached. During the ninteenth-century the expansion of economic forces changed the notion of the private sphere and civil society. It came to challenge the integrity of the state (Schecter, 2000:37). Significant differences in approaches to welfare and health care during this time became evident in both case studies. Case Study 1 showed a movement towards equality of opportunity and social justice (a commitment to liberty and democracy and sought to fuse liberal ideals with other ideologies such as democratic socialism) while Case Study 2 moved away from the concept of social justice, supporting minimalist state intervention (liberalism reformed into contemporary liberalism) and the Keynesian concept in which the state managed capitalism by using its power to supply public services with minimum economic and social inputs.

Evidence drawn from a historical study showed that the evolvement of health and social reforms within the developed countries were framed within social welfare initiatives that underscored poverty relief interventions and the development of health care initiatives. The social dimensions that underpinned attitudes towards social welfare were framed within an ideology of Christian charity which became the pivotal point from which social state functions and activities grew. This allowed governments to put together welfare structures that met specific needs, desires and demands of the citizens. The concept of natural rights played an important role in the approaches social theorists attached to political justifications. Evidence from the case studies showed that the type of welfare

structures each country supported depends on their political philosophies. These political philosophies were shaped by major events in history. The Poor Law Acts, revolutions and the Second World War were events that were recognised in literature to have a significant impact on the evolvement of welfare structures in both case studies. The Second World War and the period of industrialisation changed the role of the state in two directions. On the one hand, the role of the state moved towards that of a provider and care giver (social welfare model) that demanded heavily constrained public finances and on the other hand, a residual welfare model developed in which the state supported minimal state interference and rejected the social justice arguments entirely with an emphasis on minimal public finance (Bailey, 2004:20). However, both countries supported political, economical and social ideologies which moved the role of the state into improving and developing better social conditions for the individual that defined and supported “common good and well-being in health care”.

A major difference in health care outcomes was based on the amount of state interference which determined the type of interventions the government used to implement the distribution of welfare. While politics expressed the will of the state, the administrative structures supported the execution of policies. Thereby public administration provided a dominant base for practices and values that had to be pursued with regard to good governance and the way powers are exercised. Values and practices are deeply ingrained in the cultural practices and define the conduct of democracy in both case studies.

A capitalist and market-orientated economy framed the government’s fiscal and monetary policies and determined the size of the the public versus private sectors. Stakeholders such as the multi- and transnational organisations which dominated and played a very important role in the global economy were based on both case studies. Pharmaceutical companies became powerful voices in health policy agendas as they represented profitable incomes and are strong leaders in the economic activity. The economic systems in Case Study 1 moved towards a shareholding capitalist system while Case Study 2 moved towards a managerial capitalist system. The health systems were strongly influenced by each system. The health system in Case Study 1 moved towards primary care trusts (PCT) in which shareholding and partnerships underscored relationships. Health systems in Case Study 1 were built on highly competitive and

inflationary management systems in which profits form the driving force. The difference in approach influenced economic policies and thinking in public management and public administration. This determined how each country saw its role as enabler in facilitating conditions for economic growth and sustainable development as well as how social goods and services are distributed.

7.2.2 Developing countries

The political ideologies of the developing countries were influenced by liberalism and the Westminster-style parliamentary system (unitary characteristics). The Constitution embodies the citizens' rights and promotes cultural diversities in which traditions and caste systems complicated the political environment. The ideologies of contemporary liberalism and neo-liberalism shaped initiatives and development theories that were applied within the developing countries. This is clearly evident in Case Study 4 where government budgets comprised 58% of international aid of which the United States is a major source of funding through the World Bank, International Monetary Fund and USAID. Health care services are delivered to communities by national and international NGOs (mostly mission facilities) which formed an integral part of the operating budget. In an interview, Picazo (2005) stated that: "…this public-private thing is modelled in Africa, which I have not seen in other countries…"

Because the Case Study 4 cannot cope with the health care demands made on its budget, public-private partnerships amongst the public sector, NGOs and CBO formed a core part of its health care system. Health care reforms are therefore devised in response to public dissatisfaction. In the developing countries, the state encouraged privatisation and corporatisation of medical care through incentives in an aim to make government structures more cost-effective and leaner. This led to the state directly neglecting public hospitals and public service.

As no policies or regulations guided health care reforms in the private sector, quality and pricing turned medical care in a lucrative business that led to the creation of monopolies in private health care. Profits and an absence of supplier-demand controls dominated private health care and pushed costs of health care upwards. Pharmaceutical companies developed partnerships with specialist hospitals that demanded expensive curative treatments. A trend developed in each of the developing countries where poor

public health care and an absence of available resources required governments to seek NGO collaboration in an effort to integrate health services with wider economic and social development and achieve better participatory involvement at local levels. Decentralisation came to play a vital role in achieving participation at local levels. The developing countries were all faced by high levels of unemployment, a growth in poverty and high demands on welfare structures with poorly developed economies and infrastructure to support demands which resulted in an increased vulnerability amongst women and children to cope with the socioeconomic effects of HIV/Aids on their well-being.

7.2.3 Comparison between capacity-building initiatives within health reforms in the developed and developing countries

Available resources and capacity-building initiatives form the main determining factors in the design of effective strategies. The foundation of effective strategies was based on strategic competence (the strategic skills and knowledge required by a workforce to support strategy that drives risk), strategic technologies (the information systems and data bases required to support strategy) and the ability to create an environment for action (administrative support and finance).

Kaplan and Norton (2001:75) state that a sustainable strategic position comes from a system of activities in which each reinforced the other. Building capacity in health care reforms and achieving sustainable outcomes in HIV/Aids and health care demand that one recognises that the strategic position must come from a system of activities in which positive or negative outcomes are reinforced down the line. Therefore, solving HIV/Aids problems requires that policies must be integrated in the organisational and fiscal systems used by governments. The main actions necessary to strengthen policy implementation were consistent in all case studies investigated. However, the manner in which the operational strategies were implemented differed as well as the time schedules applied. A main constraint in achieving sustainable outcomes by building institutional capacity within the developing countries was an absence of strategies that dealt with human capacity development (skills). This affected the vertical and horizontal co-ordination within the government sectors resulting in a reliance on partnerships and the growth of monopolies and monopsonies outside the public health sector. Adding to the negative effect of monopolies was the absence of policies and regulations from the side of government that regulated the growth of public-private sectors.

Developing countries utilised a pseudo-PPP in which one saw a subvention of NGOs and mission facilities financed by international aid organisations, while the developed countries preferred to use BOT schemes which allowed the private sector to finance service delivery in the provision of general health care (Picazo, 2005; *cf.* Muller, 2005). BOT schemes encouraged private investment by the promise of profits. However, private investment shies away from risk and uncertainty which is one of the core issues affecting HIV/Aids environments. In discussions with Muller (2005), he pointed out that PPP are found to be the most effective in areas where high profits are to be made. PPP are rarely applied in rural areas where the customers are unable to pay.

Utilising PPP as procurement tool increased inflationary behaviour in the health care sector of the developed countries, mainly because shareholding demanded continuous growth in profits, forcing fees to rise. The escalating costs of health care in the developed countries reduced capacity-building initiatives in the developing countries as increased health costs diminished their ability to cope with the threat of HIV/Aids. Likewise, the high costs associated with the treatment of HIV/Aids, poor return on investment and its negative impact on the economy meant that “no PPP that dealt specific with HIV/Aids” was found to be utilised in the developed or developing countries.

Various external and internal factors influence decision-making in the type of strategies government selected to achieve fiscal responsibility in its approach to deal with HIV/Aids. Reforms that dealt with capacity-building in the health care sector are closely linked to microeconomic factors in which the focus is on the improvement of infrastructure and skills development, while the health and wealth of the industry depends on the macro-economy factors such as changing interest rates and its affect on individuals (employment) and companies (growth). Due to the high costs associated with infrastructure development and huge backlogs (both in developed and developing countries), governments were forced to find alternative ways to fund these operations. PPP and PFI were seen as attractive alternatives in the developed countries. PPP also provided the developed countries (multinational organisations) with the opportunity to finance projects in the developing countries and as such open up new markets for their own economies.

PPP and investments brought major benefits to the developed and developing countries of which investments in infrastructure development brought advantages to support economic growth. PPP provided private investment through BOT schemes in which service charges are repaid over long-term periods of 25 to 30 years through concessions. It was considered that BOT schemes secured better value for money and for this reason it became the preferred option to be utilised in the developed countries. A reason for this trend is that instead of showing large amounts on their budget, costs are converted into evolutionary costs (Muller, 2005). Instead of a once-off payment, the government pays for the infrastructure and service delivery over the life-time (wholelife cost) of the programme. This involves interest rates which go with NPV and ROI. Regulating these costs in the budgeting process becomes extremely difficult and demands high levels of skills in the workforce.

Lessons learnt by the developed countries (Case Study 1) showed that managing and containing costs in PPP are extremely difficult as increased fees over long periods (25 to 30 years) impact on the expenditure budget. As the costs are not fixed and escalate, depending on the type of service agreements, a situation develops in which government budgets are burdened by payment of service agreements which started of cheap and are becoming more and more expensive to cover profits and loan repayments. The investments through PPPs (as a procurement tool) in infrastructure tend to grow out of control if not managed properly as became evident in Case Study 1 (Economist 2005a:47; *cf.* Hyman, 2005:413; *cf*. Farquharson, 2005). Therefore, PPPs must be seen as a procurement tool that needs highly skilled people who are able to manage the process effectively (Farquharson, 2005).

7.2.4 International KPI and key issues that impact on HIV/Aids intervention strategies

The development of HIV/Aids intervention strategies followed similar trends worldwide in which capacity development was placed at the core of all strategic designs. What differed was the fiscal mechanisms used by governments to achieve their goals. The way in which fiscal mechanisms were utilised to support the activities in reaching strategic goals and objectives depended largely on factors such as skills levels of employees, the economic systems that supported the political and social environment, the strength of the economy and its impact on tax and revenue collection and the government's ideology and approach to social justice. Each country applied different

linkages between health care and social security networks and how this was built around supply and demand which influenced distribution and allocation policies in achieving a "Pareto efficiency" (Barr, 1998:73; *cf.* Abedian et al., 2003:186; *cf.* Hillman, 2003:10).

Issues that influenced efficiency in health care and its application to HIV/Aids intervention strategies, relate to aspects such as accessibility of services, responsiveness, fairness, equity and value for money (quality). *Accessibility of services* is defined through an operational definition that depended on how the government applies the concept "health for all" and how the government managed its strategic role as an effective state in the provision of health care services through regulating, enabling and facilitating opportunities. As indicated, the initial strategies took a top-down approach in combination with vertical programmes that integrated HIV/Aids into the budget process. Moving towards partnership programmes demanded a bottom-up approach which meant a move away from the vertical programmes towards horizontal programmes. As efficiency relates to interventions taken to improve internal efficiency, accessibility and equity in preventative service delivery, it now required parallel shifts that moved the government away from a focus on national targets towards strategies that took an internal and comprehensive approach (Barr, 1998). The impact of this approach entailed that HIV/Aids strategies are integrated into the NHS in which the focal point is based on internal efficiency that determines standards for quality, fewer targets with more emphasis on accessibility and responsiveness within the local spheres of service delivery.

Partnerships are a determining point in the process of service delivery at the local spheres. A shift to demand- and supply-side factors is central to the formation of strategic interventions in partnership agreements. Demand-side factors in which the patient as customer has more say in the decision-making process combined with choice and quality form a balance against previous one-sided supply factors that dominated health interventions. Government strategies support these actions by funding capacity-building initiatives that emphasise service modernisation, ITC development and improvement through partnership agreements which strengthens the NHS in its goal to improve service delivery in all the spheres of government. The main issues to be addressed in health care reforms center around the controll of the growth in health care spending and preventing health care from absorbing increasing shares of the GDP as

well as finding ways in which to improve the market efficiency for health care (Hyman, 2005:347).

7.2.5 The role of PPP within international health care reforms and HIV/Aids intervention strategies

As governments became more comfortable with involving the private sector in long-term solutions for public sector activities, the concepts on which PPPs were based reflected the desire to sustain a close working relationship with external markets (Domberger & Fernandez, 1999:29). PPPs were accepted as valuable tools that achieved value-for-money outcomes in the health care reforms because it offered access to market skills and expertise, created new markets for products and services, improved quality in service delivery, offered cost savings through competitive tendering and negotiations, managed fluctuations in demands, provided access to technology and offered better accountability mechanisms.

However, it was difficult to establish the real cost of managing a PPP relationship. Domberger and Fernandez (1999:29) argue that the management costs of PPPs are significant compared to management costs when it is kept in-house. This argument was also supported in interviews, although it was felt that some countries that combined PPPs with public works programmes were worse off as it became impossible to track the costs of services (Farquharson, 2005; *cf.* Muller, 2005).

PPPs in international health care were about the procurement of health infrastructure and not the clinical services. There was a definite difference between the applications of PPP in each country. Case Study 1 used a narrow focus (neo-liberal) in that there is a very definite political divide between health infrastructure and clinical services. PPP focused specifically on the refurbishment of the health estate within the primary, secondary and tertiary spheres of service delivery while Case Study 2 used a much broader and different definition (contemporary conservatism) which is closely tied to the ideologies and how government perceived its role in the delivery of health care (Farquharson, 2005). No single focus was placed on HIV/Aids in any of the developed countries. It was argued that by clearing infrastructure backlogs and correcting the health system it will automatically correct and solve issues related to HIV/Aids.

PPP changes the strategic departure from the way the public sector used to function. The transformation of the public sector from producer to purchaser changed the skills sets of public servants. They operate in an environment of co-operative rather than adversarial contracting which requires skills in contract management, performance monitoring and liaison with stakeholders. One can conclude that the skills needed is not so much focused on delivery as it is on being able to define and articulate very clearly what the outputs are on behalf of the citizens. Service delivery is far removed from the old production model of operation where the public sector providers determine service delivery levels, employ staff necessary to produce them and deliver the service to the end-user themselves. The complexities of service delivery used in PPP relationships revolve around clearly specified expectations that are well managed through the whole life of the relationship.

7.3 Discussion of national results (external and internal environmental analysis)

Westernised ideologies and practices influenced and shaped the national governance systems and policy-making approaches. The roleplayers in global governance formed a determining role in how case study five positioned itself as a nation-state and within the world society (Kennedy et al., 2002:122; *cf.* Krasno, 2004:4; *cf.* O'Manique, 2004:44). International relations are critical elements in the formation of partnerships between nation-states and the transition from an industrialised society towards knowledge and information (Porter, 1998:73; *cf.* Kennedy et al., 2002:30). The ability of a nation to reduce its digital divide and transform into a competitive knowledge-based society determines the success of regional development which impacts on stability and growth within the economy.

Case Study 5 based its policies on a neo-liberal approach that supports market-driven policies on trade, investment, employment and government spending. These policies enhance a social developmental approach to service delivery which is framed within a constitution and embraces democratic principles. As a middle income country the social development policies revolve around "Poverty and Growth Programmes" placing a strong focus on capacity-building within a market-driven economy. The social developmental approach demanded increased social spending in functions such as health, housing, education and social security networks which placed increased demands on public finance as well as its ability to deliver services to the poorer

communities. Each of these functions is a critical element in balancing out the effects of inequities. All of these functions work together to create poverty-reduction strategies that empower communities (through economic efficiency and pro-growth policies) and present more security and equity to communities (through the application of social justice and balancing of distribution policies). Growing inequities and ill-regulated growth in privatisation precipitates economic and political upheaval.

The socioeconomic impact of HIV/Aids on employment saw a strong relationship between poverty and ill health. HIV/Aids impacts more on the unemployed and unskilled labour category in the youth. Migrants are usually fairly young and typically in their twenties or early thirties (Haour-Knipe & Rector, 1996:18). A strong correlation between migrant labour, poverty and ill health became evident from the situational analysis.

The situational analysis identified migrant labour as both a major external threat/risk and internal threat. Its impact as an external threat was based on reducing the market success and sustainability of economic policy outcomes. Migrant labour internally threatened the sustainability of distinctive competencies in health systems as well as reduced the impact of value-creating strategies within health and thus negatively influenced the outcomes of HIV/Aids strategies and the costs associated with building an effective NHS. This directly decreased customer value and prevented operational excellence in implementing HIV/Aids roll-out plans. Case Study 5 has positioned itself as a strong leader in regional development. Evidence from Table 6.1 and Annexure H showed that the country draws heavily on migrant labour from its neighbouring states to support economic development especially in areas such as mining and trucking. Considering that migrant labour is drawn from countries such as Malawi, Zimbabwe, Mozambique, Botswana and Lesotho of which Botswana and Lesotho have the highest HIV/Aids infections within the African epicentre, it should be seen as an external and internal risk reducing the market success of health care interventions. The findings presented in the Nelson Mandela Foundation report (2005) supported this overall trend of migration in its National HIV Prevalence survey outcomes presented in December 2005. To minimise the threat that migrant labour posed through HIV/Aids required that the political, economical, social, technical and legislative aspects must be integrated within the development of alternative strategies and policies. This research study shows that the government must focus on policies that slow the spread of Aids as well as the

demographic trajectory of the pandemic. Arndt and Lewis (2000:8) stress the need to investigate the interactions between the pandemic and alternative growth and development strategies. This meant that policies that support migrant practices must focus on finding more creative ways to manage the spread of HIV/Aids from neighbouring states, without having a negative impact on the economic policies and regional trading relations.

The internal weaknesses and the compounded effect that migrant labour posed to the successful implementation of HIV/Aids strategies increased the complexities associated with public finance and its supporting administrative systems. Building a problem tree through an effect-cause-effect analysis showed that migrant labour directly contributed to shortages of skilled labour in all sectors of health care. The shortage of skilled labour within the NHS mainly occurred due to movement of labour between the different sectors as well as the movement of skilled labour from developing to developed countries for higher salaries (Haour-Knipe & Rector, 196:31). The brain drain in all three sectors was determined by issues such as job satisfaction, inadequate recognition for a job done well, insufficient information to do the job well, active encouragement to be creative and use initiative, overall satisfaction with the health sector and support level from staff functions.

The loss of human and intellectual capital (brain drain) affected the sustainability of health care initiatives and the costs of providing effective health care structures. The growth of the private sector into a monopolistic situation is the result of inadequate mechanisms that regulate the supply-side character of health care linked to medical insurance (prepaid plans) and out-of-pocket expenditure (See Table 4.2). A conflict of interest developed between the different sectors. This increased the competitive tensions between demand and supply characteristics of health care (Abedian et al., 2003:174). It also emphasised the need for horizontal policies which supported network structures that made use of strategic alliances and joint ventures which resulted in blurred boundaries (Roux & Schoeman, 2004:533).

Social development and the social model support “the right to health care” as basis for strategic interventions towards a PHCS which stand in direct opposition of profit motifs supported by a market-based economy. This aspect became a core issue that

continuously challenged the role and ideologies of the state and the desires of public-private partnerships. Profiteering, steered by supply-side characteristics increased the costs associated with health care in the public sector. This happened due to the increased complexities associated with the management of partnership agreements. The complexities were associated with broader-based horizontal policies which challenged traditional vertical authority structures in government systems and the design of accountability and governance structures between the public-private sectors.

Strategies are not co-ordinated to achieve the best value-for-money outcome in the HIV/Aids roll-out plans, and health care reforms lead to poor accessibility of clinics as well as poorly co-ordinated and fragmented gras-roots intervention strategies in health care. The PHC and DHC strategies are linked to continuous changes within an inflexible health environment. This reduced the government's ability to effectively roll-out HIV/Aids strategies. A major weakness in creating an effective state was based on inadequate co-operation and communication between sectors and government departments. This increased with the complexities of horizontal and vertical alignment of finances between national and provincial spheres of government as well as intersectoral co-ordination between governmental departments.

The impact of migrant labour on human resource management and its subsequent impact on the strategic intent of HIV/Aids strategies become even clearer when the internal weaknesses are measured against the operational processes, customer and equality processes, innovative processes, regulatory and social processes. Human capital forms the foundation and becomes the most important driver in achieving value-creating outcomes and reaching the strategic intent. Information capital and organisational capital are building blocks necessary to achieve quality in service delivery. The strategic outcome of the roll-out plans for HIV/Aids is therefore strongly influenced by the components and interrelationship that exist between the internal process measures and customer value propositions in health. Utilising PPP as a strategic measure necessary to achieve value creation in health and HIV/Aids is thus one option available in building capacity in the long term. One can therefore conclude that the outcomes achieved through utilising PPPs are linked to human capital and their ability to use PPP as a tool in achieving economic efficiency and social justice.

7.3.1 The influence of NPM approaches towards strengthening government policy capacity and improving service delivery outcomes in health care and HIV/Aids interventions

The NPM movement guided the institutional reforms (Case Study 5) towards new institutional economics that were based on concepts of public choice and simultaneously emphasised managerialism. Under the NPM, institutional reforms encouraged governance and sustainable development with a focus on 4Es that improved financial responsibility. Public finance concentrated on strengthening efficiency, thereby correcting negative economic growth towards positive economic growth with broader tax bases. This complements the economic welfare state idea in that it allows for social development initiatives that are encouraged through market-based approaches in the budgeting and allocative processes. Public Expenditure Management (PEM) formed the basis on which the PFMA, 1999 linked expenditure to measurable results. The application of market-based approaches and the implementation of user fees not only contributed to revenues and efficiency but also encouraged better synergy between social services and NHS.

PPP, co-operation and relationships gradually replaced terminology such as “competition”. Partnerships and particularly PPP became a dominant slogan in discourse about governance and development. NPM advocated that PPPs were effective development tools as it led to greater fiscal responsibility and encouraged macroeconomic planning within the fiscal and monetary policy. This was recognised in Case Study 5 and formed the core principles for the definition for PPPs as a mechanism towards fiscal responsibility within the PFMA and the supporting Treasury Regulations. It is therefore argued that PPPs offer the government an instrument to build institutional capacity and develop organisational structures. Through the development of infrastructure, the government became more comfortable to form partnerships in which long-term market-based solutions strengthened the NHS. The value-for-money approaches encouraged through partnership agreements between the NGOs or CSO, private and public sector offered quick solutions to the huge backlogs that existed in service delivery. Partnerships opened up new and innovative ways for the public sector to utilise market-based approaches and to divide the burden of high costs between each of the sectors to serve the government’s purpose in the best and most appropriate manner. However, the utilisation of PPPs in health care proved to be a bit of an enigma

because of a resistance in health care to come forward with innovative approaches in utilising PPP.

The design of the National Treasury's PPP Manual and Standardised PPP Provisions are founded on the PFMA, 1999 and Treasury Regulation 16. The PPP model proposed in the PPP manual encouraged sustainable development and state efficiency according to key economic strategies supported in the Gear. Ideally, PPPs brought with it efficiency in economic growth, improved unemployment figures and reduced social security spending, thereby building resilience towards HIV/Aids in communities. However, a major constraint that prevented the successful achievement of both macro- and microeconomic development in providing government with a competitive advantage (through the effective use of PPPs in Case Study 5), was identified within this study as:

- The negative impact that migrant labour practices had on the microeconomic policies and its direct negative effect on reaching strategic outcomes in building human capacity in health care.
- The role that human capital played in establishing value propositions centred on customer-centric business with support groups to meet the needs as efficiently as possible (Boninelli & Meyer, 2004:73; *cf.* Kaplan & Norton, 2004:13).
- The value human capacity creates for line management in that it becomes a player more than a partner in supporting the long-range plans consistent with the overall strategic priorities (Boninelli & Meyer, 2004:73).

Turnaround strategies had to focus on skills and infrastructure development as a driver for accelerated growth. The accelerated and shared growth initiative (AsgiSA) replaced the Gear strategy in 2006 (Ntingi, 2005:16). AsgiSA is designed to be a turnaround vehicle that cuts down inflation and reduces the budget deficit by targeting the micro economic reforms that extends and complements previous Gear strategies.

In the SWOT analysis (Annexure H), evidence pointed out that although the government was able to strengthen its international and regional relationships, thereby increasing its financial integration into the global economy and its competitive position within global markets, the internal weaknesses had a significant influence on reducing its position of power. Health is interwoven into the fabric of well-being which formed the pivotal point on which development theories based its believe that effective outcomes in sustainable

development are increased through capacity-building strategies that are combined in creating a balance between state-led, market-led and society-led methods of intervention.

7.3.2 Capacity-building initiatives within the NHCS

The PFMA 1999 provides a regulatory framework which regulates value-for-money strategies in financing and provision of goods and services through:

- Section 216 of the Constitution of the Republic of South Africa, 1996 in that it provides for Treasury control.
- Section 217 of the Constitution of the Republic of South Africa, 1996 as it provides for procurement legislation (Pauw, et al., 2002:44).

The type of power balance between the citizen and public sector determines the method of state interference, the degree of empowerment and the value propositions attached to the intangible assets that drive service delivery outcomes towards value creation and satisfaction. Equity in the distribution of health systems became a core determinant in establishing effective strategies and sustainable outcomes in equity. Yet, priorities for public expenditure focused on building capacity and a need to moderate consumption expenditure and ensured that investment enjoys priority in the allocation of available resources (National Treasury, 2006:101). Improvement of quality and efficiency of public administration are main targets overall as well as in the NHS through major investment in infrastructure improvement. These policy strategies are supported by strategies that reduce poverty through various empowerment activities such as BEE which empowered “black enterprise” and resolve the growing inequities between cultural groups. These actions are further strengthened by core priorities to strengthen education and improve productivity and the performance of the labour market, as well as implementing actions that provide, expanded income security nets through stronger partnerships with the NGO sector to build resilience in communities against the negative social effects of HIV/Aids. Social protection forms a system which supports social advancement through improved health and nutrition (National Treasury, 2006:103).

This process was started in the National Integrated Plan (NIP) in which the roll-out plans for HIV/Aids strategies were built around an intersectoral plan that responded to HIV/Aids interventions and is supported in the MTBPS and MTEF. These three

programmes were jointly organised into three streams of funding in which conditional grants and equitable share became the main funding frameworks for these programmes.

However, building capacity within the public sector is influenced by seven assumptions that prevent effective decision-making from occurring within the field of HIV/Aids. These assumptions influenced the approaches that were taken towards health care reforms and the way in which PPPs were utilised to build capacity within government. Evidence showed a resistance against utilising PPP in health care and the HIV/Aids environment as it was believed that PPPs did not achieve value-for- money outcomes for health care but are instrumental to inflationary behaviour. It is further argued that the rigidity of the PPP generic structure as defined under the PFMA and utilised in Case Study 5 seemed unable to meet the needs of the health sector effectively as it focused on infrastructure development alone. Although the DOH took into consideration affordability, risk and accessibility in the design of infrastructure development (hospital revitalisation programmes) they felt that the PPP model did not take a broader approach when it had to be applied to the needs of clinical service delivery.

Added to this, continued conflicts between government and advocacy groups prevented policy agendas to take coherent responses that satisfied all stakeholders, mainly because the perspective on how to approach and frame HIV/Aids-related problems were influenced by three streams of thought:

- HIV/Aids is a biomedical problem in which medical bodies and legislation facilitate core responses (strong influence of pharmaceutical companies and the medical profession).
- HIV/Aids is a human rights issue (Activists and human right groups).
- HIV/Aids is a developmental and human rights issue (Government, NEPAD).

These thoughts are mostly driven by professional careers and depended on the perspectives around which individuals framed their decisions. The medical profession is strongly represented within the National Department of Health which means that decision-makers prefer to utilise mechanisms that underscore medical practices and preferences and support HIV/Aids as a medical problem. This caused major conflict in the government sector as no consensus is formed in the DOH on the strategic intent and the identification of value-creating strategies to support the strategic intent.

The seven assumptions identified in this study thus became major constraint in how problems were defined and how solutions and possible options were selected towards strengthening the NHS. Furthermore, the assumptions caused major constraints between the views taken by the National Department of Health and the views taken by National Treasury and the PPP unit in how PPP guidelines must be executed towards achieving fiscal responsible outcomes in health care. The outcomes of the relationship between the DOH and the National Treasury proved to play a major role in the resistance to the utilisation of PPPs. The situation is exacerbated due to an absence of skills within the DOH and their ability to:

- Integrate policy-making.
- Apply the influence of economies of scale on equity in health care.
- Understand the role of public finance to achieve social advancement.
- Expand their alliance with the PPP unit to align clinical interventions with infrastructure development.

7.3.2.1 Gaps between strategic intent and internal value-creating strategies

Wadee et al. (2004:10) state that the rigidity of the PPP model prevented approaches in health care to go beyond the relationship of financing and provision. It is therefore argued that regulations and institutional policy and procedures laid down in the PFMA, 1999 prevent efficient and effective outcomes of the delivery of clinical services. This happened because of the complexities associated with the contractual relationship between the three spheres of government which may involve various contracts between parties asked for more flexible and rational approaches to contracting and the shaping of finance agreements of public-private partnerships in PHC and DHC (McCoy et al., 2000:7).

The perceived rigidity of PPP became more pronounced with the introduction of the Health Act, 2004 which showed further impacts on health care reforms and strategies as it underscored co-operation and shared responsibilities between the public and private sectors within the context of national, provincial and district health plans. Fiscal decentralisation and the building of administrative systems became important drivers to support internal value creation in each of the spheres of government. The gap between strategic intent and value creation widened as administrative actions supported political

decisions in their strategies for raising and spending public finances. The administrative actions are built on accountability, efficiency and effectiveness which are actions that presuppose an increase in the internal value of health strategies. The draft document of the Health Charter set out to initiate actions that acknowledged that PPI should be included within the scope of the PFMA Act, 1999 as they believed that PPIs contributed to the overall sustainability of the NHS. The draft Health Charter facilitates transformation in the following key areas; accessibility, equity, quality and BEE that formed core issues in capacity- and institutional building strategies.

In the health sector, the discrepancies and failures of the market are accentuated through the growing inequities in health care. Muller (2005) pointed out that: "...For some reason the demand- and supply- is not working so you must empower the other side. It seems to me that the power lies in the hands of the hospitals and the balance of the power need to be shifted so that the chain on the other side, on the demand side gets empowered…".
His statement was supported in a discussion with Picazo (2005) who indicated similar constraints and proposed that: "…What some of us in the World Bank are thinking is we have discussed this issue from the supply-side, completely from the supply-side. We talk about facilities and services. What if we attack the problem from the demand-side?"

Balancing the supply and demand factors and its immediate impact on the distribution and allocation policies relate directly to the GDP which indicates the relative size of the public and private sectors (Visser & Erasmus, 2002:27; *cf.* Abedian et al, 2003:185; *cf.* Bailey, 2004:17). Managing and balancing outcomes of economies of scale are major factors in regulating inequities in health care and the Department of Health becomes the primary roleplayer in managing the supply of goods and services. This aspect becomes crucial in the management of public finance in which the budgeting process is influenced by the Annual Budget Act, DORA, the PFMA, tender legislation and preferential procurement legislation. The combination of all these factors results in effective macroeconomic planning in which government is able to manipulate the functioning of the market together with its financial management systems, procedures and controls and as such strengthen the NHS. One has to keep in mind that the management of inequities is characterised by complex interdependencies that have second-, third-, fourth-, or fifth-order effects on any of the other policy dimensions which complicates decisions and

policymaking (Landsberg, 2002:1). Inequities are thus not only based on economies of scale (public and private) but also exist similarly between black and white, male and female, medical professions and other professions such as public administrators, Gauteng and Limpopo.

7.3.2.2 The role of PPP as a fiscal responsible mechanism within the NHS and HIV/Aids

Allocative efficiency refers to the capacity of the budget system to distribute resources according to government priorities and programme effectiveness within the three spheres of government. Social development challenges are based on achieving economic growth, broadening participation and accelerating the pace of social advancement. The main aim of the policy priorities is to reduce the growing disparities and inequities that occur in service delivery and income distribution. Currently, the country faces economic prosperity and an economic growth to average 5 % over the medium-term expenditure framework (National Treasury, 2006:1). This means that the faster the growth of GDP the lower the GDP ratios are (public expenditure/GDP ratio, public sector borrowing/GDP ratio and public sector debt/GDP ratio) while tax revenue-to-GDP ratio increases (Bailey, 2004:70; *cf*. Hyman, 2005:413; *cf.* National Treasury, 2006:45). Public sector borrowing/GDP ratio has decreased as the debt service costs continue to decline (3.3% in 2005/06 to 2.7% in 2008/09) (National Treasury, 2006:44). The influence of the rise in economic activity therefore has a positive impact on GDP ratios as more money becomes available for social advancement in this period of economic growth.

The policy priorities highlighted in the National Treasury's (2006:3), "Budget Review 2006" encourage this process by following an expansionary trend in which an acceleration of public expenditure contributes to strengthen economic growth. The importance of this process is emphasised by adding additional funding totalling R372 billion over the MTEF period of 2006/07. These initiatives of government are based within economic infrastructure development, education and health care developments. In analysing the relative scale of public finance, Case Study 5 showed a shift in social service expenditure towards quality improvement in education, health care and poverty-focused community development supported by social security networks that form the main drivers in reducing the threats that HIV/Aids poses for public finance. Liberal theories and the concept of social justice that underlines social development initiatives

regard capitalism as more efficient (market-driven) than any other system although it has major costs in terms of poverty and inequities (Barr, 1998:48). Utilising PPP as a social development tool, the government is able to correct the costs in terms of poverty and increased inequities.There are many sources of public finance. Taxation is seen as the main source of public finance and governments tend to neglect other sources available to them. A preoccupation with strategic issues has led to the neglect of finding alternative and creative ways to raise and spend public finances. Often, public spending intended to create greater equity leads to frustration if the raising of public finance creates considerable inequities (Bailey, 2004:131). Also, spending public finance and identifying potential benefits of public expenditure in health care and HIV/Aids offset potentially large direct and indirect costs of raising public finance, which has to be brought into consideration.

The government increased its public expenditure in the Budget of 2006 whilst reducing its public expenditure/GDP ratio by ensuring that there are extra public expenditure levers in additional private sector expenditure through the establishment of highly productive public sector investment in human and physical capital (PPP model). The NGO sector supports government investment in infrastructure development (human and capital investment) in terms of public expenditure in the Budget of 2006 in the rural and poverty stricken areas as it is found that the PPP model is only effective where profits are to be made. The balanced use of public, private and NGO investment in sectors provide the best value for money and becomes a main objective. By utilising PPPs, public expenditure leads to a rise in GDP greater than the monetary value of that public expenditure, as well as to subsequent increases in tax revenues derived from the increased incomes and profits facilitated by economic productive investments (Hyman, 2005:413). For the ratio of public expenditure to remain stable the GDP must rise by at least the rate of increase in public expenditure and matched by private expenditure. The generic PPP model (Figure 6.2) supports this approach. Fiscal trends indicate that over a three year-period a growth in general government consumption will decelerate as a result of lower expected inflation. Keeping inflationary behaviour under control means that interest rates remain stable. The overall management of procurement through PPPs are determined by the way in which interest rates influence borrowing and debt costs for all stakeholders involved. As long as the economy shows growth, PPPs are a viable

option in funding strategies. The picture changes when economic growth declines and interest rates increase.

7.4 Discussion of the utilisation of PPPs in roll-out plans for HIV/Aids strategies

Benchmarks established the following evaluating criteria (4Es) and highlighted the options and its effect on service delivery outcomes in the development of roll-out plans for HIV/Aids interventions tied to neo-liberal ideologies and a mixed economy:

- Effectiveness: Increased public expenditure in infrastructure, education, health and social development through the utilisation of PPPs limit markets' maximising behaviour. The social development focus dealt with the key issues in HIV/Aids as an integral part of the health care system thereby strengthening the NHS through improved quality and cost-reduction strategies.
- Efficiency: PPPs modify the market efficiency by facilitating employment opportunities (identified in the feasibility and CBA), improving investment and modifying inefficient markets. Removing barriers to economic growth caused by market failures and reducing inequities, not only between public, private and NGO sectors, lead to market efficiency. If the opportunity costs of free public services (delivery of free health services to children and pregnant women) are greater than their benefits then economic and social welfare are not maximised.
- Economy: PPPs put government in an enabling role in which it pursues equality through modified markets and a fiscal planning at macrolevel in which a regulatory role enforces specific operational standards through regulations, institutional policy and procedures.
- Equity: PPPs emphasise empowerment through equality. BEE is an integral part of PPPs' wealth-creating structures. Reducing inequities through empowerment and pro-poverty-reduction strategies must encourage practices that counteract free riding or spending behaviour in which social benefits are made conditional upon the recipient undertaking vocational training or subsidised employment. GDP rises in both cases. The draft Health Charter enforces and regulates the process in health care sectors by utilising PPIs.

PPPs are seen as mechanisms that improve performance which directly impacts on value creation in the long term. These key issues are highlighted in Table 7.1 and show the effect of the utilisation of PPPs on the public sector and on public finance.

Table 7.1: The impact of PPP on the public sector and public finance

	Evaluating criteria towards utilising PPPs as value creators in the application of strategies
Implications for the public sector:	Applying the social model in a social development approach led to a heavily constrained state that demanded new and alternative approaches in funding the growing numbers of people who are living with HIV/Aids as well as taking into consideration the growing disparities between rich and poor. PPP did provide alternative ways in which to fund the immediate needs and interventions required through infrastructure and offered solutions that had to be managed over a long contractual period (concession). These funding mechanisms required a strong administrative support system (central bureaucracy that can deliver) and highly educated workforce that must understand the workings of the public, private and NGO sectors. Skilled human capital formed the core element within the administration, management and steering of the PPP programmes. Without skilled human capital, PPPs were ineffective, poorly structured and did more harm than good. Poor intergovernmental relations and an absence of adequate skills resulted in increased resistance against utilising PPPs. The HIV/Aids environment made extensive use of partnerships agreements but did not use PPP as a solution for service delivery (value for money, affordability and risk) mostly because HIV/Aids was separated from the NHS when issues such as prevention, treatment and care were resolved.
Implications for public finance:	The enabling role of the state creates heavily constraint finances. Through PPP interventions, costs are spread over a period of time (instead of a once-off payment and big investments) shared with partners by encouraging economic efficiency and growth. PPP is not a substitute for government capital spending but does offer an alternative means to develop infrastructure in areas that attract significant amounts of private investment. The development of infrastructure in health care (hospital revitalisation, building of new hospitals and equipment) provide the most profitable outcomes for the private sector. Unfortunately, not all clinical services are profitable in health care. The PPP enhances service delivery in areas where private investment is a viable option. Partnerships with NGO sectors become a viable option when service delivery is not steered by profit motifs alone. Government then carries the costs which it shares with the institutional and human capacity of the NGO sector.

Source: Own (2006).

The ultimate objective of establishing benchmarks was to identify best practices and best value for money in performing activities in health and HIV/Aids. It was concluded that the internal capabilities (distinctive competencies) tied to PPP increased risks and weaknesses in the health care system which will be exacerbated in the HIV/Aids environment. The main driver in the HIV/Aids environment is service delivery with no profits because health care interventions are based in an environment that alleviates the outcomes of poverty reduction.

7.4.1 Developing criteria for a "best practice model"

A framework in which criteria for a best practice model was developed, was used to measure the utilising of PPPs as a fiscal responsible mechanism and thereby putting forward alternative policy options in health care and HIV/Aids. Lowering the costs in reaching for value-for-money outcomes that are linked to excellence in performance and value creation in the long term, (measured within a framework of 4Es) set forth key issues that provided a framework for best practices.

Two instruments displayed the best options and strategies available to overcome the weaknesses in the NHS: first, a situational analysis identified value-creating strategies through the utilisation of PPP and its impact as a performance driver. Secondly, the CBA determined the impact of value-for-money/value-creating strategies on future roll-out plan for HIV/Aids (Figure 6.4).

From the analysis it became clear that:

- The short-term financial objectives for cost reduction were tied to long-term objectives of possible revenue growth in the application of PPP.
- The three strategic linkages (human capital, information capital and organisational capital) are critical elements in achieving quality and efficiency in the service delivery outcomes. The three strategic linkages determine the growth and performance outcomes necessary to built capacity within government.
- Internal processes have the greatest determining impact on the success of roll-out plans as this determines the maximum leverage for delivering value to customers, shareholders and communities. The human capital, organisational capital and information capital together form critical elements in achieving

successful outcomes in PPPs. The current PPP model utilised by the government does not deal with these three elements as key issues in its KPIs, instead it focuses on efficiency in the delivery of infrastructure with a somewhat low-level focus on human capital.

The social cost-benefit analysis used in Figure 6.4 linked the effect of improved efficiency in public investment with policy-making and its impact on future value creation for health care and HIV/Aids strategies. In order to strengthen the NHS, evidence drawn from the CBA (Figure 6.4) indicates that by utilising BOT schemes in health care demanded a refocus of the approaches used to encourage investment in clinical services. Human capital becomes a key issue in strengthening the NHCS. The alignment of human capital with organisational and information capital investments is a critical success factor in achieving successful outcomes in health care.

However, implementing each of these investments as part of the budgeting process tied to PPP complicates the management of BOT schemes. This is further complicated by the rigidity of the generic PPP model as well as the fact that the PPP unit at the National Treasury sees operations and infrastructure as separate entities and does not take a comprehensive approach to strengthen capacity-building initiatives in operations (enhancement and maintenance). Further joint ventures, purchased services and out-sourcing of clinical services do not meet the criteria for PPP. Therefore, not all health interventions that fall within this scope are considered to be PPP interventions.

The resistance of DOH to use PPPs, led towards a separation of PPPs and PPIs. This situation developed because the PPP model was only effective when profits were to be made and the private sector was interested to invest in public service delivery. Major gaps developed in health care as the majority of needs were focused on areas that were unprofitable. It has become clear throughout the study that PPPs are valuable tools and contribute towards building capacity through shared capital investments and in achieving fiscal responsibility throughout government. Instead of constructing an array of mechanisms without understanding the needs and constraints in the systems, it becomes imperative to evaluate existing structures and the benefits that each provide and how they can be used together to provide the best possible outcomes. This should be seen as a challenge and an opportunity to improve the current PPP model. PPPs are

complex tools that require complex management structures and demand high skills and proficiency levels of management which become even more complicated when PPP is applied within the decentralised health structures. PPP has not proved itself within the health sector as a fiscal responsible mechanism, mainly because its generic structure is not designed to meet the specific needs of health care. The concepts behind PPP as a fiscal tool for strategic development are sound, but its focus is to narrow to meet the real needs of health care. This is increased by emotional disputes and tensions between supply and demand functions which directly link to distribution and allocation mechanisms. The growing inequities in health care are directly linked to economies of scale and the relative size of the public and private sectors. Poor design of supply and demand functions tied to inadequate interventions results in systems that support the growth of inequities. The inability to see the interdependencies and links between supply- and demand-side factors and how it is intertwined with the distribution and allocation mechanisms of government increases the risk of applying PPPs in health care.

7.5 Conclusion

It is concluded that PPPs are valuable tools that contribute to capacity building through shared capital investments that improve performance and value-creation over the long term. By uitilising PPPs as a development tool, government is able to correct the costs in terms of poverty, inequities and inequalities in health care. As long as the economy shows growth and inflationary behaviour is under control, PPPs are considered to be a viable option in achieving responsible funding strategies. Human capital, organisational capital and information capital together form critical elements in achieving successful outcomes in PPPs. Unfortunately, the current PPP model utilised by government does not meet or align these three elements. Instead the PPP model focusses on efficiency in delivery of infrastructure with a low-level focus on human capital. This becomes a core issue in the design and structure of PPPs in health care, creating major gaps in service delivery. These flaws in the design and structure of PPPs have resulted in a strong resistance from DOH to use PPPs, mainly because the model does not meet the human capital needs, organisational needs and information capital requirements for building effective health care systems.

The conclusions drawn from Chapter seven are not expected to produce solutions, but provide information and an analysis at multiple points. Finding alternative policy

strategies (macro- and microenvironment) that enhance efficiency and effectiveness in service delivery by utilising a PPP as a mechanism to encourage fiscal responsibility is a complex issue, as policy strategies do not operate in a vacuum. Social developmental challenges are closely tied to economic growth and demand the broadening of participation and acceleration in the pace of social advancement. The selection of initiatives for social advancement is based in economic infrastructure development, education and health care developments.

The next chapter provides a summary of the main results and draws conclusions of the constraints and the gaps in the health system and PPP. Recommendations towards a “best practice model” provide information to decision-makers in how to achieve value-creating strategies and the best options for HIV/Aids intervention strategies.