

**The utilisation of public-private partnerships: Fiscal
responsibility and options to develop intervention strategies for
HIV/AIDS in South Africa**

by

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Abstract

Strengthening health care systems in government meant cost containment and improved equity. Escalating costs and poorly constructed strategies are weakening the efficiency and effectiveness of service delivery in health care. This has a negative impact on value creation and internal processes as critical elements such as human capital, information and organisational capital are not aligned with strategies and roll-out plans for HIV/Aids interventions.

This research study therefore questioned the extent to which these strategies have impacted on the roll-out plans for HIV/Aids interventions, and investigated if the utilisation of public-private partnerships (PPP) resulted in applying fiscal responsible mechanisms in health care reforms (effectively, efficiently, economically and equitably (4Es)). Trends in the new public management (NPM) movement inspired a shift towards business-like reforms and saw PPP as a mechanism that improved efficiency and effectiveness in service delivery as it offered the promise to strengthen the capacity of government policy.

The study aimed to put forward value-creating strategies and develop a best practice model that strengthened government's policy capacity by providing efficient, effective, economical and equitable service in health care and thereby improving strategies that impact on the roll-out plans for HIV/Aids. This comparative study comprised four international case studies (developed and developing countries) which presented benchmarks against which the performance of the national case study was measured. A better understanding of the influence which different ideologies had on the architecture of international and global governance structures was gained as it highlighted and compared the key issues that influenced strategies for HIV/Aids intervention between the developed and developing countries.

Results of the study indicated that there are conflicting views between government departments in how to achieve value-for-money outcomes and their application of risk allocation. The conflicting views widened the gap between public and private governance structures and relations. The focus of the PPP definition as applied in the national context of health care is not perceived as being health-specific or effective as it excludes some forms of interactions occurring in the health sector. PPP goals

emphasised efficiency, affordability and value-for-money approaches, while health care goals emphasised the interest of the “patient” and public health.

KEY WORDS

HIV/Aids interventions, sustainable development, health care reforms, public-private partnerships, fiscal responsibility

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LIST OF ABBREVIATIONS

ABC	abstinence, being faithful, correct use of condoms
ACP	Aids control programme
ADAP	Aids Drug assistance programmes
AGOA	African Growth and Opportunity Act
Aids	acquired human immune deficiency syndrome
AME	annually managed expenditure
APEC	Asia Pacific Economic Cooperation
APRM	African Peer Review Mechanism
ART	antiretroviral treatment
ARV	antiretroviral
ASEAN	Association of Southeast Asian Nations
AsgiSA	Accelerated and Shared Growth Initiative for South Africa
AU	African Union
AZT	zidovudine
BAS	basic accounting system
BBB	better business bureau
BBBEE	broad-based black economic empowerment
BEE	black economic empowerment
BIG	basic income grant
BOT	build-operate-transfer
CBA	cost-benefit analysis
CBO	community based organisation
CFO	chief financial officer
CHBCS	community home-based care services
COMESA	Common Market for Eastern and Southern Africa
CoN	certificate of need
CSD	Commission on Sustainable Development
CSO	community service organisation
DAMP	district Aids mobilisation project
DANIDA	Danish International Development Agency
DFID	Department for International Development

DLO	Direct Labour Organisations
DHC	district health care
DISA	Data Interchange Standards Association
DMO	district medical officer
DoE	Department of Education
DOH	Department of Health
DORA	Division of Revenue Act
DPW	Department of Public Works
DSD	Department of Social Development
EAC	East African Community
ECOSOCC	Economic, Social and Cultural Council
4Es	efficiency, effectiveness, economy, equity
EMA	eligible metropolitan area
Epivir	lamivudine
EU	European Union
FAO	(UN) Food and Agriculture Organisation
FDA	(US) Food and Drug Administration
FDI	foreign direct investment
FMI	financial management initiative
GATS	General Agreement on Trade in Services
GATT	General Agreement on Tariffs and Trade
GDP	gross domestic product
Gear	Growth employment and Redistribution
GEMS	Government Employers Medical Scheme
GNP	gross national product
GPPP	global public-private partnership
HAART	highly active antiretroviral therapy
HCFA	Health Care Finance Administration
HIV	human immunodeficiency virus
HHS	Department of Health and Human Services
HHSPC	HIV Health Services Planning Council
HIPC	Heavily Indebted Poor Countries
HM	Her Majesty
HON	Health of the Nation

HSD	health subdistrict
IAS	Indian Administrative Service
ICJ	International Court of Justice
IDC	interdepartmental committee on HIV/Aids
IFC	International Finance Corporation
IHPF	integrated health planning framework
IMO	International Maritime Organisation
IMF	International Monetary Fund
INGO	international non-governmental organisations
IOR	Indian Ocean Rim
ITC	information technology communities
IT	information technology
JPPI	joint public and private initiative
KPI	key performance indicators
LA	local authorities
LDP	local delivery plan
LED	local economic development
LC	local councils
M&E	monitoring & evaluation
MAP	Millennium Africa Recovery Plan
MDG	Millennium Development Goals
MFPED	Ministry of Finance, Planning and Economic Development
MHS	municipal health services
MIIU	Municipal Infrastructure Investment Unit
MTBPS	medium-term budget policy strategy
MTEF	medium-term expenditure framework
MTFPF	medium-term fiscal policy framework
NACP	National Aids Control Programme
NACO	National Aids Control Organisation in India
NAFTA	North American Free Trade Agreement
NCPA	National Committee for the Prevention and Control of AIDS
NCPPP	National Council for Public-private Partnership
NEPAD	New Partnership for Africa's Development
NGO	non-government organisation

NHCS	national health care system
NHS	national health system
NIAID	national institute for allergies and infectious diseases
NIH	national institutes of health
NIP	national integrated plan
NMTEE	national medium-term expenditure estimate
NNGO	national non-government organisations
NPM	New Public Management
NPV	net present value
NRI	nucleoside reverse transcriptase inhibitors
OAU	Organisation of African Unity
OECD	Organisation for Economic Cooperation and Development
PCT	primary care trust
PEAP	Poverty Eradication Action Plan
PEM	Public Expenditure Management
PEPFAR	President's Emergency Plan for Aids Relief
PESTLE	political, economic, social, technological, legislative and environment
PFI	public finance initiative
PFMA	Public Finance Management Act
PGP	poverty and growth programme
PHC	primary health care
PHCS	primary health care system
PLWA	people living with Aids
PPI	public-private initiative
PMS	political mobilisation strategy
PPP	public-private partnership
PPPs	public-private partnerships
PRSP	poverty reduction strategy paper
PSC	public sector comparator
PUK	PartnershipUK
PWP	public works programme
R&D	research and development
RCs	resistance councils

ROI	return-on-investment
SACU	Southern African Customs Union
SADC	Southern African Development Community
SANAC	South African National Aids Council
SAP	structural adjustment programme
SCMS	supply-chain management systems
SIDA	Swedish International Development Agency
SITA	State Information Technology Agency
SSA	sub-Saharan Africa
STI	sexually transmitted intervention
SWAp	sector-wide approach
SWOT	strengths, weaknesses, opportunities and threats
TAC	Treatment Action Campaign
TANF	Temporary Assistance to Needy Families
TASO	AIDS Support Organisation
TB	Tuberculosis
TI	tageted interventions
TNC	transnational corporations
TOC	constraint theory
TRIPS	trade-related aspects of intellectual property rights
UAC	Uganda Aids Commission
UK	United Kingdom
UMA	Uganda Manufacturers Association
UN	United Nations
UNDP	UN Development Programme
UNEP	UN Environment Programme
UNFPA	UN Fund for Population Activities
UNICEF	UN Children's Fund
US	United States
VAT	value added tax
VCT	voluntary counselling and testing
Videx	didanosine
WB	World Bank
WID	women in development

WHO	World Health Organisation
WMO	World Meteorological Organisation
WTO	World Trade Organisation
WTP	willingness to pay
WSSD	World Summit on Sustainable Development

CHAPTER 1: STATEMENT OF PROBLEM AND RESEARCH DESIGN

In most governmental services, there is no market to capture. In place of capture of the market, a governmental agency should deliver economically the services prescribed by law or regulation. The main aim should be distinction in service (Deming, 2000b:6).

But to expect them then to be profitable at the same time providing services to the poorest of poor at the quality that is comparable to the service provided to the richest of the rich seems to me, is asking to much (Picazo, 2005).

1.1 Introduction

The socio-economic impact of HIV/Aids is influenced by a multitude of external and internal factors which are intertwined in complex systems of mutual reinforcing determinants necessary to achieve sustainable and competitive success. The interplay between these determinants is guided by factors such as skilled labour and infrastructure, demands on the nature of products and services, the international competitiveness of products and services and the ability to create conditions that increase the nature of domestic rivalry. These forces work together and impact on the performance of markets, political structures and the creation of well-being. Well-being enhances productivity and sustainable outcomes. As soon as well-being is negatively affected, it reduces productivity and the sustainable success of economies.

HIV/Aids reduces productivity outcomes as it impacts directly on well-being and socio-economic outcomes. Poverty increases vulnerability and the ability to cope with the negative social and economic outcomes of the disease. In an effort to create resilient environments, it was deemed necessary to estimate the “cost of the disease” as it offered some measurement of control. However, attempts to draw medical comparisons of the costs of HIV/Aids with that of other illnesses have failed as it did not deal with the real issues that led to the negative socio-economic outcomes. Rather, estimating the “cost of HIV/Aids as a disease” provided short-term solutions that satisfied roleplayers in that they provided some form of control over the problems faced within the health sector. Through these controls they were able to identify and allocate specified amounts of resources that offered the best effect in certain areas.

Unfortunately, high inflation figures pushed the cost of health care upwards, making fewer resources available to cope with the effect of HIV/Aids. Even though all the demands made on health expenditure were necessary, one will find that there would not be sufficient resources available to meet the required needs across the globe. This forced governments to choose amongst what they perceived as important items and what they were able to finance from scarce resources. Regrettably, the costs associated with health care are mostly based on emotional connotations and asymmetric information instead of applying efficiency, economy, equity and effectiveness (the four Es) to cost assessments. Arguments that shaped health interventions, increasingly centred on issues that debated “equality and health-for-all” versus “health markets and for-profit motifs” (Barnett & Whiteside, 2002:5). Conflicts develop as soon as efficiency and value-for-money approaches are applied to health care. Efficiency and value-creating strategies tied to market forces challenged “equality and health-for-all” as it proved to have significant impact on cost associated with health care and the demands made on its capacity to deliver services.

In addition, HIV/Aids-related problems magnified the complexities associated with capacity- and institutional building, the requirements to strengthen health systems and quality in service delivery. Public-private partnerships became a mechanism through which governments were able to improve their capacity and service delivery outcomes. However, creating public-private partnerships and networks demanded a shift towards horizontal and broaderbased policy issues that showed no respect for boundaries or did not fit neatly into areas of jurisdiction. Traditional models that described public and private relations changed and forced governments to revisit their role and the type of outcome they wanted to achieve. The symbiotic relationship between the economy, society, political philosophy and public finances increased the difficulty of finding a balance between the relative sizes of public and private health sectors. This occurred because markets were steered by supply and demand functions, against a background of political performance.

Understanding the broader economic and social impacts of HIV/Aids on health and social security systems became a crucial factor in making “choices” and in considering alternative options during strategic planning, budgeting and internalising the impact of

the broad objectives with scarce resources. By placing monetary values on the consequences, provided opportunities that explored whether the benefits are greater than the costs and whether the costs incurred are worthwhile. However, the focus on monetary values alone should not become a core issue in policy-making. Rather, policies and its effects must be considered in a systems model approach as the outcomes of policies have different angles that stretch across all fields. Two dimensions influenced policies. On the one hand, policies have “diamond” effects (the most favourable approach to reach competitive advantage) and on the other hand, it has complex interdependencies of which the strength and direction are largely undetermined. The outcome in one of the dimensions often has unpredictable effects on any one of the policy dimensions which complicates decisions and policy-making. Therefore, the high levels of uncertainty and risk that surround HIV/Aids require that health and finance structures must build an environment that can adapt, be flexible and change to the needs of the environment (Porter, 1990:72; *cf.* Barnett & Whiteside, 2002:164; *cf.* Landsberg, 2002:1).

Budgets within the public sector provided the basis for preparing detailed plans of action for short-term operations (operational excellence), medium-term activities (increasing customer value) and a long-term vision (building the organisation) for future periods (Kaplan & Norton, 2001:76,86; *cf.* Fourie, 2005:681). Consequently, it became imperative that health care programmes were evaluated on a consistent basis complementing the activities in education, nutrition, the environment and social security in order to ensure that interventions were desirable, effective and efficient. Strategies identified new operations, initiatives or programs, new capabilities and new ventures that need to be established. Many strategies fail because the operational aspects are separated from the strategic aspects such as omitting actions that build human and financial resource commitments for strategic initiatives into the planning. The government has considerable difficulty in defining clear strategies for HIV/Aids policies, mainly because initiatives and activities are not clearly defined before performance targets are set and programme completion becomes the target rather than departmental effectiveness.

1.2 Statement of the problem and research question

The successes of policies in health are closely tied to social development initiatives. The clinical features of HIV/Aids and the long-term features of the epidemic have a significant impact on the structures and design of social security safety nets which are directly linked to public finance structures. Enhancing security needs becomes an intrinsic part of well-being and of combating the negative effects of HIV/Aids. Gaining a deeper understanding of poverty and the way in which different aspects of poverty interact and reinforce each other has a significant impact on public finance and budgetary decisions. It should also be kept in mind that the issues of poverty are closely linked to governance structures and how democracy is applied towards strengthening well-being. HIV/Aids is also intertwined with the definition of *disability* and the definition of *terminally ill* and how health care is interwoven into the social security networks.

The impact of policymaking on the HIV/Aids scenario is intricate, as policy outcomes are multidimensional and are triangulated in outcomes of social development, the economic strategies and outcomes of the micro and macro fiscal policies as well as its impact on the political environment. Defining and framing the HIV/Aids problems have continuously led to failing public programmes and policies exacerbating medical, social and developmental problems associated with HIV/Aids (Fourie, 2005:398). Health system reforms, social development structures and public finance structures are unable to cope with the demands that HIV/Aids places on service delivery outcomes. The absence of multidimensional and multisectoral approaches in dealing with the HIV/Aids-related problems and an inability of public managers to link the needs of those whom they serve with good governance and administrative support, reduce the resilience of communities towards HIV/Aids (Landsberg, 2002:3; cf. Hsu, 2004:2,9).

The escalating costs of health care and HIV/Aids are impacting negatively on the economic growth and gross domestic product (GDP), the social development of communities, the political environments and the government's available resources for taxing. The burden of the high cost of HIV/Aids is carried more heavily by government. This has a carry-through effect on revenue-gathering structures and the funding mechanisms available to deliver future services needed not only in taking care of the HIV/Aids pandemonium but also in the provision of other and related health care services.

For this reason, the purpose of this study will be to analyse those constraints that prevent policy-makers from identifying effective policies which result in efficient financial support and efficient organisational and administrative structures. These structural designs must be aligned with health care reforms, economic and environmental policies and social support systems in all spheres of government in order to determine the:

Best practices that strengthen policy capacity and improve its ability to deliver services effectively, efficiently, economically and equitably.

Therefore, the research question will explore:

The extent that strategies impacted on the roll-out plans for HIV/Aids policies in South Africa.

1.3 Aim and objectives of the study

The study aims to put forward recommendations that will allow policy-makers to utilise mechanisms that define and frame the HIV/Aids problem in a fiscal responsible manner. This means that policies must be responsive to the perceived needs and communicate the legislative intention. Policies must be easily administered and take account of the short-, medium- and long-term interests by enabling and providing opportunities to sustain themselves as well as deal with the political, social, health and developmental issues associated with HIV/Aids.

The aim of this study will be to explore four variables (health care reforms and strategies, HIV/Aids policies and interventions, public finance and public-private partnerships) as part of the descriptive research question under the following five objectives:

- 1.3.1 Investigate the influence of ideologies on the architecture of international/global governance and its impact on shaping state intervention, health care reforms and HIV/Aids strategies.
- 1.3.2 Investigate the influence of ideologies on national funding mechanisms utilised in state intervention and health care reforms to support HIV/Aids strategies.
- 1.3.3 Establish criteria for utilising public-private partnerships (PPP) in HIV/Aids intervention strategy policies.
- 1.3.4 Establish alternative fiscal responsible mechanisms and determine its impact on HIV/Aids strategies in South Africa.

1.3.5 Draw conclusions and develop recommendations for dealing with the HIV/Aids policy strategies in South Africa which will allow for efficient, effective, economic and equitable service delivery outcomes.

The study defines the role and functions of the state and its impact on shaping trends and options for public finance strengthening policy capacity and improving service delivery in health care. The study further highlights the influence of the New Public Management (NPM) approach on decision-making in public finance management and public administration. In addition the study analyses the public-private mix, health care reforms and the utilisation of public-private partnerships in health care with its subsequent impact on HIV/Aids policy strategies. Emphasis is placed on investigating public-private partnerships and the development of agreements, procurement of services, creating value for money and risk management and legislative measures to control and regulate policy outcomes. The NPM approach advocates decentralisation as a good option that allows for effective and efficient primary and district health care systems. It will be argued that decentralisation of structures offers mechanisms to cope with the complex demands of HIV/Aids. The study further includes ethical, moral and legal issues such as dealt with in the Constitution of the Republic of South Africa, 1996 and the Bill of Rights.

It should be made clear that the study did not focus on treatment and testing protocols for HIV/Aids and other related illnesses such as Sexually Transmitted Diseases (STD's), Tuberculosis (TB), malaria and other infectious diseases; the implementation of HIV/Aids in the workplace, school or tertiary institutions; the implementation of HIV/Aids policy strategies in national, provincial and local spheres of government or the ethical, moral and cultural practices that increase HIV/Aids vulnerability in communities.

1.4 Assumptions

Various assumptions shape decision-making and problem-solving strategies in the field of HIV/Aids and PPP. It is crucial to identify these assumptions and test their impact on the study as they change the focus and outcomes to be reached:

- HIV/Aids is assumed to be a medical and behavioural problem that can only be solved by medical treatments (medicine) and by changing behavioural practices through abstinence, prevention and education. The problem itself is Aids (Holden, 2003:65).

- Antiretroviral drugs cure HIV/Aids and improve the quality of life and well-being of individuals. It is believed that by developing a vaccine there is no need to focus on the wider issues such as development and its relationship with poverty, gender inequalities, health sector reforms and social environments (Holden, 2003:65; *cf.* Nelson Mandela Foundation, 2005:144).
- By applying democratic governance principles, health care services and administrative structures are strengthened and improve responsiveness to HIV/Aids (Hsu, 2004:31).
- PPP is a win-win situation in its application for health in the case of multi-stakeholder interactions (Richter, 2004:45).
- Interactions between business partners (PPP) should be conducted as a “partnership” based on trust and mutual benefits (Richter, 2004:45).
- PPP as a policy paradigm in health care is the policy innovation of the new Millennium and an unavoidable necessity (Richter, 2004:45).

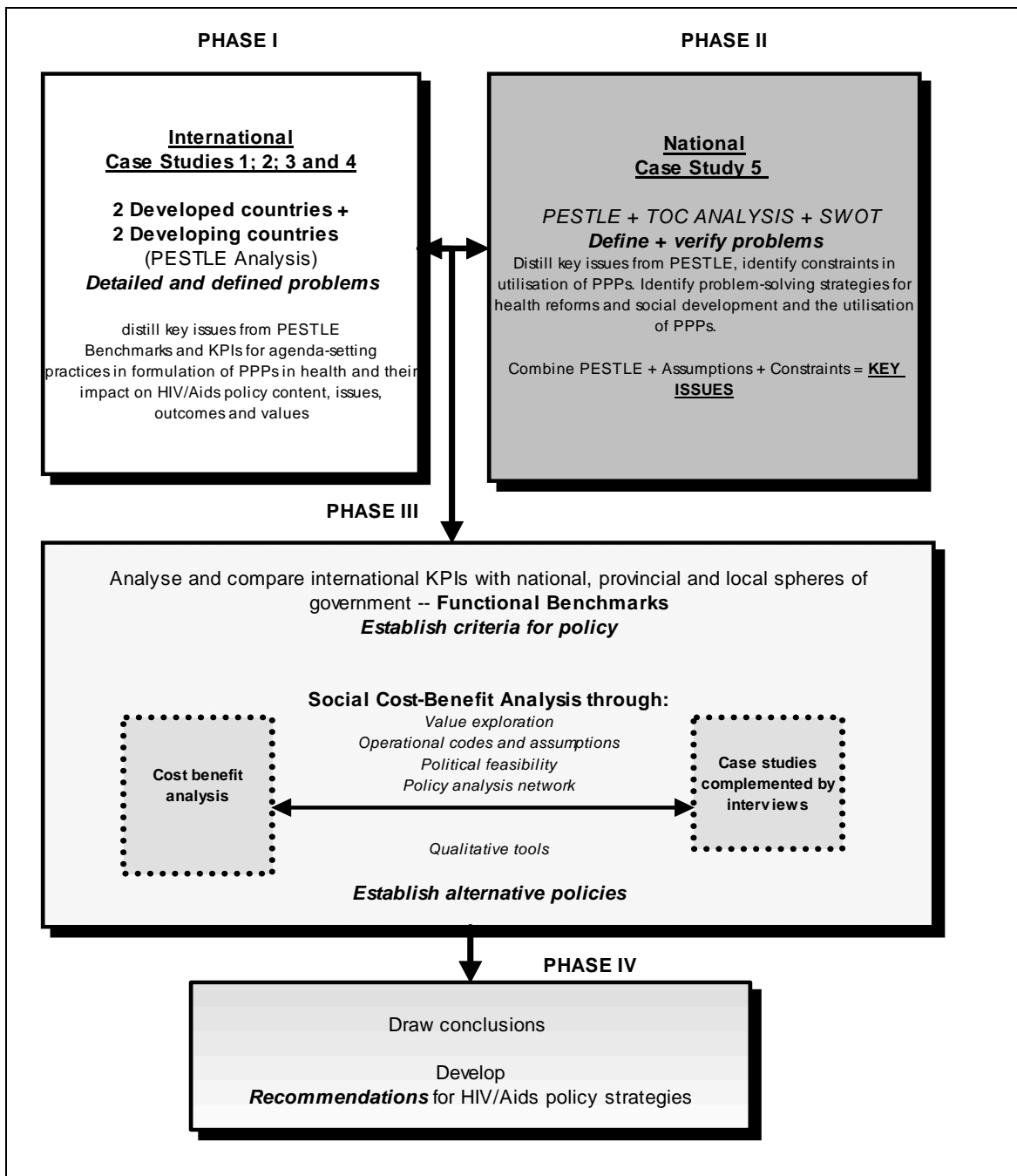
1.5 Research approach and methodology

The qualitative study is planned according to a longitudinal design in order to isolate and define issues and categories, study contents, patterns, meanings and experiences and be more focused as the research unfolds. The unobtrusive and applied research provides an inductive exploration of key issues influencing the outcomes relating to the field of public finance and public administration. The descriptive research question in this phenomenological paradigm investigates the problems and phenomena by using comparative case studies. A cross-case analysis over a fifteen-month period involved multiple sources of data and in-depth descriptions to provide a rich narrative of each case study.

Figure 1.1 presents the research model designed to systematically assess the factors that impact on the international environment. The model provides a framework for an in-depth background study into the external components of political, economical, social, technological, legislative and environmental factors which impact on how strategies are formulated within the field of HIV/Aids and health care. Furthermore, it investigates the internal environment and identifies the main constraints having the greatest impact on internal value-creating strategies, leading the researcher to identify gaps within the system thereby finding alternative options which could improve internal value and

external competitiveness through its policies. Figure 1.1 displays a layout of the research design followed in this study with the methodology which will be used to define and verify problems.

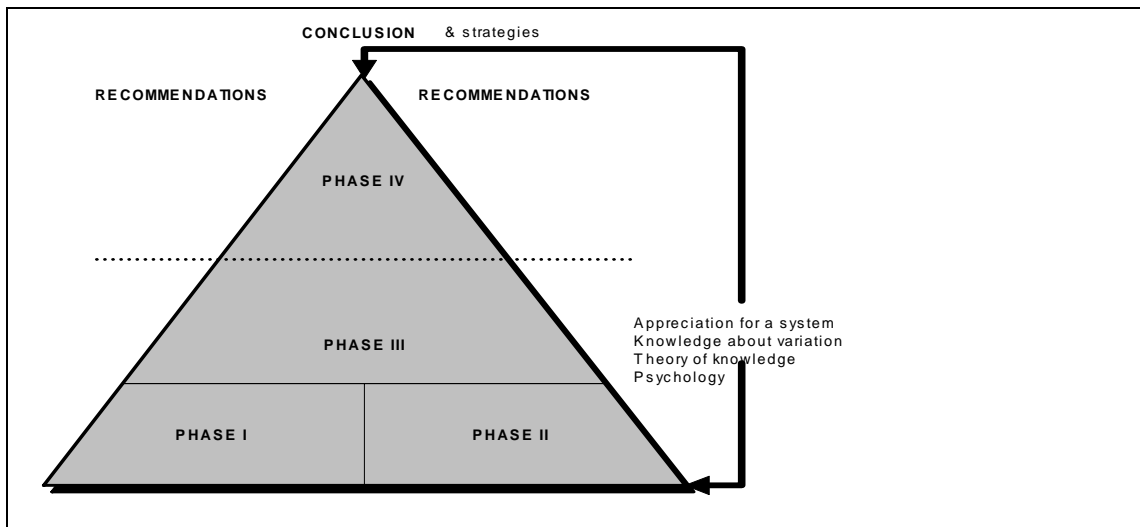
Figure 1.1: Research model



Source: Own model (2006).

The approach followed in this research methodology and model (Figure 1.1) is divided into four phases. Each phase is aligned with the objectives of the study. As the four phases unfold, it systematically leads the researcher towards building a system of profound knowledge from which policy is analysed and alternative options are developed, as illustrated in Figure 1.2. The first two phases of this study form part of a comparative study (international and national case studies) in which background studies isolate the external factors that have the greatest impact on strategy and the internal processes which influence operating outcomes. The international and national studies define and verify the problems and key issues in the field of HIV/Aids and health care. The third phase analyses and compares the international performance with the national situation through benchmarking in which the ultimate objective is to identify the best practices and provide best value for money options in performing an activity. Phase III processes and analyses data gathered in the first two phases. All decisions taken as the study evolves are based on the data collected in the first two phases. Conclusions and recommendations are put forward by building a system of profound knowledge in which the proposed methodology is applied to this research. This is based on gaining an appreciation of the system, getting knowledge about the variations (the processes and the effect of the system on the performance of the people within), interpretation and predicting behaviour within the system as well as understanding the interaction that occurs within the system when the generic functions that supports management achieves certain outcomes (Deming, 2000a:92-115).

Figure 1.2: Building a system of profound knowledge



Source: Own observation (2006).

The alignment of Figure 1.2 with the research methodology set out in Figure 1.1, provides the basis on which results were achieved in each of the four phases. The result of data collected in Phase I deals with the first objective of the study and identifies the main issues in the developed and developing countries that influence performance in service delivery. It presents key performance indicators for international benchmarks that proved to have a significant impact on long-term strategies. A comparative research between the developed and developing countries assesses the factors that influenced the international environment through a PESTLE analysis (political, economic, social, technological, legislative and environment) (Pearce & Robertson, 2000:84). The PESTLE analysis is supported by a PESTLE framework (Table 2.1) allowing the researcher to distil key issues and establish key performance indicators. Personal contact, structured questions and interviews provided qualitative tools to support data collection and strengthen and expand the literature study. The criteria set out in Table 1.1 formed the determining factors in selecting the four case studies against which the national case (Case Study 5) is to be compared.

Table 1.1: Criteria for data collection in Phase I

Developed country		Developing country	
Colonial powers		Historical ties with colonial rule impacts on governance structures, policies and public administration systems	
Strong competitive economic countries		High incidence of population growth, poverty and socio-economic inequities	
Shape global thoughts on development and policy		High incidence of HIV/Aids	
Provide development aid for developing countries		Enabling state: decentralisation of health care through Primary Health Care (PHC) systems and District Health Care (DHC) systems	
Strong health markets: public-private partnership becomes a mechanism to contain health costs		Successful interventions in HIV/Aids through partnership formation towards building HIV/Aids resilient communities	
Effective economic and social policies increase health outcomes		Constitutions underscore social development and decentralised governance structures	
Case Study 1	Case Study 2	Case Study 3	Case Study 4
United Kingdom	United States	India	Uganda
"Global Commonwealth" and unitary state	"Federal state"	"Federal Republic" a creation of British colonial administration	"Unitary state" a creation of British colonial administration
Ideologies: Neo-liberal based on contemporary liberalism	Ideologies: Libertarian based on conservatism	Ideologies: Neo-liberal. After independence based on democratic socialism and later on more contemporary market-friendly regimes	Ideologies: Neo-liberal. Based on democratic socialism

Source: Own observation (2006).

Evidence described in literature support the criteria set out in Table 1.1 and direct the final choice in selecting each population sample. Case Study 1 created a body of knowledge on public-private partnerships and quasi-government sectors (Rennie, 2003:31). PartnershipUK (PUK) played a significant part in inspiring the National Treasury's *Standardised Public Private Partnership Provision* document in South Africa

(Rennie, 2003:31; *cf.* PPP Unit, 2004; *cf.* Farquharson, 2005; *cf.* Pillay, 2005). The concept of *welfare statetism* is based on the ideologies of neo-liberalism which determine the role and functions of the state as an enabling state that provides goods and services within a mixed economy (O'Manique, 2004:7). The services and goods are organised to provide for the “common good of its citizens”, a central theme of the British National Health System (NHS) which underscores these ideologies (Bailey, 2004:20)

Case Study 2 formally designated HIV/Aids as a threat to national security, arguing that it could lead to destabilisation, ethnic conflict and war (Siplon, 2002:126; *cf.* AVERT.ORG, 2005). This resulted in Case Study 2 becoming a major roleplayer in funding HIV/Aids initiatives and providing aid to developing countries (Siplon, 2002:126). UN Secretary General Kofi Annan called for new public-private partnerships to combat Aids. His arguments are supported by PEPFAR and the United States Leadership against HIV/Aids, TB and Malaria Act of 2003 (AVERT.ORG, 2005). Case study 2 utilises the UN to spearhead a widespread network of Non-government organisations, community-based organisations (CBOs), religious organisations, international summits and conferences towards integrative approaches through its six UN organisations (Siplon, 2002:115). As the leader of the world economy and political environment, Case Study 2 supports a philosophy that underpins the libertarian ideologies in which the *laissez-faire* state provides goods and services within a capitalist system. The capitalist system enhanced competitiveness and consumerism as the main driving force to support and guide all actions as propagated under the Washington Consensus. Added to this, the profit motive and monopolies in combating HIV/Aids have become a major point of dispute between the United States and pharmaceutical companies who have all the resources while the developing countries are poor and have approximately 90% of the actual cases (Siplon, 2002:128-134).

Case Study 3 is described as the country with the highest number of HIV/Aids-infected people in the world (Panda, Chatterjee & Abdul-Quader, 2002:38). The Indian government is commended for their early interventions. Their targeted interventions (TI) with high-risk groups and vulnerable populations for the prevention of HIV/Aids are hailed as the most effective control programmes worldwide and are globally recognised as a best practices model (Panda et al., 2002:38; *cf.* NACO, 2005). National Aids Control Organisation (NACO) in India's founding was not only a turning point in the HIV/Aids

policy, but also the point at which the essential role of the NGOs' efforts became an explicit element in planning towards intersectoral and grass-roots planning. The NACPI, NACP II and NACP III recognised the need for decentralised approaches in harmony with the constitutional responsibility for health systems. Initiatives targeted state and district levels while local action was carried out with the help of community-based NGOs (NACO, 2005a; *cf.* NACO, 2005b:3; *cf.* Panda, et al., 2002:63).

Case Study 4 is a sub-Saharan African country and part of the East African Community (EAC), a member of the African Union (AU), NEPAD and African Peer Review and the Common Market for Eastern and Southern Africa (COMESA). Case Study 4 was one of the first developing countries to encounter HIV/Aids (Okware, Opio, Musinguzi & Waibale, 2001:1113). The UN and USA describe the HIV/Aids strategies applied in Case Study 4 as the role model for fighting HIV/Aids worldwide (Brown, 2005:2). No other country has matched this achievement (Landsberg, 2002:14; *cf.* UNAID/WHO, 2003:10). Furthermore, Aids specialists cite Uganda and Botswana as running the continent's most extensive treatment networks (NYT News Service, 2005:19). The country is actively involved in partnerships between community-based NGOs and governments (Okware et al., 2001:1118).

The impact and the value offered by case studies 1 to 4 enriched the outcomes of this study. The four international case studies offered solutions for Case Study 5 by presenting trends, key issues and alternative options that were systematically evaluated. Phase II dealt with the second objective of the study. Each of the participants in the national case study was purposefully selected. Each participant (case studies) was seen as a main roleplayer and leader in the field of health care, HIV/Aids and public-private partnerships.

Phase III discussed the third and fourth objective of the study and established criteria for utilising PPPs in HIV/Aids intervention strategy policies. This is achieved by benchmarking the international performance against the national performance, measuring organisational effectiveness. It isolates (strengths and weaknesses) and compares performance to ascertain whether the best value for money has been achieved. In providing criteria for policies and seeking for alternative options in health care policy a best practice model is presented. Furthermore, it determines the extent to

which strategies have impacted on the roll-out plan for HIV/Aids in South Africa and identifies alternative strategies to be considered when roll-out plans for HIV/Aids policy agendas are put together. A social cost-benefit analysis (CBA) establishes the social benefits and costs attached to alternative policies through value exploration and the identification of risks. It takes into consideration the operational determinants and assumptions as well as political feasibility and how decisions impact on the administrative systems.

Mouton (2001:108) states that the analysis of data involves “breaking up” the data into manageable themes, patterns, trends and relationships. It becomes crucial to understand the various constitutive elements of the data collected through an inspection of relationships between concepts, constructs and variables. In order to improve objectivity and validity of data, it is necessary to apply various techniques of data analysis to the study as part of a systematic policy analysis. Cloete and Wissink (2000:116) identify various stages in the policy process. These stages are integrated into the study and formed a framework from which tools were selected to support the data analysis process presented in Table 1.2.

Table 1.2: Theorists and stages in policy process as applied in Phase I, Phase II, Phase III and Phase IV of study

TOOLS USED TO SUPPORT THE STAGES IN POLICY ANALYSIS	Quade in 1981	Stokey and Zeckhauser in 1978	Patton and Sawicki in 1986
PHASE I and PHASE II			
PESTLE ANALYSIS & TOC	Formulate the problem	Determine the problem	Verify, define and detail the problem
PHASE III			
FUNCTIONAL BENCHMARKS			Establish evaluating criteria
COST-BENEFIT ANALYSIS (CBA)	Search alternatives + Forecast the future environment	Identify alternatives + Predict consequences of each alternative	Identify alternative policies + Evaluate alternative policies
PHASE IV			
Best practice model	Model the impacts of alternatives	Determine criteria for measuring the achievement of alternatives	Display and select among alternative policies
Recommendations	Evaluate alternatives	Indicate preferred choice of action; Recommendations and conclusions	Monitor policy outcomes

Source: Adapted from Cloete and Wissink (2000:116).

Each of the tools used to collect and analyse data in this study is linked to the stages set out in the policy process presented in Table 1.2. To identify alternative policy options Roux (in Cloete & Wissink, 2000:145) proposes that cost-benefit and cost-effectiveness analysis should be incorporated to arrive at the best policy options available. Once realistic policy options have been identified, these options will be re-assessed in terms of the criteria relevant to the policy objectives deduced from the PESTLE analysis.

The result of the data analysis in Phase III allows the researcher to draw conclusions and provide recommendations by indicating the preferred options in Phase IV. Phase IV dealt with the last objective of the study and provides alternative options and recommendations for the HIV/Aids policy strategies in South Africa allowing for efficient, effective, economic and equitable service delivery outcomes.

Phase IV draws together the main results and findings by providing an overview of key issues, trends and options for HIV/Aids intervention strategies in South Africa. Gaps in strategic and operational strategies are highlighted, thereby making the larger significance of results explicit. Conclusions are drawn by predicting the possible consequences of each proposed action and allowing for the measurement of achievements and best practices by evaluating alternative options. Landsberg (2002:36) refers to options and suggests that strategic decisions yield positive outcomes in best-case scenarios. Recommendations presented in this study indicate the preferred option for alternative approaches in HIV/Aids policy strategies that support value-creating outcomes.

1.5.1 Materials and methods of data collection in Phase I and Phase II

The methods and tools used to collect data during Phase I for each comparative international case study are supported by an in-depth literature study and a structured interview. Triangulation of data-collection methods in this qualitative research increased confidence and validity in the research findings.

1.5.1.1 Literature

There is an abundant source of international literature on HIV/Aids and PPP available. The literature on PPP focuses mainly on infrastructure development as a mechanism to improve general delivery of health care. However, no models that focus on HIV/Aids are described in literature. It meant that the researcher had to select what was appropriate for this study and combine this knowledge with literature on ideologies and the role of the state as enabler, facilitator and regulator within the framework of public finance. Literature on developmental issues, socio-economic development and “well-being” became the pivotal point in understanding health-related issues and its relationship with economics, and how it impacts on service delivery outcomes. Literature discussing the national issues around HIV/Aids and PPP is very limited, but available.

1.5.1.2 Interviews

Each case selected for interviewing was done purposefully as it offered the researcher the opportunity to select those participants that cut across different variations (maximum variation sampling) searching for common patterns, trends and issues (Glesne, 1999:29). Information-rich participants provided an instrument from which one can learn about the issues of central importance to the purpose of the study (Glesne, 1999:29).

Gaining access to the international roleplayers was a slow and time-consuming process and resulted in a low response. Gaining access included the acquisition of consent and access from the participants before a date and method for an interview were negotiated. An invitation to participate in the research, a letter of consent that provided information on the scope of the study together with a layout of the questions the researcher planned to use became important aspects of gaining access (Annexure C and D). Case Study 1 and Case Study 2 responded positively to the request for an interview and were prepared to offer access through their international branches.

In order to reduce the elements of uncertainty, pitch questions were developed beforehand. The same set of questions was applied in each interview, internationally and nationally. These standardised open-ended questions were shared with the interviewees in advance giving them the opportunity to prepare as much valuable feedback as possible. This minimised variation in the questions and reduced possible bias but allowed the researcher to gain an understanding of the research problem (Patton, 1980:198; *cf.* Glesne, 1999:80). Each interview stretched over a period of one hour. Table 1.3 (Phase I) and Table 1.4 (Phase II) provide an interview log of the participants.

Table 1.3: Interview log of participants in Phase I

Interview	Interview	Internet	Personal visit
Case Study 1: <i>Government department</i> Her Majesty (HM) Treasury: PartnershipUK	07/10:Assistant director	X	X
Case Study 2: <i>Government department</i> National Council for Public- Private Partnerships (NCPPP) <i>UN organisations and NGOs:</i> World Bank	20/09: Snr. economist	21/09: Executive director	X

Legend: X = Response

Even though the rate of response was low, the respondents that did show an interest in participating in the study provided balanced and broad-based insight with valuable inputs for this study. Their combined inputs allowed the researcher to identify the international key issues dealing with the first objective that formed a background and basis for measurement in the national study. By transcribing each interview, aspects that needed further investigation were highlighted. Adding this to the PESTLE analysis enriched the text and formed an important part of determining the key issues that directed decision-making in formulating solutions for HIV/Aids-related problems.

Participants were selected for interviews in Phase II through a purposeful approach. An interview log (Table 1.4) presents a list of the participants and supporting data-collection strategies. The same questions used in Phase I were conducted according to the structured layout (Annexure C) and transcribed. Valuable phrases were highlighted and intertwined into the study. The problem statement provided a boundary for the exploration of issues, trends and options in Phase II. Gaining access to respondents was complicated because no PPP programmes were applied in the HIV/Aids environment at the time interviews took place. Another factor that negatively influenced respondent behaviour was a strong resistance against PPP as a mechanism for funding health programmes in South Africa's Department of Health because all HIV/Aids interventions

are funded through conditional grants and equitable share. Respondents were also perceived as being uncomfortable to answer questions on PPP and public finance. Table 1.4 presents a log of interviews during Phase II.

Table 1.4: Interview log of participants in Phase II

Interview	Interview	Internet	Telephone	Personal Visit
Case study 5				
<i>Government departments:</i>				
National Treasury: PPP unit	17/08: Director	X		X
National Department of Health	14/10, 26/10: Chief financial officer			X
Department of Social Development		19/09: Director	X	
Municipal Infrastructure Investment Unit (MIIU)	Municipal infrastructure specialist			
<i>NGOs:</i>				
SIDA	01/09: Programme manager			X
Heartbeat	06/09: General manager			X

Legend:

X = Response

Each interview was transcribed and synthesised in search of issues, patterns and trends. This provided a background to theorise about the benefits, risk-taking and decision-making strategies which influenced the social phenomenon under study. The interviews provided inputs for the situational analysis. Interview records and reports supported the verification process and enabled the researcher to keep focus, organise what was said, and describe and explain it.

1.5.1.3 Meetings, conference and publication

Findings drawn from this study were presented at the 6th Annual Conference of the South African Association for Public Administration and Management, 20-21 October 2005 and the first International African Conference: Gender, Transport and Development

Conference, 27 to 30 August 2006 held at the Nelson Mandela Metropolitan University in Port Elizabeth. An abstract is submitted for approval to present findings drawn from this study at the Global Health Council's 2007 International Conference for Global Health as part of the NIGH programme for students enrolled in degree-seeking programmes, May 29- June 1, 2007 in Washington, DC.

An article, "Public-private partnerships: a mechanism towards fiscal responsibility. An overview of issues, trends and options for HIV/Aids intervention strategies in South Africa" was published in 2005 in the Journal of Public Administration and a second article titled "Managing inequities in health reforms: A strategic policy approach that aligns gender mainstreaming, development and mobility in building HIV/Aids resilience in South Africa", is considered for publication in the Africanus. International interest is shown from the United States for the publication of an article that takes a closer look at health reforms, titled "Managing inequities in health care reforms: Fiscal responsible measures that improve service delivery and build resilience of communities towards HIV/Aids in South Africa".

1.5.2 Tools used to support data collection in Phase I and Phase II

The PESTLE analysis supports, analyses and documents the data gathered during the data collection process in Phase I and Phase II. By gathering as much relevant data as possible, the key issues, trends and options available to HIV/Aids-related problems were explored. This explained the impact of individual policies in different contexts and allowed future policies to be set in context and to be identified as determinants (McPake & Mills, 2000:811).

1.5.2.1 PESTLE Analysis (Political, Economical, Social, Technological, Legislative and Environmental)

The PESTLE is an acronym for the following components (political, economical, social, technological, legislative and environmental). As the remote external factors have the greatest impact on strategy and the internal processes influence the operating outcomes Pearce and Robinson (2000: 65, 71, 84) initially proposed a framework called PEST that allowed management to do a trend analysis through a comprehensive background study. The PEST analysis was extended in later years to include legislation and the environment (PESTLE).

Dr Arvind V. Phatak, an international expert on international environmental assessment, presents a global strategy in action in which he lists the economic, political, legal, and social (cultural) factors which must be taken into consideration when determining the factors that influence the international markets (Pearce & Robertson, 2000:83). He points out that the interplay amongst markets complicate this process of assessment and must therefore be taken into consideration during the assessment. The work of Phatak supports the framework developed for the background study in the assessment of health care services for the international case studies.

Utilising the PESTLE analysis as a framework for an in-depth comparative background study into the external and internal environmental components, namely political, economical, social, technological, legislative and environmental aspects assisted the researcher to point out certainties, hidden assumptions, risks and uncertainties that frame core problems (Proctor, 1997:143; *cf.* Schoeman, 2002:36; *cf.* Pearce & Robertson, 2003:83). Drawing on an intensive literature review, a framework was built for the PESTLE analysis drawing the boundaries of the research to complement this study (Table 2.1). The PESTLE framework ensured consistency in collating data for each separate case study. Likewise, the PESTLE analysis provided a “system of profound knowledge” and formed the foundation for the decision-making in this study.

Deming (2000a:50) states that a system cannot understand itself and therefore needs a view from the outside to gain appreciation of a system, knowledge about variations, and knowledge of the effects of the psychology and dynamics of the organisation. Building a system of profound knowledge through a PESTLE framework, guided the researcher in applying a systematic and consistent approach to analyse the external and internal environments in policy-making and identify the core problems, issues and trends in each case study (Deming, 2000a:92). Landsberg (2002:15) emphasises the value of taking the political, economic, social, technological, legislative and environmental aspects into consideration with policy analyses. Uncertainties in most programmes are numerous and interrelated into the organisation’s functions affecting the outcomes in complex ways. Literature indicates that one of the major failures of HIV/Aids strategies and programmes is based on an inability to analyse and frame the HIV/Aids problems (Department of Health, 2003). Also, high levels of uncertainty and risk surround HIV/Aids and therefore requires that health and finance structures must be build in an environment that can

adapt, be flexible and change to the needs of its customers and environment (Landsberg, 2002:23,40). Problems arise when the objectives do not match the set goal. Behind each logic connection lie assumptions and hidden assumptions (Goldratt, 1990:48; *cf.* Landsberg, 2002:37). Verbalising, challenging/testing and validating these assumptions ensure that the problems are systematically analysed and solutions for the problems can be found.

1.5.2.2 Situational analysis

In this study, situational analysis formed the basis for decision-making, policy-making, strategising and planning in order to reach the strategic intent (Landsberg, 2002:41). The situational analysis forms the basis for both the international (Phase I) and the national (Phase II) case studies. Schoeman (2002:40) and Pearce and Robinson (2003:202) describes the situational analysis as a systematic development and evaluation of past, present and future data enabling the researcher to identify opportunities and threats in the external environment as well as strengths and weaknesses in the internal environment (SWOT).

This provided an overview of the “market success requirements and risks” together with the “distinctive competencies” that contributed towards a sustainable and competitive advantage for the government sector, private sector and non-government organisations. W. Edwards (Deming, 2000a:2; *cf.* Deming, 2000b:3) revolutionised concepts of quality and productivity with his theories of management. His concepts of the theory of management were integrated into the field of public administration and management. It became part of the New Public Management (NPM) movement towards applying businesslike approaches into its day-to-day practices. Deming’s theories on quality management became the theoretical underpinning for creating sustainable and competitive environments in which the driving force for governments and business was to provide value for money and cost-effective services. However, measuring quality in medical services is complicated by emotional and asymmetric information (Deming, 2000a:172). Quality management is further triangulated into a systems approach of which strategic management determines its core practices.

SWOT is the acronym for internal strengths and weaknesses and external opportunities and threats (Pauw, Woods, Van der Linde, Fourie & Visser, 2002:97; *cf.* Pearce &

Robinson, 2003:202). By establishing the internal and external position in the environment Pearce and Robinson (2003:136) present the type of actions to be taken to achieve sustainable outcomes for resource planning and deployment. The SWOT analysis (strengths, weaknesses, opportunities threats) was the framework of choice as its simplicity offered sound strategy formulation and assisted management towards internal value-creation initiatives.

1.5.2.3 Theory of constraint (TOC)

Finding the constraints/problems that prevent effective, efficient and economic outcomes due to bottlenecks or gaps in service delivery and performance is interlinked with one's understanding of the system (Goldratt, 1990:4; cf. Lepore & Cohen, 1999:10). Constraints/problems limit the systems' throughput, having a negative influence on the final outcome (Goldratt, 1990:5; cf. Lepore & Cohen, 1999:11, 16). Cloete and Wissink (2000:116) point out that problem identification or the statement of the problem leads nowhere if there are no clear goals and objectives that direct one where to go, what to achieve and how to tackle the issue at stake. Goldratt presented a theory of constraints (TOC) that became a business management tool to identify constraints within the organisational system, enabling the management to develop focused strategies, manage effectively and create an atmosphere of continuous improvement.

1.5.2.4 Functional benchmarking: best practice benchmarks

Functional benchmarks provide a comparative analysis of similar programmes and strategic positions for the use of reference in formulating objectives. By benchmarking each of the case studies, opportunities were created to build on relative strengths while weaknesses were avoided (Turban, McLean & Wetherbe, 2001:571; cf. Pearce & Robinson 2003:217).

Best practice benchmarks emphasise a comparison of how activities are actually performed. The functional benchmarks involve comparisons with organisations (internally and externally) that carry out the same functional activity. Functional benchmarking has the potential for making breakthrough-type improvements (Boninelli & Meyer, 2004:68). The ultimate objective in benchmarking is to identify the best practice and best value for money in performing an activity (Pearce & Robinson, 2003:217). This means the focus is on lowering costs to achieve value-for-money outcomes that are

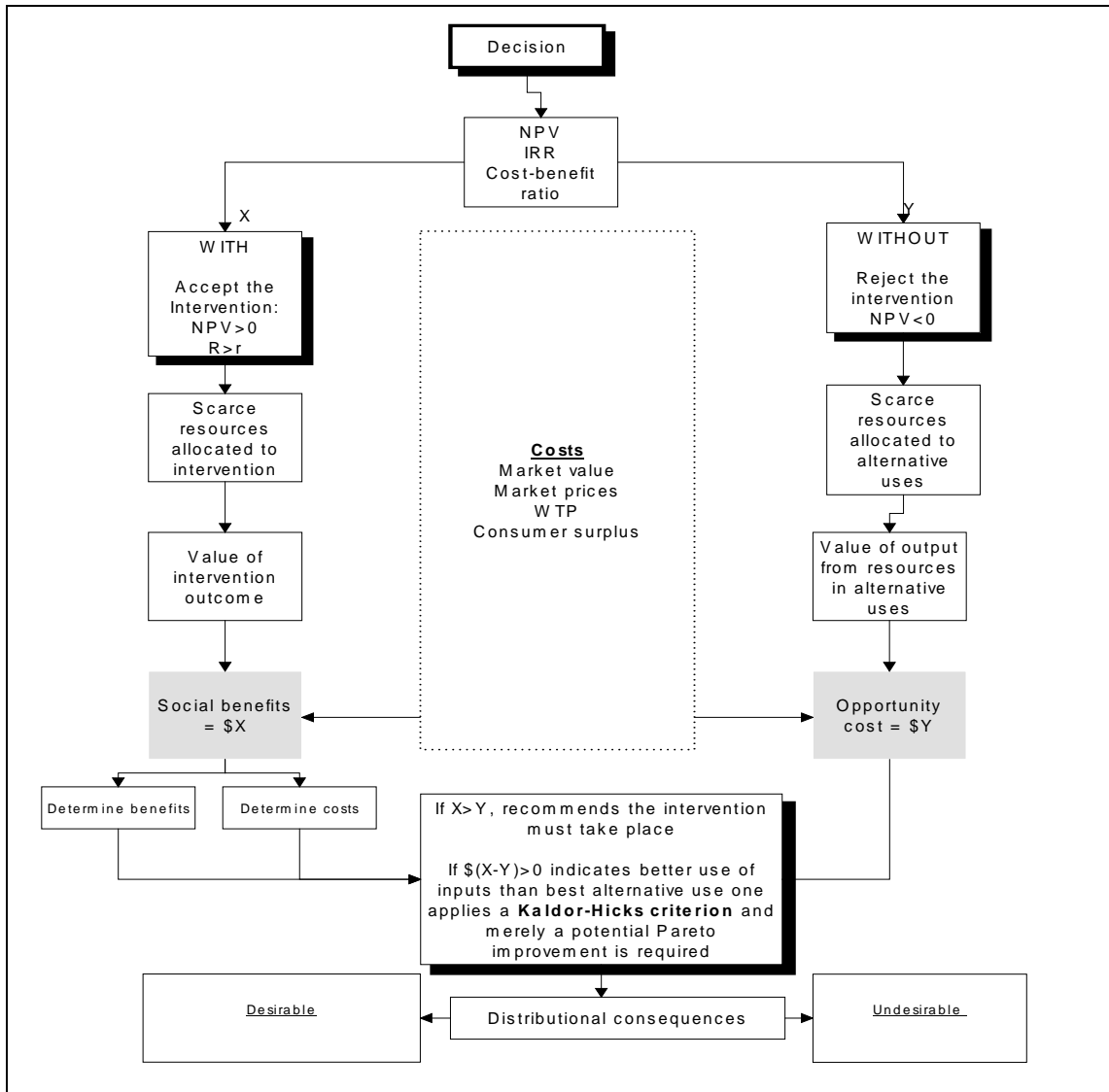
linked to excellence in performance and value creation in the long term. By comparing key issues between the international and national case studies, an attempt was made to isolate and identify where costs or outcomes are out of line. It determined the best practice and a particular activity according to experience, previous trends and perceptions that achieved sustainability and efficiency. It also proved useful in ascertaining whether the internal capabilities were strengths or weaknesses. Attempts were made to change existing activities to achieve the new best practice standards (Turban et al., 2001:571; cf. Pearce & Robinson 2003:217; cf. Boninelli & Meyer 2004:68).

1.5.2.5 Cost-benefit analysis (CBA)

The technique of social cost-benefit analysis is used in this study to analyse the effects of changes in health care policies and forecast its impact on the roll-out plan for HIV/Aids policies. *Cost-benefit analysis* is therefore described as a qualitative tool that enables decision-makers to make better choices between alternative programmes which reduce uncertainty by ensuring that optimal capital expenditure is incurred (Abedian, Strachan & Ajam, 2003:116; cf. Campbell & Brown, 2003:2). *Capital costing* is thus seen as one of the key elements in preparing a budget as it pertains to expenditure items such as hospital construction as well as costing of human skills. Public projects are thought of in terms of the provision of physical capital. *Cost benefit analysis* is described as a framework to incorporate the multitude of options and considerations that arise when assessing the desirability of interventions or program outcomes. When cost-benefit analysis are applied to developing countries these models are referred to as project appraisals (Brent, 1998:3; cf. Campbell & Brown, 2003:1). Brent (1998:3) points out that the basic difference between cost-benefit analyses of the developed and developing countries is the emphasis given to market values. Market values are assumed to be the starting point for the measurement of social values.

Figure 1.3 provides the theoretical underpinning of the CBA compiled for this study. The with-and-without approach forms the centre of the cost-benefit process which determines the social benefits and costs derived from the utilisation of PPP within the HIV/Aids intervention strategies.

Figure 1.3: Cost-benefit analysis



Source: Adapted from Campbell and Brown (2003:3-5); Brent (1998).

The with-and-without approach described in Figure 1.3 forms the centre of the cost-benefit process and underlies the concept of opportunity costs (Campbell & Brown, 2003:2). Costs are therefore measured as an opportunity cost and provide the value of services and goods. The benefit is the value of the increase in future supply over and above what it would have been in the absence of the intervention. The CBA thus provides relevant information to the existing decision-making processes about the distribution of benefits and costs, this means pointing out if the “with” path (X) and “without” (Y) will be available. If the $X > Y$ benefits exceed the costs, or equivalent, the benefit/cost ratio exceeds the unity and creates a presumption in favour of the

intervention. The decision-maker has to take the distributional effects into account, considering who receives the benefits and who bears the costs. All social CBA must work out how the overall net benefits (or net costs) of the proposed intervention will be shared amongst interested parties, public and private as well as consumers and producers (Pauw et al. 2002:239; cf. Campbell & Brown 2003:1).

1.6 Clarification of terminology

HIV/Aids: Aids is caused by HIV or human immunodeficiency virus. The curve of HIV infection is followed by the curve of Aids illness and death which determines the third curve of "impact" describing the shock and vulnerability of individuals.

NGO: A non-profit organisation as is defined in the Non-profit Organisations Act No 71 of 1997 is independent from government and its policies. The NGO obtains its funding from private sources or donations.

PPI: Public-private interaction according to the health charter, is involved in health care within the private or NGO sector, but is not limited to a PPP.

PPP: A public-private partnership (PPP) speaks of the formation of co-operative relationships between government, profit-making organisations and not-for-profit organisations to fulfil a policy function. The South African regulatory framework for PPP is based within the Constitution of the Republic of South Africa, 1996 (Act 108, Section 217 (1)) and is defined in Treasury Regulations No 16 issued in terms of section 76 of the Public Finance Management Act, 1999 (Act 1 of 1999) which states that PPP is a contract between government institutions and private parties where substantial risk is transferred to the private party.

Private sector: Persons or entities outside the public sector and NGO.

Public sector: Government departments, organs of state and institutions that exercise public power or perform public functions.

1.7 Structure of the research

The dissertation is composed of eight chapters. A literature study and empirical research framed the boundaries for the research question. Chapter 1 is an introduction to the study and presents a statement of the research problem, the research question and the objectives that shaped the research approach and methodology of the study.

Chapter 2 presents a description of the international environment referred to the international dimension of the global environment. The various factors used to assess the international environment and the interplay amongst the markets, social and political factors, as well as technological trends, are discussed in detail in this chapter as this has significant bearing on the type of intervention strategies government selects in health care reforms. Added to this, the nature and degree of competition play a determining role in the way strategies in HIV/Aids intervention are structured. Globalisation and regionalisation influence developments in such a way that market forces are central to all strategies. Therefore, it becomes imperative to explore and understand how policy decision-making in government impacts on all spheres of life and influences HIV/Aids intervention strategies.

Chapter 3 investigates the global situation of the HIV/Aids pandemic and its global, regional and national impact on health care systems and public finance structures. This chapter highlights the impact of conflicting issues such as “humanistic valuing” versus “market forces” on government policy-making. A short introduction to the disease and its epidemiology provides important knowledge in coming to understand why the epidemic takes different forms in different societies and why governments use different approaches to solve these vulnerabilities. Both epidemic curves (HIV and Aids) have political ramifications. Concerns raged about strategies and interventions that focused mainly on clinical-medical issues and individual behaviour change. Both failed to recognise the structural and distributional factors that resulted in those behaviours.

Chapter 4 probes the value of public-private partnerships and public finance as a mechanism to strengthen policy capacity, thereby improving the quality of service delivery outcomes in health care. It takes a closer look at how PPP are constructed and

how they can benefit HIV/Aids intervention strategies. This chapter concludes by exploring the impact of PPP on public finance and health care reforms.

Chapter 5 takes a closer look at the historical evolvement of political thoughts and ideologies and their influence on shaping the nature of government functions. The political ideologies and forms of government become the binding factors between choices made in intervention strategies and the government's approach towards its role as enabler, facilitator and regulator. The influence of the New Public Management movement changed the role of the public administrator as it blended together businesslike approaches with themes of "efficiency and effectiveness" in government reforms and service delivery outcomes.

Chapter 6 establishes criteria for health care policies and presents a model of best practice. This is achieved by presenting international best practices within a 4E framework highlighting the key performance indicators that are critical elements in the PPP environment and shape service delivery when formulating HIV/Aids intervention strategies. The international best practices form a benchmark for the national situation against which performance is measured. This chapter puts forward new best practice standards linked to service excellence in the long term, displaying the best options and strategies available to overcome the weaknesses experienced in the NHS and to identify those factors that prevent successful outcomes in the roll-out plans for HIV/Aids.

Chapter 7 analyses the results of each case study and points out how PPPs are used as a mechanism to achieve fiscal responsibility by providing alternative policy options to develop intervention strategies for HIV/Aids in South Africa.

Chapter 8 concludes with a summary of the main results and presents recommendations for alternative approaches in health care reforms. It identifies the main issues that determine strategic choices and why PPPs are attractive options in health care interventions and how they can be used effectively in HIV/Aids policy agendas. This chapter identifies future research topics flowing from this dissertation which require further investigation.

1.8 Conclusion

Finding a cure for HIV/Aids is top of the government's agenda as HIV infections continue to grow, impacting negatively on wealth creation in South Africa. Although research studies mostly focused on the medical issues associated with Aids, few studies dealt with this topic from a public finance management perspective. All actions in this study were directed towards finding effective service delivery outcomes through allocative, distributive and accountable mechanisms. This was done by investigating the impact and influence of strategies on the roll-out plan for HIV/Aids policies.

This research is important in that it deals with immediate problems in the HIV/Aids environment that needs attention. The qualitative tools did not produce solutions but aim at providing information and analysis at multiple points. Hence, it points out specific areas that need further investigation. The problems associated with HIV/Aids have major impacts on future health strategies as HIV/Aids costs are escalating and take bigger a proportion of the GDP every year reducing money available for other life-threatening illnesses. Finding mechanisms for improved service delivery through scientific research, tested and validated, offers decision-makers the opportunity to make well-informed decisions.

The strength and value of this research study lies in its research design and the methodology followed to find evidence of patterns, trends and options across cases. The study takes a wide-angle approach to policy in that it looks at the whole policy process and not at a specific part of it. Literature indicates that few researchers use applied research and therefore do not take into consideration the whole policy-making process and also do not apply a systematic analysis of the dimensions and variables that influence public policy. Because policy analysis is an indispensable part of policy management, strategic management tools such as the PESTLE, SWOT, TOC, strategy maps and CBA offer reliable and accepted management tools to validate the qualitative data. The reliability of the data is based on the systematic approach in which the qualitative data was collected. The systematic approach allowed for both an inductive and a logical approach to the analysis of data and verification of evidence against referenced data.

The next chapter investigates the factors and dimensions within the international environment that influence public policy-making. Public policy does not occur in a vacuum. The relationships shaping the outcomes of structures developed to advance “well-being and common good” directly impact on public finance and public administration and determine how problems in the HIV/Aids environment are defined and framed. People’s interaction with health care systems define their experiences of the state and determine their place in broader society as health care communicates and enforces values and norms through different aspects of its operation. Therefore, one has to keep in mind that citizens’ claims of entitlement to services, necessary to promote health, are their assets in a democratic society. This makes health a highly complex and emotional environment.

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 regimen 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 themselves 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

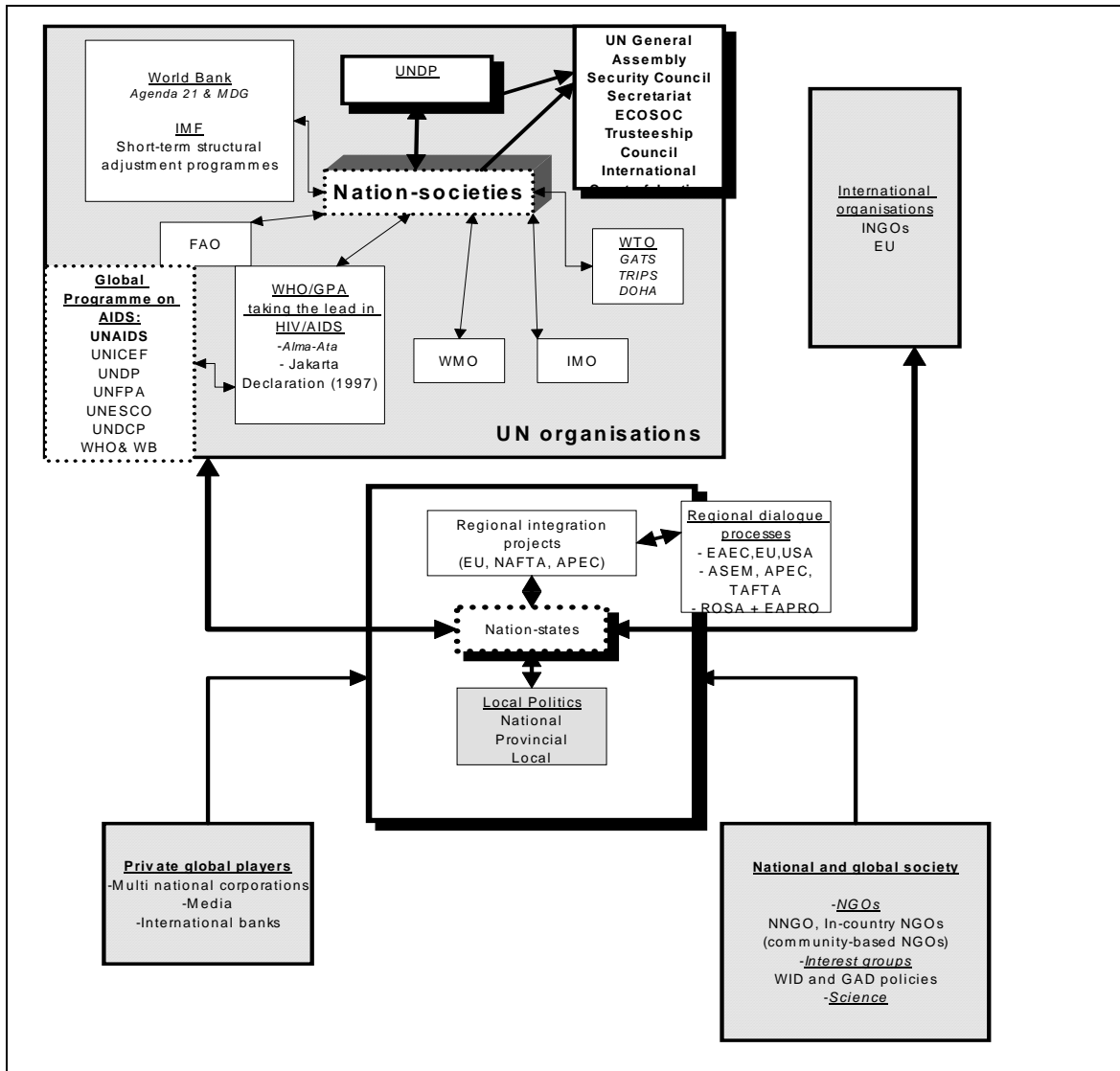
Global trends in global structures identify transnational interaction, concatenated interdependencies and a variety of border-crossing integration processes (Kennedy, Messner & Nuscheler, 2002:30). The impact of the transnational interaction is becoming a determining factor in the policy environment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

<p>Political</p>	<ul style="list-style-type: none"> ○ The ideology and “class structures” that shape the role of the state through: <ul style="list-style-type: none"> ○ Constitution ○ Democracy and participation ○ State intervention ○ Building state capacity in health care: <ul style="list-style-type: none"> ○ Reforms ○ Electoral processes ○ Role of executive and policy ○ International relations and global governance structures <ul style="list-style-type: none"> ○ Regional trading blocks ○ International aid
<p>Economical (Enabler and facilitator)</p>	<ul style="list-style-type: none"> ○ Market outcomes and government interventions <ul style="list-style-type: none"> ○ Government fiscal policies: macro and micro policies ○ Economic systems and supporting economic policies ○ Implications for the public sector and public finance <ul style="list-style-type: none"> ○ Socio-economic arrangement and its impact on employment ○ Influence of religion and culture upon social policy ○ HIV/Aids impact on: <ul style="list-style-type: none"> ● Employment, economic systems and growth ● Influence of religion and culture ● government fiscal structures ● private sector
<p>Social (Distribution of goods and services)</p>	<ul style="list-style-type: none"> ○ Role of the state ○ Intervention - approach to social development and poverty: social justice <ul style="list-style-type: none"> ○ Main determinants of social policy <ul style="list-style-type: none"> ● Predominantly internal factors <ul style="list-style-type: none"> ▪ Demographic factors ▪ Political factor ▪ Institutional evaluation factor ▪ Economic factors (rate of growth per capital) ▪ Influence of interest/pressure groups ▪ Social psychological factor

	<p>Political factor = sum total of demographic + economic + social psychological factors. This means social security is a political problem</p> <ul style="list-style-type: none"> • Predominant external factors <ul style="list-style-type: none"> ▪ Cultural diffusion ▪ Technical development ▪ International standardisation and co-operation ○ Health care markets and HIV/Aids interventions <ul style="list-style-type: none"> ○ Health care reform and policies: link between health, social welfare and poverty <ul style="list-style-type: none"> • Privatisation: Health care markets: Public-private partnerships • HIV/Aids intervention strategies <ul style="list-style-type: none"> ▪ Costs ▪ Constraints in system ▪ Assumptions ▪ Policies ○ Employment and ill health/ HIV/Aids <ul style="list-style-type: none"> • Government income and budgeting • Impact of New Public Management on service delivery and financial management • PPPs and HIV/Aids
Technological	<ul style="list-style-type: none"> ○ IT, development and health care reforms <ul style="list-style-type: none"> ○ Financial information systems a key element in organisational planning and decision-making ○ Administrative structures and IT support
Legislative	<ul style="list-style-type: none"> ○ Role of government <ul style="list-style-type: none"> ○ Health care policies and its impact on HIV/Aids intervention ○ HIV/Aids policies and fiscal structures
Health Environment: (global, regional and national)	<ul style="list-style-type: none"> ○ Millennium Declaration and environmental policies for HIV/Aids: developed and developing countries <ul style="list-style-type: none"> ○ Poverty and social inequities: urbanisation, rural (cultural environment) ○ Infrastructure ○ 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 occurs 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 horizontal 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 research 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.

CHAPTER 3: HIV/AIDS AND HEALTH CARE REFORMS

Evidence from many countries shows that income is probably the most important factor outside of the health sector, while others include social inputs such as education, environmental inputs, access to clean water, and general economic measures such as food rationing and subsidies, etc...This approach identifies economic and political factors as the most significant determinants of health, as these factors determine who has control over resources and decision-making and who has power of whom... (Labonte et al., 2004:173)

3.1 Introduction

Formulating the problem requires insight into the dynamics and patterns of the disease, the design of biomedical and behavioural interventions as well as gaining insight into the social and economic impact of the HIV/Aids epidemic on health care systems. Therefore, careful consideration has to be given to where the epidemic is located, how it will spread and affect communities and health care systems in order to implement effective roll-out strategies for HIV/Aids interventions. Defining the HIV/Aids-related problems and identifying the assumptions that constrain decision-making are critical elements in putting together interventions that are able to target the real needs and issues. Strategic forecasting becomes a key success factor in building a system of profound knowledge and in coming to understand the driving forces necessary to design effective health care intervention strategies for HIV/Aids.

This chapter focuses on the origin and epidemiology of HIV/Aids, the distribution and determinants of health-related conditions with the aim of providing a basis for a best practice model to control this health care problem. Many strategies fail because the operational aspects are separated from the strategic aspects. Only by bringing together all the different aspects that influence the biomedical and behavioural interventions can risks be managed and actions be implemented that offer adequate resources and capacity-building structures.

3.2 HIV/Aids, the disease

According to Tabane (2004:26), HIV is a human immunodeficiency virus that can be transmitted sexually through blood and during pregnancy. She states that like herpes and syphilis, HIV affects the whole body. Tabane (2004:26) and van Dyk (2001:4) describe Aids, an acronym for acquired immune deficiency syndrome, as being caused by a virus (HIV) which enters the body from the outside. Deficiency means that the body is unable to defend itself against infections and disease. Aids should be seen as a syndrome of opportunistic diseases, infections and certain cancers. All of these diseases result in death in the final stages of the disease. Treatment does not cure the disease but buys time and quality life.

Aids has killed more than 25 million people since it was first recognised in 1981 (UNAIDS/WHO, 2005:2). This makes it one of the most destructive epidemics recorded yet. According to the UNAIDS (2005:2), the total number of people living with HIV has reached 40.3 million. Newly infected people grew by close to 5 million for the year 2005. Women in the developing countries are the hardest hit by the epidemic. The infection levels amongst pregnant women are shown to be 20% higher than those that are not pregnant (UNAIDS/WHO, 2005:4). Ababio (2005:331) and Van Dyk (2002:88) point out that the causes and spread of HIV/Aids vary. By reducing the stigma, discrimination, violence accompanying sex and isolation of people living with HIV/Aids, the impact of this disease on women will be made softer as the success of prevention strategies depends on treating HIV like any other disease (Van Dyk, 2002:95). Only when people feel safe to be open about their status can the real issues be resolved successfully.

As HIV/Aids is a collection of many different conditions that weaken the body's immune system, each person who is diagnosed as HIV positive reacts differently to the virus. People who are already chronically ill (affected by TB or malaria) will move much quicker through the phases of the disease and show varying degrees of illness that demand alternative measures of medical interventions. Table 3.1 presents five phases of HIV infection identified by Van Dyk (2001:36-40) and Barrett-Grant, Fine, Heywood & Strode (2003:22-23). Van Dyk (2001:36) states that in practice it is difficult to demarcate the boundaries. The phases are theoretically divided and offer a framework in which the progress of the disease can be monitored and measured.

Table 3.1: The phases of HIV infection

Phase	Symptoms and treatment	CD4 count
1. The primary HIV infection phase.	Fever-like symptoms 4-8 weeks after infection with HIV virus. Window period (3-4 weeks) is the period between onset of HIV infection and the appearance of detectable antibodies to the virus. Treatment immediate and aggressive with antiretroviral therapy (ART) to reduce viral loads.	Detectable viral loads. Considered to be the most infectious.
2. The asymptomatic latent phase.	Show no symptoms and are productive workers.	CD4 cell count between 500 and 800 cells/mm.
3. The minor symptomatic phase.	Show minor and early symptoms of HIV disease through shingles, fevers, skin rashes, recurrent upper respiratory tract infections, weight loss, chronic diarrhoea and fatigue.	CD4 cell count between 350 and 500 cell/mm.
4. The major symptomatic phase and opportunistic diseases.	Begin to appear as the immune system deteriorates The person is usually bedridden for at least 50% of the day.	The viral load becomes high. CD4 count between 150 and 350 cell/mm.
5. Aids-defining conditions and severe symptomatic phase, also known as full-blown Aids. Takes 18 months to develop into Aids. People with full-blown Aids usually die within two years.	Patients do not respond to antibiotic treatment and more persistent untreatable opportunistic conditions and cancers manifest. ART and prevention may prolong the person's life. This	CD4 count is below 200 cells/mm. Patients are considered to be very infectious when full-blown Aids appear.

	depends on nutrition and management of opportunistic conditions, resistance to treatment.	
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Source: Adapted from Van Dyk (2001:36, 65-67); Barrett-Grant, Fine, Heywood, Strode (2003:22).

One can therefore deduce from Table 3.1 that each phase requires a specific set of medical, administrative and managerial interventions. Unpacking the internal processes to support actions and strategies for each phase of the disease will provide governments with a means to determine its impact on the national health care system and economy. Unfortunately, the only way to stop Aids is to prevent transmission of the virus. Behavioural interventions were developed in an effort to contain the spread of HIV/Aids. Even though the focus now not only was on medical interventions but also included the mind, there still seemed to be gaps in tackling the disease. Poverty and instability proved to be the main drivers in the spread of the disease. Barnett and Whiteside (2002:76) deliberate on the strategies that supported the biological goal aimed at tackling the epidemic and reducing the rate of transmission. They pointed out that such strategies required considerable financial and logistic resources and are dependent on the availability of treatment.

The ultimate purpose of antiretroviral therapies (ART) is to reduce the HIV viral load as much as possible during the phases of HIV infection. There are three main categories of antiretroviral drugs (ART) that are used to treat HIV/Aids. These three main categories are used in various combinations to treat patients with the best results (Van Dyk, 2001:67). The categories are described by Van Dyk (2001:67) as follows:

- Nucleoside reverse transcriptase inhibitors (NRTI) which include: zidovudine or zalcitabine (AZT), didanosine (Videx), lamivudine (Epivir) and stavudine.
- Non-nucleoside reverse transcriptase inhibitors such as nevirapine.
- Protease inhibitors.

While the aid responses have grown and improved access to ART in the developing countries, it has been recognised that gaining the upper hand against the pandemic requires rapid and sustained expansion of HIV prevention (UNAID/WHO, 2005:5).

Treatment of HIV/Aids has been the most effective where a combination of two or three antiretroviral drugs were used. For optimum suppression, a triple therapy is recommended. Mono-therapy is no longer the preferred option as it produces only temporary reduction in viral load and a resistance to the drug develops within a few weeks. When resources are limited bi-therapy is used, though drug resistance may also develop (Van Dyk, 2001:68). It is found that where patients build a resistance against the combinations a new combination that often needs multidrug combinations must be used to treat patients effectively. The challenge thus lies in finding the most suitable combination of drugs as well as the most cost-effective treatment.

ART and multidrug therapy calls for a pattern of chronic care in which individual patients receive follow-up treatment for the rest of their lives (Van Dyk, 2001:68; *cf.* Barnett & Whiteside, 2002:79; *cf.* World Health Organisation, 2004:57). As a result, delivering quality ART involves a broad range of activities that stretch beyond the purchase and disbursement of ARVs. Quality programmes require a diverse set of interventions that include activities to promote adherence. Unless patients adhere to treatment programmes, resistance will spread and current treatments will become ineffective (Office of the US Global Aids Co-ordinator, 2004). Even though prices of drugs are falling in many of the developing countries, poor infrastructure and inadequate resources to fund interventions will remain a constraint (Labonte et al., 2004:39). Accommodating the demands of multidrug treatments requires that infrastructure be scaled up and more service delivery points are made available.

HIV/Aids is a complex disease masked by uncertainty and risk. Identifying adequate resources to cope with the increased demands made on the health system will allow governments to turn the pandemic from a fatal to a chronic condition. The high costs of health care make this extremely difficult and often impossible to achieve, as a country is steered by the minimum standards of health care a government can afford. To reach the turning point from a fatal to a chronic condition is indeed a cost-intensive exercise as it requires strengthening of health care systems to accommodate new patterns and management practices supporting ART aligned with effective roll-out plans for HIV/Aids intervention strategies (World Health Organisation, 2004:58). For this reason, finding alternative mechanisms that offer governments ways and means towards fiscal responsibility becomes a critical aspect in dealing with HIV/Aids and health care reforms.

3.3 The epidemiology: global, regional and national impact of HIV/Aids on health care systems and public finance

Both social and economic characteristics influence the patterns and spread of HIV/Aids. Identifying the determinants which make a society more susceptible and vulnerable to an epidemic spread, requires that high risk or core groups, must be pinpointed. One has to keep in mind that all diseases move through epidemic curves (S-curve) in which one sees infection in some while others are missed. HIV/Aids is unique in that it has two curves. The HIV infection curve preceded the Aids survey by between five to eight years (Barnett & Whiteside, 2002:47; *cf.* Landsberg, 2002:41). The HIV curve reflects a long incubation period between infection and onset of the disease. This aspect impacts on how communities perceive the threat of HIV/Aids against more aggressive types of diseases that show short periods from onset to death. The long incubation period of between three to eight years also offers governments some leeway to plan adequate resources and provide infrastructure that support strategies through future forecasting (Barnett & Whiteside, 2002:168; *cf.* Landsberg, 2002:42). All public policies are future-orientated and aim at promoting the well-being of citizens (Ababio, 2005:330).

A global view of HIV prevalence shows that Sub-Saharan Africa remains the hardest hit. Two-thirds of all people living with HIV are based in sub-Saharan Africa of which women form the main group with 77% of all infections (UNAID/WHO, 2005:2). The cause and spread of HIV/Aids in Africa is ingrained in cultural beliefs and practices while the spread in Europe and Asia is more related to drug abuse and the use of dirty needles. There has been a significant growth in the epidemic in Europe and Central Asia (UNAID/WHO, 2005:2). The poor developing countries are therefore the hardest hit. Coping with the pandemic requires an abundance of resources which these countries do not have. Barnett and Whiteside (2002:169) state that ART are therefore unlikely to make a difference to the life expectancy in the poor world and that price decreases and withdrawal of recent litigation in South Africa by multinational pharmaceutical corporations will have little effect as these drugs are too expensive to implement successfully.

Achieving a turnaround of HIV/Aids from a fatal to chronic condition is thus a dream only rich developed countries can afford. Seeing health as a basic human right with no limit on the costs and resources becomes an unreachable dream for the middle and poor

income countries. Policies therefore aim at promoting well-being through the promotion of accessible, affordable and equitable health care within cost structures that governments can afford. This becomes the pivotal point for determining standards of health care provision and supply of services. HIV prevalence varies between rich and poor families, educated and uneducated, employed and unemployed. It has been noted that the first reaction of most families are similar in rich or poor families. Families pay and take care of treatment. How each household is able to cope with the impacts of the disease over long periods of time depends on their economic status which increases their vulnerability (Barnett & Whiteside, 2002:195; *cf.* Nattrass, 2004a:32; *cf.* UNAID, 2005:31). Poor families rely on public health systems while rich families are able to rely on private health care provision and are more resilient to the negative effects of the disease.

3.4 HIV/Aids: health care reforms, social security networks and fiscal balance

Strengthening national health care systems continue to play a key role in the delivery of effective prevention, treatment and care as part of the overall poverty reduction strategies. Health is recognised as a central part of development and it plays a leading role in how communities perceive democracy and their entitlement to services (Barnett & Whiteside, 2002:295; *cf.* Haacker, 2002:7; *cf.* Freedman, 2005:21). In the developing countries the government is the main force and provider of social welfare, the major producer as well as the biggest employer (Barnett & Whiteside, 2002:296).

HIV/Aids increases the demand for both public and private health services. This means that health care costs rise as personnel costs rise. Looking at the wider impact of HIV/Aids on public revenue and spending, the following critical aspects stand out. Distribution and allocation policies must be able to cope with the effects of HIV/Aids on growth and social justice (Barr, 1998:44). Social security networks are faced with increased demands on their budgets. The impact depends on the type of benefits governments choose to offer (Haacker, 2002:7). This means that HIV/Aids affects the entire social security system. Haacker (2002: 17) points out that it is necessary for governments to distinguish between three types of programmes: provident funds, social insurance or social security programmes. The type of programme selected depends on the strength of the private sector, the revenues government can raise and its approach to social justice. HIV/Aids is expected to deteriorate governments' fiscal position in

several ways. Absenteeism, sick leave and disability pensions, medical care, pensions to surviving dependants, loss of productivity and funeral costs and attendance all have carry-through effects on governments' fiscal position (Haacker, 2002:20).

Research into trends in the composition of health services expenditure identifies medical services (clinical services) and acute hospital care (chronic care) as the two major components of the driving force behind health expenditure. The growth in medical services expenditure is contributed to the overall growth in health services expenditure per person while acute hospitals refer to services in public and private sectors that include recurrent treatments. Trends include a growth in demand for services as technology advances and new drugs extend the boundaries of treatment. Also, increased education of consumers about available treatments raise their expectations of access to a full range of health care. These aspects combine to increase costs of health care as governments are forced to promote higher and higher standards of health care to satisfy the needs and desires of communities.

3.5 International legislation and special features of the HIV/Aids policy process

Legislation that facilitates full community participation and integration of people who are HIV positive into society must provide for non-discrimination and privacy. Its drafting can be complex due to inherent contradictions necessitating exceptions but the need for legislation cannot be underestimated. Also, one cannot ignore the fact that the general principles of Aids legislation are universally applicable. However, enforcement mechanisms must be adapted to suit local situations. Panda et al. (2002:167) state that legislation must be in accordance with United Nations Resolution No. 1995/44 passed by the Commission on Human Rights. The resolution calls upon states to: "ensure where necessary that the laws, policies and practices, including those in the context of HIV/Aids respect human rights standards, including the right to privacy and integrity of people living with HIV/Aids, prohibit HIV/Aids related discrimination and do not have the effect of inhibiting programmes for prevention of HIV/Aids and the care of persons infected with HIV/Aids" (Panda et al., 2002:167).

Efforts dealing with the growing pandemic worldwide in a practical and humane manner raised many pertinent issues. These included issues of mandatory testing and the discriminatory practices in employment. This meant that human rights provided a critical

perspective in the evaluation of Aids policies. It also meant that the legal mechanisms had to reflect the basic rights of individuals in accordance with various international charters and declarations. The multipronged approach to the problems is thus based on human rights obligations which further directed legislation towards considering if it adopts an isolationist approach (mandatory testing) or an integrationist approach (informed consent and confidentiality providing for dignity through anti-discriminatory treatment).

WHO advocates an integrationist approach as it treats the patient as central to the strategy in combating HIV/Aids. Panda et al. (2002:169) point out that the Commission on Human Rights Resolution No. 1994/49 calls upon states to take the necessary steps to ensure full enjoyment of civil, economic, social and cultural rights by people living with HIV/Aids. It urges states to review their legislation and practices to ensure the right to privacy and integrity. On its 57th meeting, the Commission on Human Rights in Resolution No. 1997/33 through a number of guidelines observed that states must review and reform public health law to ensure that they deal with public health issues raised by HIV/Aids (Panda et al., 2002:170).

3.6 Conclusion

International legislation provided a framework by national governments for the development of health rights, access to services and a human rights standard. Fulfilling these three issues has major financial implications for governments. The role and importance of women as a main catalyst in development has been emphasised in development discourse. However, women are the hardest hit by the evolvement of the HIV/Aids epidemic in developing countries. Parallel to this, the long incubation period between infection and the onset of the disease pushed the threat of HIV/Aids to the back of most political agendas. Huge investments into social spending that provides no prognosis after eight to ten years emphasised the discrepancies that develop between each of these issues.

Partnerships propagated by the UN agencies only seem to increase the developing countries' inability to achieve these aims as it highlights the inequities that exist between the rich and poor. Coping with the enormous financial demands needed to support health care and HIV/Aids requires adequate forecasting of future trends whereby

continuous risk management allows governments to identify opportunities and strengths to overcome risks. The utilisation of public-private partnerships is seen as a mechanism that provides opportunities to improve policy initiatives to build capacity and improve service delivery outcomes. The next chapter investigates public-private partnerships as a tool for macroeconomic planning and its ability to enhance value-for-money outcomes in health care.

CHAPTER 4: CONCEPTUALISM OF PUBLIC-PRIVATE PARTNERSHIPS (PPPs) OR PRIVATE FINANCE INITIATIVE (PFI)

While in the past, governments have defended their turf against the encroachments of free enterprise, today some governments are keen to shift more welfare provision into private hands to keep public spending under control and to avoid having to raise taxes or cut benefits (Rosenau, 2002:2)

4.1 Introduction

Neo-liberal arguments shaped ideas on public management reforms within the developed world during the 1980s and 1990s. They shaped public policy by emphasising market efficiency and the government's role as an enabler. The influence of both the libertarian and collectivist schools on political thinking in the developing world cannot be ignored. Chapter 4 discusses the balance between efficient spending on public goods and how to correct market failures against the impact of income distribution and voting through collective decision-making that benefits the majorities.

As governments accepted more and more responsibility for reducing poverty they found themselves pulled into matters that had less to do with economics and more with social policy. Considering that the demands on the welfare state grew, the complexities of governance in governmental institutions and administrative systems became more challenging. Privatisation brought about management reforms, load-shairing, asset sales and contracting out to cope with demands. The dividing line between the public and private sectors were continuously redrawn. Public sector reforms covered aspects such as layers in hierarchy, division of responsibilities, the creation of new relationships between service delivery agencies and changes in budgeting processes.

A paradigm shift occurred in budgeting with a movement from conventional budgeting towards public expenditure management. This shift forced governments to make choices regarding the financing of public expenditure and the allocation of resources which influenced health care outcomes. It became clear that separating the effects of public finance from public policy on social justice (distribution) and efficiency is impossible as outcomes are intertwined with choices, trade-offs and political promises. The raising and spending of public finance is predominantly influenced by political philosophies and the

ideologies a government supports and this underpins the citizen-state relationship. These relationships underscore the systems and tasks of those accountable and how the relationship of power is applied. Administrative reforms support political decisions and philosophies in their strategies for raising and spending of public finances. Chapter 4 explores the impact of political ideologies on the strategic role of public finance. It focuses on core issues of accountability and its influence on determining the role of the state as an enabler, facilitator and regulator.

4.2 Accountability and responsibility in public finance

The concept of voice and accountability has dominated development discourse (Goetz & Jenkins, 2005:8). Demirag, Dubnick and Khadaroo (2004:4) emphasise that *accountability* is a complex, abstract and elusive concept that takes on various forms which can include communal, contractual, managerial and parliamentary accountability. Governments' increased focus and responsibility to reduce poverty means that social justice cannot be separated without the insistence that the powerful must take into consideration the voices of the ordinary people, or that the citizens must be empowered to hold the powerful to account. Participation in decision-making forms the basis of the democratic process. Not all outcomes of participation in the democratic process are always the best available option, but they do portray the community's needs and desires at a specific time. The alignment between empowerment, responsiveness and voices of citizens with accountability becomes more complex as policies become broader-based and support hierarchical structures that develop towards horizontal and flexible frameworks.

Accountability is central to good governance. Good governance is an essential complement to sound economic policies (Dia, 2001:13). Defining accountability is therefore necessary in order to establish the impact of good governance structures on public finance. *Accountability* is described as a relationship of power that calls for answerability and enforcement by the key actors (Dia, 2001:13; cf. Pauw, Woods, Van der Linde, Fourie & Visser, 2002:136; cf. Goetz & Jenkins, 2005:12). The key actors in this relationship consist of a person who is obliged to give account of their actions and the seekers of accountability who insist on explanations or impose punishments. However, Goetz and Jenkins (2005:12) state that accountability is not synonymous with responsiveness or responsibility. They describe *responsiveness* as the desired attitude

of power-holders towards citizens in which concerns and problems of citizens are listened to with impartiality and fairness. Likewise, *responsibility* is closely related to accountability and is distinguished by the lack of formal compulsion. It corresponds closely to the notion of moral accountability, being accountable by virtue of shared humanity rather than a stipulated contract or an agreed set of standards.

Pauw et al. (2002:137) provide a broader description of *accountability* which includes aspects of responsibility, responsiveness and moral accountability and views accountability as a legal obligation of the administrative authority to report to other organs giving effect to the administrative authority's responsibility. By adequate separation of powers between the political and administrative authorities combined with oversight of the legislature, accountability is ensured (Pauw et al., 2002:137).

4.3 Comparing the operationally relevant objectives for public finance against the 4Es and public finance

The new public management (NPM) approach inspired a widespread shift to business-like reforms in pursuit of improved efficiency and effectiveness in regulation and service delivery. Bailey (2004:19) points out that the NPM literature emphasises the need to secure economy, efficiency and effectiveness (3Es) in the use of public finance while the social policy added equity to the issues (4Es).

Reddy, Sing and Moodley (2003:133) and Visser and Erasmus (2002:76) discuss the 3Es relationship between costs, resources, inputs, outputs, outcomes, impacts and results and emphasise that these processes are all value-based and associated with quality. The value-for-money approach introduced a new look at public finance in which the expected outcome of a function or service, and the resources required to achieve the outcome, must warrant the budget objective and policy intentions. Other Es such as equity, excellence, entrepreneurship, expertise and electability are part of the value-for-money chain and explain the complex processes associated with value concepts (Reddy et al., 2003:133).

Quality is associated with performance management and underpins practices and processes towards enhancing value for money. It defines the customer or user's judgement to the extent that it surpasses their needs and expectations. Therefore, the quality of a service or product includes the intrinsic value and factors such as

accessibility, reliability, durability, timeliness, accuracy, completeness, excellence and compliance with legal standards (Reddy et al., 2003:133). Quality and the perceptions of quality, value provided and willingness-to-pay (WTP) in health care defines claims to entitlement and how citizens experience their democratic rights (Freedman, 2005:21). Applying value-for-money approaches to the political ideologies clarifies the contributing issues that impact on shaping health care delivery. Table 4.1 offers insight into each of the three main political philosophies and provides a matrix for the 4Es and its implications for the public sector and public finance (Bailey, 2004:20).

Table 4.1: Comparison of the three political philosophies and its approach to efficiency, equity, economy and effectiveness

	Libertarian (origins in classic liberalism, focuses strongly on individual responsibility; no such thing as social justice)	Neo-liberal (Welfare statism) or liberalisation (Development ideology enjoyed increased popularity from the mid-1970s. Emphasises individual responsibility, and social justice is a strong factor)	Collectivist (Origin in socialism, a protectionist approach)
Efficiency (Ratio output: input)	Has a very narrow concept: based on market efficiency: Minimum production costs, Maximise consumption of commodities, Concerned with private benefits (securing property rights).	Modified market efficiency: qualified by public interest, Enables the creation of employment opportunities, investment potential, modify inefficient markets, Remove barriers to economic growth caused by market failure.	Has a very broad concept: based on social efficiency, Concerned with community-benefits such as equal education and health.
Equity	Judged in terms of free market welfare outcomes: reward for effort and talent.	Judged in terms of work-based welfare: horizontal equity, a need for government intervention to ensure all have the same opportunities, rights and responsibilities.	Judged in terms of social welfare: vertical equity (re-distribution through taxation and public expenditure) and social needs.
Economy (minimising cost of government intervention)	Secured by restricting government intervention in a capitalist economy (minimal state intervention) to safeguard only negative rights.	Secured by an enabling state, pursuing equality of opportunity through modified markets in a mixed economy.	Not a relevant concept when meeting collective needs through equality of outcomes.
Effectiveness (Goal attainment: Exclusive)	Market outcomes: Best achieved by laissez-faire, freeing markets to maximise productivity and	Limiting markets' maximising behaviour Abandons laissez-faire and recognises that market failure	Best achieved by eschewing markets' maximising behaviour in favour of government intervention to

focus is output targets, outcomes and impacts)	profits, but limits government intervention to negative rights. The economic welfare state resulting from laissez-faire relies on a trickle down to all social groups.	and government failure must be managed.	secure socially acceptable outcomes: Securing social outcomes requires copious amounts of public finance.
Implications for the public sector	Minimal state that enforces only ¹ negative rights (via justice). Private sector provision for public services: public-private partnerships. Minimal welfare state with focus on providing a safety net, Private insurance.	Heavily constrained state with some limited positive rights, Private and public sector provision through public-private partnerships. Conditional welfare state supported by public and private insurance.	Expansive state with full ² positive rights. Goods and services provided through public sector provision, unconditional welfare combined with public insurance schemes.
Implications for public finance	Laissez-faire state with emphasis on minimal public finance for goods or services. Private spending replaces public spending. Minimises the taxation burden, Regressive taxes, Borrowing and public debt very limited.	Enabling state with a heavily constrained public finance. Seeks additional finance for public spending. Tax is perceived as “bads” and not as “goods” for efficiency, Proportional taxes, Borrowing debt for efficiency purposes.	Provider state with unrestrained public finance. The implications for public finance in which: public spending replaces private spending redistributive taxes for equity progressive taxes, borrowing/debt for welfare.

Source: Adapted from Bailey (2004:6,20,21,22).

Table 4.1 demonstrates that various factors are affected by the components of public finance and this substantiates the symbiotic relationship between economy, society, political philosophy and the implications that these relationships have for public finances.

¹ Freedom from coercion, interference and discrimination (Bailey, 2004:6)

² Social and economic rights (Bailey, 2004:6)

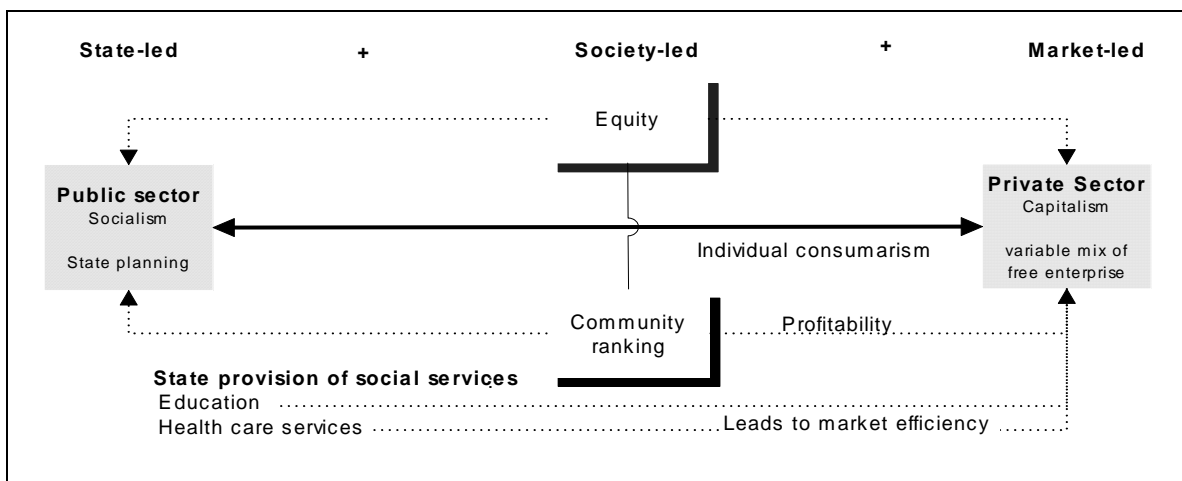
Each of the three philosophies has significant implications for the scale of public finance relative to the economy as a whole (Bailey, 2004:53):

- *Efficiency* defined by the libertarians is described as the ability of free markets to minimise costs of providing services through market efficiencies so that customers can maximise their consumption while collectivists argue that *efficiency* can only be defined in social terms such as community benefits. Neo-liberals try to prevent market failures by enabling the creation of employment opportunities through modified market efficiencies (Bailey, 2003:21).
- Libertarians define *equity* as rewards of the abilities and aptitude that generate profits. Collectivists define *equity* as extensive government interventions through redistribution of income (vertical equity) while the neo-liberals accept equity of market outcomes through regulation.
- *Economy* refers to the minimised costs of government intervention (value-for-money approaches). Libertarians argue that minimised costs are achieved through minimal state intervention. The collectivist sees no relevance of economy since public finance must meet the collective needs at all levels. The liberals argue that the best operational and strategic economic outcomes are achieved through an enabling state that modifies market processes and improves efficiency.
- *Effectiveness* means goal attainment. Libertarians believe that markets are the best at what they do and the government should not interfere but leave business and profits to the private sector. Collectivists judge effectiveness in terms of social outcomes. Neo-liberals acknowledge that government failure can be greater than market failure but government interventions must be justified through effective use of public finances (Bailey, 2003:22).

Determining which type of service needs public finance and the amount of public investment necessary to maximise social and economic efficiency and welfare, becomes a core issue which is closely tied to the political performance of a country. *Political performance* is the ability of political parties to find the correct inputs for political, governmental and administrative systems in order to deliver quality outputs that meet the needs to the satisfaction of society.

Public finance (public sector) and private property rights (private sector) have become synonymous resulting in the relative scale of public finance becoming greater to secure the desired mix of negative and positive rights (Bailey, 2004:53). Therefore, finding a balance between the relative size of the public and private sectors in a mixed economy (Neo-liberal philosophy) steered by the demands (benefits) and supply function, has become a major issue in policy-making. Market failures, government failures and distributional concerns underlie perceived policy problems. Figure 4.1 provides a layout of the issues that influence policy-making in a social welfare state:

Figure 4.1: “Relative size” of public and private sectors in a mixed economy



Source: Adapted from Bailey (2004:15).

Figure 4.1 illustrates that equity (society-led) becomes the pivotal point in the relationship between the market- and state-led policies. Visser and Erasmus (2002:27) support this argument by indicating that the distribution and allocation policies relate directly to the gross domestic product (GDP), facilitating and stimulating of the market. The GDP provides a picture of how distribution and allocation are divided between the public and private sectors. The trade-offs between distributive and allocative spending are becoming more and more difficult to manage, especially if revenue sources remain more or less stagnant (Visser & Erasmus, 2002:27). The way in which government manages its own finances are crucial as government spending constitutes a large part of the GDP (Visser & Erasmus, 2002:61).

The free market system functions on a demand and supply theory which dominates production and allocation of resources and means (Visser & Erasmus, 2002:24; *cf.*

Bailey, 2004:74-75). This means freeing markets are associated with deregulation, legalisation and privatisation. Unfortunately, because the free market system is based on the principles of capitalism, the supply and demand economics cannot ensure equitability in distribution and allocation (Visser & Erasmus, 2002:24). Rather, the changing demands of modern democratic societies have changed the role of government from a passive spectator to an active participator which implies that majority representation requires finding the most efficient solution to the scarcity problem (Visser & Erasmus, 2002:23; *cf.* Bailey, 2004:21). As the mixed economy presents features that enhance strategic richness and collective action, it is the best suited to provide solutions within democratic societies according to the principles of supply and demand with predetermined intervention from government (Visser & Erasmus, 2002:23). The public sector becomes the primary roleplayer in the modern economic systems in the supply of goods and services. Government functions in a political environment and its decision-making is influenced by a competitive market. Still, the government system is driven by politics and not economics (Greene, 2005:321). Although governments need money to operate it is only one part of the equation. Political elections in the democratic process determine which policy decisions are perceived as important and how health issues are pursued.

4.4 The relative scale of public finance

Distribution and allocation policies are executed through government budgets. Determining the balance between social and economic spending becomes a critical element that establishes wealth and physical well-being of all citizens. The difficulty of decision-making in allocation, distribution and stabilising policies is increased due to specific societal conditions. The distribution and allocation policies relate directly to the gross domestic product (GDP) and how the two major economic role-players, government and the private sector, are divided (Visser & Erasmus, 2002:27).

Bailey (2004:54) and Visser and Erasmus (2002:61) state that the gross domestic product (GDP) is the most accurate and reliable indicator of the relative scale of public finance within the domestic economy. Likewise, Gross National Product (GNP) can also be used. Table 4.2 presents available figures for the total expenditure for health as percentage of GDP in the developed and developing countries:

Table 4.2: GDP for health of developed and developing countries, 2002

	Case Study 1	Case Study 2	Case Study 3	Case Study 4	Case Study 5
Total expenditure on health as a percentage of GDP	6.5% Spending is forecast to rise to 7.6% of GDP, 2006	14.6% Is expected to increase to 20% over the next few years due to high inflation in health care. Highest health care spending of all developed countries.	6.1%	7.4%	8.7% Forecasts indicate that health spending will increase significantly over the next four years due to inflationary behaviour.
Public health expenditure	83.4%	44.9%	21.3%	27.9%	40.6%
Private health expenditure	16.6%	55.1%	78.7%	72.1%	59.4%
Out-of-pocket expenditure	55.90%	25.40%	98.50%	52.30%	20.9%
Prepaid plans	18.6%	65.7%	0.7%	0.2%	77.7%
Definition: Total health expenditure is the sum of public health expenditure and private health expenditure					

Source: Adapted from WHO (2006).

Table 4.2 provides a comparison of how public and private health care is divided between the two major economic roleplayers. Public health spending is the highest in Case Study 1, while the other countries all show a trend of high health care spending in the private sector. Case Study 3 mainly finances its private health care expenditure through out-of-pocket schemes. This means HIV/Aids-infected people are very vulnerable as poverty restricts access to health interventions. The public sector is relatively smaller than the private sector. Government encourages public-private partnerships (PPP) in health care. Case Studies 2 and 5 mainly use pre-paid plans such as private health insurance schemes to pay for health care. Health care in Case Study 5 is viewed as one of the world's highest inflationary medical systems and compares to

Case Study 2. The inequities that developed in health care due to market-driven economies (supply theory) affected both the developed and developing countries.

A comparison of how the distribution and allocation are divided between the private and public sectors showed the following results. Questions that centred on health care markets and the relative size of the public-private sectors in health care provision showed that there was a strong growth in the private sector. The private sector was perceived as being more effective and efficient in service delivery. Competitive tensions between sectors were important and determined the relative size of the public and private sectors. It was essential that governments managed these tensions to prevent monopolies from forming.

Public finance/GDP ratio is referred to as a proportion of public expenditure within the GDP. Table 4.3 further explains the four public finance/GDP ratios as presented by Bailey (2004:54, 55) and how this impacts and steers decision-making in allocation and distributional policies:

Table 4.3: Four public finance/GDP ratios

Public expenditure/GDP ratio: "... provides an indication of the balance between public and private sector provision" (Bailey, 2004:54). It also gives an indication of the degree to which government intervenes in the economy. Society attempts to influence the availability and consumption of services such as health care.

Tax/GDP ratio: "... provides an indication of the extent to which the state appropriates citizens' incomes directly from employment, interest, dividends, capital gains and wealth or indirectly by taxing subsequent expenditure" (Bailey, 2004:55).

Public sector borrowing/GDP ratio: "... reflects the excess of public expenditure over public revenue. It can be affected by either or both of the following: Investment in long-lived physical infrastructure such as roads, schools and hospitals. Borrowing spreads costs over successive generations benefiting those that use the infrastructure. In this way those who benefit bear the cost, consistent with "intergenerational equity". The extent to which the current generation of taxpayers is living at the expense of future generations of taxpayers" (Bailey, 2004:55).

Public sector borrowing/GDP ratios are influenced by political philosophy. Both neo-liberals and libertarians believe that the private sector must play a major role in providing physical infrastructure. They require that the public sector borrowing/GDP ratio must be small in contrast with collectivists that require high borrowing/GDP ratios.

Borrowing/GDP ratios are part of the budget cycle and must adopt the "golden rule":

Borrowing in the public sector must not exceed its net capital spending (should not be used in part to finance current expenditures), but must finance that part of capital expenditure not funded by capital receipts.

Public sector debt/GDP ratio: Provides the measure of commitment to repay annual interest on debt and repaying over a period of years the original sums borrowed.

Source: Taken from Bailey (2004:53-58).

Each of the four public finance/GDP ratios discussed in Table 4.3 is interlinked and is detrimental factors in determining the relative "size" of the public and private sectors. Strategically they provide different measures of relative scale of public finance within the national economy and have different implications for public policy. The macroeconomic strategy sets out the medium- and long-term objectives within an uncontrolled and constantly changing environment. Through an effective macroeconomic plan

government is able to manipulate the functioning of the market together with its financial management systems, procedures and controls (Visser & Erasmus, 2002:59).

Public-private partnerships (PPP) became a mechanism within the macroeconomic plan that manipulates the functioning of the market together with its financial management systems as it impacts on the relative size of public finance. PPP are procurement tools of the public sector. It created environments within the national, provincial and local spheres of government that are congenial to private sector participation. Changing perceptions and a broader view towards social responsibility moved public-private partnerships to the top of many national and international agendas and they are becoming an integral part of the regulatory framework dealt with in policy agendas (Tegegn, 1997:31; *cf.* Ketchum, 2001:7; *cf.* Reich, 2002:2).

4.5 Building state capacity: allocation mechanisms

Allocative efficiency refers to the capacity of the budget system to distribute resources according to the government's priorities and programme effectiveness (Schick, 2001:20). By using public finance sparingly, many social and economic benefits are gained. It does not only improve the standard of living by fostering national prosperity through investment in physical and human capital in the long term but in the short term, it also offsets greater private sector income and economic growth (Bailey, 2004:164).

There are various ways in which the state can promote economic growth. This can occur through economic regulation where decisions are based on determining whether an investment is socially beneficial and improves productivity. Likewise, the role of the state is to regulate monopolies, provide public goods and correct externalities. Therefore, an effective state intervention in the economy is to regulate allocations and interventions through various measures (Kraan, 1996:179; *cf.* Przeworski, 2003:167). In a sense the regulation is endogenous and depends on the consequences and alternative actions to be taken. The efficiency of allocations in the market is influenced by three key issues:

- An increase in returns.
- Whether the goods are commodities which are non-rival in consumption.
- The externalities effecting the actions of an individual and the welfare of others.

However, as soon as one of the three issues becomes filled, the market fails. The “command optimum” becomes a tool to determine the allocation by society. The Pareto efficiency stipulates that no one can be better off without someone else being worse off. This is balanced by someone voting against changing the situation towards achieving an allocation associated with an efficient equilibrium (Przeworski, 2003:27).

Efficiency in the allocation of resources requires local rather than central decisions regarding tax costs and how services should be financed. Bailey (2004:224) stresses that allocative efficiency underpins the decentralisation principle of decision-making. It requires local governments to be as small as possible. The size and structure of local governments have profound implications for the costs necessary to enable efficient and equitable service delivery. Whilst smaller local governments are able to match service provision with preferences, problems are created with spillovers and tax exporting as well as horizontal equity (Bailey, 2004:224). This means that service responsibilities must be allocated to the local sphere of government rather than central government.

Public-private partnerships (PPP) or private finance initiative (PFI) are terms that were introduced in the United Kingdom by the Thatcher government (Feigenbaum, Henig & Hammett, 1998:59; *cf.* Rennie, 2003:31). The provision of investment finance by the private sector is a major component and relates particularly to the provision of infrastructure which often includes the outsourcing of related services. In the past, outsourcing was a common route followed by local governments. It is therefore seen as the forerunner to partnership agreements. The partnership agreements involve an invitation of bids from the private sector on a strict tender basis. Competition between private service providers becomes a cost-effective deal in the outsourcing process. However in outsourcing, the risk is passed to the private sector and there is no element of partnership.

Competitive tendering is a variation on outsourcing (Reddy et al., 2003:204). Through competitive contracting government enables the private sector to compete for government contracts and as such implement more effective measures of financing and choices through voting by matching service provision with the citizens’ preferences (Feigenbaum et al., 1998:8; *cf.* Reddy et al., 2003:204). Competitive tendering is sometimes called market-testing. Procurement under competitive tendering ensures

transparency, fairness and acquiring comparative value for money (Pauw et al., 2002:235). Europe and the United States have used competitive tendering as mechanisms to create more efficient public sector departments.

Joint ventures relate to informal arrangements whereby parties agree to work together or share equity on an informal basis for the provision of services. As soon as the joint venture is formalised within a legal binding agreement it becomes a partnership with its own legal status and tax status. A *partnership* can be defined as a contractual agreement with another organisation for the delivery of a service or goods. Various types of partnerships are formed and depend mainly on the nature of the party with whom the partnership is formed. As soon as there are more than five partners, the alignment becomes more complex, fluid and the boundaries shift continuously. Some of these partnerships can then be seen as networks (Kickert, Klijn & Koppenjan, 1997:54).

The concept of policy networks for problem-solving and societal governance provides an alternative to the reaction of governments to the limits of governance proclaiming a strategic retreat by privatising, deregulating and decentralisation (Kickert et al., 1997:2). Kickert et al. (1997:4) disagree with the ideas of the NPM which has been dominant for the past ten years. Rather, they support the idea of public management as network management in which the public, semi-public and private sectors participate in certain policy fields. Network management is a form of steering aimed at promoting joint problem-solving and policy development. Network steering is about creating strategic consensus for joint action within a given setting (Kickert et al., 1997:46, 167). *Networking* therefore refers to strategies and patterns of relations that are characteristic to policy networks and consist of operational and institutional levels. On the operational level, behaviour is goal-driven in which the context is given and immutable. The institutional level is that of the network. Various types of partnerships or networks determine how the institutional level is constructed and how interaction between players occurs. Table 4.4 provides a layout of the different types of partnership and their subsequent impact on contract negotiations.

Table 4.4: Types of partnerships utilised to improve service delivery

Type of Partnership	Definition
Public-private partnership (PPP)	<p>This is the most common form of partnerships. Reddy et al. (2003:204) defines a <i>public-private partnership</i> as:</p> <p>“...A contract between a public institution (municipality) and an individual or privately owned or controlled partnership, company, trust or other for-profit legal entity”.</p> <p>Arrangements are based on medium- and long-term contracts that include a well-functioning system of rule of law, transparency and accountability. The technical process for creating a PPP is tied to the budgeting and financial systems.</p> <p>There is a range of differing forms of public-private partnerships (Rennie, 2003:6). These forms are interlinked with the least amount of risk and the duration of the contract:</p> <ul style="list-style-type: none"> ○ Subcontracting ○ Operation and maintenance contracts: <ul style="list-style-type: none"> Includes service contracts or classical contracts. Governs exchanges of discrete and specific nature. Obligations are straightforward. Stretches over periods of one to three years (McCoy, Buch & Palmer , 2000:4) ○ Leasing ○ Concessions: <ul style="list-style-type: none"> • Build-operate-transfer concessions (BOT) <p>The build-operate-transfer (BOT) schemes are used as a form of non-debt financing of public sector activities that stretches over periods of 25 to 30 years. Private contractors finance the construction of capital assets through non-debt financing in which the cost of capital assets is recovered through user fees. (Adam, Cavendish & Mistry, 1992:8) state that BOTs represent a contracting out of the process of fixed capital formation. Asset ownership and control are reverted to the public sector. It follows a pay-back period during which the private operator earns revenue from the asset. In reality there is no true privatisation as the basic authority and responsibility for service delivery are retained by government (Cooper, Brady, Hidalgo-Hardeman, Hyde, Naff, Ott & White, 1998:396; Rodrigues, 2002:2). Adam et al. (1992:8) argue that BOT</p>

	<p>schemes were a variant of the standard practice of public works contracting in the face of financial constraints by which the remuneration system for the contractor is switched from a lump-sum payment to a risk-bearing payment scheme spread over a specific time.</p> <ul style="list-style-type: none"> • Build, operate, own concessions (BOO)
Public-public partnership	Reddy et al. (2003:204) defines a <i>public-public partnership</i> as "... a contract between a municipality and any public sector entity, including another council or parastatal".
Public-NGO/CBO partnership	Reddy et al (2003:204) describes a <i>public-NGO/CBO partnership</i> as: "... a contract between council and a not-for-profit non-governmental organisation (NGO) or community-based organisation".

Source: Adapted from Adam, Cavendish, Mistry (1992:8); Cooper, Brady, Hidalgo-Hardeman, Hyde, Naff, Ott, White (1998:396); McCoy, Buch, Palmer (2002:4); Rodrigues (2002:2); Dutz (2003); Reddy, Sing, Moodley (2003:204); Rennie (2003:6).

Table 4.4 shows that the difference in allocations greatly impacts on the type of contract and context negotiated between the sectors. These forms of service agreements include a range of service contracts, long-term concessions and management contracts. In general, service agreements (contracts) within the public sector are viewed as mechanisms to enhance performance by clarifying and formalising roles and responsibilities. It encourages planning and adherence to priorities. An aspect which managers often misjudge is the variety of contract costs that increases as soon as contracts become more complex, intricate and detailed (Walsh, Deakin, Smith, Psurgeon & Thomas, 1997:40,128; cf. McCoy et al., 2000:7-8). The PPP option is interwoven with the type of contract, the form of relationship and co-ordination arrangements and how administrative processes are developed to enhance the structure and execution of the PPP throughout the project life cycle. Public-private partnerships are only viable options when return on investment (ROI) is maximised and risks are minimised. As soon as risks become too high and costs rise, investors cut on operational costs and shift the risk back to government. Cutting operational costs can lead to inferior services and more costs for government to maintain and improve services or goods. The key success factor of a PPP is therefore based in the management of the initiative and the associated risks throughout the project life cycle.

Fiscal decentralisation and the difficulties associated with the construction of partnerships in the health sector are nowhere more evident than in the delivery of primary health care. The responsibilities for delivering a comprehensive primary health care system never belong to one sphere of the health system, but require a vertically integrated and tiered health care system where the different levels of management and administration work together in a complementary way (McCoy et al., 2000:7). The vertical division of resources is based on the constitutional allocation of functions. This means that the delivery of health care services is a provincial responsibility (Visser & Erasmus, 2002:27). The complexities associated with the contractual relationship between the province and local spheres of government may involve various contracts between the parties. This means PPP in the primary health care system need flexible and rational approaches to the contracting and shaping of financial strategies (McCoy et al., 2000:8). These complexities are increased by variations in resources, administrative capacity, geography, population size and experiences in health care. Decisions on the role of government and who should provide the services and goods are determined by the distinction between public and private goods and the supply and demand function of the market.

4.5.1 Supply and demand function of the market

While public and private goods are both provided by government, the most important building block becomes the distinction between public and private goods and how it is influenced by the two supply characteristics also known as rivalry (example, health) and non-rivalry (example, defence) (Bailey, 2004:74-75). One can therefore conclude that the nature of public goods is not determined by whether it is financed privately or publicly but rather if it benefits one person or a number of people (Hillman, 2003:63). This means the benefit of public goods is collective (non-rival) to a number of people, e.g. defence is a pure non-excludable public good in that it benefits all members of society while toll roads are an impure collective public good in that it excludes some members of society from these benefits. There are certain reasons why public goods may be provided more efficiently in the public rather than the private sector and vice versa (rivalry and ³non-rivalry theories) (Kraan, 1996:197). Table 4.5 presents a matrix of commodities that exist

³ Non-rival consumption refers to a characteristic that determines that by using the good or service, the availability does not decrease (Pauw et al., 2002:19).

and the factors that influence consumption of goods and services in a Walrasian economy.

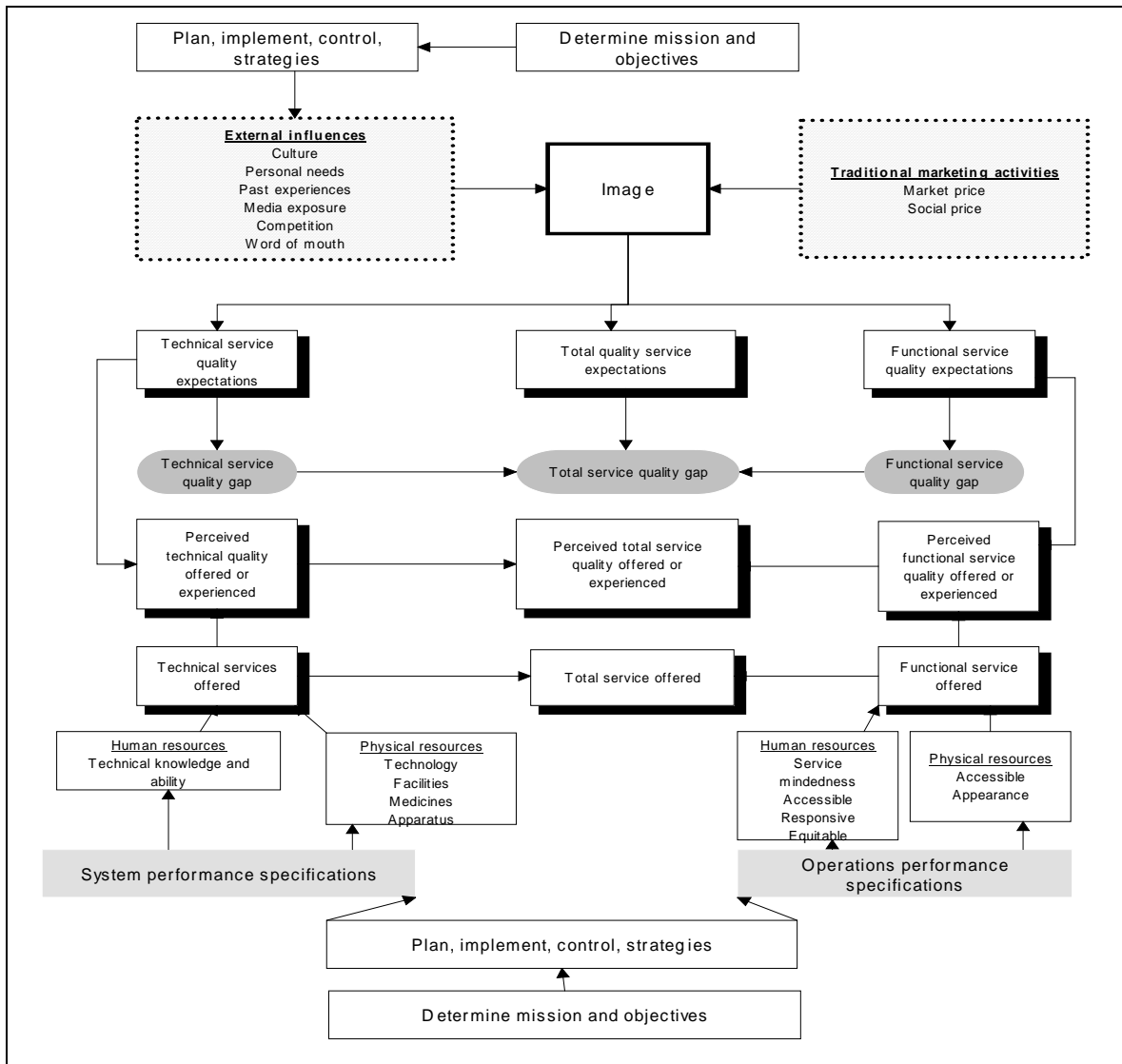
Table 4.5: Supply characteristics of commodities

	Excludable (Refers to a characteristic of certain goods that excludes members of society from their benefits)	Non-excludable (Refers to a characteristic of certain goods in that it is impossible to exclude members of society from their benefits)
Rival	Particular or private	Quasi-collective
Non-rival	Collective Impure public: Club, toll “...Individual benefit from an impure good declines with the number of users because of congestion effects” (Hillman, 2003:64)	Collective Pure public: defence “...A pure public good provides the same level of benefit for everybody independent of the number of users” (Hillman, 2003:64)

Source: Adapted from Hillman (2003:64); Przeworski (2003:32); Pauw, Woods, Van der Linde, Fourie, Visser (2002:19).

As indicated by Hillman (2003:67), a distinction between public and private goods is based on how people value the same quantity of goods and their willingness-to-pay (WTP). Quality is often considered to be a key to success. In a service context, technical and functional quality becomes the foundation of effective governance. Creating a technical advantage is paramount to quality issues and the most difficult to sustain (Gronroos, 2000:70). Developing a functional service quality adds substantial value, though the technical quality of the outcome of a service process is the prerequisite for good quality. WTP is linked to expectations and experience variables. Added to this, perceived quality is tied to image and brand. WTP is directly tied to people’s perception of the market value plus social value. WTP is determined by the market price and their perception of the context of quality and value for money. The synthesised model of quality in Gronroos (2000:70), adapted in Figure 4.2, provides further insight into the service delivery in the public sector, quality and customers’ WTP.

Figure 4.2: Synthesised quality model for public service delivery



Source: Adapted from Gronroos (2000:70).

The weakest-link public goods are a form of public goods for which the amount available is the least amount that is voluntarily financed by any member of society (Hillman, 2003:84). WTP is therefore tied to people’s expectations of service outcomes and the image created (Gronroos, 2000:70; cf. Hillman, 2003:93). Figure 4.2 explains the factors that are instrumental in creating the image people have of services. This depends on their perception of the technical (knowledge and skill of clinician, the medical infrastructure, apparatus and medicines) and functional service quality (accessibility, responsiveness, equitability and service-mindedness of providers). The combination of

the technical and functional aspects influences the WTP. Government's role in co-ordinating weakest-link public goods is to avoid free riding and to set and enforce standards that avoid opportunistic behaviour.

As the benefits of public goods are supplied in the same quantities to everyone, efficient supply of inputs and efficient spending become the key issue. This requires co-ordination of decisions and efficient access to goods and services to everyone who wishes to benefit from it. Hillman (2003:94) is of the opinion that efficient access and natural monopoly introduce the question of whether the government should be involved in directly supplying goods as opposed to financing public good benefits.

4.5.2 Raising public finance: strategic budgeting and the effect of public-private partnerships on service delivery

Public policy refers to a proposed course of action and may be viewed as whatever government chooses to do or not to do (Anderson, 2000:4-5; *cf.* Kuye, Thornhill, Fourie, Crous, Mafunisa, Roux, Van Dijk & Van Rooyen, 2002:71-73; *cf.* Greene, 2005:272). *Policy* is defined as a statement of intent and is therefore directed towards accomplishing a purpose or a goal (Anderson, 2000:4; *cf.* Kuye et al., 2002:71). The way in which public resources are used determines if the policy objectives were achieved (ODI, 2005:1). Distributive policies involve using public funds to assist particular groups. Distribution relates to the distribution of resources such as transfers in kind, subsidies and cash grant transfers in line with socially acceptable and equitable terms. Distributive justice requires that public goods are made available to people equitably (Pauw, Woods et al., 2002:7, 155). As Pauw et al (2002:7) point out, *equity* means that everyone gets an equal amount or is required to make exactly the same input. The distribution of income in the form of services and goods thus depends largely on the distribution of national income and the degree of participation of the community in the economy (Visser & Erasmus, 2002:28). However, to distribute goods and services based on preferences of individual members is a case of impossibility as emphasised by the impossibility theorem. The situation changes when a market approach is followed and preferences are based on market prices (Pauw et al., 2002:7,18)

Various sources for raising public finance are available to governments, although the largest revenue comes from taxing (McKinney & Howard, 1998:356; *cf.* Bailey, 2003:132). Other sources include charges (user fees), privatisation sales, borrowing,

state lotteries, donations, payments in kind and special assessments (Bailey, 2004:132). Public-private partnerships and the allocation of private finance are viewed as a more sustainable form of privatisation. Planned acquisition and use of resources are therefore tied to public policy decisions while public finance administration provides the relevant information for making budgetary decisions. Progressive tax policies have come to be a basic tenet of democratic societies for they promote equity. Revenue allocation is a political activity (process) provided for in the constitution through the budget in which the ultimate objective is based on meeting the people's needs and desires. The Government collects taxes until the revenue equals expenditures and those whose preferences count are represented by an amount. Parallel to the public economy the private sector allocation is determined through market forces in which the pricing process determines how the ultimate objective is met (McKinney & Howard, 1998:359).

Pauw et al. (2002:100) state that *strategy implementation* is an operational process which involves the sum total of all actions by the selection of choices to achieve the objectives in the most efficient way. It is essential to link specific spending objectives through an operational plan, the budget. *Budgets* are mechanisms that contain all the monetary implications in a dynamic and ongoing process (McKinney & Howard, 1998:360; cf. Visser & Erasmus, 2002:49). With the devolution of powers and the decentralisation of budget responsibilities, line managers became primarily responsible for the development of their own strategies which gave them more operational discretion (Schick, 2001:11). With the introduction of the value-for-money approach the focus within departments shifted from managing inputs towards managing the outcomes (Visser & Erasmus, 2002:79). This meant that managers now have to work towards a vision and outcomes instead of providing inputs (ODI, 2005:1).

The overarching mission determines the starting point and defines how the service delivery is to be constructed towards the vision and outcomes to be achieved (Kaplan & Norton, 2001:72). The emphasis in budget decision-making is placed on strategic and operational (tactical) planning which includes maintaining aggregate fiscal discipline, allocating resources in accordance with government priorities and promoting the efficiency of service delivery (Schick, 2001:13). These three tasks become central to the spending (fiscal objectives) and delivery of services and goods that influence public sector planning where the public sector benefits from lower costs while the private sector

derives profits. The budget serves as a mechanism through which its fiscal policy (loans, budgeting, taxes) is put into effect (Visser & Erasmus, 2002:50). A typical public-private partnership allows for the provision of capital assets through loan agreements that entails an element of risk in terms of costs and benefits, necessary for the provision of services (Bailey, 2004:141). Whether PPP do save money compared to solely public sector provision of services over long periods of time, is according to Bailey (2004:143), still an unknown factor. He believes that the strategic issue is to ensure that there should be a substantial transfer of risk to the private sector and that there is a large net gain for the public sector in achieving the 4Es.

4.5.3 New roles for accountability actors

Blurred boundaries between the public, private and NGO sectors have had significant impacts on the roles and actions of vertical-horizontal accountability (Kettl, 2003:39; *cf.* Goetz & Jenkins, 2005:80). Traditionally, citizens and civil societies have been relegated to participate in vertical channels of accountability through voting and advocacy. As participation moved towards horizontal channels and the boundaries became more blurred, one saw an increase in loose networks of service providers. Governments found it difficult to maintain legitimacy and to retain their roles as leaders of the network instead of just being another participant in the network process (Kickert et al. 1997:9). This happened as managers managed less through vertical authority and more through horizontal and a wide variety of other strategies. Officials found themselves delegating authority in the traditional ways but were discovering that the old mechanisms for ensuring accountability were ineffective (Kickert et al., 1997:9; *cf.* Kettl, 2003:59; *cf.* Goetz & Jenkins, 2005:80). Co-ordination is the cornerstone of public management. A lack of co-ordination can be seen as the diagnosis for its failures as the responsibility for implementing programmes are more broadly shared through horizontal policies. Devising effective co-ordination strategies is becoming more difficult and authority becomes a less effective tool to solve problems (Kettl, 2003:60). Pursuing efficiency or responsiveness is far more difficult when the boundaries of responsibility are undefined.

When partners share the responsibility for managing programmes it all depends on how well partnerships work. Managing government programmes effectively depends on bridging vague boundaries that separate those who make it from those in the complex interdependent chain of who share responsibility to implement it. Kettl (2003:60)

identified six unclear boundaries that are of particular importance in public programmes as they impact on accountability structures:

- Policy-making versus policy execution.
- Public versus private versus non-governmental sectors.
- Layers within the bureaucracy. Flatter bureaucracy trims middle management and widens the gap between responsibility for critical management and administration decisions.
- Layers between management and labour cause tensions in public and private sectors and affect performance of public programmes.
- Connections between bureaucracies are more difficult because service recipients and policy reformers are demanding more service co-ordination and managers find it difficult to sort out the responsibilities of each bureaucracy.
- Connection with citizens: reformers treat citizens as customers.

The relationships between the public and private sectors are further complicated by powerful actors such as multinational firms that exercise vast power over citizens in the country from which they operate. These multinational organisations are steered by profitability and return on investment (ROI) which finances future operations. Goetz and Jenkins (2005:78) question the accountability of the pharmaceutical industry and point out the benefits that an industry gains from publicly funded research, government-granted patents and large tax breaks. Although these actors are not new, activist pressures and public deliberation have changed the criteria on which performance is assessed. This meant revising the criteria by which performance is assessed and changing the relevant standard of accountability rather than enforcing compliance on financial and technical rules (Goetz & Jenkins, 2005:78).

4.5.3.1 New standards of accountability: a new accountability agenda

The new accountability agenda shows a shift in standards when actors assume new roles and they reach across old accountability jurisdictions to create new ones by using new methods that demand answers. *Standards* refer to the set of activities for which power-holders are accountable and the criteria determine the methods used to assess the performance and behaviour of actors (Kettl, 2003:59; cf. Goetz & Jenkins, 2005:78).

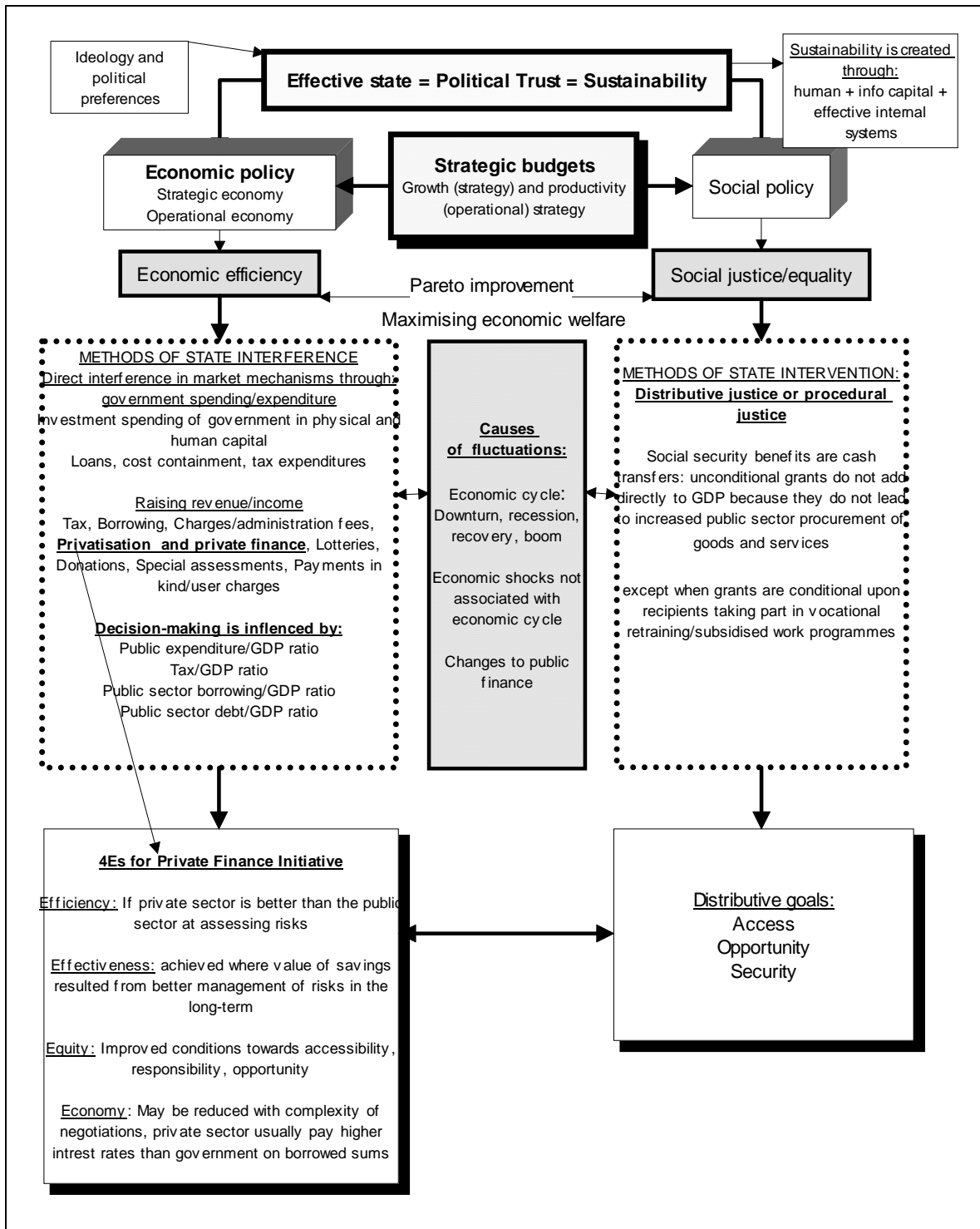
How public administration perceives values and practices has profound implications for the effectiveness and efficiency of government. Public administration represents a manifestation of governmental power. The structure and function of public administration and governance refer to the way government gets the job done. Due to emerging gaps between how government gets the job done and the supporting governance structures, tensions are developing between what government has to do and its capacity to do the job. Standards and procedures define the conduct of democracy and shape the relationship between government and its citizens. The absence of clear and internalised distinctions between public and private actors has weakened governance structures and complicated the standards for accountability.

4.6 Strategic public finance: “4Es” on spending and delivery

Fiscal policy deserves a wider acceptance as a tool for implementing and planning a development strategy. Fiscal policy offers a set of instruments that pursues the best use of resources in terms of efficiency, equity, employment, price stability and satisfactory growth. Welfare is thus a composite of efficiency, equity, price stability employment and growth objectives (Wolfson, 1979:3; *cf.* Hyman, 2005:70). Through its fiscal policy government aims to steer the economy in the direction that will benefit the society and its economy. Social spending is not regarded as value-adding in the growth of economies because the more government spends on social issues the less it has available to use on investment spending which results in the decline of economic growth. Rather, investment spending promotes economic growth and increases wealth (Bailey, 2004:86).

Creating changes in the macroeconomic and microeconomic environment, as well as finding a balance between the outcomes, force governments to continuously change their spending strategies (Abedian & Biggs, 1998:11; *cf.* Bailey, 2004:5). Also, spending patterns are linked to ideologies and influence budget mechanisms and controls, preferences and elements of coercion. Political philosophies in neo-liberal markets have mostly favoured increased social spending due to a social welfare approach to interventions. Figure 4.3 illustrates the balance between economic and social policy and the role that strategic finance plays in allocating and distributing incomes.

Figure 4.3: Strategic public finance



Source: Adapted from Barr (1998:69-83); Visser and Erasmus (2002:5, 49-51).

All government activities and programmes are affected by the way revenues are raised and how public money is spent (Abedian & Biggs, 1998:11-13). In order to obtain the optimum supply of goods and services from the market, procurement management through competitive tendering offers positive economic growth in that it enhances competitiveness and job creation. Fiscal policy provides a way to improve the co-ordination of the economy as it involves minimal coercion while it economises on administrative resources and scarce decision-making capacities (Wolfson, 1979:6). As an indirect tool, fiscal policy supplements and improves the operation of price mechanisms as the principal co-ordinator of the economic system.

Figure 4.3 identifies four trends in the economic cycle that influence government revenue structures and the economy. These trends create fluctuations in the market that have major impacts on revenue-collecting structures of public finance. The causes of fluctuations are attributed to a downturn in the economic cycle that results in recession, recovery or an economic boom. Financing the distribution of social security benefits depends on the methods government uses to raise revenues to support its distributive goals and how government is able to forecast the effects of these trends on its revenue allocation.

4.7 PPPs and public finance: adding value for money

The budget is the primary instrument through which governmental functions and objectives are reached (Visser & Erasmus, 2002:71). Greene (2005:235) provides us with an overview of public budgeting and identifies five goals for budgeting. These five budgeting goals are important drivers for decisions on allocation, equity and stabilisation of the fiscal and monetary policies. They manage the economy, choose among competing alternative priorities, produce the right mix of programmes that can balance the needs of the public and private sectors (relative scale) allowing the economy to be productive and see to it that individuals are provided for, review and control the performance of government departments and are a valuable form of accounting that provides comprehensive statements about activities. Rosenau (2002:37) states that the increased use of PPPs reflects an underlying desire to develop and sustain close working relationships with the external markets. Through public-private partnerships government works directly with private firms in formal and informal relations where they jointly pursue common goals (Feigenbaum, et al., 1998:8). A shift occurred in which the

state now purchases final services, leaving the private and NGO sector to design, build and own the assets. Buying services rather than assets required that governments created different incentive structures in order to achieve efficient service delivery.

The role of the private and NGO sector in delivering services for which the government remains the primary purchaser by utilising the public-private partnership (PPP) model is investigated and questioned in this study. The PPP model comprises two main tasks: the building of assets and the service delivery using the asset. In building the assets, investment improves efficiency of the asset for its purpose. The design of the asset makes the asset more efficient and lowers service delivery costs (Farquharson, 2005). It is imperative that government creates incentives through appropriate contract design to observe and align both the builder's investment and the resulting cost implications of structural designs on the costs of service delivery. "...So in the overall scheme of things perhaps a bit more time and money spent at the front end, unattractive as it might seem, is actually a cheaper option overall" (Farquharson, 2005).

Public programmes that require private sector finance through investment must be viewed on a whole-life cost basis. The whole-life cost view allows the private sector partner to formulate the most effective approach to the provision of services and infrastructure (Reddy et al., 2003:147). Value for money is thus tied to feasibility studies. Competitive tendering utilises bidding/procurement whereby the competitive process offers optimal value for money in terms of the specifications and conditions laid down by the tender document (Pauw et al., 2002:235). Farquharson (2005) states that competition is absolute key to the PPP process, if one does not have a competitive tension the prices go up. Risk allocation must be sensibly done. Placing too much risk on the private or NGO sector reduces competition as people will not come to bid and too little risk does not give government value for money. Balancing risk and competition complicates the problems associated with the creation of incentive structures for PPPs. Therefore PPP must be seen as a complex procurement mechanism. How concessions are managed and awarded are critical elements in preventing the creation of monopolies. "...there are two activities taking place. It is what happened during the concession itself, how do you regulate the terms upon which services are provided and the terms on which it is paid for. That is the terms of the concession and there is then the

regulation on how to manage the process of selecting and awarding concessions or bids to the private sector. It is all about maintaining competitive tension” (Farquharson, 2005).

Public procurement is used as a mechanism in developing countries to achieve certain social objectives. Various definitions are available to describe procurement. Reddy et al. (2003:147) define *public procurement* as: “... the science or perhaps the art, of getting the most for the taxpayer’s money in a whole spectrum of buying, leasing or otherwise acquiring goods and services. While Pauw et al. (2002:227) define *procurement* as: “... the acquisition of goods and services – other than the services of officials – for the People and their administration by means of commercial transaction”.

4.7.1 Defining public-private partnerships (PPPs)

PPP describes the formation of co-operative relationships among government, the private profit-making organisations and non-profit private organisations (NGOs) to fulfil a policy function (Rosenau, 2002:5). Partnerships represent efforts to bring competitive market discipline to bear on government provision of goods and services through procurement. There are mixed feelings worldwide about utilising PPP as a mechanism to improve efficiency and effectiveness. It is argued that PPPs are complex and that the different cultures of public and private sectors weaken accountability structures (Rennie, 2003:29-30).

PPPs are on top of the list of UN agencies and are seen as mechanisms that enable effectiveness and efficiency (Richter, 2004:43). The term *partnership* is a dominant slogan in the rhetoric of public sector reforms (Wettenhall, 2003:77) Even though the UN leaders have promoted closer interaction with the commercial private sector, there is no single agreed definition in the UN system for PPP (Richter, 2004:44).

Privatisation is sometimes referred to as a public-private partnership or “market decentralisation” and it is described as a subtype of delegation (Cohen & Peterson, 1999:29). *Public-private partnership*: “...occurs when government divests itself of responsibility for carrying out a given public sector task or providing a given service” (Cohen & Peterson, 1999:29). It is therefore seen as one of the approaches that can be used within the privatisation continuum (Feigenbaum et al, 1999:8). Likewise, public-private partnerships describe the relationship in which government works directly with

private firms in formal or informal relationships to jointly pursue common goals. Privatisation became an instrument for institutional reform by which economic activity is transferred from the public to the private sector thereby reducing excessive government spending (Wettenhall, 2003:78).

Wettenhall (2003:78) notes that “competition” was gradually replaced by the language of “public-private partnerships, cooperation and relationships”. Many neo-liberal democracies emphasise new governance structures that are associated with holistic government features and that assume prominence in efforts to improve service delivery. Partnerships became an alternative to privatisation, corporatisation and contracting out (Wettenhall, 2003:78). Partnerships, in particular PPP, became the dominant slogan in discourse about government, governance and development. Theories of privatisation and development thinking confused sectoral mixes and sectoral blurring. Privatisation often resulted in some sort of private mix. These forms of private mix were applied in different combinations in each country. The semantic problems inherent in privatisation actually led to sectoral blurring as the term *partnership* in many of these applications led to increased confusion (Wettenhall, 2003:88).

Rennie (2003:29) explains that the issues facing PPP seem to be similar across countries. The success factors, advantages and disadvantages also do not differ significantly, but the regulatory frameworks appear to be the turning point that creates success. During an interview with Farquharson (2005), he emphasised that the definition used by a country shapes the regulatory frameworks of PPP as implemented in that country. He pointed out that the UN definition of PPP is very different from the definition used by the PartnershipUK (PUK) mainly because the UN definition is much broader and follows the US definition (Rennie, 2003:31; cf. Farquharson; 2005).

PPP have become a cornerstone of government modernisation programmes. Flinders (2005:215) claims that PPP raise a host of political issues concerning capacity, structure and the residual core of the state, commitment to collectivised health care, as well as the democratic legitimisation of new forms of governance.

4.7.2 The role of PPP in health care reforms

A *global PPP for health care* is defined as: "...a collaborative relationship which transcends national boundaries and brings together at least three parties, amongst them a corporation (and/or industry association) and an intergovernmental organisation, so as to achieve a shared health-creating goal on the basis of mutually agreed division of labour" (Buse & Walt, 2000:550). Gro Harlem Brundtland was one of the prime movers behind the surge of partnerships in the health arena. She believed that the complex health problems faced worldwide cannot be solved by WHO, governments, NGOs or private sectors alone. It needed a new and innovative partnership approach to bridge the gaps in service delivery and achieve health for all (Richter, 2004:54). PPP has become a prominent feature of the global health landscape.

Financing health-related issues showed clear resource gaps. It was estimated that the worldwide resource gap for implementing PHC was 50 billion US dollars per year (Lee et al., 2002:99). Severe fiscal deficits due to a weak tax base required many countries to increase their foreign debt and pursue structural adjustment programmes (SAPs). A main feature of SAPs (propagated by the UN agencies) was to create policy conditions that reduced public expenditure in social sectors including health. The rationale behind this was to reduce bloated state apparatus and provide the private sector with resource-generating activities such as user fee structures to fill the resource gap. The introduction of SAPs worsened the health problems faced in many of the developing countries as existing infrastructure became obsolete.

PPP in health is about procurement of health infrastructure such as the refurbishment of health estates and getting value for money doing so (Farquharson, 2005). Most countries used PPP to develop infrastructure and not for clinical service delivery. Countries are moving towards applying PPP in clinical services, though they are still hesitant (Muller, 2005). No single focus on HIV/Aids was found (Farquharson, 2005; cf. Muller, 2005; cf. Picazo, 2005; cf. Pillay, 2005). The reason for this was that HIV/Aids centres on social values, poverty and development. PPP is focussed on profit-making. Combining profits with behavioural issues, poverty and development was impossible.

Reducing poverty and applying social justice were the responsibility of government as there were no profits to be made. HIV/Aids are therefore weakest-link public goods.

4.8 Conclusion

Introducing value-for-money approaches to public health care and finding a balance between the relative size of the public and private sectors steered by demand- and supply functions did not only become a major issue in national policy-making scenarios, but also the core issue of disputes in international HIV/Aids policies worldwide. As the distribution and allocation policies relate directly to the GDP, the trade-offs between distributive and allocative spending becomes very difficult to manage. This is evident in the prominent international policy struggles steered by six giant pharmaceutical companies (GlaxoSmithKline, Boehringer-Ingelheim, Bristol-Myers Squibb, Hoffman-LaRoche, Merck & Co. and Pfizer) and their profit motives, as well as the US's manipulation of the six UN organisations together with their regulatory systems that enable them to further their own interests and underscore their free market ideologies.

One has to take into consideration that the developed rich countries have sufficient resources available to cope with the increased demands that HIV/Aids places on their health care systems and less than 10% of the HIV/Aids case loads which enable them to turn Aids from an inevitably fatal diagnosis to a chronic condition. The contrast between the developed and developing countries lies in how they solve the pandemic as this becomes the central theme in understanding the issues relating to HIV/Aids and framing challenges. In contrast, the developing poor countries are faced with increased social spending, neo-liberal market ideologies, 90% of the HIV/Aids cases, poor infrastructure that reduces access to health care resulting in high debt/GDP ratios. At the basis of all disputes the central issue is not material costs but the strength of competing values and the tensions between the structure and function of public administration and governance and how each government applies its values to further its own needs.

Finding ways to fund the increased of demand for social services and providing adequate infrastructure to improve access to health care as well as resolving huge service backlogs become critical. PPP are mechanisms that offer government new ways to procure services and assets through financing schemes with the private sector and that provides them the chance to pay for it over the life time of the project instead of

once-off payments that immediately requires big amounts of cash. Utilising PPPs as a mechanism towards fiscal responsibility is therefore tied to how government perceives its role and function in creating intervention strategies that attend to the collective interest of its citizens and enhance well-being. The external markets forced a shift from the state-centric policies to more complex forms of governance. The influence of the NPM movement changed the role of government and the public administrator as it blended together with businesslike approaches and value-for-money approaches through improved governance. The next chapter explores the influence of ideologies on formulating government policies and strategies.

CHAPTER 5: THE ROLE AND FUNCTION OF THE STATE AND ITS IMPACT ON INTERVENTIONS

Public policy is what governments do, why they do it, and what difference it makes
THOMAS DYE (Greene, 2005:272).

5.1 Introduction

This literature review investigates the issues, trends and options that influence decision-making and determine the role government plays in formulating policies and strategies that attend to the collective interest of its citizens. The changing relationships between the different spheres of government impact significantly on the role and function of public administration. These relationships shape the outcomes of structures developed to advance the common good and serve the needs of its citizens. Because public administration does not occur in a vacuum but is influenced by the environment in which it operates, the open systems model provides the best option as a framework for a generic approach to public administration. Furthermore, the systems model allows for the exploration of needs, demands and desires that shape decision-making and the functions of the state while the generic approach refers to the totality of generic processes aimed at achieving predetermined goals.

Chapter 5 begins by taking a historical overview of political thoughts and ideologies. It investigates the relationship between theories, ideologies and the philosophical base of assumptions and knowledge. It establishes how ideologies played a determining role in formulating government policies and strategies. Globalisation has changed development thinking and the role government plays as a service provider. Because political ideological orientations laid the foundation for the study of public administration it is imperative to understand how this body of knowledge developed over the years. Also, public administration becomes intertwined in the relationships in political institutions - their experiences - and political preferences, in such a way that all have a determining impact on the type of policy chosen. Although public administration has been an integral part of early civilisations such as the Egyptian, Greek and Roman empires, it is only since 1887 that Public Administration has emerged as a discipline within the United States. Not all development of public administration took place in Europe and the United States. The influence of cultures such as Asia, Africa and Latin America, as well as the religion and philosophies of Islam, Hinduism and Confucianism should not be ignored as

they all contributed in some way to the current forms and characteristics of governments. Unpacking the dynamics that influenced the different political ideologies and its contribution towards the international and national public administrative debates, allows for an in-depth analysis of the purpose and functions that drive government goals and objectives today.

A shift from pluralistic management to generic management emphasised the approach taken by the NPM movement with its focus on “steering” and “telling” the public what services are important. The new public management-type reforms have promoted a number of market-like features. “Management by hierarchy” shifted to “management by contract” with information issues becoming the key element in success. ITCs became a major factor in delayering hierarchies, downsizing organisations and external functions. Since the early 1990s, governments worldwide have drawn on new ideas on how elected and accountable governments are to conduct a coordinating, enabling and regulatory role in society. These new ideas moved the New Public Management towards a New Public Service approach with its focus on “serving” and “listening” instead of steering.

The chapter concludes with how a democratic government adapts to changes in the national and international environment and its ability to identify and exploit co-operative patterns of public-private exchange. The New Public Service approach utilises public-private partnerships as a mechanism for achieving policy objectives. Achieving these objectives is based on redefining the relationships between the political and administrative branches of the state. The challenge lies in finding a balance between the state and the market, between collective actions within the local, provincial, national, regional and global spheres and between governmental and non-governmental actions.

5.2 Political ideologies: building blocks in development thinking, public policy-making and public administration

Schumaker, Kiel and Heilke (1996:8) claim that the most comprehensive grand theories of politics are ideologies. They state that: “... ideologies provide logically related empirical statements about historical and present realities of social, economic and political life, and they provide a coherent system of ideals or values about how societies, economies and governments ought to be structured and perform in the near future” (Schumaker et al., 1996:8).

Christman (2002:190) elaborates as follows: "... ideology refers to a set of beliefs consciously held (though some might claim they can be unconscious) by members of a society, beliefs which are about some aspect of society but which are also caused by the material structure of that society".

As indicated by Heywood (1994:7); Schumaker et al. (1996:11); Cloete and Wissink (2000:26); Christman (2002:189); and Needler (1996:35), political ideologies and political values are directly relevant to the actual practices of politics as this influences many political, economic and social practices. The changes that occurred in both social and economic institutions and practices provide an intellectual history of ideas that have influenced the development of political life (Schumaker et al., 1996:9). Rothstein and Steinmo (2002:6) state that although different countries may have similar ideological orientations, the final policy choice and type of strategy selected to solve problems are strongly influenced by political institutional structures and previous experiences that shape political preferences. Development theories are closely tied to the ideological orientations that shape beliefs at a given time (Pieterse, 2001:8). Variations in patterns of colonialism and imperialism became a critical determinant in shaping early twentieth-century attitudes and policies in development thinking (Rothstein and Steinmo, 2002:6).

Even though the term *ideology* only came into existence in the early nineteenth century, establishing true political ideas dates back to the birth of political philosophy among the ancient Greeks (Heywood, 1994:7; cf. Schumaker et al., 1996:2, 12, 13; cf. Cooper et al., 1998:5; cf. Coleman, 2000a:3; cf. Coleman, 2000b:6; cf. Pieterse, 2001:8). Political ideological orientations formed the foundation for theories of policy and policy-making and shaped public administrative structures. The ideas of the classic and modern thinkers influenced the executive leadership, the structure and organisation of the executive authority and the types of administrative systems implemented (Schumaker et al. 1996:9; cf. Cooper, et al. 1998:3; cf. Cloete & Wissink, 2000:26; cf. Gildenhuis & Knipe, 2000:155; cf. Pieterse, 2001:7; cf. Rothstein & Steinmo, 2002:6; cf. Van Dijk, 2003:30). Likewise public administration relates to the activities of the executive branch of government which is the decision-making body in the day-to-day administration of government affairs (Gildenhuis & Knipe, 2000:155; cf. Van Dijk, 2003:33). Morrow (1980:49) describes the role of theory in the study of public administration as the ability to understand and improve what administration does and to uncover causes for specific

behaviour to provide guidelines whereby this behaviour can be changed to serve the mandated goals. Bayat and Meyer (1994:4) provide a broader meaning using an open systems approach as fundamental premise to define *public administration* as: "... that system of structures and processes operating within a particular society as the environment, with the objective of facilitating the formulation of appropriate governmental policy and the effective and efficient execution of the formulated policy"

Authors such as Henry (2001:1), Van Dijk (2003:33) and Botes, Brynard, Fourie and Roux (1992:257) provide similar definitions for *public administration*. They view *public administration* as a scientific discipline that is primarily concerned with the implementation of government policy through joint actions seeking to achieve predetermined goals within specific standards by reaching the desired objective as effectively, efficiently and economically as possible. Roux et al. (1997:8) argue that *public administration* is a: "... combination of generic functions and functional activities"

The generic administrative functions; namely policy-making, organising, financing, personnel, determination of work procedures and control, are increasingly used on the higher levels of public institutions to achieve objectives in an efficient and effective manner (Roux et al., 1997:9). Management is viewed as a human capability to perform administration effectively and becomes an intergeneric part of administrative functions. This implies that an organisation has both administrative and management dimensions (Roux et al., 1997:11).

The influence of the private sector instigated a managerial approach based on business models and triggered tighter control of spending in government by initially reducing budgets through manpower cuts. It set out to decentralise managerial functions and responsibilities by means of a more devolved budget system, providing more responsibility to line managers, placing more emphasis on organisational responsiveness to customer and client interests focusing on growth in management education and training (Farnham & Horton, 1996:74). By strengthening line management functions, emphasis was placed on management by objectives. Public management became object-driven rather than problem-driven and managers facilitated change instead of resisting change. Emphasis was placed on short-term targets. The development of performance indicators and performance measurement became the

pivotal point from which the outcomes and targets were measured. Traditionally used, individual staff appraisals were now linked with the performance management actions.

A gradual move towards accountancy procedures in the public sector and value for money became the core aspects on which efficiency and effectiveness in decision-making were based (Farnham & Horton, 1996:74). A series of financial changes followed which included accountability, external relations, internal systems and the conception of government itself (Kuye et al., 2002:100; cf. Hughes, 2003:7). Legislation and policies formed the cornerstone of sound management and accountability in financial management (Kuye et al., 2002:100). Although public expenditure management has developed as a framework for control and accountability, literature indicated that few public service managers spend time on finance management (Kuye et al., 2002:100). Farnham and Horton (1996:74) describe *financial management* as the processes and techniques that link delegated financial responsibility with financial accountability, resource inputs with service outputs and planning and control of the management process and operational managers with financial providers.

5.3 Historical overview of political ideologies: shaping the role of the state and the market

The evolution of policy analysis and public administration is a global enterprise that traces its roots far back into antiquity (Cooper et al., 1998:3; cf. Coetzee, Graaff, Hendricks & Wood, 2001:58). Public policy and its consequential administration have undergone centuries of change. These changes were based on the growth of urban settlements and conquests which had devastating impacts on historically significant societies and the governing systems each society developed (Cooper et al., 1998:5; cf. Coetzee et al., 2001:58). The significance of the evolvment from one governing system into another brought about a variety of social, political and economic changes. Power relationships formed the pivotal point in each system as this enabled one group to dominate the other and control the processes of growth through new technologies (Pieterse, 2001:8). The coercive and compulsory authority governments took to stay in control to protect their power, impacts on all governmental activities and reflect sovereignty (Heywood, 1994:43; cf. Joseph, 1999:348).

The history of Westernised political theorising began in ancient Greece and determined the way in which the European and Euro-American identity came to be constructed over

the centuries (Cooper et al., 1998:5; *cf.* Coleman, 2000a:21). Cultures such as Asia and Africa should not be ignored (Mughan & Patterson, 1992:29). Davidson (2001:7) draws our attention to the crucial role that early human development played in Africa and stresses that Africa cannot be separated from this role. The Egyptians of the Pharaonic times became intertwined with the African and European history as its rulers were sending large expeditions as pioneering traders to the south and the west (Cooper et al., 1998:3; *cf.* Davidson, 2001:30).

Greece initiated a tradition of “legitimate” government and state building tied to justice and civil society (Keulder, 1996:3). Democracy and democratisation became an integral part of collective action ever since the earliest times of the Greek city-states (Barker, 1959:3; *cf.* Keulder, 1996:3; *cf.* Needler, 1996:19; *cf.* Schumaker et al., 1996:49; *cf.* Coleman, 2000a:21). The highly participative democracies practiced in Greece were seen as a successful arrangement for collective action by which society is governed by imposing laws and other forms of regulation (Heywood, 1994:51; Pierre & Peters, 2000:15). Still, Western democracies derived more from the Roman law and Canon law (church) supplemented by the Old and New Testaments (Sabine, 1961:3; *cf.* Schumaker et al., 1996:49; *cf.* Cooper et al., 1998:3-4; *cf.* Pierre & Peters, 2000:15; *cf.* Coleman, 2000a:4).

5.3.1 The classic thinkers: civic virtue and civil society

Classic thinkers influenced Westernised political debates on aspects of good governance and questioned the role of government from the ancient times up to the Renaissance (Coleman, 2000a:1). The main theme of the classical and Christian thinkers’ philosophy rested on civic virtue and civil society and seeking for political truths (Schumaker et al. 1996:2). Plato (427-347BC) believed that the habits of civic virtue orientated people to uphold the common good. Aristotle (384-322BC) described the civic life of the citizen as the highest expression of humanity and claimed that the essence of justice was that equals should be treated equally (Heywood, 1994:31; *cf.* Christman, 2002:61; *cf.* Van Dijk, 2003:30). Both Plato and Aristotle’s views encouraged citizen participation and citizenship in political processes that ensured common good and questioned the “best” and most “just” form of government (Heywood, 1994:31). This included concepts such as justice, liberty, respect for the law and constitutional government. Achieving “one world” is inherent to all political institutions. Cicero (106-

43BC) spearheaded the establishment of a unified government by solving the problem of “one world” (Sabine, 1961:159; *cf.* Hammond, 1966:3,127).

Papal centralisation extended beyond the field of judicial decisions and gradually engaged in the field of legislation. Many popes trained as lawyers and they became increasingly aware of their role as legislators and creators of new laws for the church (Sabine, 1961:187). They recognised the claim of a community to defend itself against the abuse of power and provided influential perspectives on constitutional thinking in which the medieval church thinking was perceived as pro-state. The rise of the Roman Catholic Church with its secular theory of the state dominated thoughts on authority (Sabine, 1961:256; *cf.* Cooper et al., 1998:4). The Church represented the fullest embodiment of unity of humankind. The revival of papal absolutism in the middle of the fifteenth-century was paralleled by a tremendous growth of monarchical power in almost every part of Western Europe. The medieval culture gave economy a central place in what they called practical moral philosophy and the constitutional organisation of cities (Coleman, 2000b:12). From the church, a system of complex hierarchy and control called papal monarchy, evolved (Cooper et al., 1998:4). Machiavelli (1469-1526), compared the two types of government structures, namely monarchies and republics (Heywood, 1994:19; *cf.* DeLue, 1997:99). He believed that a republic would possess important characteristics of a civil society and would offer individuals the chance to pursue their own conception of common good (Hammond, 1966:4, 128).

5.3.2 The modern thinkers: civil society and development thinking

Heywood (1994:12) points out that although political science originated in the twentieth-century, it drew upon roots which date back to the empiricism of the seventeenth-century. Similarly, public administration has its historical foundation in the roots of political ideologies such as liberalism, socialism and conservatism (Heywood, 1994:8; *cf.* Schumaker et al., 1996:38; *cf.* Van Dijk, 2003:30). Modern thinkers dominated the scene with their political thoughts on civil society, private property, government and the economy. The concept of natural rights played an important role in the approaches social contract theorists attached to political justifications (Christman, 2002:27).

With the rise of a new European class of bourgeoisie, a civil society emerged to protect the individuals against feudal rule (Bruyn, 1999:25). The royal government replaced

feudal nobility (Schumaker et al., 1996:46; *cf.* Coleman, 2000b:39). Absolutist governments gave way to constitutional democracy. The Catholic Church was a rival to secular political authority until various religious wars culminated in the Treaty of Westphalia (1648) (Schechter, 2000:27; *cf.* Philpott, 2001:3). The period of absolutism runs from the Treaty of Westphalia in 1648 until 1789 (Schechter, 2000:28; *cf.* Philpott, 2001:16). With the French Revolution absolutism toppled in the name of sovereignty and the natural rights of equal citizenship, and the conception of sovereignty became a common form of political thought (Sabine, 1961:331).

Classic liberalism emerged as a response to the problems Europe faced as it abandoned its feudal and medieval past (Schumaker et al., 1996:44). The world of commerce and business became an alternative to feudalism and the economic markets began to take on an important role in organising economic life (Schechter, 2000:26). The increased growth and the complexity of life in Europe associated with the colonies it acquired, required new systems of law and trade to cope with these demands (Cooper et al., 1998:4). This led to improved and changed systems of tax collection, recordkeeping and administration (Cooper et al., 1998:4).

Two philosophers, Thomas Hobbes (1588-1679) and John Locke (1632-1704), proposed a new relationship between citizens and the state which they described in their social contract theories (Heywood, 1994:27, 117, 150; *cf.* Schumaker et al., 1996:47, 53, 54; *cf.* DeLue, 1997:107; *cf.* Bruyn, 1999,:25; *cf.* Christman, 2002:42). The social contracts emphasised the role of government as the state or governing authority with the power to provide peace and defence in a civil society (Heywood, 1994:117; *cf.* Goodin & Pettit, 1997:29; *cf.* Coleman, 2000b:116). Locke located the power in the majority through a social agreement in which the natural law principles or notions of civic virtue were based on the belief that the majority will never undermine the natural rights provided to all its citizens. He viewed government as accountable to the people, even when the source of authority resides in the people themselves (Heywood, 1994:117; *cf.* DeLue, 1997:107, 124, 131; *cf.* Goodin & Pettit, 1997:29; *cf.* Christman, 2002:43, 44).

The eighteenth-century was characterised by debates that criticised arguments of Hobbes and Locke and the doctrines of the Enlightenment (DeLue, 1997:143). The American context was earmarked by debates described as “Enlightenment” while in the

European context, modernity was described as the “Renaissance” (Pieterse, 2001:21). Enlightenment challenged absolutism. Enlightenment discourse followed Judean-Christianity and developmentalism arose from a rejection of religious explanations (Pieterse, 2001:25). Thoughts challenged the transparency against state secrecy and mutually reinforced pursuits of morality and politics (DeLue, 1997:143; *cf.* Schechter, 2000:30). Montesquieu proposed a new conception of the governing processes in 1748 in which he argued for the separation of constitutional powers into three distinct parts, namely; legislative power, executive power and the judicial power (Gildenhuys & Knipe, 2000:95).

Britain, the industrial and political world leader, influenced governing processes. Industrialisation was seen as the birth point of complex economic organisations and organisational theory (Cooper et al., 1998:207). The classic organisation model associated with the factory system found its theoretical underpinnings in the free market model laid down by Adam Smith (1723-1790) in 1776. His free market model provided powerful arguments against existing government regulations and systems of market regulation (Szirmai, 1997:56; *cf.* Cooper et al., 1998:207). He encouraged free markets with no rules thereby revolutionising organisational thinking and specialisation (Szirmai, 1997:57; *cf.* Cooper et al., 1998:207). Against a background of views on market principles and government interference Rousseau (1712-1778) and Immanuel Kant explored class differences in society and the resulting inequalities that influenced wealth and political power in society (Heywood, 1994:52; *cf.* DeLue, 1997:150). Rousseau believed that citizens must determine the nature of common good through a collective interaction in a legislative setting. He pleaded for a doctrine of liberal civil society and encouraged democratic participation that protects individual rights through a social contract which embodies the general will of the people (DeLue, 1997:159; *cf.* Christman, 2002:49, 51). Unlike Rousseau, Kant advocated the protection of intellectual freedom and criticized those who restricted public reasoning or introduced laws that restricted the social and political life (DeLue, 1997:163). Kant’s views on civil society which are important precursors to the theories of civil society and the public sphere describe speech and action as crucial for the functioning of democracy (Schumaker et al., 1996:62; *cf.* DeLue, 1997:167; *cf.* Schechter, 2000:34).

5.3.2.1 Ideologies of the nineteenth century

The expansion of economic forces changed the notion of the private sphere and civil society and challenged the integrity of the state (Schechter, 2000:37). Ideologies that had the greatest impact on western political thought emerged as classic liberalism, socialism and conservatism (Heywood, 1994:7, 8). Each ideology spawned a range of traditions, movements and perceptions. Annexure E investigates the perceptions of each ideology and its impact on shaping the role of government. Each ideology also brought with it alternative movements that influenced policy outcomes and decision-making.

The political philosophy of Georg Wilhelm Friedrich Hegel (1770-1831) influenced both the liberal and fascist thinkers and introduced a period of economic expansion which came to dominate civil society (Heywood, 1994:4; *cf.* Schechter, 2000:37). His writings portrayed the state as an ethical ideal founded on universal altruism. Hegel's modern state is predicated on a constitution that defines the state's nature and the institutions that carry these principles into practice (DeLue, 1997:186). For Hegel, the state stood above the particular interest of civil society and provided the basis for moving society towards a concept of welfare. He introduced the theoretical underpinnings for an economic welfare state (Heywood, 1994:21).

Principles such as equality of opportunity and social justice became an integral part of the modern liberal thinking and the nineteenth century reforms (Heywood, 1994:9; *cf.* Schumaker et al., 1996:47; *cf.* Barr, 1998:19). It became evident that prosperity and social stability could only be brought about through government interventions in the form of welfare provision and the management of economic life (Heywood, 1994:9) John Maynard Keynes (1883-1946) contributed significantly to the social welfare state idea (Chatterjee, 1996:246; *cf.* Gildenhuys & Knipe, 2000:35). The concepts of a social welfare state are based on the ideologies of a mixed economy (combination of capitalism and socialism) that emphasised the communal basis of the state (Chatterjee, 1996:246; *cf.* Needler, 1996:42; *cf.* Gildenhuys & Knipe, 2000:36). Most western countries including the United States have mixed economies. The Keynesian concept taught the state to manage capitalism by using its power of spending as an instrument to counter inflationary trends by encouraging investment. The Keynesians argued that the government must not enter the domain of the private entrepreneur. This meant that government accepted the responsibility for supplying public services by which the

minimum economic and social requirements for existence are guaranteed (Gildenhuys & Knipe, 2000:35).

When the colonial powers took their emerging economic models to the developing world and applied market justice principles to the colonies, it resulted in increased bureaucratic problems (Bruyn, 1999:2). This was tied to the difficult problem of demarcating a vast but not clearly demarcated territory. The Berlin Conference of 1884/5 became a mechanism between the European powers to collude for their common good and peacefully divide Africa (Herbst, 2000:22). Many of the development theories applied in these colonies by westernised industrial powers were first and foremost theories of economic growth and economic transformation without the application of any social dimension (Martinussen, 1999:5). The development theories rarely concerned themselves with political or cultural considerations and did not question the extent to which political or cultural factors influenced economic development (Van der Velden et al., 1995:21; cf. Martinussen, 1999:5). Industrialisation was separated and not seen as part of colonial economics because the competitive advantage of colonies was solely based on the export of raw materials for the industries of metropolitan countries (Pieterse, 2001:6).

While social dimensions had little or no impact on the development thinking for developing countries, this was not the case for the westernised and developed countries (Martinussen, 1999:5). Robert Nozick rejected the needs-based principle of justice and any presumption in favour of equality. He championed the “principle of justice” based on the idea of rights and entitlements. Human rights became the core from which his thoughts evolved. Robert Nozick clarified and extended on the liberal principles of market justice with his entitlement theory in which he questioned whether the distribution of wealth and “distributive justice” are justified on the basis of people’s contribution to the marketplace (Schumaker et al., 1996:67; cf. Goodin & Pettit, 1997:203-204; cf. Barr, 1998:74). The welfare liberals advocated numerous economic and political reforms and contemporary liberalism now emerged as “welfare-state liberalism” (Needler, 1996:43; cf. Schumaker et al., 1996:76).

John Stuart Mill (1806-1873), David Ricardo (1772-1823) and Thomas Malthus (1766-1834) shared Adam Smith’s preference for free markets and the *laissez-faire* policies. They believed that government should intervene as little as possible in the economic

process (Szirmai, 1997:57; *cf.* Cooper et al., 1998:8). Mill criticised laws, social arrangements and systems of education that influenced individual liberty. He encouraged liberal reforms that supported production of goods according to capitalist principles arguing that government had to distribute the goods in a more equitable manner (Heywood, 1994:114; *cf.* Schumaker et al., 1996:237; *cf.* DeLue, 1997:199; *cf.* Szirmai, 1997:57; *cf.* Cooper, Brady et al., 1998:8). However, to distribute goods in a more equitable manner demanded complex bureaucratic systems and reforms. Government's role changed as it separated the role of the state from the economic process. This demanded widespread reforms that supported the ideological framework that contributed to the purpose and functions that drive government goals and objectives. In response to these widespread reforms, Woodrow Wilson (1856-1924) argued that government administration must be separated from political and policy concerns (Fry, 1989:2; *cf.* Denhardt & Denhardt, 2003:6). He believed that public administration should be concerned with detailed and systematic execution of public laws (building of hierarchies and controlling them through authority) while politicians should determine the tasks of an administrator (Fry, 1989:2; *cf.* Cooper et al., 1998:7). Based on these arguments Wilson called for the development of a science of administration (Fry, 1989:2; *cf.* Henry, 2001:28; *cf.* Denhardt & Denhardt, 2003:6). Political scientists created these ideas into what came to be called the politics/administration dichotomy (Cooper et al., 1998:7; *cf.* Henry, 2001:28). Thinkers of the politics/administration dichotomy wanted to clarify roles so that public administrators could work more efficiently (Henry, 2001:28; *cf.* Denhardt & Denhardt, 2003:6).

In the late nineteenth century (1887), public administration emerged as an academic discipline in the United States of America (Fry, 1989:2; *cf.* Cooper et al., 1998:1; *cf.* Henry, 2001:27; *cf.* Van Dijk, 2003:32). The field of public administration was founded as a profession based on the improvement of service efficiency and the enhancement of service delivery (Cooper et al., 1998:1). Frank J. Goodnow contended that two distinct functions of government were provided through the separation of powers. On the one hand, politics had to do with policies and expression of the will of the state while, on the other hand, administration were actions involved with executing the policies (Henry, 2001:28).

Max Weber (1864-1920), a constructivist, developed much of the theory of bureaucracy and emphasised the principle of rationality with an increased focus on the origins of capitalism (Kamenka, 1989:160; *cf.* Heywood, 1994:90; *cf.* Szirmai, 1997:60; *cf.* Cooper et al., 1998:5; *cf.* Schechter, 2000:58; *cf.* Pieterse, 2001:11). Weber argued that bureaucracy was an ideal model which offered the best solution in structuring large-scale organisations because it contained certain characteristics such as hierarchy, authority, division of labour by specialisation, employment by merit, merit judged by education, compensation based on performance of official functions and complex systems of record-keeping (Cooper et al., 1998:6, 212). In Weber's theory of rationalisation he described the difficult distinction between value and instrumental rationalisation accompanied by structural transformation of the public sphere into a bureaucracy (Cooper et al., 1998:5; *cf.* Schechter, 2000:61; *cf.* Van Dijk, 2003:32).

Parallel to the developed countries, neo-Marxists in the developing countries such as Samir Amin and Arhiri Emmanuel, formulated theories of unequal exchange. Their theories emphasised the structural characteristics of the economies of the developing countries. Both Marxists and structuralists were in favour of government planning and highlighted the importance of the role of the state in the development process. They were against free market policies in the developing countries. Paul Baran indicated that capitalism applied to the developing economies, differed significantly from capitalism in advanced and developed economies (Szirmai, 1997:72; *cf.* Martinussen, 1999:86). Andre Gunter Frank analysed the exploitive relationships running from the centres to the periphery and rural sectors.

5.3.2.2 Ideologies of the twentieth century

Widespread reactions to classic liberalism resulted in the development of ideologies such as traditional conservatism, anarchism and Marxism. The influence of each of the reactions to classic liberalism changed the role of the state as well as its functions and objectives. As public administration was concerned with detailed and systematic execution of public laws determined by politicians the impact of the ideologies on future roles of the state cannot be ignored. The ideologies of the twentieth century played an important part in the evolvement of current trends that shape public administration and management.

Marxism later spread into the totalitarian ideologies, namely; communism, Nazism and fascism. The democratic ideologies played an important role in shaping ideas about politics and the strong-state principles. The revolutionary ideologies of Marxism resulted in democratic socialism (Annexure E: 304). Marxism influenced the development thinking of the twentieth century. Nascent ideologies such as religious fundamentalism, environmentalism and feminism became more prominent and visible in debates on development thinking as the role and contribution of women in society strengthened (Pieterse, 2001:11).

Long-term trends in development theory and general shifts in social science brought many changes in perceptions and knowledge (Pieterse, 2001:11). This meant a shift from the classic and modern thinking structuralist perspective whose ideas centred on large-scale patterning of social realities through structural change to the economy, the state and the social system towards more agency-orientated views (Preston 1996:183; cf. Pieterse 2001:11). Schumpeter (1883-1950) was primarily interested in the twentieth-century capitalism (Szirmai, 1997:60). He believed that capitalism characterised a “gale of creative destruction”, undermined by its success rather than the failures identified by the Marxists. Capitalism generated new forms of injustice and inequalities which became a driving force behind Marxism. The influence of Marxism implied a shift towards institutional and agency-orientated views. These changes emphasised macro policies, intersectoral co-operation, social diversity, human security, gender and environment as well as changes in development co-operation and structural reforms (Pieterse, 2001:12).

Europeans showed a commitment to liberty and democracy and sought to fuse the liberal ideals with other ideologies such as democratic socialism rather than to reform towards liberalism (Schumaker et al., 1996:238). For the Americans, liberalism remained an ideal American enterprise that was reformed into contemporary liberalism in the early twentieth century. This contemporary liberalism extended democracy, reformed capitalism, enhanced the role of government and developed to include more egalitarian theories of justice (Schumaker et al. 1996:238).

The contemporary liberalism influenced development thinking and economics. Herbst (2000:21) indicates that a major flaw and constraint in explaining development in the African states was based on applying the European experiences when they were trying

to understand state development in the African states. He stresses that the European experiences do not provide a template for state-making in other regions, although this became a measuring tool by which performance was measured and analysed in development discourses (Herbst, 2000:22). During this period, the core meaning of development for the colonial economies was based on economic growth enhanced by the application of the growth theory and big push theory (Pieterse, 2001:7). Unfortunately, these theories rarely concerned themselves with political or cultural considerations (Martinussen 1999:5). Herbst (2000:29) emphasises that: "...The colonial state in Africa lasted in most instances less than a century – a mere moment in historical time. Yet it totally recorded political space, social hierarchies and cleavages, and modes of economic production. Its territorial grid – whose final contours congealed only in the dynamics of decolonisation – determined the state units that gained sovereignty and came to form the present system of African polities".

The science of democracy changed perceptions and the nature of the field of public administration (Kettl, 2000:488). The formal study of organisations began to expand towards a behaviourist approach where the main concern was centred on what managers do in order to understand public management. The modernisation theory of the 1950s focused on growth, political and social modernisation, fostering entrepreneurship and achievement orientation (Pieterse, 2001:7). The modernisation theories were conceived within traditional feudal societies as a stage preceding modern economic development (Szirmai, 1997:73). Central to the change from Fordism to post-Fordism were changes in the structure of production, the organisation of labour processes and strategies of management. Henri Fayol (1841-1925) and Luther Gulick became important creators of management concepts applied to large-scale organisations (Cooper et al., 1998:212). Gulick focused on the span of control and its impact on efficiency. Managing large-scale organisations in both the public and private sphere brought the newly developed field of organisational theory to centre stage. The formal study of organisations took shape in the form of the classic organisational model which served as a foundation for bureaucratic systems (Cooper et al., 1998:207).

Taylorism and the principles of "scientific management" subjected labour to rigid time mechanisation to improve performance outcomes in a formal and mechanistic way (Roux et al., 1997:74; cf. Cooper et al., 1998:207). This also became part of Rostow's

“Stages of Growth” (1960) in which he sketched a stage theory of economic growth (Szirmai, 1997:62; *cf.* Pieterse, 2001:6). Public administration became the device to reconcile social demands with democracy through bureaucracy (Szirmai, 1997:63; *cf.* Henry, 2001:3). These changes brought about the rejection of the politics/administration and the principles of administration dichotomy. It was accompanied by a shift in focus in which political scientists insisted that public administration could no longer be separated from politics (Henry, 2001:33).

The 1960s marked the growth of the welfare state, free speech, civil rights movement and antiwar demonstrations and prompted citizens to rethink their allegiance to contemporary liberalism (Martinussen, 1999; *cf.* Rothstein & Steinmo, 2002). The dependency theory embraced economic growth under the heading of accumulation. Unfortunately its distorted form “dependent development” evolved into “development of underdevelopment” (Martinussen, 1999; *cf.* Pieterse, 2001:6).

As a welfare consensus emerged in the Westernised countries one saw a movement that embraced democratic socialism, contemporary liberalism and contemporary conservatism (Heywood, 1994:226; *cf.* Schumaker et al., 1996:17). Annexure F provides a comparison between contemporary liberalism, contemporary conservatism and democratic socialism.

During the 1970s, development thinking moved towards alternative development initiatives in which new understandings of development came to the fore which focused on social and community development. Hamza Alavi was one of the first social scientists to draw attention to the political legacy which colonial rulers left behind. He argued that the colonial state was overdeveloped in relation to the societal structures. The governmental apparatus was created to suit the colonial interests (Martinussen, 1999:183). At the same time, due to a marked increase of public expenditures in social spending, tax revolts known as the “welfare backlash” and “re-privatisation” of the welfare state occurred. This changed the relationship between the public and private sectors of welfare. The welfare backlash was not simply a reaction against high public expenditures but was also based on the speed at which social spending increased. This led to the restructuring of the welfare state, described as reprivatisation. Reprivatisation meant a movement away from direct state provision of services to public subsidisation

and the purchase of privately produced services. This period laid the basis for developments that changed policy-making approaches and the role government plays in providing social services. One can thus argue that the origin for the conceptualisation of public-private partnerships started at this point.

Western democracies of the 1970s and 1980s saw a rise in new ideological perspectives such as Feminism, Black Nationalism, Environmentalism and various types of religious fundamentalists. The nascent ideologies such as fundamentalism, environmentalism and feminism should not be ignored as their ideas and knowledge influenced current political practices and shaped policies. Their views had significant impacts on the application of concepts of Fordism and post-Fordism to welfare. This meant that changes in the development of the welfare state occurred by analysing and restructuring welfare in the industrialised countries. The amount of influence depended on their power base and how much control they had to sway policy agendas within democratic societies. Annexure G highlights the difference in goals, philosophical base and the political principles which guided decisions and actions of Fundamentalists, Environmentalists and Feminism.

The most extreme form of state intervention and control was found in the totalitarian states in which the essence is the construction of an all-embracing state whose influence penetrates every aspect of existence (Heywood, 1994:45). Communism, Fascism and Nazism rejected Capitalism and Liberalism. Communism became entrenched in tyrannical and totalitarian regimes (Schumaker et al., 1996:203; *cf.* Szirmai, 1997:59). The crumbling of the communistic block and the collapse of the Soviet Union in 1989 are widely interpreted as the end of communism as an attractive ideological alternative. Its impact on shaping the role of government cannot be ignored as one can only understand recent world history and the current conditions prevailing in many countries when the ideas central to communism are grasped (Schumaker et al., 1996:175,179; *cf.* Szirmai, 1997:59). Parallel to the crumbling of the communist block a wave of democratisation swept Africa in the 1990s. The revolts against African authoritarianism were largely urban affairs with little participation of rural groups.

The late twentieth-century welfare state views staged intense debates over equality (Heywood, 1994:226). The era of reinvention represented a countermovement against

the new public administration which ranged from incremental changes to radical reforms (Greene, 2005:66). Movements towards egalitarianism, welfarism and state intervention occurred. These movements proposed the idea that the poor had the right to be protected and governments should provide basic health services and various forms of welfare based on social justice (Heywood, 1994:44; *cf.* Schumaker et al., 1996:283; *cf.* Barr, 1998:277). In the 1980s, the core definition of *human development* was “the enlargement of people’s choices”. Two radical perspectives on development came to the foreground, namely; neo-liberalism and post-development (Pieterse, 2001:6). These development perspectives were influenced by the philosophies of the contemporary liberalists. The neo-liberalists wanted market forces to determine prices and believed that economic growth would be achieved through structural reforms, deregulation, liberalisation and privatisation. The post-development perspectives used authoritarian engineering, and development served as a mirror of changing economic conditions and social capabilities, priorities and choices influenced by the ideologies followed by a country (Pieterse, 2001:7). The structural changes applied in the developing country presented different changes in the structure of employment than in developed/advanced countries (Pieterse, 2001:7). The outcomes initiated through structural adjustment programmes (SAPs) as proposed by the Bretton-Wood institutions, did not align the needs of those in the developing countries. This occurred because the developing countries did not follow the traditional shift from agriculture to industry followed by the shift from industry to services, but instead agriculture developed parallel to the industrial sector which explains the expansion of government sectors in the developing countries (Szirmai, 1997:88). The growing gap between how power is exercised in Africa and the international assumptions of how states operate, are significant (Herbst, 2000:3). It became evident that the success of interventions in Africa and other developing countries depends on understanding the nature of state building by analysing the problems of state consolidation from precolonial periods through the short and intense interlude of formal European colonialism to the modern era of independent states (Herbst, 2000:4).

By the beginning of the twenty-first century public finance and public policy decisions of governments had extensive impacts on individual lives (Hillman, 2003:600). The focus was on “public good”. Public policy determined that the supply and distribution of goods and services enhanced public good while public finance identified available revenues

and determined efficient spending on public goods and services (Hillman, 2003:600; *cf.* ODI, 2004).

5.4 State intervention: the role of the state in health and health care

As a result of the failures in structural adjustment programmes (SAPs) and development initiatives the outcomes promulgated through Westernisation, no longer seemed to be such an attractive alternative for the developing nations. Development education and programmes often highlighted the causes of rather than the results of poverty. This scenario was emphasised by economic, political and social constraints in the north-south relationships. The causes of poverty were tied to ideologies, development thinking and colonialism which caused increased discomfort for northern governments. The differences became more apparent where the complexities of cultural diversity and local culture were re-evaluated (Pieterse, 2001:1).

Even with the failure of development programmes health, health care and education improved in the poorest countries. Improved health care and education strategies dominated the political landscape in terms of the model of a constitutional democracy in which regulated but competitive economic markets overruled political thinking and philosophy. Central to all these philosophies, questions explored, included:

- The political authority and its approach to find the most fair and just distribution or allocation of material goods and social benefits for society. This included exploring the degree of inequalities in wealth that economic markets produced and questioned to what extent the state should promote the good of its citizens as opposed to protecting their liberty in pursuing their own good (Christman, 2002:3).
- Democracy supporting participation and states questioned their tolerance towards opposing interest groups.

These questions brought about sharp changes in how the development community perceived the role of the state over the past three decades (Pieterse, 2001:11; *cf.* Van de Walle et al., 2003:4). The role of the state changed considerably as its emphasis under state-led, market-led and society-led periods shaped intervention strategies. State-led strategies influenced the first period from 1960 to 1980 in which an interventionist role for central government was considered essential to overcome market failures (Van de Walle et al., 2003:4). With a shift towards market-led strategies during

the 1980s, it was believed that government failure and unintended effects of government intervention were far worse than the market-induced ills it was designed to overcome. Society-led strategies during the third period showed two sides. On the one hand, there was a growing realisation that markets left alone can result in unacceptable inequities while on the other hand, mounting evidence suggests that states are more likely to be effective agents of development when they are embedded in a network of linkages to societal institutions and organisations (Stiglitz, 2003:16; cf. Van de Walle et al., 2003:4) .

Martinussen (1999:221) emphasises the different approaches between the conventional economic theory which refers to the state as an initiator and catalyst of growth and the classic dependency theories in which the actions of the state are determined by the interests of international capital. He believes that none of the conceptions offered by these schools of thought are suitable if it is the objective to reach a deeper understanding of the role and possibilities of the state in relation to the economic and social problems, especially of developing countries. Cloete and Wissink (2000:26) identify three approaches that influence policy-making and shaped the role of the state:

- A libertarian *laissez-faire* or classical liberal approach based on individualism (Barr, 1998:46; cf. Bailey, 2004:7). This approach determines that the state should concern itself with the maintenance of law and order, the protection of society and of property, establishing conditions conducive to the promotion of free enterprise and limited state interference with the lives and activities of individuals.
- Socialist or collectivistic approach framed within a protectionist approach (Barr, 1998:54; cf. Bailey, 2004:9). This approach emphasises the state's control over the economy through economic institution which functions as government enterprises and tend to be in favour of public provision of goods. Their values are strengthened by union and employer organisations or conservative and socialist parties.
- Welfare statism or neo-liberal approach. This approach determines that the promotion of the highest degree of material and spiritual well-being is the task of the state focusing on the well-being and differences in class structures (Barr, 1998:48; cf. Bailey, 2004:8).

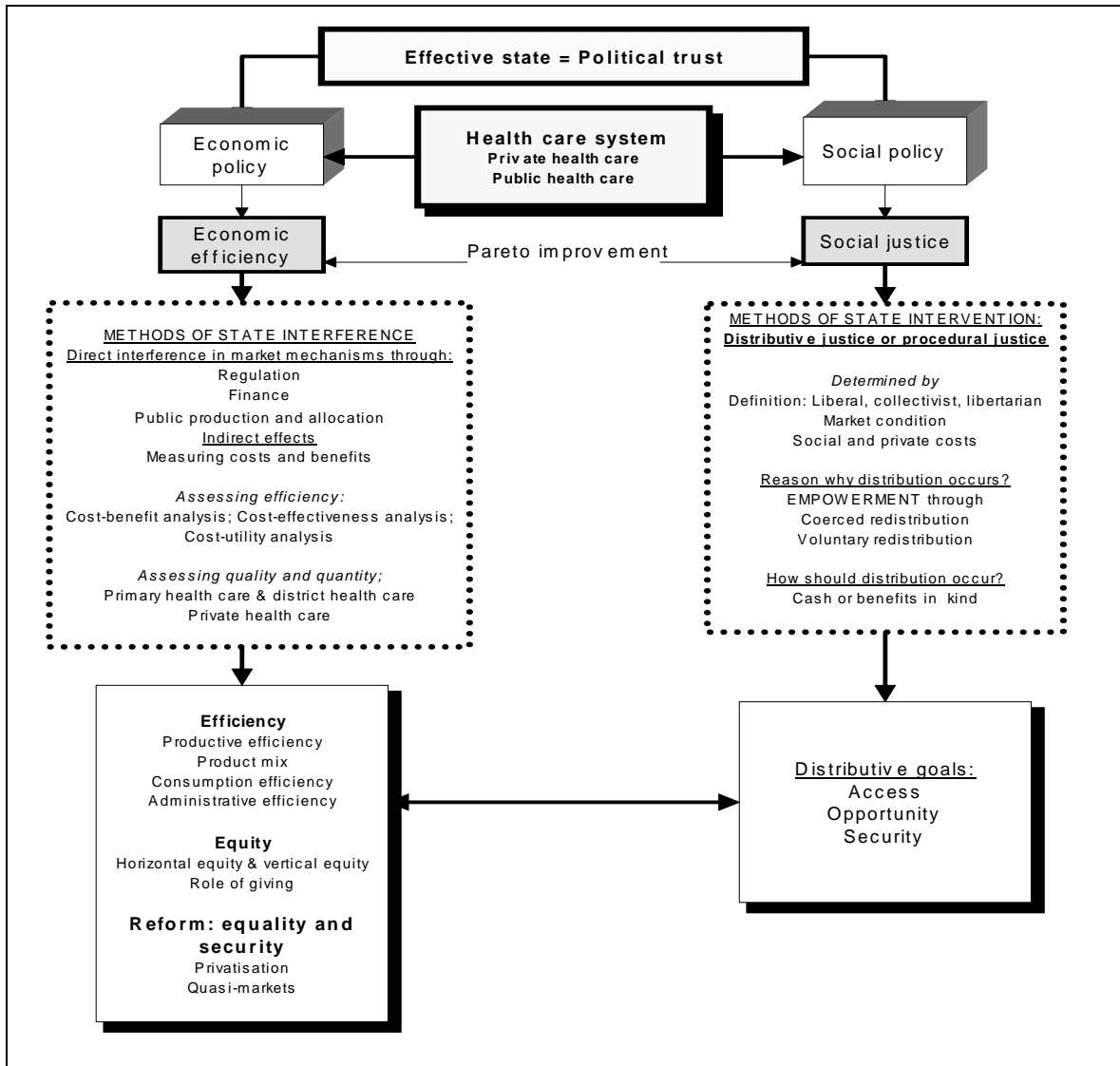
Each of these three approaches applies different methods of state intervention through regulation, finance and public production or through a mix of the intervention methods. However, all the intervention methods involve direct interference in the market mechanisms (Barr, 1998:77, 83; *cf.* Bailey, 2004:20). The role of the state becomes a key variable in every social security system and is an important feature to distinguish between countries and the role the state is accorded as a provider of welfare.

An effective state and a stable political environment are vital for the provision of goods and services (Van der Velden et al., 1995:23; *cf.* World Bank, 1997; *cf.* Bovens, Hart & Peters, 2001:12). An effective state is necessary for wealth-creating initiatives and well-being of individuals. Health is interwoven into the fabric of well-being and includes a whole range of human experiences such as the spiritual, psychological, social and material experiences. These basic indicators express the embodiment of responsible human well-being and are formulated by sustainability, equity, and security in livelihoods in the creation of opportunities through capabilities. Without an effective state, sustainable development both economically and socially is not possible (Van der Velden et al., 1995:23; *cf.* World Bank, 1997; *cf.* Barr, 1998:69). Growth can be used to sustain investment necessary in public goods such as health care and may lead to reduced poverty, resulting in changing the determinants of health (Labonte et al., 2004:4).

The main issues that influence sustainable development concern the ability to find a balance between economic efficiency and social justice (Barr, 1998:69). Barr (1998:69) claims that the efficiency aim is common to all theories of society, but that redistributive goals depend on which definition of social justice the state chooses; and the conditions in which the market will allocate efficiently combined with the measurement of social and private costs and benefits. These issues determine the type of role the state should adopt to bring about equality of access, opportunity or outcome (Barr, 1998:69). The power balance between the citizen and the public sector can weigh in favour of either one. The type of power balance applied by each determines the method of state interference, the degree of empowerment and values each would utilise towards decision-making and accessibility of services distributed (Barr, 1998:277; *cf.* Rothstein & Steinmo, 2002:24). The main aim is to develop a framework which explains and justifies the fact that the state produces and allocates some goods and services such as health care, welfare and education but leaves other goods to the private market (Barr,

1998:68). Figure 5.1 presents a framework determining effective state interference tied to the health care system.

Figure 5.1: Effective state: methods of state interference in health



Source: Own interpretation taken from Barr (1998:69-73, 277-279); Szirmai (1997:141-143); Rothstein and Steinmo (2002:24).

It is evident from Figure 5.1 that economic efficiency becomes a policy aim central to welfare economics that facilitates the best use of limited resources given people's preferences. Productive efficiency, efficiency in product mix (allocative efficiency), efficiency in consumption and administrative efficiency must be in equilibrium. The relationship between efficiency and social welfare is based on determining which

allocation is both efficient and socially just by utilising the concept of a Pareto improvement (Cullis & Jones, 1992:4; cf. Barr, 1998:73; cf. Campbell & Brown, 2003:4).

A *Pareto improvement* is defined as a situation in which some people are better off but no one is worse off as a result of the undertaking (Campbell & Brown, 2003:4; cf. Hillman, 2003:10,11). According to Hillman (2003:10), Pareto efficiency for production is achieved when: "... no more of any one good can be produced without giving up some quantity of another good". *Pareto efficiency* therefore defines the absence of waste (Hillman, 2003:10). Moreover, efficiency relates to the overall size of the health sector as a proportion of the gross domestic product (GDP). *Allocative efficiency* is concerned with producing quantity, quality and the correct mix of health interventions whereby it provides more valuable health interventions for which society has the highest value (Cullis & Jones, 1992:3; cf. Barr, 1998:73; cf. Lee et al., 2002:123).

Internal efficiency includes preventive care and health education which, according to Barr (1998:279) and Lee et al. (2002:123), bring about the greatest improvement in health. Product efficiency is concerned with the running of medical institutions. As Lee et al. (2002:124) point out, product efficiency and health care efficiency are directly linked to a user fee policy (⁴Bamako Initiative) and the correct use of inputs (staff). Throughput is determined by information. Measuring health care efficiency is complex because asymmetric information in the health care sector creates problems as consumers have to rely on the recommendations of doctors and are not given the chance to choose between alternative treatments (Brent, 2003:6; cf. Abedian et al., 2003:185-186; cf. Hillman, 2003:618). The people making decisions about health-care expenditures are not the people paying the costs. This introduces the possibility of opportunistic behaviour, deception or fraud as well as increasing the risk of excessive health outlays by medical practitioners (Hillman, 2003:618). Asymmetric information encourages adverse selection in markets by systematically imposing costs on others who know that they have a lower than average likelihood of acquiring medical care. Rather, adverse reactions can be avoided by making both private and government health insurance an

⁴ The Bamako Initiative was developed by the World Bank in 1992 as an alternative model for user fee policy. The missing quality component in public health services was identified in poorer communities as drug supply. The Bamako Initiative also recognised that all people of all income groups shop around for health services (Lee et al., 2002:123).

entitlement to the entire population (Hillman, 2003:621). Low-risk people then systematically subsidise the health costs of high-risk people.

A crucial point in any health system is that it must constitute a genuine strategy. Barr (1998:318) identifies two types of effective strategies:

- Mainly through public funding (taxation and social funding) plus public production.
- Mainly through public funding plus private production plus regulation to contain costs (public-private partnerships).

What stands out in literature is that no health system is perfect. Governments who use non-market mechanisms such as risk pooling, social insurance funds, block-funds and cross-subsidisation to deliver services, are challenged as anticompetitive in terms of GATS. The relationship between health systems and economic development continues to be a much-debated topic. In short, health policy means different things to different people but for most, health policy is concerned with content. It is all about finding the best method of financing health services, which all boils down to who influences the policy decision process and how this process happens.

The changing environments tied to new perspectives and problems involve co-operation among government, civic and international organisations and market forces. Increased importance is given to issues of human development, social choice, public action, urban development and local economic development initiatives (LED) involving inter-sectoral partnerships (Pieterse, 2001:17). For government at local and national spheres, this involves a co-ordinating role as facilitator and enabler of intersectoral co-operation (Pieterse, 2001:17). Combined with the forces of competition and globalisation the increased complexities of intergovernmental and intersectoral relationships are making public law and legal processes more important. Increased attention to public law issues is required to structure new mechanisms to deal with the complexities of fiscal, social and economic relationships in order to provide tools that meet the challenge together with the growing demand for accountability, empowerment and flexibility (Cooper et al., 1998:29).

5.4.1 Building state capacity

Current debates focus on the role of government concerning its economic aspects and on questions of who should provide the services and goods (Hughes, 2003:71). The government has a variety of roles of which the full scope is often difficult to measure. The government's role has become more problematic and complex over the past decades (Bovens et al., 2001:12). Finding the most suitable option to produce goods and services therefore raises the question whether there are differences between private and public domains and how this impacts on decision-making processes, human resources and organisational and management structures (ODI, 2004:1). As the market mechanism alone cannot perform all the economic functions, public policies are needed to guide, correct and supplement the market in certain respects (Hughes, 2003:77; *cf.* ODI, 2004:2).

The public sector has an important role to play in determining the real living standards and quality of services in community care, the environment, health and welfare through economic development. Governments utilise various mechanisms to intervene and encourage this process. Table 5.1 presents a layout of these mechanisms as identified by Hughes (2003:81) and Farnham and Horton (1996:27):

Table 5.1: The role of government and mechanisms of intervention

Role of government	Mechanism of intervention
The government as <i>an enabler</i> through provision where goods and services are provided through the government budget.	<p>Subsidy</p> <p>A subcategory of provision where the government assists someone in private economy to provide the goods or services. The private sector provides particular goods or services with some assistance of the government. The government is mainly involved in the monitoring of efficiency of provisions.</p>
The government as <i>a facilitator and co-ordinator</i> occurs through the production of social goods or public production. The government produces and monitors goods and services for sale in the market with its emphasis on the public choice theory by utility-maximising bureaucrats.	<p>Internal markets or managed competition:</p> <p>Public organisations provide services but are encouraged to compete with one another for either the contract or individuals. The purchased-provider system introduced in health services is an example of this (Farnham & Horton, 1996:28).</p> <p>Contracting out public services to private suppliers (Public-private partnerships). Central and local governments use private construction companies to build public schools and hospitals (Farnham and Horton, 1996:28).</p>
The government as a <i>regulator</i> .	<p>Regulations which involve using coercive powers of the state to allow or prohibit certain activities in private economy. Regulations can be either economic or social and encourage actors to undertake certain activities, enabling value choices to be redefined in technical terms to fit the dominant political ethos.</p>

Source: Adapted from Huges (2003:81); Farnham and Horton (1996:27-28).

Building state capacity to ensure that these mechanisms are effectively, efficiently and economically applied requires administrative reforms that are simultaneously aligned with political demands and with the existing administrative structures and economical factors. Administrative reform became intertwined in the broader political economic

context and resulted in a spectacular growth of quangos or quasi-non-government sectors in health, education, agriculture and housing in both the United Kingdom and the United States (Skelcher, 1998:2). A range of common trends occurred in public administration which transformed the role of the public administrator. These trends impacted on how government shaped its role as enabler, facilitator and regulator. Cooper et al. (1998:389) identify the trends as deregulation, delayering, decentralisation, reengineering, privatisation, accountability enhancements and technological developments.

5.4.2 The role of government and the New Public Management (NPM) movement

Since the 1980s and 1990s, changing perceptions in public administration and management had a significant impact on the design of service delivery structures in both the United Kingdom and the United States (Skelcher, 1998:40). The business model for quangos arose from some underlying belief that private business is better and more efficient and effective in getting the job done. Fiscal constraints pressured government to reform bureaucracies. These reforms did not necessarily translate into increased state capacity. Through the reforms, the re-emergence of bureaucracies were seen as a multiplicity of smaller bodies in contractual and market-type relationships (Cooper et al., 1998:145; *cf.* Skelcher, 1998:197). The interpretation of choices was influenced by human motivation and social organisation. Purchasing and delivering of services were interpreted as a managerial task to be undertaken by business-oriented expertise (Skelcher, 1998:2,197). This first wave of reforms included privatisation and deregulation which reduced and redefined the state's functions (Kraan, 1996:197; *cf.* Rothstein & Steinmo, 2002:59). Advances in public choice theory provided the cause for privatisation (Cullis & Jones, 1992:18; *cf.* Kraan, 1996:9-10; *cf.* Hyman,2005:184). The launching of budget cuts and programme reforms together with demands for improved performance highlighted the importance of the quasi-non-governmental sector and brought public-private partnerships to the fore in public discourse in the United States during the 1980s (Salamon, 1995:3).

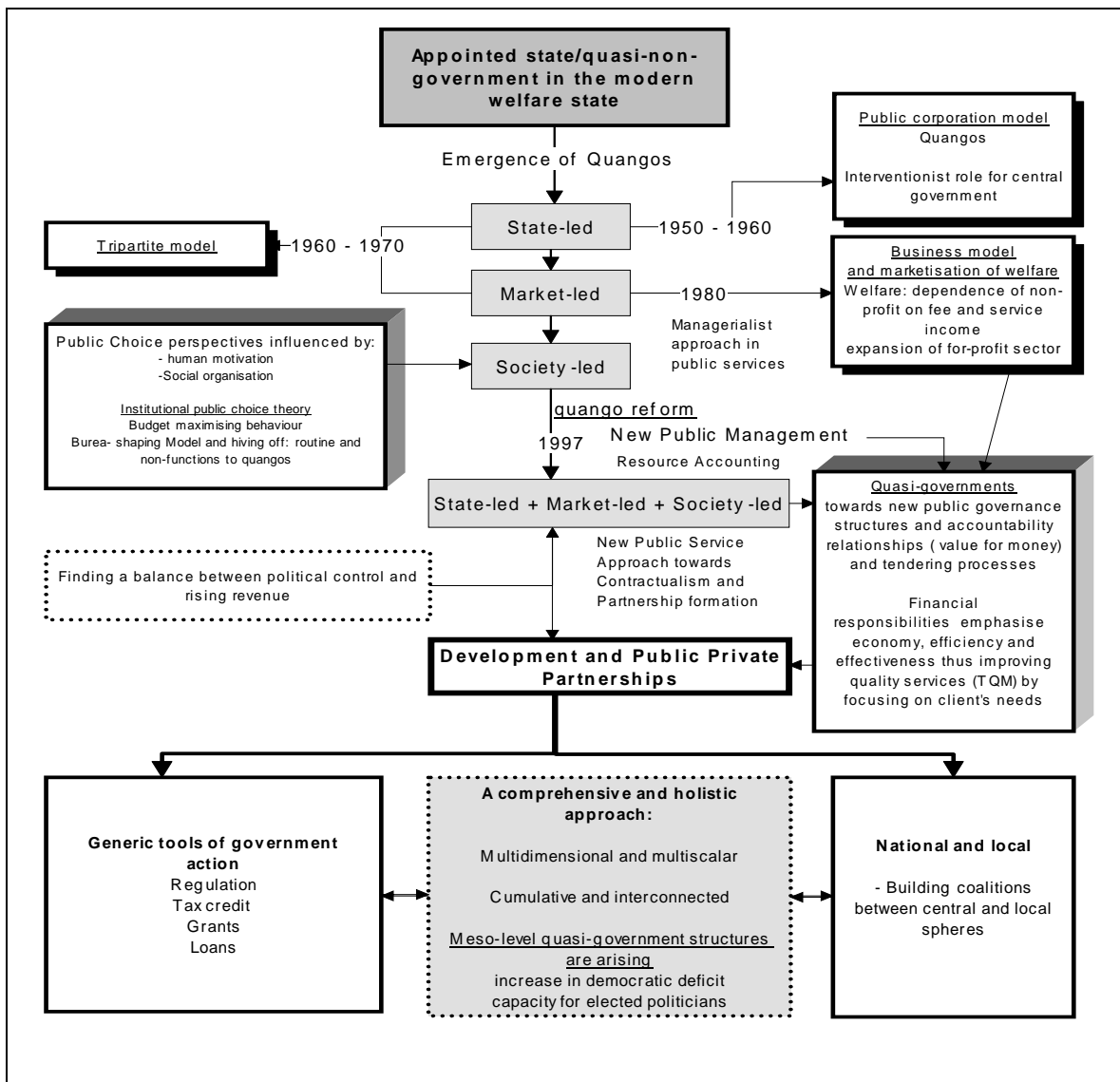
In the 1990s, capacity-building reforms and good governance became focal points of development. Administrative reform became part of the evolving "Washington consensus" in which inefficient states were blamed for postponed growth and social development (Munshi & Abraham, 2004:111; Maxwell, 2005:1). The Washington

consensus argued for unregulated markets and free trade with conservative fiscal and monetary policies for macroeconomic stability as the fit-all formula for global development (Munshi & Abraham, 2004:111). It included a new focus on what constitutes good governance. Governance constitutes both policies and processes while development is seen as the consequential outcome of governance. Four notable characteristics, which included decentralisation, task specification, output focus and performance contracting, became integral parts of capacity-building reforms and good governance strategies during this period. A major problem for reformist governments that adopted decentralised policies in pursuit of efficiency and effectiveness improvements in the public service was to keep the decentralised structures accountable. This was further complicated by three specific characteristics of public bureaucracies that increased the lack of efficiency and effectiveness, namely:

- Monopolistic structures of public service markets.
- Absence of valid indicators of organisational performance.
- Large size of government agencies (Boyne, Farrel, Law, Powell & Walker, 2003:6).

Figure 5.2 presents the emergence of quasi-autonomous government organisations, quangos (developed world) and “parastatals” (developing world) and describes how the NPM movement influenced the economic and political choices towards building state capacity through privatisation of production with special emphasis on contracting out and competitive tendering and public-private partnerships (Wollmann, 2003:5). The NPM movement guided institutional reforms such as downsizing, agencification, contracting, outsourcing and performance management (Wollmann, 2003:3). Privatisation complemented the economic welfare state idea as it is directed at the rationalisation of the supply of goods and services in the most effective and efficient way (Gildenhuys & Knipe, 2000:213). Figure 5.2 illustrates the evolution of PPP within the NPM movement.

Figure 5.2: New public management (NPM) and public-private partnerships (PPP)



Source: Adapted from Salamon (1995:15-34); Farnham and Horton (1996:93); Skelcher (1998:40, 197); Pieterse (2001:1-17); Wollmann (2003:2-3).

The NPM has two strands; the first strand derived from the “new institutional economics” based on public choice while the second strand derived from managerialism (Ranade, 1997:30). Core state functions, such as tax collection, maintaining monetary stability and law enforcement became crucial issues in administrative reforms. The emergence of the market and consumerism occurred in the period from 1997, as well as the process of managerialism which formulated the emergence of the NPM. This included the

decoupling of operational units from direct political control as a result of contracting and hiving-off (Wollman, 2003:3).

Tensions between managerial discretion and democratic accountability led to the investigation of governance-related issues with an emphasis on financial responsibility (Wollmann, 2003:5). The ideas and practices of the NPM reshaped thinking about public policy and management (ODI, 2004:1). Critics argued that the dominant paradigm of the NPM was an updated version of Taylorism which developed from Fordist labour disciplines and controls because developments reflected contradictory tendencies bringing with it new rigidities and flexibilities for employee and employers (Ranade, 1997:30).

Public services were restructured in order to enhance efficiency and improve negative economic growth with shrinking tax bases towards positive economic growth with a broader tax base. Emphasis was placed on more competition by introducing the private market discipline into public administration domain which meant a more open and accountable culture with results and citizen-orientated governments (ODI, 2004:1). Because less conflict existed between the sectors of the market the pursuit of contracting in the public sector became a preferred option of purchasing through procurement processes. The public managers had to be more aware of the financial implications of their spending decisions and their commitment to the delivery of high quality public services (Gaster & Squires, 2003:41-42; *cf.* ODI, 2004:1). However, contracting systems were often inordinately complex. Mechanisms of accountability changed. In the United Kingdom, the so-called Westminster model influenced decision-making and determined who was responsible, while the United States emphasised legal accountability. A tendency in recent years has been to converge these two poles with an increased importance placed on market accountability (Cooper et al., 1998:398). Cooper et al. (1998:399) state that market accountability emphasises performance measures of accountability in which service to customers is the metaphor used to guide assessment. They further claim that market accountability emphasises:

- Economic efficiency and cost dimensions.
- A cost-benefit approach in which a government action meets the test of market accountability.

- Performance standards anchored in an input/output efficiency model which measures outcomes.
- Client satisfaction if customers receive adequate levels of quality service at a good price.
- Recognise citizens as consumers or customers.

There are, however, a number of difficulties associated with the application of market accountability measures or market-choice models. These difficulties are integrated with budgeting systems and tax systems. Within a market accountability system, one assumes that public policies should function as fee-for-service operations. However, social development policies are not created as a fee-for-service because most customers are unable to pay for services. Also social and health care systems operate in synergy. In applying market-based approaches, charging user fees contributes to revenues and efficiency (Cooper et al. 1998,399; *cf.* Lee et al. 2002:100). It is argued that efficiency and equity will be achieved by introducing user charges for public health service improvements (Lee et al. 2002:100).

Market-based approaches transformed budgeting and allocative processes, shifting from the “due process approaches” to public expenditure management (PEM) which highlighted the complexities involved with various actors and institutions in the budget process and linked expenditure with measurable results (ODI, 2004:1). The quality of services forms the basis of specification in the contractual agreements of partnerships. However, Farnham and Horton (1996:93) argue that problems arise when the government’s policy towards social welfare programmes are not in accord with its willingness to commit the necessary financial resources to fund these initiatives. Also, as soon as the options for improving value for money through procedural, managerial and financial initiatives have been exhausted, the overall public funding is the only variable that can be adjusted. This means that politics replaced managerial rationality which resulted in an increase in state funding for these services or that the state withdraws from providing these services leaving it to individuals, families, voluntary groups or private organisations to take on the responsibility to deliver these services (Farnham & Horton, 1996:93).

With the introduction of quangos or public-private partnership agreements the effectiveness of traditional hierarchical public service models was questioned, as well as the feasibility of applying bureaucratic models and capitalism to current changing public administrative environments. The traditional model of public administration has been replaced with a new model of public management that focuses on serving instead of steering (Hughes, 2003:281). A New Public Service approach developed in which outcomes of the previous New Public Management model were improved. Worldwide, administrations were realising that they should “listen” rather than “tell”, and “serve” rather than “steer” the governance process. These views gradually changed the essence of public administration and how service outcomes in the developed and developing worlds were defined by governments. Along with changing environments, the Washington consensus was replaced by a new and improved orthodoxy called the “meta-narrative”. Maxwell (2005:3) notes the direct link between the Millennium Development Goals (MDG) and the Washington consensus. The linkages of MDGs with rights, equity and social justice emphasised national poverty reduction strategies, macro-economic policies, and strengthened the need for effective public expenditure management in the developed and developing countries (Maxwell, 2005:4).

In the developing countries, administrative decentralisation became a mechanism for administrative reforms. Administrative decentralisation supported programmes and enhanced development objectives with the improved provision of public goods and services (Coopers et al., 1998:391; *cf.* Cohen & Peterson, 1999:24). The improved provision included restructuring of public service organisations through contractual or semi-contractual arrangements with the emphasis on developing competition in the delivery of services, cost reduction and greater use of managerial techniques, as well as a customer orientation in the provision of public services (Munshi & Abraham, 2004:157). Partnership agreements gradually dominated restructuring efforts. Various frameworks for administrative decentralisation were implemented to achieve improved provision of services. According to Cohen and Peterson (1999:4), these frameworks depended on:

- The different forms of decentralisation such as political, spatial, administrative and market decentralisation.
- The different types of decentralisation such as deconcentration, devolution and delegation.

Decentralisation became an instrument to assist with human development and improved quality of life. The success of decentralisation depended on a strong centre that provided supporting roles. The administrative design framework developed around:

- The principles of administration (accountability, efficiency and effectiveness).
- The purpose of the public sector (stabilisation, distribution and allocation).
- The properties of design (funding and monitoring) (Cohen & Peterson, 1999:105).

The stabilisation and distributional functions are based centrally while allocative functions are decentralised. New approaches included institutional monopoly, institutional pluralism and distributed institutional monopoly which shaped the networks on which partnerships were based. *Institutional pluralism*, a plurality of co-operative forms of networks, is a strategy that allows the public sector to break up monopolies over task-related roles and serve as brokers for leveraging private resources for public objectives (Cohen & Peterson, 1999:105-108). Moving from hierarchical organisations towards network organisations required that changes had to be made to the way that public services operate, the scope of activity and impacts on the processes of accountability (Cooper et al. 1998:398; cf. Hughes 2003:281; cf. Roux & Schoeman 2004:521).

5.5 Conclusion

The ideological philosophies (neo-liberal, collectivist and libertarian approaches) that a government supports, direct the methods of state intervention through regulation, finance and public production or a mix of the intervention methods a government chooses to apply. The role that the state is accorded as a provider of welfare (social justice) and health is the key variable that distinguishes it from different countries. This is further determined by the relative size of the public and private sectors.

At the core of an effective state is wealth-creating initiatives that enhance the well-being of the individuals. Continued growth is critical to support and finance the social models a government supports to achieve well-being. Well-being and health care initiatives are linked to each other. The businesslike approaches propagated in the NPM movement have changed the role of the public administrator as themes of efficiency, effectiveness, economy and equity (4Es) became driving forces behind reform initiatives and service delivery outcomes. Cost containment and improved service delivery demanded that a

best practice model guides strategies into finding the best options available. The next chapter analyses and compares international practices with the national environment in an aim to present new best practice standards linked to service excellence in the long term.

CHAPTER 6: CRITERIA FOR HEALTH REFORM POLICIES

Public-private partnerships are heralded by some commentators as something of a 'panacea' for the developing countries. The lessons of grant-in-aid in India suggest that such policies should be treated with more caution (Tooley, 2004:71).

Because first of all there will always be constraints on the fiscus and the needs of our population grow all the time. We will have to rely on private sector money and private sector expertise. But through a partnership we still ensure that the poorer populations get increased access to health care as the years go forward. And there is still a role for the private sector even as we get socialised health care. We will never have the resources to provide the kind of things we need for socialised health care. I am very optimistic (Pillay, 2005).

6.1 Introduction

By categorising countries into more similar groups, lessons emerge as novel individual policies are assessed. These lessons provide insight and understanding into the different contexts of individual policies and identify those aspects that become a determinant for future policy directions. However, to categorise countries into similar groups requires an empirically informed process in which health care systems are evaluated in relation to the health, social and financial policies. This process is central to Chapter 6 as it sets out policy features by highlighting governance and accountability practices that framed HIV/Aids strategies and policy in order to provide a framework for best practices in public finance.

Evidence derived from the previous chapters showed that various external factors played a determining role in pinpointing the key issues and best practices that affected performance and service delivery outcomes. The key contributors were identified as the impact of ideologies on the architecture of governance and state interventions; the symbiotic relationship that exists between the economy, society, political philosophy and its impact on public finance: the economic impact of the political philosophies of the developed countries and its influence on policy trends in the developing countries: the role that public-private partnerships play as a mechanism to strengthen policy capacity and improve the government's ability to deliver quality services. The delivery of quality

services were tied to the relative size of the private sectors and how supply and demand functions were intertwined with the intervention strategies.

These factors formed the background for Chapter 6 in identifying key issues and trends within a 4E framework. Interviews provided a measuring tool of what happens in the task environment. The key issues derived from the framework provided a benchmark for the measurement of performance within the national environment. By benchmarking the international key performance indicators (KPIs), opportunities were created nationally allowing for alternative strategies to build on relative strengths, thereby reducing the effects of constraints and weaknesses within the internal environment. Improving functional activities directly ensued in lowering the costs of service delivery to achieve value creation in the long term resulting in new best practice standards. Chapter 6 concluded with a social cost-benefit analysis, in which the social costs and benefits of utilising PPPs in the HIV/Aids environment are highlighted and the benefits of future supply over and above what it would be in the absence of the intervention are brought to the fore.

6.2 International best practice framework

A 4E framework (effectiveness, efficiency, economy and equity) presented those key performance indicators that are critical success factors in the PPP environment and shape health care interventions. The framework further identified key issues in the public health care sector and public finance as this determined the benefits and opportunities available in health care.

6.2.1 Effectiveness: goal attainment in service delivery

The developed nations play a determining role in global policy-making and the design of the global architecture. They influenced and shaped ideas on development thinking and prescribed the approaches that developing countries took towards state intervention (nation-societies). The interventions were influenced by the market forces that set the tone for development. Constitutionalism formed the basis on which democracy and development initiatives were introduced. Transnational interaction became a determining factor in policy and development initiatives especially in the health care markets. At the core of the health care markets were the MDGs which became an instrument of sustainable development in which the governance structures were developed to reduce social and economic inequities. The governance structures provide a management

framework for the distribution of health systems which are central to the effectiveness of strategies and establish priorities of public expenditure based on the improvement of existing and new infrastructure.

The promotion of health care is seen as an active part of the global governance system. It utilises global PPP to achieve its aim through the service sector. Arrangements are managed through GATS. The growth of global markets in health care is manipulated through PPP. Development thinking and the utilisation of PPP are enforced through human rights and the enlargement of people's choices which are interwoven into the democratic structures of each country. PHC (developed parallel to PPP) with its emphasis on equity strengthens the argument that health is a human right. PPP forms the link between the state, society and economy. Participation occurs in a bottom-up approach, instead of the traditional top-down hierarchy (vertical and horizontal networks) and involved co-operation amongst government, civic and international organisations and market forces. In the evolvement of these market forces multinational and transnational corporations (private sector) are powerful stakeholders in the PPP environment and the provision of goods while NGOs became important stakeholders in health service provision, research, support services and policy advocacy.

An effective state and a stable political environment are vital for the provision of goods and services in health care and form an integral part of capacity-building and good governance structures. These structures enhance efficiency and effectiveness through systems that are based on a decentralised approach. The decentralised approach assists in human resource development and improves quality in life, task specification through performance and project management. Task specification and performance management are tied to timeframes and outcomes-based approaches that encourage social and health care systems to operate in synergy and provide value for money. The expected outcome in quality is associated with performance management (total quality expectations). The total quality expectations consist of both motivators and satisfiers. The intrinsic value (motivators) provides functional quality that is offered in accessibility, reliability, durability, timeliness, completeness, excellence, accuracy and compliance with legal standards. The extrinsic value (satisfiers) is perceived as the technical quality services offered through human resources (knowledge and ability) and physical resources (technology, facility, medicine and apparatus) (See Figure 4.2). Performance

contracting and competition in the private market are central issues that focus on cost reduction in health care through greater use of managerial techniques and an accountability culture. Goal attainment is achieved through good governance and the development of new accountability structures. Customer orientation in the provision of health care in public services underpins the arguments of performance contracting and competition.

The raising and spending of public resources in health care are influenced by political philosophies. It underpins the citizen-state relationship as it defines those who are accountable and how power is applied in managerial, contractual, communal and parliamentary accountability. The combination of these four forms of accountability impacts on trade-offs between PPP and the traditional public administrative system. Administrative reforms support political decisions and philosophies in their strategies for raising and spending of public finance.

6.2.2 Efficiency: outcomes in health care

The utilisation of PPP modifies market efficiency and improves outcomes and strategic intent. Market efficiency is achieved through the forces of competition and globalisation underscoring efficiency and effectiveness in intergovernmental and intersectoral relationships. It is argued that fewer conflicts exist between the disciplines of the market thereby making the pursuit of contracting in the public sector the preferred option of purchasing assets and services through prescribed procurement processes.

Allocative efficiency in health care focuses on the distribution of resources through the budgeting process according to government priorities in order to achieve programme effectiveness. This is based on an increase on returns, the effects of individual actions and the type of goods or services (rival or non-rival). Allocative efficiency requires local rather than central decisions regarding tax expenditures and finance structures and fosters national prosperity through investment in physical and human capital in the long term and the short term). Greater private income and economic growth support the concept of allocative efficiency.

An increased importance has been placed on market accountability as this leads to market efficiency. Health care markets encouraged the implementation of user fees in

order to contribute to revenue and improve service quality and customer satisfaction (WTP). Performance standards and cost-benefit approach assisted in determining future opportunities to overcome weaknesses and build on relative strengths. The importance of performance and good governance in the health markets demanded that new accountability agendas had to be created to fill the gaps that developed in current health care structures.

6.2.3 Economy: reducing health care costs

Minimising intervention costs in health care resulted in economy and value-creating strategies. These value-creating strategies determined the type of role the government played in partnership agreements, as well as the way it applied the value-creating strategies towards reaching its strategic intent.

In the formation of partnerships, the government was required to transform its role into an enabling, a facilitating and a regulatory function. The formation of partnerships moved government into an enabling role in which the state pursued equality of opportunity through mechanisms that modified the markets in a mixed economy. PPP is a fiscal planning tool at the macroeconomic level and is integrated in the budgeting process. The budgeting process provides the government with a mechanism that utilises the private sector/economy to provide goods and services through subsidies or loan agreements. The private sector assists the government with capital through investments. The relative high transaction costs involved in PPP determined that it is policy in most countries not to do straightforward PPP/PFI projects below a specified cost. The government identified health, education and housing as those sectors in which PPP work well.

Partnerships transformed the government into a facilitating and co-ordinating role in its production of social goods through the management of internal markets and managed competition (procurement processes through competitive tendering). It moved procurement in PPP from public sector comparator (PSC) to a more holistic approach in which more weight is given to the quality of competition, standardisation of PFI contracts, payment mechanisms and output specifications as well as the contracting out of public services to suppliers in health care. The value of the co-ordinating role that unions play in the design of PPP agreements must be taken into consideration. Appropriate legislation must be in place to deal with public sector transfers and benefits.

Partnerships compelled government to take on a more regulatory role through the application of coercive powers and primary legislation to provide security to long-term contracts. Security is given upon the basis of which services as a provider is regulated and bound up in terms of the concession agreement. The economic and social regulations encourage actors to undertake certain activities and enable them to make value choices.

6.2.4 Equity: social justice

Market-based approaches in a mixed economy transformed budgeting and allocation. Public expenditure management linked expenditure to measurable results and value-for-money approaches tied to horizontal or vertical equity in the budgeting process. Finding the optimal balance between socially acceptable distribution of income is a critical success factor in the development of social justice systems. However, it must be kept in mind that greater vertical equity cannot be at the expense of social justice.

6.2.5 Implications of the 4E framework for the public sector and public finance

Various implications for the public sector in the PPP environment must be considered when “best practices” are established in health care. The social model regulates health care inputs with a central focus on development, equity and empowerment. This is achieved through partnerships in which a heavily constrained state is able to share health care costs. Partnerships are at the core of relationships in the provision of health care and must offer affordability (economy) and efficiency, value for money, quality and accessibility (effectiveness). By transferring some risk increased security and equity needs. These outcomes require a heavily constrained state in which allocative and distribution policies determine how economic efficiency and social justice are applied, the borrowing/GDP ratios necessary to support its social needs are influenced by political philosophy, and infrastructure development is a critical element in sustainable development. The conditional welfare state is supported by public and private health insurance. The relative scale of public finance identifies the balance between social and economic spending which is crucial for wealth creation and the physical well-being of citizens. GDP indicates the relative size of the public/private sector. Health care is inflationary because it is supply-driven, high-tech and super profits are to be made

(rivalry). Private sector shows signs of strong growth through the successful utilisation of PPPs.

There are various technical implications for public finance that must be considered while evaluating the impacts of PPP has on public finance. An enabling state with heavily constrained public finance seeks additionality of finance through private and public investment driven through partnerships. This is encouraged through economic growth and efficiency and by increasing borrowing debt for efficiency purposes. Sustainable projects are identified and risks are managed in various stages of the PPP process (completion, bidding and development costs, return-on-investment (ROI), participant and operational failure, financing costs increase due to interest rate changes and technological impacts). Co-operative finance structures are intertwined in the budgeting process while borrowing debt for efficiency purposes through loans is influenced by external factors and risks (foreign exchange, syndication risk, political decisions, and interest rates). The internal factors and risks are influenced by the participants in the project, the way agreements are negotiated and the impact of proportional taxes on allocation policies. The internal processes such as the management of projects impact on completion time and costs involved, as well as oon technology, environment (labour and administration), and site issues (design and construction). The government contract/agreements and how it is negotiated are key success factors in the formation of PPP agreements as relationships and co-operative structures change in an enabling environment. The legislation, political ideologies, human resources and skill levels must support the initiatives. Proportional taxes are linked to decentralised structures to support budgetary processes and allocative efficiency.

6.3 Situational analysis

Trends or patterns of behaviour influence the way in which business is conducted in the public and private sectors. The accelerated change demands the crucial responsibility to ensure the capacity for survival which can be done by adapting and by anticipating changes in ways that provide new opportunities for growth and development. The impact of changes on the remote environment (external) and task environment (internal) must therefore be understood and predicted. Through a situational analysis, environmental variables that are critical to survival are systematically identified (Pearce & Robertson, 2000:158-164; *cf.* Landsberg, 2002:41).

6.3.1 External environment (Remote environment)

Key issues in the remote environment highlighted in Table 2.1, are used to assess the national health care environment. The PESTLE analysis (Table 6.1) assessed the remote environment and identified those factors that influence decision-making in health care and HIV/Aids intervention strategies.

Table 6.1: PESTLE analysis for national case study

CASE STUDY 5	
The ideology: NEO-LIBERALISM (quasi-federal system)	
P	<p>The Republic of South Africa is a constitutional democracy with a three-tier governmental system and an independent judiciary operating under a parliamentary system (bicameral). Unlike the Westminster-style parliamentary systems, the president is both the Head of the State and the Head of Government. The bicameralism is an integral part of the system of intergovernmental relations (Levy & Tapscott, 2001). The Constitution of the Republic of South Africa 1996, as well as the White Paper on Reconstruction and Development of 1994 guides development in South Africa (ANC, 1994). The Constitution introduced the concept of a social welfare state in which government is expected to create conditions in which individuals can develop their social and physical well-being (Van der Walt, Van Niekerk, Doyle, Knipe & Du Toit, 2002:7).</p> <p>The Constitutional framework provides for a decentralised approach which has both unitary and federal qualities and is run on a system of co-operative governance that was specifically formulated to suit the deeply divided plural societies. The Constitution of the Republic of South Africa, 1996 determines that public administration must be governed by democratic values and principles (Van der Waldt & Du Toit, 1999:13; Coetzee et al., 2001). These principles include a development-orientated approach to service delivery by which government is able to respond to people's needs through the encouragement of grass-roots participation in policy-making (World Bank, 2001). Democracy is about social justice. Sufficient wealth and prosperity broadens the tax base and provide income to pay for the social welfare services to poorer communities without crippling the economy (Van der Walt et al., 2002:7). Health is identified in the Constitution of the Republic of South Africa, 1996 as a concurrent function. Concurrent areas of the national and provincial legislative competence thus dealt with these social and economic factors in the functional areas described under Schedule 4 and indicate those social and non-social functions that can be performed by both spheres of government in order to improve the quality of life of society through development initiatives. As the Intergovernmental Fiscal Review (1999) indicate, non-social services are important for promoting provincial economic development and poverty alleviation and include economic affairs such as trade, tourism and industry, public works, transport, local government, housing and agriculture. The National Health Act, 2004 (Act 61 of 2003) and the Draft Health Charter (Charter of the Public and Private Health Sectors) play crucial roles in aligning and supporting the development of organisational structures in the functions, "Health services" and "Municipal health services" in a system of co-operative governance as is specified in Section 41 of the Constitution of the Republic of South Africa, 1996.</p>

Government sees itself as an enabling state in which market-based strategies determine that a development-orientated approach facilitate and regulate economic growth and efficiency as a prerequisite for applying social justice through horizontal equity. Heavily constrained public finances support the high demands made on social security and health care services. The introduction of the White Paper on Transforming Public Service Delivery (1997) brought a new attitude amongst public servants regarding service delivery, namely *Batho Pele*, forward. The main focus is placed on improving service delivery outcomes by strengthening government policy capacity and administrative structures. This meant a shift away from the inward-looking rigid bureaucratic systems towards a more flexible, faster, and more responsive way of working, advancing the needs of the community through a more customer-focused approach. The changing needs and shift in service delivery outcomes brought new challenges and risks that increased the complexities associated with decision-making and responsibility. Vision linked to strategic impact became the pivotal point in decision-making and framed service delivery outcomes (Moorman, 2001:83). This systems-level approach became consistent with the conceptual rationale for the presence of a strategic impact that required the reaching of objectives and goals in set timeframes, creating-value services that are both transparent and accountable. PPP became one component of government's overall tools of implementing the development strategy for the provision of public services and infrastructure. This was done by linking PPPs to the budgeting process and integrating it as a part of the fiscal policy that increases growth, equity, employment and price stability and thereby reducing social spending. By taking a closer look at the health sector and the impact of PPP projects on service delivery outcomes, one is faced with additional project risks associated with the complexities of intergovernmental relations. Local economic development (LED) in local areas receives recognition from national and provincial governments, funding agencies, NGOs and CBOs. Ketchum (2001:7) believes that with limited resources and the added pressure placed on local governments to deliver services, partnerships have proved to be a responsible fiscal way. LED share the common notion of development from below and describes localised economic activity initiated by a local community. LED is an endorsement of the ANC government's ideological focus and strengthens its principle of community-based development.

The Republic of South Africa (see Case Study 5) has become a significant player in world politics and is an important player in the IMF, the World Bank and the UN organisations. Its foreign policy seeks to prevent conflict and promote peaceful resolution of disputes by promoting democratisation, disarmament and respect of human rights. The country plays an important role in the upliftment of Africa. Asia and the Indian subcontinent and Australasia have become priority areas in its foreign policy. They are part of the Indian Ocean Rim (IOR) which encompasses

	<p>the eastern African coastal countries, the Arabian Peninsula, Australia and the Indian subcontinent. The IOR for Regional Co-operation (IOR-ARC) is an important regional economic entity (Attorneys, 2005). Strong reliance is placed on the Global Fund for the fight against AIDS, TB and Malaria (GFATM) to provide funds. The Joint Public and Private Initiatives (JPPI) bring together funding. However, emphasis is placed on the supply of drugs rather than building capacity to sustain treatment and preventative programmes. Canada is the largest provider of development assistance to South Africa and has granted the country the benefit of its General Preferential Tariff.</p> <p>PEPFAR: The supply-chain management contract is under negotiation in the Eastern Cape. Issues of importance are the review of fixed dose combination and co-packaged products.</p>
<p>E c o n o m i c a I</p>	<p>Market outcomes and government interventions</p> <p>Neo-liberal policies involve market-driven policies on trade, investment, employment and government spending which influence market outcomes and undergrid development (structural economic reforms) with regard to labour, social spending and poverty levels (ABSA, 1999). South Africa has avoided SAPs prescribed by the World Bank and IMF. However, one should keep in mind that Gear is a structural adjustment programme that is just as rigorous as those the international finance institutions draw up (Bauer & Taylor, 2005:340). The survival of governments depends increasingly on its external resources, exterior respectability and interior legitimacy. The South African free-market economy is the largest in sub-Saharan Africa. It is classified as a middle-income country by the World Bank. Its dual economic system and sophisticated industrial economy have developed alongside an underdeveloped informal economy. The stock exchange ranks amongst the 10 largest in the world. South Africa has a world class modern infrastructure supporting an efficient distribution of goods to major centres throughout the region and a sophisticated transport system and telecommunication facilities. The unemployment rate is 40%. The government intends to boost its public works programme to provide employment to the unemployed and unskilled. These programmes concentrate on 21 urban and rural nodes identified in terms of the Government Urban Renewal and Integrated and Sustainable Rural Development Programs (Attorneys, 2005). Economic growth has remained stable at 3% per year but has shown an improvement in 2004 to 4.8% in the second quarter of 2005. Agriculture forms less than 4.8% of the GDP.</p> <p>Big disparities exist between income groups which also have a significant impact on health care spending patterns and the relative size of public and private sectors. Privatisation and restructuring initiatives are main objectives in facilitating economic growth and promoting the</p>

development of disadvantaged and poor communities. Black empowerment and extended private ownership of government controlled-assets, the reduction of national borrowing as well as skills transfer and the promotion of fair competition are critical aspects that support governments main objectives (PPP represent these objectives) (Attorneys, 2005). South Africa is a founder member of the WTO and is amending its tariff structures in accordance with WTO rules and GATT. A trilateral trade pact exists between India, Brazil and South Africa. In January 2000, South Africa and the European Union concluded a trade, development and co-operation agreement. After passing the African Growth and Opportunities Act (AGOA) trade with the United States has grown as it ran trade surpluses with the United States. South Africa is a major beneficiary of AGOA. The United States exports higher-value goods to South Africa while the country exports auto components to the United States. AGOA benefits only limited countries as 75% of export under AGOA consists of unprocessed products such as petroleum and textile. South Africa's largest trade partners are the European Union, the United States and Japan. South Africa is the single largest investor in Africa.

Government fiscal policies

South Africa has a reputation for sound fiscal management. Both the fiscal and budgetary reforms have built a firm foundation through the development of a medium-term framework, strengthening revenue administration, adapting consistent planning into budgeting systems, stabilising the fiscal balances and investing in growth and development (Ministry of Finance, 2004). The macroeconomic strategy set out in the Growth, Employment and Redistribution (GEAR) strategy provided the basis for the objectives in 2001 which led towards an expansionary growth and pro-fiscal position that reduced the debt-GDP ratio, provided for a moderate inflation and healthy balance of payments and set the scene for economic growth and improved Standard and Poor's ratings. The PFMA, 1999 focuses on outputs and responsibilities that shape strategies and aim to improve public finance (Unit, 2004). Departmental heads of national and provincial departments are held accountable for their actions and must constantly evaluate their value-for-money choices. PPP entails targeted public spending according to outputs and predetermined standards, leveraging private sector finance and efficiencies and allocating risk to the parties which are best able to manage it (Unit, 2004). Project finance is generally used to finance PPP because they are mostly involved in some kind of infrastructural development project. These projects are closely integrated with Public Works Programs and BEE in PPP. The PPP Unit is seen as an enabler but is also a regulator as it has to control and steer the process. PPP are part of the budgeting process of government and firmly entrenched as part of the service delivery instruments (Treasury, 2005). Treasury Regulation 16, 2004 of the Public Finance Management Act (Acts 1 and 29 of 1999) laid the legal foundation for PPPs in the national and provincial sphere while the Municipal Finance Management Act, 2003 (Act 56 of 2003) and the Municipal Systems Act, 2000 (Act 32 of 2000) governs the process of PPPs in the local sphere through the Municipal Infrastructure

Investment Unit (MIIU). No PPP on municipal sphere is involved with health care or HIV/Aids interventions. The PPPs in the municipal sphere are involved in water, electricity, solid waste, fleet and other basic municipal services. Toolkits are being developed in areas such as tourism, health care and manufacturing. Government faces significant fiscal exposure through HIV/Aids interventions and welfare support. A means-tested disability grant of R740 per month is available to severely disabled people over 18 years of age. This includes people living with Aids. No clear policy on Aids-related disability grants exists. The number of people in need of disability grants has increased sharply since 2002. The children in need of childcare dependency grants have also increased. Costs associated with care dependency-grants will increase due to Aids. People who receive a disability grant and responds well on HAART are no longer eligible for a disability grant. Natrass (2004b) recommended that government introduces a new and lower income grant instead of taking away all financial support. Despite wide-ranging support for a basic income grant (BIG), government has been reluctant to endorse it. Finding alternative ways of channelling income into the hands of the poor and unemployed is based on PWP. Low-wage PWPs that target the poor through government-funded programmes have the potential to alleviate poverty and the additional benefit of creating assets and infrastructure. A major disadvantage is that a substantial proportion of resources is absorbed through administrative costs. BIG has the added advantage of reaching the poor that are too ill to work. Other options available to government to drive down costs of Aids treatment programmes are through an aggressive approach to drug pricing; support for domestic production of generic antiretroviral medication, namely i.e. Aspen.

Economic systems and supporting economic policies

The BEE is articulated in the Strategy for Broad-based Black Economic Empowerment Act, 2003 (Act 52 of 2003) (BBBEE Strategy) that facilitates broad-based BEE and provides a code of good practice to be applied in government and public entities when entering in partnership agreements. The BEE is woven into all the charters, such as the Finance and the Health Charter. PPPs are seen as a way to promote black empowerment within the South African economy. PPP supports and is good for social development initiatives. Procurement encourages fair and open competition within a mixed economy.

Implications for the public sector and public finance

Government's economic policy, Gear, is premised on investment becoming the driving force for growth. Hope was centred on investors responding to falling budget deficits and falling inflation. Government policy focus shifted to greater capital and skills intensity to provide more sustainable growth in the medium and short term. Skill shortages and the brain drain impacted negatively on growth. Aids added to skills-shortages and the brain drain. Its economy is much more capital-intensive than other economies in sub-Saharan Africa. Lessons learnt from

other countries with high HIV prevalence may not apply to South Africa (ABSA, 1999; *cf.* Arndt & Lewis, 2000:856). The macroeconomic impact of HIV/Aids on the South African economy was found to be substantial as it impacted on the GDP, lowering the population and per capita GDP by 8% (Arndt and Lewis, 2000:856). The macroeconomic impact will be felt through an increased pressure on public spending in health and social services.

Nattrass (2004b:87) states that unemployment and Aids are major challenges faced by the economy and social security system. Significant income disparities between incomes exist in provinces. The Eastern Cape and Limpopo are the poorest provinces (Guthrie & Hickey, 2004). Guthrie and Hickey (2004:102) state that there is a strong relationship between poverty and ill health and poverty-related illnesses. Even if modifications of high-risk behaviour change are implemented and begin to reduce the number of Aids deaths in the next five year, the full effect will still lag by a decade. Unemployed have neither access to earned income or life-prolonged medication. Aids impacts more on the unemployed and unskilled labour category. This affects mostly the youth. The economic impact of Aids is much higher than the growth rate of GDP or the effect of increased mortality on existing land as it destroys human capital and family structures (Bell, Devarajan & Gersbach, 2003). As the prevalence of the disease increases (due to the effects of absenteeism and morbidity), more progressive collapse of human capital and productivity will occur. Transmission of knowledge from parents to children is affected which will influence growth and education within three generations. The unemployment rate for unskilled labour increases as a result of the epidemic. Aids tend to affect young adults, is slow moving (illness has a gradual onset with declining labour productivity and increased health costs) and infection differs by skills class. The unskilled labourer is more vulnerable to the impact of Aids. Household expenditure is greatly influenced by the increase in health spending. Saving rates are affected creating a spending shift and an increased demand on governmental social spending. The epidemic has moved from a health issue to a development issue with social, political and economic dimensions (Arndt & Lewis, 2000:857). Poverty and Growth Programmes (PGP) builds on the capacity of middle-income countries and designs and implements effective poverty-reduction strategies. Developing countries are required to formulate poverty reduction strategy papers (PRSP) representing the macroeconomic, structural and social policies that achieve economic growth and poverty reduction. The PRSP describes government's commitment to poverty reduction in a participatory approach. These programmes must provide a three-year macroeconomic framework together with a policy matrix that includes the main elements of the poverty reduction strategy (Laterveer, Niessen & Yazbeck, 2003:138-145). Any strategy of poverty reduction must begin with an interim poverty-reduction strategy and include an assessment of the health and disability of the environment, age and size of families,

	<p>education levels and gender. Vertical equity implies that more resources are spent on the poor.</p> <p>Other scenarios: Due to increased government spending on health one sees reduced spending on education. This reduces skills accumulation and changes labour force growth rates. Arndt and Lewis (2000:857) advise government to focus on policies that slow the spread of Aids and the demographic trajectory of the pandemic as well as emphasise the need to investigate the interactions between the pandemic and alternative growth and development strategies.</p>
<p>S o c i a I</p>	<p>Government takes a developmental approach to social and health reforms. The Constitution of the Republic of South Africa, 1996 confers rights on various social services and benefits which include housing, health care, social security and education. Provision is made for budgetary constraints in which it is seen as the responsibility of the state to make reasonable provision to expand access to the services or benefits (ABSA, 1999). Expanding access to services and benefits intends to advance social development by steadily reinforcing the social wage. This includes improving benefits such as nutritional needs, education and improving the well-being of poor households. Redistribution of wealth is a key tool that supports interventions enabling markets and strengthening them to work better in order to fund social development programmes that improve allocative and distributive strategies. The main challenge lies in resolving poverty and Aids simultaneously. This means it requires new ways of allocating funding from national to provincial spheres aligning it with the growth strategies and spending and taxation decisions. According to Natrass (2004b:87) this is done through direct interventions (income support and public works) and through policy measures that support labour intensive activities and growth in order to maximise employment outcomes. Social services continue to absorb nearly 60% of the government's non-interest expenditure. This expenditure is necessary to lay the foundation for growth in human capital and direct support to the poor (Treasury, 2004). The government aims to reduce the dependence on social grants, deepen the capacity of communities to meet their basic needs through normal participation in the economy. There is an increased focus on housing delivery and improved infrastructure to reduce the effects on health.</p> <p>Improving the health and well-being the government is working towards a social health care plan for all. Partnerships, especially PPPs and PPIs, have become dominant forces in public sector reform (Wettenhall, 2003:77). However, the government is faced by an uneven distribution (inequities) of health care and ownership of health establishments, poor accessibility to services, provision of necessary human resources and infrastructure to support health care structures are core issues to be solved in health care reforms. The National Health Act, 2004 (No 61 of</p>

2003) and the Draft Health Charter support this process of transformation towards a national health system (NHS). Amendments are recommended and accepted in the Budget, 2005 to the way medical aid contributions are taxed with the aim of lowering costs of medical aid and making medical aid accessible to poorer families. The development of a “basic package of care” that reflects the minimum standard of health services will assist in determining the public-private mix and balancing this ratio. Health care reform and privatisation has had a strong negative net effect on the public sector. Rapid expansion of private hospitals has undermined the public provision by draining large numbers of skilled staff and paying patients out of the public health system (Moorman, 2001:83; *cf.* Sanders & Meeus, 2002:4).

The White Paper on the Transformation of the Health System in South Africa (1997) initiated and guided this process of transformation. It stated that the activities of the public and private sectors must be integrated in such a way that it makes use of the available health care resources, and as such promote equity in service provision. All health care activities are aligned within the National Health Act, 2004 and the Public Service Regulations (2001) which together formed a comprehensive health care program. The implementation of a Primary Health Care Plan changed the focus of the health care systems from a medical problem towards a social model that encompasses the needs of the society it serves. Treatment moved away from expensive curative care to palliative care with an increased focus on preventative measures. PPP in health care offered the option to tap into the concentration of resources to the benefit of everyone (Moorman, 2001). The public sector saw PPPs as a mechanism to improve efficiency, customer service and revenue. The key prerequisite is centred on reduced cost through collaboration and closer interaction with the private sector which brings new management styles and facilitates new skills especially in finance. PPPs are long-term concessions with private sector to provide services or infrastructure on behalf of government and must provide value for money, affordability and transfer risk (Pillay, 2005) The health sector is currently engaged in substantial investments into the procurement of health care infrastructure and health care services through PPP projects, though there is substantial resistance against PPP in DoH. HIV/Aids is not specifically dealt with through PPPs. There is only one PPP in the Eastern Cape, called the Pharmaceutical Supply Chain Management PPP which is in its final stage of procurement and involves the management of the supply of pharmaceuticals for people (Pillay, 2005). This project is part of the PEPFAR (SCMC) funded by Global Health initiatives. It became evident that human resource practices within the health sector are closely linked to organisational strategies and goals. The success of the transformations within the health sector in each of the functional domains depended on both the line and responsibility manager’s ability to combine the administrative and management work areas together with effective human resource practices and their ability to utilise resources. The intergovernmental relations are tied into the contract

negotiations and role contracts in an effort to define the nature of intergovernmental relations. This is critical to the success of the PPP arrangements in the health sector (McCoy, Buch & Palmer, 2000:6). The difficulties associated with the construction of partnerships are nowhere as evident as in the delivery of the Primary Health Care System (PHCS). The responsibility for delivering a comprehensive PHCS can never belong to one level of the health system but requires a vertically integrated, tiered health care system where different levels of management and administration work together in a complementary way (McCoy et al., 2000:1).

Response to HIV/Aids was limited before 1994 and focused mostly on condom provision. Activity in Aids policy increased from 1999 to 2001. Much of the activities in the developing countries stemmed from the decision made by the South African Government to amend its Medicines and Related Substance Act of 1965 with a new provision referred to as Article 15(C) (Siplon, 2002:120).

1997: A Review of HIV/Aids Strategy and programmes

1998: The Partnership Against Aids. It also saw the establishment of the national Interdepartmental Committee on HIV/Aids (IDC) which was responsible to coordinate and support the HIV/Aids response.

The HIV/Aids and TB Unit was established in 2000 within the DOH. It also established a Donor Coordination Forum in which bilateral and multilateral donors were represented. Their activities were integrated into the national strategies and a national integrated plan (NIP). The Chief Directorate HIV/Aids and TB developed policy to support research and surveillance and administer and drive national programs. The Directorate is also responsible for managing the conditional grants to provinces and ARV treatment funds, NGO funds through an NGO Funding Unit (loveLife and LifeLine) and allocations for SANAC. Setting up NIP programmes entailed new management structures, employing co-ordinators in provinces, developing financial transfer and monitoring systems, formulating programme standards.

In June 2000, DOH launched the HIV/Aids/STI Strategic Plan for South Africa, 2000-2005 and the TB Medium Term Development Plan guiding DOH in setting objectives to improve multisectoral participation. The needs are further met in the Strategic Priorities for the National Health System, 2004-2009. The overall goals were structured according to four distinct components:

- Prevention: Communication through information improved awareness (Low-Beer & Stoneburner, 2004:5). Soul City has had considerable impact around HIV/Aids issues in South Africa. The Soul City model utilised the mass media vehicle through educational and health promotion aimed at 8 to12-year-olds (IHDC, 2005).
- Treatment

- Human rights
- Monitoring and research. The National Integrated Plan (NIP) is an inter-sectoral national government plan for responding to HIV/Aids. Three programs are jointly delivered by health (Prevention, treatment and care programmes are delivered by DOH), education (life skills, voluntary counselling and testing (VCT) implemented by DoE) and the welfare sectors (community and home-based care and support implemented by DSD).

The main funding framework for HIV/Aids is organised into three streams:

- Nationally financed and implemented programmes. These programs are funded primarily through the budget of the Chief Directorate: HIV/Aids and TB Unit in national DOH and are directed through conditional grants. Conditional grants are given to provinces for specific interventions and are the largest form of funding.
- The Provincial grants are increasing at a faster rate than the HIV/Aids conditional grants administered by DSD and DoE.
- The Provincial interventions are funded through the equitable share grant. These grants are intended to strengthen health care services (Guthrie & Hickey, 2004).

2000: the South African National Aids Council (SANAC) was established. It was restructured in 2003. The formal partnership between Government and the South African Aids Vaccine Initiative was established.

2001: Additional funding was secured through the “Enhanced Response to HIV/Aids and TB in the Health Sector”. The development of an Integrated Plan for Children and Youth Infected and Affected by HIV/Aids was developed. More emphasis was placed on co-ordinated care to deal with community home-based care, counselling and prevention.

2002: A revision of the “Enhanced response” allowed for further mobilisation of funds over a three-year period. IDCs were established in all the provinces. Partnerships with major sectors were strengthened. These included partnerships with pharmaceutical companies, traditional leaders, and high-risk areas such as shebeens, bars and taverns. The Diflucan Partnership Programme whereby Pfizer provided Fluconazole free of charge was extended indefinitely. Awareness campaigns focused on commuters, drivers, taxis and buses. During 2001, donor funds increased to a peak after which it gradually decreased (Guthrie & Hickey, 2004). However, it was found that it is difficult to provide an accurate figure of the amounts donors invest into HIV/Aids in South Africa as donor revenues are not included in the national budgets and expenditures are not synchronised with national spending patterns. South Africa provided a R20-million payment to the Global Fund.

2003: A mid-term review of the Strategic Plan was conducted and focused on government’s response. HIV/Aids and life skills were introduced

into education systems. A number of government departments integrated HIV/Aids programmes into their line functions.

Local spheres: service delivery and budgeting for HIV/Aids

DOH is the main authority to determine how the total conditional grant is divided between the nine provinces. Business plans are key factors in determining the amounts needed for effective interventions. In 2003 DORA relocated additional funds to provinces that were able to spend their income. DOH costs the components of interventions to be financed and submits its requests to National Treasury who elects to fund some components of the conditional grants fully or partially. The Directorate Financing and Economics in DOH is responsible for the costing of the expenditures. A new tool for sending money to the provinces for HIV/Aids was introduced in the 2002/2003 budget by drawing from the equitable share pool. For provinces, conditional grants funds are thus ringfenced for particular purposes defined by the national departments while the equitable share funds allow provinces the freedom to allocate the money where they deem necessary (Guthrie & Hickey, 2004). It is very difficult to track equitable shares as they are allocated via the provincial budget process. Details of expenditure are presented in parliamentary hearings and are reported in the Auditor-Generals report two years later. Ringfencing conditional grants caused bureaucratic hurdles and delays in spending and transferring funds. The bulk of public health expenditure is found in provincial budgets (98%) because provinces are responsible for service delivery and implementation. Provinces are reliant on the national government for their revenue and are largely responsible for service delivery. HIV/Aids requires focused budgetary allocations for specific programs and must provide indirect support to provincial departments to mitigate the impact of HIV/Aids and encourage a developmental response (Guthrie & Hickey, 2004). Allocations in health have shown a gradual increase in spending. Consolidated national and provincial health expenditure has grown with an average of 3.6% per year from 2000/01 to 2005/06. Expenditure as a share of the total budget and GDP: OAU Special Summit on Aids in Abuja in 2001 pledged 15% of national budgets to be allocated to health.

NGO sector

The government relies on NGOs for the implementation of HIV/Aids interventions at grass roots; for care prevention and support. Of the HIV/Aids and TB Unit's budget 7.5% was spent on NGOs and CBOs and an additional 4.8% was allocated to loveLife and LifeLine. CBOs identified the importance of "community development facilitators" in building relationships between the clinics, hospitals (medical professions) and local communities (patients). Service delivery within clinics depended on the administrative skills and management capacity of nursing sisters. Rural or urban clinic's quality of service depended on administrative skills and not on policy issues. Partnerships in health and social care with NGO and CBO were financed through conditional grants from provincial governments which are the implementers of service delivery.

	<p>The funding for services in NGOs and CBOs is tied to a strict regulatory system which is questioned by these organisations as the government seems ineffective in the management of data. More transparency of data will benefit all parties involved as they can measure performance and outcomes of services provided. It will offer them great benefits if they can improve on service delivery. The role of government in this partnership must be renegotiated.</p>
<p>T e c h n o</p>	<p>Problems with data and statements of expenditure were emphasised by:</p> <ul style="list-style-type: none"> ○ Government works on a cash accounting and not accrual system. Expenditure is recorded only when a payment is made. ○ Provinces correct errors in books at the end of the financial year. ○ No information on roll-overs of funds. Adjusted estimates are published in October and November and include information on funds rolled over in previous budget. <p>Challenges faced by budgeting systems and health care delivery are based within human resources as a shortage of skills impact on systems and affects the implementation of programmes and interventions. An information system is developed by SITA. Data sources will include patient information systems, National Health Laboratory Services DISA, and district health information systems, BAS, impact research and evaluation research. Patient data will be stored in Master Patient Index and program information will be kept on M&E data base. Data management protocols are necessary to control decentralised service delivery.</p>
<p>L e g i s I a t i v</p>	<p>The Health Act, 2004 shapes the future of the South African health system. The Health Act reaffirms the goals the 1997 White Paper for Transformation of the Health System in South Africa identified. Decentralised health care between the private and public sector professionals and providers are emphasised. Since 2001, numerous new judgments were passed from the Constitutional court that had a significant influence on HIV/Aids (Barrett-Grant, Fine et al. 2003:v, 93). These new judgments were in accordance with the international law and the United Nations Resolution, No. 1995/44, passed by the Commission on Human Rights calling for states to ensure that practices, policies and laws respect human rights standards. South Africa follows an integrationist approach in which informed consent and confidentially providing for dignity through antidiscriminatory treatment are the main objectives (Panda et al. 2002:167). Three judgments supported their action in supporting the guidelines set out in the International Law:</p> <ul style="list-style-type: none"> ○ <i>Grootboom</i>: The Constitutional Court stated that government must have clear plans to realise the socioeconomic rights. Plans must be reasonable and must meet the needs of the most vulnerable and at risk. Improving the quality of care was enforced through a Patients

<p>e</p>	<p>Rights Charter launched in 1999 and in 2001 a National Policy on Quality was brought forward to co-ordinate provincial policies with a PHCS. Through an audit of the hospital infrastructure in 1996, it was found that one third of hospitals needed upgrading. The revitalisation of hospital infrastructure started of with strategic position statements that were converted into the Integrated Health Planning Framework (IHPF). This provided a planning tool to determine the shape and size of the health system. PPPs are seen as a method to invest in infrastructure and health care provision (Barrett-Grant et al., 2003:iii, 77).</p> <ul style="list-style-type: none">○ <i>TAC and the Ministry of Health</i>: Dispute over extent of government's responsibility in prevention programmes using Nevirapine (Barrett-Grant et al., 2003:iii).○ <i>The Jordan and Others v S and Others</i>: Criminalisation of prostitution was a violation of the constitutional right to equality and discriminated unfairly against women. (Barrett-Grant et al., 2003:iv). <p>The right to health forms the core issue on which all decision-making is based in international and national law. South Africa amended its Medicines and Related Substance Act of 1965 and replaced it with the Medicines and Related Substance Act of 2002. The WTO rules, (TRIPS), revolved around the application of the South African law. The US was demanding a TRIPS-plus; a level of accomplishment higher than the standard set by the WTO. The revision of Guideline 6 of the <i>International Guidelines on HIV/Aids</i> and Human Rights, 2002 recommended that governments have a duty to ensure that all people have access to health services essential for treatment of HIV/Aids. People have a right to access to “antiretroviral and safe and effective medicines” (Barrett-Grant et al., 2003:v,106) This ruling has a significant impact on budgeting decisions of government. Although international laws are recommendations they are important aspects in national legislation and jurisprudence. The private sector has specific regulations and compulsory registration of health care institutions and agencies is required. Specific legislation for HIV/Aids has been adopted in the work environment.</p> <p>The PPP Unit has been set up to regulate and oversee the regulatory framework in terms of national and provincial government institutions in how they established and enter into PPP agreements. The central legislation that governs PPP is set out in Treasury Regulation 16 issued to the PFMA, 1999. Each national and provincial department established its own PPP directive that is responsible to co-ordinate with the PPP unit and formulate projects that comply with the departmental strategies effectively are determined by the MTBPS and MTFPF. Local government and PPP agreements are governed through the Municipal Systems Act, 2000 and the MFMA, 2003. The municipalities are not subject to the</p>
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	PFMA or Treasury Regulation 16.
E n v i r o n m e n t a l	<p>Southern Africa is a land of enormous contradictions. It leads the continent as being the wealthiest per capita, most urbanised population, the greatest industrial base and the leading agricultural output. It has an abundance of natural resources and mineral deposits, natural gas, petroleum, boasts of vast transportation networks and communication networks. It has the highest HIV/Aids infection rates in Africa and is home to the world's fifteen poorest countries. South Africa, Namibia and Botswana are the strongest countries in this region. South Africa's economic development, its leadership and its hegemony all combine to give it a leading profile in the region. South Africa is a founder member of NEPAD and the African Union (AU). Through NEPAD health care commitments are met through sustainable development, sectoral priorities such as improved infrastructure and the mobilisation of resources in Africa. Its main goal is to eradicate poverty by meeting the MDG. NEPAD recognizes the interconnectedness between health and development, but does not recognise health as a basic human right or as an outcome of equitable development. HIV/Aids is inadequately dealt with as the country is unable to provide the most basic health needs. It encourages other countries to give higher priority to health in their budgets and increase health spending (Sanders & Meeus, 2002:1-2; Attorneys, 2005).</p> <p>The World Bank initiated partnerships between public-private health sectors as the way forward as it is believed that the private sector is able to provide better technical efficiency. South Africa is one of the six countries that form part of the global HIV/Aids epicentre for the epidemic in the southern Africa region. The health care system is reeling under the impact of the epidemic (Bauer & Taylor, 2005:248). South Africa experienced impoverishment and disenfranchisement, rapid urbanisation, labour migration, widespread population movements and displacements and social disruption. The virus is transmitted almost exclusively through heterosexual intercourse and a higher level of sex outside marriage which resulted in high level of STDs. These variables are grounded in individual behaviour and cultural norms. NGOs such as the TAC took the lead in challenging multinational pharmaceutical companies in South Africa to produce ARV drugs that sought to prevent the production of cheaper and affordable drugs. They have also forced government to supply ART to those in need of it. The migrant labour system involves internal migration of men from rural areas to mines and other places of employment. Influx controls were lifted which led to huge numbers of people from rural areas seeking better opportunities in urban areas. The migrant labour system contributes to a vicious cycle of poverty and facilitates the spread of HIV/Aids (Bauer & Taylor, 2005:292). The SADEC Draft Protocol on Free Movement of persons in southern Africa contains the most radical and visionary model of future regional migration regime in southern Africa. Legal contract migration to mines and farms in South Africa were drawn from Botswana, Mozambique, Swaziland and Lesotho (Crush, 2003). The majority of</p>

undocumented migration comes from Malawi, Zimbabwe, Mozambique and Lesotho. An increase in undocumented migration has taken place from the rest of Africa, Europe, North America, Asia and the Indian subcontinent. Since 1990, South Africa has become a new destination for refugees from the rest of Africa (Crush, 2003) . The Mozambicans form 25% of the mining labour force.

Southern Africa region:

There are three principal organisations that represent different levels of economic integration in the southern Africa region: the Southern African Customs Union (SACU), the Common Market for Eastern and Southern Africa (COMESA) and the Southern African Development Community (SADC). South Africa has the most sophisticated manufacturing in sub-Saharan Africa (SSA), the best infrastructure, a highly developed mining industry and advanced agricultural sector. Its GDP is four times that of the other thirteen SADC countries combined. The SADC's principal function is an economic body but it is also involved in security issues in the region. It plays a pivotal role in the developmental of Africa.

The AU is established to foster continental unity and development. The launching of the Economic, Social and Cultural Council of African Union (ECOSOCC) is devoted to building partnerships between government and all segments of society. The organising principle of ECOSOCC is one of civil society (National NGO and CBO networks). NEPAD is the result of two competing visions for Africa: Millennium Africa Plan (MAP) articulated by South Africa and the Omega Plan advocated by Senegalese President A. Wade. MAP and NEPAD promote the African Renaissance (Venter & Neuland, 2005:7). NEPAD is intended to force international partnerships with the global north and on the continent. NEPAD rejects withdrawal from the world system and seeks greater integration into the global economy, embracing neo-liberal paradigms. It relies completely for its funding on donor organisations (Venter & Neuland, 2005:234). NEPADs African Peer Review Mechanism (APRM) materialised in 2003 (Bauer & Taylor, 2005:339). Participation in APRM is voluntary. South Africa is currently participating in the APR process.

Source: Adapted from ANC (1994); ABSA (1999); Nel (1999); Van der Walt and Du Toit (1999:13); Arnt and Lewis (2000:856-857); McCoy, Buch, Palmer (2000:1-6); Coetzee, Graaff, Hendricks, Wood (2001); Ketchem (2001:7); Moorman (2001:83); Levy and Tapscott (2001); Ketchum (2001); Landsberg (2002); Sanders and Meeus (2002:1-4); Siplon (2002:120); Panda, Chatterjee, Abdul-Quader (2002:167); Van der Walt, Van Niekerk, Doyle, Knipe, Du Toit (2002:7); Barret-Grant, Fine, Heywood, Strode (2003:iii-v, 77,

93, 106); Bell, Devrajan, Gersbach (2003); Crush (2003); Laterveer, Niessen, Yazbeck (2003:138-145); Wettenhall (2003:77); Guthrie and Hickey (2004:102); Low-Beer and Stoneburner (2004:5); Ministry of Finance (2004); Natrass (2004b:87-108); Unit (2004; Attorneys (2005); Bauer and Taylor (2005:248, 292, 339-340); IHDC (2005); Pillay (2005), Venter and Neuland (2005:7, 234).

Distilling the key issues from Table 6.1 offered insight into those factors in the remote external environment that influenced health care reforms and impacted on the strategies for HIV/Aids. Political ideologies and values are directly relevant to the actual practices that influence and shape political, economical and social policy-making strategies and the interventions selected. Likewise, politics and administration are inseparably linked to the outcomes of service delivery and the type of funding structures government utilises to support its intervention strategies towards health care reform as effectively, economically, equitably and efficiently as possible.

HIV/Aids proves to have a major impact on the government budget and its revenue structures. Balancing the economic efficiency and social justice determines how effective the state is in providing services contributing for the well-being of its citizens. Health and well-being improves productivity which becomes the key element in growth (economic efficiency) and which is central to welfare economics. A discussion follows in which the key issues that have the greatest impact on decision-making in the policy environment for Case Study 5 are highlighted:

6.3.1.1 Political factors

The British Westminster model with its doctrine of ministerial responsibility was firmly entrenched in South Africa by 1910. Policies adopted by each government since 1910 shaped the South African society and gave the background to the negotiations preceding the Interim Constitution of the Republic of South Africa, 1993. In a government of national unity, westernised norms and standards were replaced with policies that focused on the majority, indigenous and underdeveloped. The Constitution of the Republic of South Africa, 1996 introduced the concept of a social welfare state. The principles included a development-orientated approach to service delivery through grass-roots participation in the policy-making process. A system of co-operative government provided for a decentralised approach set out in section 40 which provided for a national, provincial and local sphere of government that is distinctive, interdependent and interrelated. The principles of intergovernmental relations are specified in section 41 of the Constitution. Health is identified as a concurrent function under Schedule 4A and indicates that the social and non-social functions can be performed in national and provincial spheres of government to improve the quality of life. The regulatory framework for PPP is based on section 217 (1) of the Constitution of the

Republic of South Africa, 1996 which emphasises the role of the accounting authority in all three spheres of government or any other institution identified within the national legislation and their responsibility. The regulatory framework emphasises effective and efficient use of fiscal resources in the public interest as well as the process of procurement which must be fair, equitable, transparent, competitive and cost-effective.

The main focus of state intervention is based on strengthening policy capacity and administrative structures to improve service delivery. The government is seen as an enabler through market-based strategies, as it facilitates developmentally orientated approaches and regulates growth and efficiency as a prerequisite for applying social justice through horizontal equity. To achieve these outcomes government structures had to move towards more flexible, faster and more responsive methods that advance community needs and had to become more customer-focused. PPP became an important part of the development strategies as it linked fiscal policy objectives to support growth, equity and price stability. The bottom-up approach to organisational planning promoted financial co-ordination which laid down measurable objectives and outputs. PPP integrated the operational budgeting process with the strategic intent and included actions that build human and financial resource commitments for strategic initiatives in their planning.

Initially the Reconstruction and Development Programme (1994) encouraged an upwards social mobility whereby state capacity was built through partnerships to meet the basic needs of society and develop human resources by building the economy and democratising the state and society through participation. The government avoided Structural Adjustment Programmes (SAP) prescribed by the IMF and World Bank and focused on Growth Employment and Redistribution (Gear) as this was premised on investment in becoming the driving force for growth by focussing on macroeconomic stability, curbing inflation and cutting the budget deficit. The Accelerated and Shared Growth Initiative for South Africa (AsgiSA) took over from Gear early in 2006. The emphasis in AsgiSA is placed on targeting the microeconomic reforms, focussing mainly on skills development and infrastructure development. At the core of the capacity-building initiatives lay BEE, articulated in the Strategy for Broad-based Black Economic Empowerment Act, 2003 which is interwoven in the Finance and Health Charters. Local

Economic Development (LED) strengthened the principle of community-based development while electoral processes aligned national and local initiatives.

International relations and partnerships are important drivers for economic growth and regional development. Case Study 5 is part of the Indian Ocean Rim (IOR-ARC) for Regional Co-operation, the southern African region in which COMESA, SACU and SADC are the principal organisations driving economic integration in the region and the EU and UN organisations (Breton-Wood agencies). Through its membership in the AU the government fosters continental unity and development in its support of ECOSOCC, NEPAD and APRM.

6.3.1.2 Economic factors

Market outcomes and the role government plays in stimulating the economic environment are determined by the Constitution of the Republic of South Africa, 1996. A neo-liberal approach supports market-driven policies on trade, investment, employment and government spending. Growth and sustainability is achieved through increased investment in the National Health System (NHS) by strengthening the NHS through cost containment and the provision of equitable services. These outcomes are supported in the market-based strategies for PPPs that offered value for money, affordability and transferred risk to the private sector. During June 2003, the Growth and Development Summit Agreement strengthened the call for partnerships between government (public) and business (private) and civil society (NGOs). It became an integral part of the government's performance improvement strategy. The medium-term budget policy strategy (MTBPS) set out the government's major policy proposals and provides a framework for strategic intent. The strategy forms the basis for the national medium-term expenditure estimate (NMTEE) in that it supports the operational plans. The medium-term fiscal policy framework (MTFPF) focuses on realising the external opportunities and preventing threats through sound financial management of strategies and risks while the Medium Term Expenditure Framework (MTEF) forms the basis for a three-year budget cycle of spending on the national and provincial spheres of government. The PFMA, 1999 regulates financial management practices within the national and provincial spheres of government. Additional to the PFMA 1999, the intergovernmental relations between each sphere is spelled out in the Intergovernmental Fiscal Relations Act, 1997 which co-ordinates fiscal and budgetary matters. The Division of Revenue Act (DORA)

provides input and resources for the short-term activities set out in programmes and sub-programmes through the Appropriation Act approved in Parliament.

Case Study 5 is classified as a middle-income country, a dual economy with a sophisticated industrial economy that developed alongside an underdeveloped informal economy. The government's fiscal policy shifted its focus towards greater capital investment and skill intensity in order to provide more sustainable growth in medium- and short-term strategies. Unfortunately, the government faced fiscal exposure through increased HIV/Aids interventions and welfare support as it indirectly affected saving rates by increased spending shift that were created for health care, as well as increased demands made on social spending. No clear policy on Aids-related grants exists. Cost associated with care dependency grants increased and health expenditure grew towards 8.7% of GDP. HIV/Aids has moved from a health issue to a development issue with social, political and economic dimensions.

Poverty and Growth Programs (PGP) build on the capacity of middle income countries and implement effective poverty-reduction strategies. However, increased spending on health issues reduced spending on education which led to increased poverty levels as well as reduced skills accumulation changing the labour force growth rates. Through the implementation of PPP the opportunity was offered to introduce large investments from the private sector into the public sector and clear backlogs in infrastructure and service delivery. The socioeconomic arrangement and impact of HIV/Aids on employment showed a strong relationship among poverty, ill health and poverty-related illnesses. The impacts were more severe on the unemployed and unskilled labour category and the youth. The socioeconomic impact on the youth thus has serious negative effects for future economic growth and allocation policies.

6.3.1.3 Social factors

The government took a developmental approach to social and health care reforms. Partnerships form the core of relationships and are an important aspect of creating a co-operative environment between public, private and NGO sectors. The Health Act, 2004 and Draft Health Charter support the White Paper for the Transformation of the Health System in South Africa (1997). All activities in the NHS are aligned with the Health Act, 2004 and the Public Service Regulations (2001) to form a comprehensive health care

program. However, mixed approaches are taken to HIV/Aids strategies. Interest groups still see HIV/Aids as a separate issue from health care with separate budgets and strategies. The national and provincial departments of health apply HIV/Aids as a separate entity of health with separate budgets which are not integrated in the NHCS. The MTBPS does see HIV/Aids as an integral part of development planning. PHC is seen as the main vehicle to deliver services regarding HIV/Aids and PPP becomes a mechanism to improve efficiency, customer service and revenue.

The growth of health markets and the growth in the private sector profits and shareholding impacted negatively on the net outcomes of the public sector. Increased inequities between public and private sectors developed. Resources moved towards private and expensive curative care with fewer resources available for PHC. Human resources moved from public to private sectors. PPPs were mainly interested in providing services where profits were to be made. Response to HIV/Aids was limited before 1994. Activity increased from 1999, and in 2000 a top-down approach in combination with vertical programmes was applied. HIV/Aids was placed on the national agenda and became part of the budget process. The Department of Health launched the HIV/Aids/STI Strategic Plan for South Africa, 2000-2005. The government initially approached HIV/Aids and TB as separate issues in health care through its “Enhanced response to HIV/Aids and TB in the Health Sector” (2001). More emphasis was placed on a co-ordinated response to deal with community home-based care, counselling and prevention through awareness campaigns in a National Integrated Plan (NIP) which served as an intersectoral government plan responding to HIV/Aids to be delivered jointly by health, education and DSD. Funding is organised in three streams:

- The first stream is nationally financed and implemented.
- Secondly, it occurs through conditional grants for provinces for specific interventions.
- Thirdly, provincial interventions are funded through the equitable share (DORA) and are intended to strengthen health care services.

Strengthening of partnerships with major sectors encouraged a bottom-up approach. Inequities of infrastructure and services in rural areas increased HIV/Aids-related problems and costs which forced the government to gradually shift its approach away from a system that is driven by national targets towards an integrated and intertwined

approach of HIV/Aids in the NHS. The introduction of the Health Act, 2004 and Draft Health Charter changed the previous approach to HIV/Aids strategies. The shift is supported in the MTBPS (2005) and the Health Act, 2004 in which the emphasis is on strengthening of the NHS through improved quality services, more emphasis on PHC, emphasis on outcomes-based approaches and demand-side factors in service delivery, the expanded role of PPPs and PPIs in health service improvement and increased investment in information technology.

6.3.1.4 Technological factors

Greater investment in information technology is crucial. Telemedicine and Information Technology Communities (ITC) brought a paradigm shift as health care is brought to the rural areas and the digital divide is reduced. Build-operate-transfer (BOT) scheme hospitals use well designed Information Technology (IT) Systems to manage patient data. The State Information and Technology Agency (SITA) developed an information system that is utilised in the NHS. Data management protocols are necessary to control the decentralised service delivery in health care.

6.3.1.5 Legislative factors

All programs in the NHS are based on “the right to health care” as determined by WHO regulations. International law influences policy decisions and legislation takes an integrationist approach as the right to health forms the core issue on which all decision-making is based and in which patients are central to the strategy in combating HIV/Aids. Informed consent and confidentiality providing dignity through antidiscriminatory treatment are the main objectives of treatment. Issues pertaining to HIV/Aids are dealt with through the Health Act, 2004. A regulatory framework for PPP procurement is provided through Regulation 16 of 2002 issued in terms of the PFMA (1999) which requires that all PPP projects in the national and provincial spheres must obtain approval from the National Treasury.

6.3.1.6 HIV/Aids environmental factors

Within the HIV/Aids environment, the Treatment Action Campaign (TAC) and pharmaceutical companies are powerful stakeholders. As interest groups they have become powerful lobbyists in policy agendas for HIV/Aids. However, conflict of interest between the private and public health sectors impacts on equities, cost structures and accessibility of services. The private sector strongly supports expensive curative care

(medical model) while public health sectors moved towards palliative care (social model) and support mechanisms that underline prevention in order that the government can provide affordable care to the masses. Sustainable development strategies are framed within 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 sees poverty eradication as a major component in dealing with HIV/Aids issues. This is supported by NEPAD who recognises the interconnectedness between health and development. PPP becomes a mechanism in which capital investments by the private sector in infrastructure and human capital provide the opportunity to build state capacity which affects service delivery outcomes and as such becomes an instrument towards achieving sustainable development.

Overstretched budgets especially in health spending are unable to cope with the demands of societies in rural areas. Lack of adequate skills and inequalities in infrastructure in the public sector increased the pressures on government as 80 - 85% of its customers are unable to pay for services they receive. Added to this, South Africa draws heavily on migrant labour within its economy. The migrant labour system involves internal migration from mines and other places of employment. South Africa is one of six countries that form the global HIV/Aids epicentre in southern Africa. Swaziland, Botswana and Lesotho have the highest HIV/Aids. Labour is drawn from Botswana, Mozambique, Swaziland and Lesotho while the highest migration comes from Malawi, Zimbabwe, Mozambique and Lesotho. Against this background, the situation is exacerbated by a brain drain from developing countries to developed countries. Health care delivery is affected by medical staff moving from public to private sectors and from private to other developed countries (UK and US).

6.3.2 Internal task environment

A situational analysis questioned the extent to which strategies have impacted on the task environment in Case Study 5 and set out to identify those factors that affected the roll-out plan for HIV/Aids policies. This was done by applying a theory of constraint (TOC), interviewing stakeholders (Annexure C), and testing the assumptions that frame preset ideas and notions. By applying a SWOT analysis gaps are identified within the system. The SWOT analysis frames the gaps that exist between outcomes in service delivery and strategic intent and determines its impact on the formation of partnership

agreements. The situational analysis took into consideration how the various policy implications were influenced by:

- The medium-term budget policy statement (MTBPS).
- The medium-term fiscal policy framework (MTFPF).
- The medium-term expenditure framework (MTEF) affected government's approach to service delivery and its strategic intent for health care.
- The Public Finance and Management Act (Act 1 of 1999), Division of Revenue Act (DORA) and the Intergovernmental Fiscal Relations Act, 1997 (Act 97 of 1997).
- Equitable share and conditional grants.

This meant that the researcher had to establish how the macro, sectoral and micro goals of fiscal policy shaped decision-making within the government's macroeconomic and microeconomic objectives and strategies towards strengthening the National Health Care System (NHCS). Secondly, the analysis scrutinised the Health Act 2004, in order to determine the main constraints that prevented the government from achieving the desired objectives in utilising its available resources as efficient, effective, economic and equitable as possible. Thirdly, as the study unfolded it became evident that conflicting ideologies between the health care sector and the National Treasury especially in the PPP environment, impacted on strategies and the type of interventions selected to strengthen the NHS.

6.3.2.1 Health care reforms

The health care reforms centred on strengthening and building a comprehensive NHS through improved quality in service delivery. PHC and DHC were utilised as the means by which provincial departments funded the implementation of health to improve the quality of service delivery. Health care reforms further supported effective government and management structures that led to increased human capital investment and empowerment (BEE) and by providing affordable and equitable services.

The MTBPS of 2005 did not separate HIV/Aids issues from the health care reform strategies but dealt with HIV/Aids as an integral part of the growth and development plans. The MTBPS proposes an "Operational Plan for Comprehensive HIV and Aids Care" implementing two key programmes in HIV/Aids. These key programmes are based

on a comprehensive Primary Health Care (PHC) plan and an Antiretroviral Treatment (ART) plan which encourages partnerships with pharmaceutical companies and partnerships with NGOs. The partnerships with NGOs mostly focus on education, home-based care and Voluntary Counselling and Testing (VCT). The funding mechanisms for these interventions are based in conditional grants and equitable share budgets for provinces. The departments of health and education continued their funding strategies under the conditional grant system while the department of social development falls under equitable share of the provincial budget (DORA).

Applying the PPP in the NHS became an important aspect of creating a co-operative environment between the public, private and NGO sectors in that it should benefit the health system as a whole as well as foster a developmental state that focuses on the strategic priorities providing for a comprehensive and holistic NHS. The high costs involved in PPP procurement for health infrastructure and its poor success rate due to an absence of high-level skills necessary to understand PPP as a procurement tool, created a resistance in utilising PPP as a procurement tool in the health care environments. This resistance grew stronger amidst arguments describing the PPP process as time-consuming and not always an effective mechanism for service delivery (Muller, 2005). The fragmented accounting systems in health, poorly constructed PSC tools and Department of Public Works (DPW's) traditional role in maintaining and providing health infrastructure complicated costing mechanisms. Questions in the health sector centred on how much value for money and efficiency was achieved through the utilisation of a PPP model (BOT scheme). During an interview, Muller (2005) pointed out that Inkosi Albert Luthuli hospital in KwaZuluNatal is an example of: "... a nice hospital but the jury is still out on exactly how much it cost us and could we have reduced or created a similar facility at less of a cost. The general consensus at the present moment is that the department could have done better."

The complexities associated with PPP in health care interventions for service delivery were increased by assumptions and asymmetric information. This made CBA ineffective tools due to asymmetric information provided by the medical profession and the array of assumptions that frame health care and the HIV/Aids environment. Fragmented accounting in the health care system increased complexities around transparency and weakened the functions of the state. Blurred boundaries between health, the Health Act

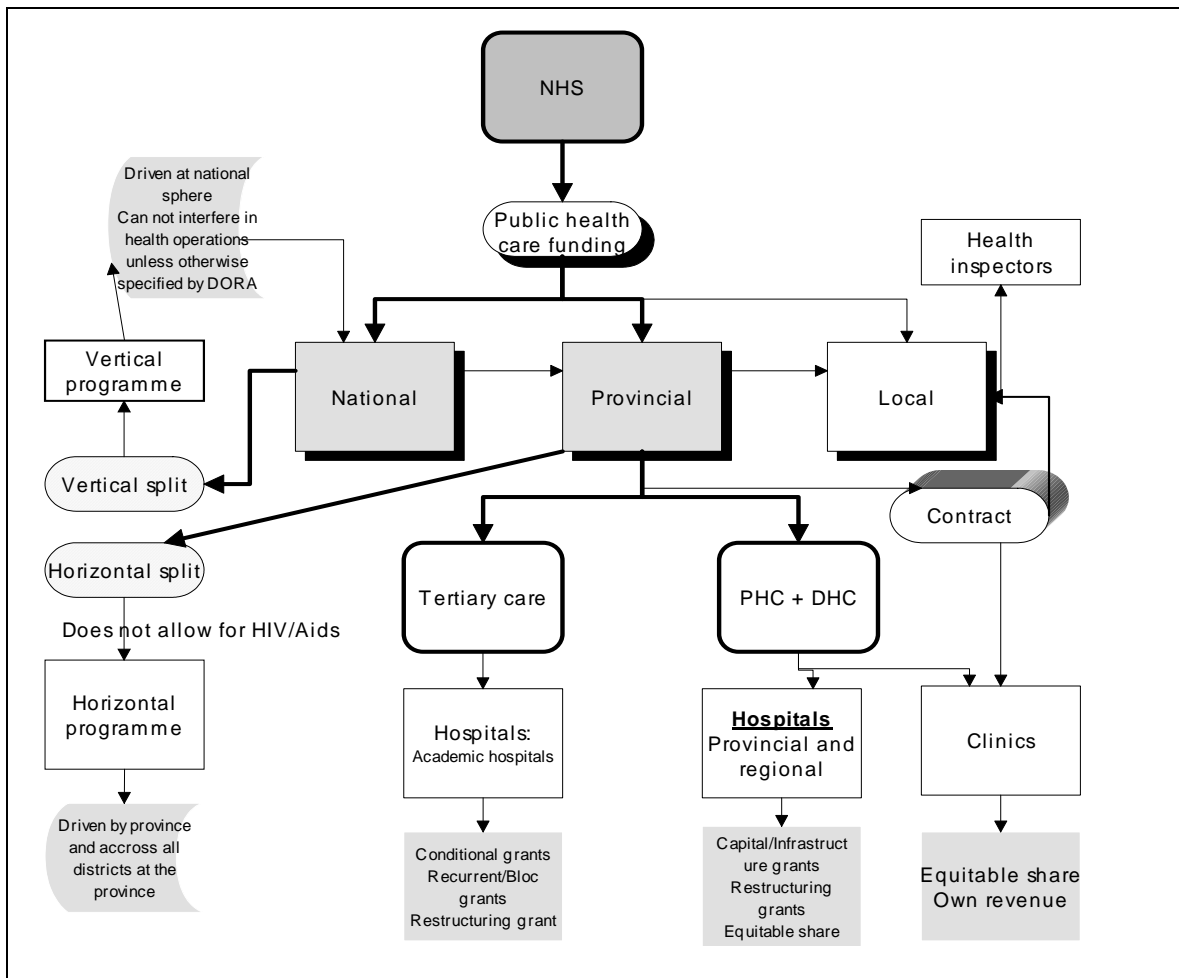
2004 and the PPP Unit (PFMA, 1999 and Treasury Regulation 16) strengthened the difference in focus and definition. The difference in focus placed an increased strain on intersectoral relations which are critical elements in the successful roll-out of PPP projects as this impacts on the successful alignment of strategic intent and operational strategies between the Department of Health and the National Treasury. Added to this scenario, blurred boundaries between PHC and DHC and PPP procurement and legislation complicated the identification of responsibilities and how accounting structures were designed to enhance effective service outcomes. The difference in strategic and operational focus between the Department of Health and the PPP Unit resulted in the development of PPIs that widened the gap between the PPP generic structure and the needs of health care and PPIs (Muller, 2005). The supply- and demand functions were perceived as ineffective as PPPs were unable to meet the needs of the health care sector as a whole in an effective and affordable manner through financing and provision of services and goods.

The Health Act, 2004 brought significant changes to future health care interventions. Devising output specifications, payment mechanisms and the monitoring of clinical services over and above everything that goes with maintenance operation of the health demanded new approaches and increased the complexities. Primary Health Care (PHC) provision is the responsibility of the provincial departments of health who must fund the implementation of all the health services. However, no consistent approach to service delivery exists between different provinces and different districts. The provincial department of health is responsible and accountable for ensuring that the district health system (DHS) works effectively (Muller, 2005). Clinics were shifted under the control of the Provinces (defined under the Health Act, 2004 and the Municipal Structures Act, 1998). Municipalities' categorised within Category A can still maintain clinics but must fund these from their own revenue basis. Provinces can also contract a local municipality to provide the services at a clinic, but at present there are no standardised rules or regulations (Muller, 2005). None of the municipalities' considered health care as their responsibility. With the implementation of the Health Act 2004, changes were introduced in the NHS which transformed the function and role of government in each sphere and impacted on financial structures. This influenced choices and the type of PPP or PPIs selected. The Health Act, 2004 redefines the role of the municipal health service (MHS) towards:

- Water quality monitoring, food control, waste management, health surveillance of premises, surveillance and prevention of communicable diseases.
- Restricting municipalities to the responsibility for the provision of environmental health services as opposed to a comprehensive PHCS.

The provincial government became the main implementer of the Health Act, 2004 which required the devolution of the environmental health functions that were currently rendered by provincial health departments to district and metropolitan municipalities (Ijumba & Barron, 2005:47). This change in definition impacted on funding mechanisms for CHBCS resulting in the phasing out of conditional grants within social development which moved towards equitable share mechanism of provinces (Ndlovu, 2005:1). While education and health sectors continued to receive conditional grant funds for HIV/Aids interventions, social development in provinces now allocated resources from the equitable share and own budgets.

Figure 6.1: NHS and funding mechanisms



Source: Own interpretation (2005).

Although significant problems were experienced since the conditional grants were introduced in 1998/1999, the Department of Health still prefers to utilise grants as its main source to finance projects in health care even though the Health Act, 2004 promotes partnerships as a means to strengthen the NHS. The conditional grants extend the effect of capacity-building and structural adjustments as well as clear backlogs and regional disparities in the economic and social infrastructure. The health sector made extensive use of the conditional grants to fund hospital revitalisation programmes as well as HIV/Aids programmes.

The Health Act, 2004 states that it aims to promote co-operation and shared responsibility amongst the public and private sectors within a context of national, provincial and district health plans (Ijumba & Barrow, 2005:47). Core instruments in this

process are the certificate of need (CoN) as it does not only achieve a more equal distribution of service delivery but also a more balanced approach to the skewed supply- and demand functions. This is seen as the most appropriate mechanism to reduce the wide disparity in health financing between the public and private sectors. Additionally, finding a balance between the relative size of the public and private health sectors within a mixed economy steered by its demand- and supply functions formed the pivotal point in accountability, responsiveness and finding fiscal responsible mechanisms in health care service delivery (Fourie & Schoeman, 2005:32). The task of securing and providing enough resources to cope with the demands made on health care is extremely difficult as health care is entangled in ideologies and personal values which are in synergy with social conditions and often depend in part on developments well outside the health sector. These emotional polemics are further tied to aspects of distributive justice and procedural justice and relates to each person's perception of distributive fairness or social justice.

The growing complexities surrounding relationships in service delivery moved the Department of Health to go beyond the relationships of financing and provision. The legislative framework for PPPs provides for a specific application and definition of the PPP model in the national, provincial and local sphere in South Africa. The South African generic PPP model prescribed by the PPP unit at the National Treasury was too rigid when applied in the health care sector mainly because the PPP model was not applicable in all circumstances and often did more harm than good.

Parallel to PPPs, in 2000, the Department of Health developed a policy document Public-Private Interactions (PPIs) which focused on creating improved relationships between the public-private sectors by improving its service delivery outcomes within the clinical field (Wadee, Gilson, Blaauw, Erasmus & Mills, 2004:14). PPIs formed an umbrella that pertained directly to various categories of actual health service and its method of delivery. In this scenario, PPP became one of the key categories within a variety of partnerships to be used in PPIs, namely:

- Purchased services.
- Outsourced non-clinical services.
- Joint ventures.
- Public finance initiatives (PFIs).

- Public-private partnerships (PPPs).
- Tax relief and asset swap (Wadee et al. 2004:24).

Different views of what constitutes a PPP developed. Pillay (2005) states: "... I want to have a point of clarification. PPP by its very nature cannot be a joint venture or outsourcing. The definition of a *PPP* is, we give a long-term concession to the private sector to provide infrastructure or services on behalf of government".

Although a massive input with regard to PPP occurred in the health care environment in general it was not utilised within the HIV/Aids environment (Pillay, 2005). Also, no PPP was found that dealt specifically with HIV/Aids except the pharmaceutical supply chain management (SCMC part of PEPFAR) contract which was awarded to the John Snow Inc. in November 2005. It was deduced from the interviews that the difference in service delivery outcomes between the public health sector and the private health care markets led to increased disparities between health care interventions. The government is working towards a social health care plan to reduce the effects of the disparities (Pillay, 2005). PPPs are advocated by the PPP unit as a means to make health care more affordable, while Department of Health sees PPP as a mechanism that increases the costs of health care adding to the burden of inflationary behaviour (Muller, 2005). The World Bank emphasises inefficiency, little autonomy and little discretionary funding to meet local health needs in the public health sector as contributing factors towards the disparities in service delivery (Picazo, 2005). They are concerned about utilising PPP as a means to increase the government's budget and in that way to try and improve services as this shifts the responsibility of solving problems to the private sector. The increased demands on goods and services have a big influence on costs in health care.

The private sector tends to be inflationary because it is supply-driven, prefers high-technology products and services and emphasises quality which means that it is supposed to be more efficient. Profits are the driving force in the private health care market which means that PPPs are only seen where profits are to be made (Muller, 2005). Providing health care in areas where high levels of poverty are experienced means that the public sector is the sole provider of health care and the focus shifts to demand-driven services. Mixed views on the efficiency and effectiveness of health care in the rural areas were given. It was perceived that in some communities the clinics are

more effective than in others (Pienaar, Venter & Maluleka, 2005). Accessibility of clinics therefore depends on community involvement. The main problems of accessibility were based on poor quality of services which included not operating at specified times (functional services) and overworked staff (technical services).

6.3.2.2 PPP and value-creating strategies

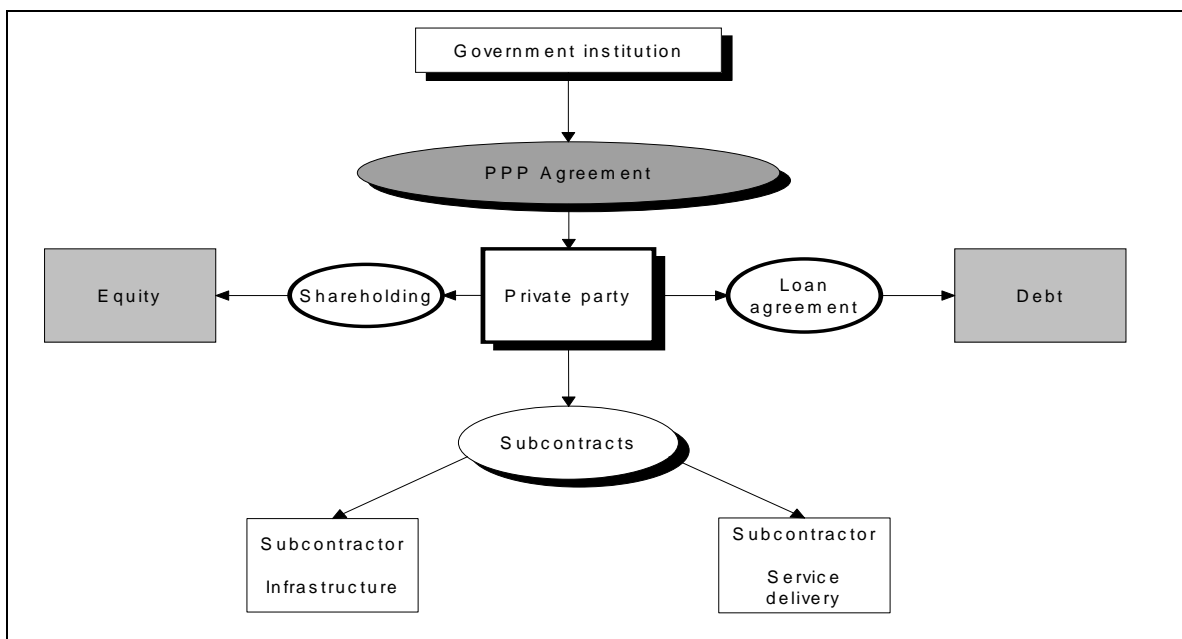
The National Treasury supported a value-for-money approach towards service delivery that offered affordability and risk transfer to the private sector to form the main criteria for decision-making. The PPP regulatory framework is based on the Constitution of the Republic of South Africa, 1996 (section 217 (1)). PPPs are supported by co-operative government and decentralised structures described in section 40(1) (2), and section 41 of the Constitution of the Republic of South Africa, 1996. The competitive and cost effective structures are provided for in the procurement, transparent and accountable structures, section 41(c) and supported in a development-orientated approach described in section 195 (c) of the Constitution of the Republic of South Africa, 1996.

The generic project finance model for a national PPP defined in Regulation 16 of the PFMA, 1999 as regulated by the PPP unit for national and provincial projects and therefore applied within the health environment is presented in Figure 6.2. Figure 6.2 is developed according to a BOT scheme and allows the government to build state capacity through long-term financial objectives which are linked to improved infrastructure delivery such as private sector investment, direct lending or balance sheet financing. The projects implemented in terms of the PPP model generally use project finance to fund the capital investments for health care initiatives. BOT schemes offer improved and affordable service delivery through operations and maintenance programmes, improve allocation policies through the mitigation of risk and provides opportunities for equity (BEE) and empowerment. PPP is used to leverage huge capital investments (project finance) from the private sector and optimise private sector involvement and efficiencies towards improved infrastructure and service delivery outcomes.

Worldwide, build-operate-transfer (BOT) schemes are the preferred option for utilising and strengthening health care services (Picazo, 2005; cf. Pillay, 2005). This model used private contractors to construct the building in which they are simultaneously responsible

for service delivery. By combining the risk of construction together with service delivery, meant that overconstruction of infrastructure was reduced and value for money would be achieved. Joining these two risks meant that the constructor will build and refine the building in such a way that it is sustainable and suits the needs of the population it serves (Picazo, 2005). Private sector investment prefers to invest where profits are to be made and are therefore not interested in becoming involved in BOT schemes or other forms of PPP that are unsustainable in poor and economic underdeveloped areas (Muller, 2005).

Figure 6.2: Generic project finance structure for a national PPP



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

According to the generic PPP model a *public-private partnership* is defined as “...a contract between the public sector (institution) and private sector (private party) where the private party performs an institutional function and/or uses state property in accordance with output specifications. Although substantial transfer of financial, technical and operational risks to the private party occurs, the private party benefits through unitary payments by the institution and/or user fees. The institution retains a major role as main purchaser of the services or as main enabler of the project” (PPP Unit, 2004b:4).

The PPP procurement focuses more on infrastructure development and financing. Efficiencies and management objectives in the private sector are guided by strong profit motives in order to achieve value-for-money outcomes in which the private sector manages its risks towards keeping a competitive advantage. PPP in health is about procurement of health infrastructure and clinical service delivery.

Feasibility studies support a strict procurement process underlined by the PFMA, 1999 and Treasury Regulations for the delivery of health services within the provincial sphere. The feasibility study and CBA are key areas for determining if a PPP offers best options at lower costs in health care. The feasibility study identifies risks thereby implementing effective management strategies and control mechanisms. The standardised PPP provision issued by the National Treasury as a PPP practice note in terms of section 76 (4)(g) of the PFMA is a template for the transfer of risk. Feasibility studies (CBA) are time-consuming as the process can take 40 months. It is imperative that all risks/constraints associated with the potential contract are identified and categorised. The impact of the risks on the overall performance of the project and how it contributes towards increased uncertainties and assumptions must be mitigated. An important part of assessing value for money is based on the public sector comparator (PSC) model as this tests the market. Service delivery is the driving force and main goal when a PPP is utilised. Evaluating the social costs and benefits as part of the feasibility study and CBA are central parts of government's social development strategy and requires that links with the expanded works programme and BEE are shown before continuing with the process. If the risks identified in feasibility study are not managed or transferred to the private sector it leads to poorly constructed agreements and a high risk of failure. CBA plays a key role in determining if value for money is achieved and identifies where social benefits are provided in the application of PPP. It therefore requires highly skilled personnel to implement and manage the whole PPP project cycle efficiently. Negotiations with unions are critical as their views impact on the success, timeliness and how relationships and co-ordination structures are implemented.

6.3.3 SWOT analysis

Seven assumptions were identified in this study that framed problems within the field of HIV/Aids, health care reforms and PPP. Each of the assumptions directly influenced the perception of what the reality is. This meant that decision-making occurred in reaction to

the perceived problem. Testing and challenging each of the seven assumptions were necessary to seek out profound roots that prevented ongoing service and apply it as an effective tool in risk management. It was found that each assumption was perceived as a real truth within the HIV/Aids policy environment and this framed problem solving and decision-making around HIV/Aids, health care reforms and how PPP were implemented:

- HIV/Aids is seen as a medical and behavioural problem that can only be solved by medical treatments and by changing behavioural practices through abstinence, prevention and education. This view impacts on the type of interventions and strategies selected by policy-makers. Thoughts and decision-making on health care reforms, HIV/Aids and the utilisation of PPPs in health care are driven by medical professions and often tend to become one-sided.
- It is believed by some that antiretroviral drugs cure HIV/Aids and improves the quality of life and well-being of individuals. This approach sees HIV/Aids as a medical problem only and does not see it as an integral part of growth and development strategies.
- By improving health care services and strengthening systems and administrative structures, the responsiveness to HIV/Aids is improved. This is supported in the HIV/Aids/STI Strategic Plan for South Africa, 2000-2005 and the Strategic Priorities for the National Health System 2004-2009.
- PPP is a win-win situation in its application for the Department of Health in the case of multi-stakeholder interactions. The MTBPS encourages the utilisation of partnerships as a mechanism towards multistakeholder interaction and innovative funding mechanisms.
- Interactions between business partners (PPP) should be conducted as a “partnership” based on trust and mutual benefits. Agreements between business partners are constructed on trust and mutual benefits and tend to ignore the driving forces that shape the reasons for the business relationship.
- PPP as a policy paradigm in health care is the policy innovation of the new millennium. This argument forms the theoretical underpinnings for decision-making in the PFMA, 1999 but is contradicted by the actions and beliefs of the Department of Health.

In order to find the gaps between outcomes and the strategic intent, a SWOT analysis was conducted to determine:

- The external factors (macroeconomic) that identified opportunities and risks which influenced overall policy strategies proposed in the MTBPS, 2005 and MTFPF. This means the external factors identify those market success factors the government must implement in order to provide sustainable policy outcomes. It also identifies the requirements necessary to reduce risk taking (Republic of South Africa, 2005).
- The internal factors (microeconomic) and internal processes (strengths and weaknesses) that influenced approaches taken towards national funding mechanisms used in state intervention and health care reforms as prescribed in the National Health Act, 2004 and its subsequent impact on MTEF. The internal factors identify those distinctive competencies the government must implement in order to provide sustainable outcomes through its strategies and roll-out plans in service delivery.

An overview of the internal and external environments (Annexure H) identified those factors that influenced the government's ability to achieve its vision. Highlighting the internal strengths and weaknesses and identifying the external opportunities and threats in this analysis provided a clear identification of the strategic intent (market success factors plus risks) and the internal value-creation strategies (distinctive competencies) to be followed. Numerous environmental opportunities were available and strengthened government's competitive position within the global markets. Unfortunately, the findings presented in Annexure H weighed heavily towards critical internal weaknesses which had to be overcome if the the government wants to keep its position of power within the region and work towards gaining a competitive advantage within the international markets. This means that government supports a turnaround strategy which focuses on overcoming the internal weaknesses by building state capacity and strengthening existing structures. Building capacity and improved performance means the government can utilise the opportunities available to it and overcome some of the external threats. The importance and value of the application and impact of PPP in health care as a fiscal responsible mechanism are strengthened in the analysis as it becomes a core element in managing the whole public finance process towards achieving sustainability through value-creating strategies.

6.4 HIV/Aids interventions and strategies

Value-creating strategies must be reflected in the long-term strategies (building the NHS), medium term strategies (increasing customer value), short-term strategies (operational excellence) that support the external (opportunities and threats) and internal factors (strengths and weaknesses) which have an impact on sustainable service delivery outcomes.

6.4.1 Criteria for best practices

The ultimate objective in functional benchmarking involves the comparison between the international and national situation to identify the best practice and best value-for-money approaches in directing roll-out plans for HIV/Aids intervention strategies. By comparing the key issues between the international and national case studies, an attempt was made to isolate and identify where costs or outcomes are out of line. It determined the best practice and a particular activity according to experience, previous trends and perceptions that achieved sustainability and efficiency. It also proved useful in ascertaining whether the internal capabilities were strengths or weaknesses. This meant that a focus was placed on lowering costs to achieve value-for-money outcomes which were linked to excellence in performance and value creation in the long term.

6.4.1.1 Effectiveness: goal attainment in service delivery (Case Study 5)

Goal attainment in service excellence is measured against the achievement of “public good” (social justice and economic efficiency) and well-being within a framework of Constitutionalism and its definition of a social developmental state. Market forces set the tone for sustainable development. Public policy determines how the supply- and demand functions are put together (relative size of the public and private sectors) and how these sectors are intertwined with economic growth (allocation) and distribution of goods and services in health care. Public finance identifies the available revenues and determines efficient spending on public goods and services. It is the role of the government to manage intervention strategies in such a way that it complements and aligns policies between sectors and prevents monopolies from forming.

The improvement of quality of service delivery and cost reduction is ascertained when the PPP Unit performs its role as an enabler and regulator and provides facilitation and technical guidance in the achievement of goals. Transnational interaction is a

determining factor in policy and development initiatives and forms the core factor in the establishment of an effective state through the development of strong international relations and partnerships (UN, EU, NAFTA, APEC, ASEAN and AGOA) as well as an increased focus on forming regional relationships (SADC, SACU, COMESA, AU and NEPAD). Multinational and transnational corporations such as the pharmaceutical industry are powerful lobbyists and providers of goods. NGOs such as TAC, and INGO such as United States Agency for International Development (USAID), Oxfam and Global AIDS are important stakeholders in health services and strongly influence policy agendas of governments. UN organisations and EU play an important role in shaping policy decisions through international funding/aid.

The MDGs are interwoven in MTBPS, MTEF and DORA (budgeting process), Health Act 2004 and NEPAD. NEPAD identifies economic and political factors as most significant determinants of health. The economic and political factors determine who has control over the resources and who has decision-making powers. HIV/Aids is not separated from health but forms an integral part of health care and is therefore seen as a basic right rather than a commodity. PHC and DHC are instruments to meet community needs equitably in the bottom-up approach. The development thinking and utilisation of PPP are enforced through the strengthening of the NHS by means of infrastructure development and PPP (hospital and clinic revitalisation), human resource development, performance in contracting (PPI) and equity through procurement (BEE) as specified in the Draft Health Charter.

The PPP unit is an instrument that builds the government's policy capacity and implements effective and sustainable service delivery outcomes through procurement and partnership agreements. Forming vertical and horizontal networks between the state, society and the economy is a critical element in the successful execution of the agreements. More funding from the private sector (PPP) and minimal public finance for goods and services from the government resulted in a weakening of the state. Capacity-building and good governance structures support the government's drive towards effectiveness and efficiency in outcomes-based approaches. PPP is enforced in negative rights through justice (legislation) and is financed through private sector provision for public services in the form of loans, subsidies or grants and investments. PPPs are driven by a great deal of political influence with regard to desires and

outcomes. The electoral processes impact on political decision-making and funding decisions (raising and spending of public finance) within health care reforms. These processes determine citizen-state relationship and administrative systems and support structures, as well as the final decision on the type of PPP supported. Not sufficient emphasis is placed on outcomes-based approaches. This has a negative impact on growth and development as economic welfare results as it trickles down to all social groups. This happens because the social and health care systems do not operate in synergy with each other encouraging dependency which has negative impacts on health and well-being.

6.4.1.2 Efficiency: outcomes in health care

PPP modify market efficiency through forces of competition. It has a direct impact on productivity and employment which stabilises prices (inflation) and interest rates. Market competition is central to the process of procurement in PPP as this encompasses a framework of market accountability. Market accountability becomes the core issue in PPP design.

Competitive procurement processes are the preferred option in providing health services and goods. Competitive procurement encourages allocative efficiency and fiscal responsibility through the utilisation of PPPs. The distribution of resources is interwoven in the budgeting processes leading to better value-for-money approaches and allowing for the balancing of competitive tensions with cost-reductions as result. This is necessary to achieve programme effectiveness linked to feasibility studies and conditions specified in the bidding process. In this way, efficiency and increases on returns (ROI, NPV) will be determined. The effects of individual actions on the outcomes are determined through risk allocation, namely balancing technical, operational and financial risks. Strategic issues are based on substantial transfer of risk to the private sector which provides a large net gain for the public sector. The management and reduction of monopolies impact on revenue structures. Health services are a combination of rival (particular, quasi-collective and private) and non-rival (pure and impure public) services and goods. Decentralised fiscal structures support a framework in which local decision-making supports tax cost and finance structures. PPPs are developed in terms of local rather than centralised decisions, however, these decisions are regulated through the PPP unit (centralised agency). In procurement legislation, the emphasis is on the upgrading of

infrastructure through PPP because inadequate and run-down physical estate hampers the delivery of clinical services (PHC). PPP foster national prosperity through investment in physical and human capital (long- and short-term objectives) thereby encouraging the achievement of social goals (benefits). The importance accorded to private income enhances the negative effects of economic poverty. Value-for-money outcomes are provided in quality through PPP in its intrinsic value through social good (PPP impacts on accessibility, security and empowerment) and extrinsic value (PPP structures support a framework that draws on technical quality and human resources).

Performance standards and cost-benefit approaches are tied to performance agreements that specify an efficient supply of inputs and efficient spending mechanisms achieved through satisfactory negotiations between all stakeholders. New standards of accountability are directly tied to performance standards and a cost-benefit approach. These decisions are influenced by a shift towards horizontal and broader-based policy issues (HIV/Aids strategies) and show no respect for boundaries or do not fit neatly into areas of jurisdiction resulting in sectoral blurring.

6.4.1.3 Economy: cost containment and the strengthening of service delivery

Utilising PPP to contain costs and strengthen service delivery in all spheres of government moves government intervention strategies into an enabling, facilitating and regulatory role. The government as an enabler pursues equality of opportunity through modified markets within a mixed economy. PPP becomes a fiscal planning tool at macro level and forms an important part of the budgeting process. On the strategic and technical level, the decisions on who delivers the services is based on the directive of the ministry set out in strategy (MTBPS) while on the operational level, transfer payments must be budgeted for every year through DORA and over a three-year period through the MTEF. The government assists the private sector/economy to provide goods and services through subsidies or loan agreements and provides infrastructure through its own capital. Government option (DPW) is very complex when applied to the health sector. Huge capital investments are made over long periods by the private sector through concessions (15-25 years) in infrastructure. The BOT schemes are the preferred option in health and hospital revitalisation projects because it combines construction and service delivery and prevents overconstruction and underutilisation. Through the BOT schemes the government is able to transfer risk to the private sector and negotiate costs

with the contractor in such a way that it satisfies both stakeholders and provide sustainable flow of fiscal resources. The PPP unit is developing thresholds on when PPP is a viable option to pursue (Pillay, 2005).

The government as a facilitator and co-ordinator has to manage and manipulate internal markets with the production of social goods by contracting out public services to suppliers in health care through PPP and PPI. Benchmarks (PSC) form the basis of the feasibility study as it demonstrates affordability and value for money in risk-adjusted costing and provides estimations for particular interventions. However, the Standardised Public-Private Partnership Provision issued by the National Treasury is perceived as being too rigid and complicated and therefore prevents innovative approaches to be utilised through the construction of PPP in health. The importance of parallel monitoring and evaluation mechanisms increased as more and more PPP/PPI arrangements are put together. The PPP unit forms the intermediate in negotiations between government departments, private sector and NGOs. It plays an important co-ordinating role with unions and other stakeholders during the negotiation phase. BEE is applied in PPP and in line with the broader BEE policy. The BEE policy is also integrated in the Health and Finance Charters (Draft Document). No legislation is in place to deal with public sector transfers and benefits to the private sector, but if employees do not sustain or improve their work conditions the PPP unit prevents the deal from going through (Feasibility and CBA indicate social benefits).

Partnerships moved the government into a regulatory role where the PPP unit is the overseeing agency which provides technical support and guidance and enforces specific operational standards as set out in regulations and legislation. The PFMA determines the procurement and budgeting processes and presents guidelines for accountability structures. The PPP unit negotiates the basis upon which services are regulated and bound up in terms of agreements/contracts. Economic and social regulations force actors to undertake certain activities that benefit society. The PPP process enables value choices through the generic project life cycle that forms the basis for service delivery.

6.4.1.4 Equity: social justice

Market-based approaches within a mixed economy shifted the government towards outcomes-based expenditure measurable in value-for-money approaches which are tied to horizontal and vertical equity in the budgeting process. The optimal balance in the socially acceptable distribution of income is applied through redistribution of wealth (equity-based). This is achieved through wealth-creating initiatives where PPP demands a link with the expanded works programme (DPW), utilising employment programmes, subsidising low-paid jobs or retraining schemes and highlighting the social benefits in projects. Empowerment through BEE is integral to PPP negotiations. Political decisions and electoral processes affect policies on redistribution and the achievement of optimal taxation. Social justice provides the framework for tax policy.

6.4.1.5 Implications of the 4Es Framework for the public sector and public finance (Case study 5)

The social model regulates health care decisions and forms the central point in development, equity and empowerment. Partnerships allow for increased access to health care through affordability and efficiency. This is achieved by bringing in socialised health care provision in the public sector to balance out the effects of the private health insurance on the relative size of the public and private sectors. The introduction of the Government Employers Medical Scheme (GEMS) aims to reduce the effects of inflationary costs in health care and make health care accessible to the poor. The private sector expenditure has grown faster than public expenditure due to high inflationary costs leading to an increase in a skewed and growing divide between the public and private health care sectors. Equity in the distribution of health systems became a core determinant in establishing effective strategies. Increased demands in social development and health care placed a heavy constraint on the state finances. PPP offers mechanisms for the strengthening of social development. Allocative and distributional policies within a framework of social justice and economic efficiency are a core issue in policy-making and strategies for health care. HIV/Aids interventions placed heavy constraints on the public finance in realising the government's role as an enabling state and thereby strengthening the NHS. PPP offers additionality through private investment and partnership agreements (BOT schemes are the main vehicles used by PPP unit and on which legislation is built). A dedicated tax for HIV/Aids is proposed in a study conducted by the Nelson Mandela Trust (2005:144) as costs of providing ARV are expected to escalate. This is proposed as a recommended option to ensure the

sustainability of ARV therapy programmes. However, implementing a dedicated tax for HIV/Aids is not a simple solution for a complex problem. Adding to the tax burden without careful consideration of its social impact can often have the opposite effect on economic growth and well-being. Increasing fiscal pressures through added tax structures may increase the burden on those whom government aims to assist and also come to increase the costs of social security for government. Utilising the PPP model within the HIV/Aids environment demands a comprehensive knowledge how the model can be best applied as part of the expansionary budget approach and in ensuring productive public expenditures.

The PPP model relies on how it manages borrowing debt for efficiency purposes through loans from the private sector. Currently, the country has a 1% borrowing/GDP ratio which reflects that the government's overspending is very low for a developing country. External influences and risks impact on the management of interest rates and therefore indicate that the internal processes are controlled. Mixing public-private finance by encouraging additional private sector expenditure through highly productive public sector investments in both human and capital investments supported through Black Economic Empowerment (BEE), ensures productive expenditure. Equity investors (BEE) are integral to the procurement process. However, due to tax obstacles based within equity and shareholding it has discouraged more widespread share ownership of employees. The government must align BEE initiatives with tax legislation, particularly if disposal of assets are required to settle part of loan obligations. One therefore has to try and achieve greater unconditional redistribution of income through tax and social security systems by ensuring that the public expenditure is as economically productive as possible.

6.4.2 A search for alternative strategies and policies

In a search for alternative strategies and policies that allowed the government to overcome its own weaknesses, two instruments explore the strategic architecture of efficiency and effectiveness themes as well as mirror productivity and revenue growth. On the one hand, value-creating strategies were linked with a series of cause-and-effect outcomes while on the other hand a social cost-benefit analysis provided insight into particular allocations of scarce resources and how investments provided opportunities to

be shared amongst the public, private and NGO sectors as well as identified opportunities between consumers and producers.

Value creation and strategic intent became key issues that minimised and overcame the negative threat that HIV/Aids-related problems posed for the NHS and public finance structures. Although the frameworks utilised for value creation in the public, private and NGO sectors are similar, there are several important distinctions that influence value creating actions in the PPP environment (investment) and these should be highlighted as follows:

- The ultimate definition for success in public and NGO sectors is based in their mission statement (Kaplan & Norton, 2004:7). However, the public sector and NGOs span a broad and diverse set of missions to define their social impact and high-level objectives. Value creation and strategic intent are based on meeting the needs of targeted customers. Success is created through internal process performance and reflects the objectives of the electorates, taxpayers or donors who supply funding. Furthermore, success is supported by the intangible assets of the human capital through learning and growth (Kaplan & Norton, 2004:9, 199).
- This is different to the private sector that uses homogeneous financial perspectives based on the increase of shareholder value, and for which all actions are guided by profit motifs.

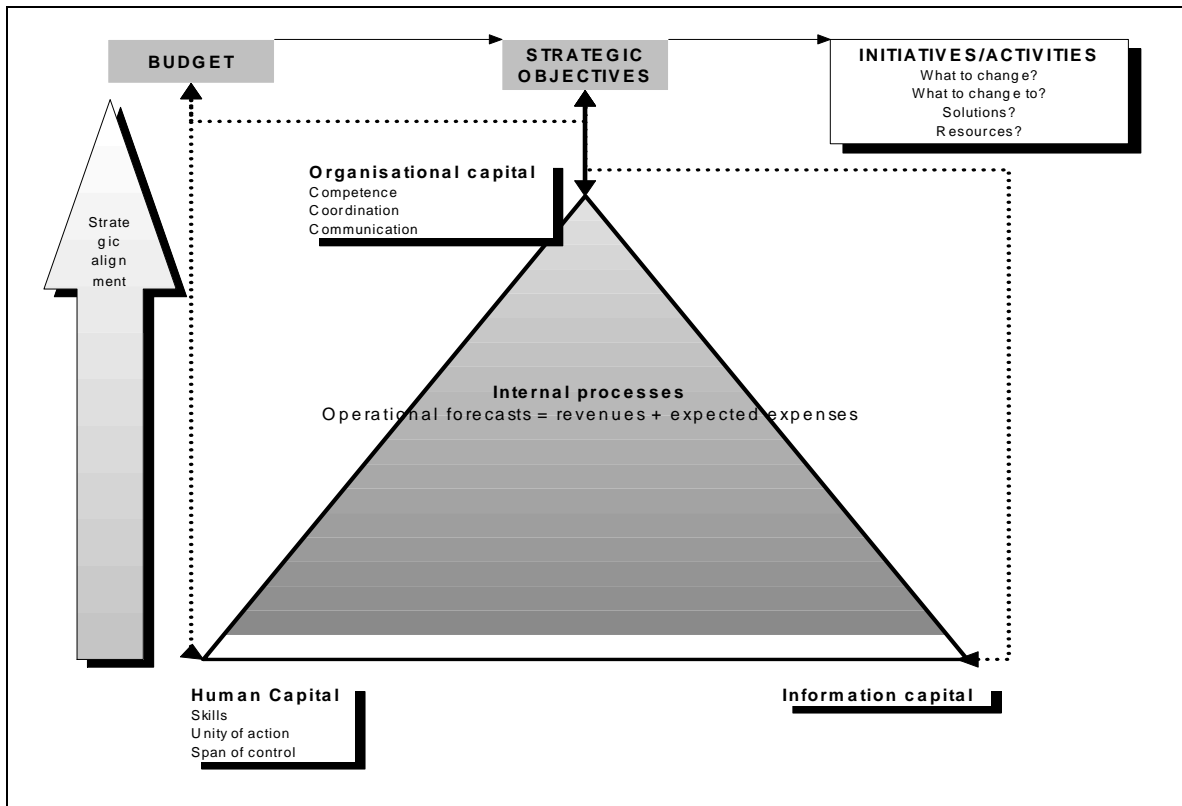
One can therefore conclude that a value-creating strategy provides strategic measures not as performance indicators but as a series of cause-and-effect linkages amongst objectives. These linkages identify specific capabilities that promote exceptional performance in the internal environment. The extent to which strategies impacted on the roll-out plans for HIV/Aids policies were mainly influenced by the components and interrelationships that existed between internal process measures and customer value propositions in health. Added to this, problems were exacerbated by issues such as no clear objectives for innovation (rigid organisational structures based on strict vertical authoritative structures) set within strict regulatory control mechanisms, vague objectives for employee skills and motivation (absence of effective performance evaluations and job matching) as well as an absence in determining the role of information technology as a value-creating mechanism (Kaplan & Norton, 2004:13). However, human resource and

IT investment per se are unlikely to facilitate the organisation's ability to execute their strategies or generate a positive return on their human resource or IT investment. Kaplan and Norton (2004:10) identify several principles which form the theoretical underpinnings for value creation proposed in this study:

- Strategy balances the short-term financial objectives for cost reduction and productivity improvements tied to long-term objectives of possible revenue growth.
- Strategy is based on differentiated customer value propositions and their WTP. Clarifying the value proposition and defining the attributes that must be delivered to satisfy the customer are important dimensions.
- Sustained value-creation is achieved through strategic themes.

How these principles are combined and applied to health care policies lead to the success of the value creation and improvement of service delivery outcomes. Identifying core aspects that influence performance and then aligning the constraints with the internal processes offer the opportunity to provide practical solutions for the actions that supports a 4Es framework in roll-out plans for HIV/Aids intervention. Each of the linkages (human capital, information capital and organisational capital) provides strategic measures necessary to achieve change towards value-creation and identifies those issues and capabilities that are critical in achieving improved quality and efficiency in service delivery in health care. Figure 6.3 demonstrates the strategic alignment of the organisational, human and information capital with the internal processes that have a critical impact on the outcomes of strategy. Critical elements within the organisational capital such as leadership, organisational culture and teamwork must be combined with horizontal and vertical hierarchies and the administrative structures that support health outcomes.

Figure 6.3: Strategic measures to achieve value-creation in HIV/Aids strategies



Source: Own interpretation (2006).

One can therefore deduce from Figure 6.3 that service delivery within the HIV/Aids environment depends on how the organisational, human and information capital is aligned with the overall strategic priorities within the budgeting processes. The sharing of synergies across sectors through balanced supply- and demand programmes strengthens efficiency and the achievement of strategic goals. The alignment of financial implications such as:

- Direct costs on health expenditure.
- The indirect costs on the economy.
- Intangible cost impacting on how the community reacts to the problem (image), must be taken into consideration with the Batho Pele principles and in determining strategic choices.

These choices are influenced by the impact that HIV/Aids has on the overall health care system. Each of the phases of HIV infection requires specific sets of medical, administrative and managerial interventions. Table 6.2 identifies in terms of a

comparison of the cost-benefit analysis of the with-and-without approach the benefits or positive costs for HIV/Aids and the negative costs resulting from HIV/Aids.

Table 6.2: Cost-benefit analysis applied to health care and HIV/Aids

With: Benefits or positive costs	CBA: Health care and HIV/Aids	Without: Negative costs
Savings in expenditures.	Direct costs (health expenditure).	Expensive long-term treatments and long periods of hospitalisation. Chronic relapses. Travelling, inaccessibility of health care. Increased poverty due to poor health.
Restored earnings. Restored revenue and tax base.	Indirect costs (forgone earnings) = inputs and outputs that pass outside the health care. The main measure of indirect effects is via earnings forgone or enhanced due to treatment, impacting negatively on productivity, education and social issues. Determines quality of care and the willingness-to-pay (WTP) which is measured by market price.	Sick leave, absence for long periods, unemployment, loss of income.
Reduction of pain and suffering.	Intangible costs (pain, suffering associated with treatment or intervention)	Stigma. Mental health depression. Side-effects of medication. Building resistance to medication.
Outputs or effects = quality-adjusted life-year (QALY)	Consumer surplus	Inputs or costs

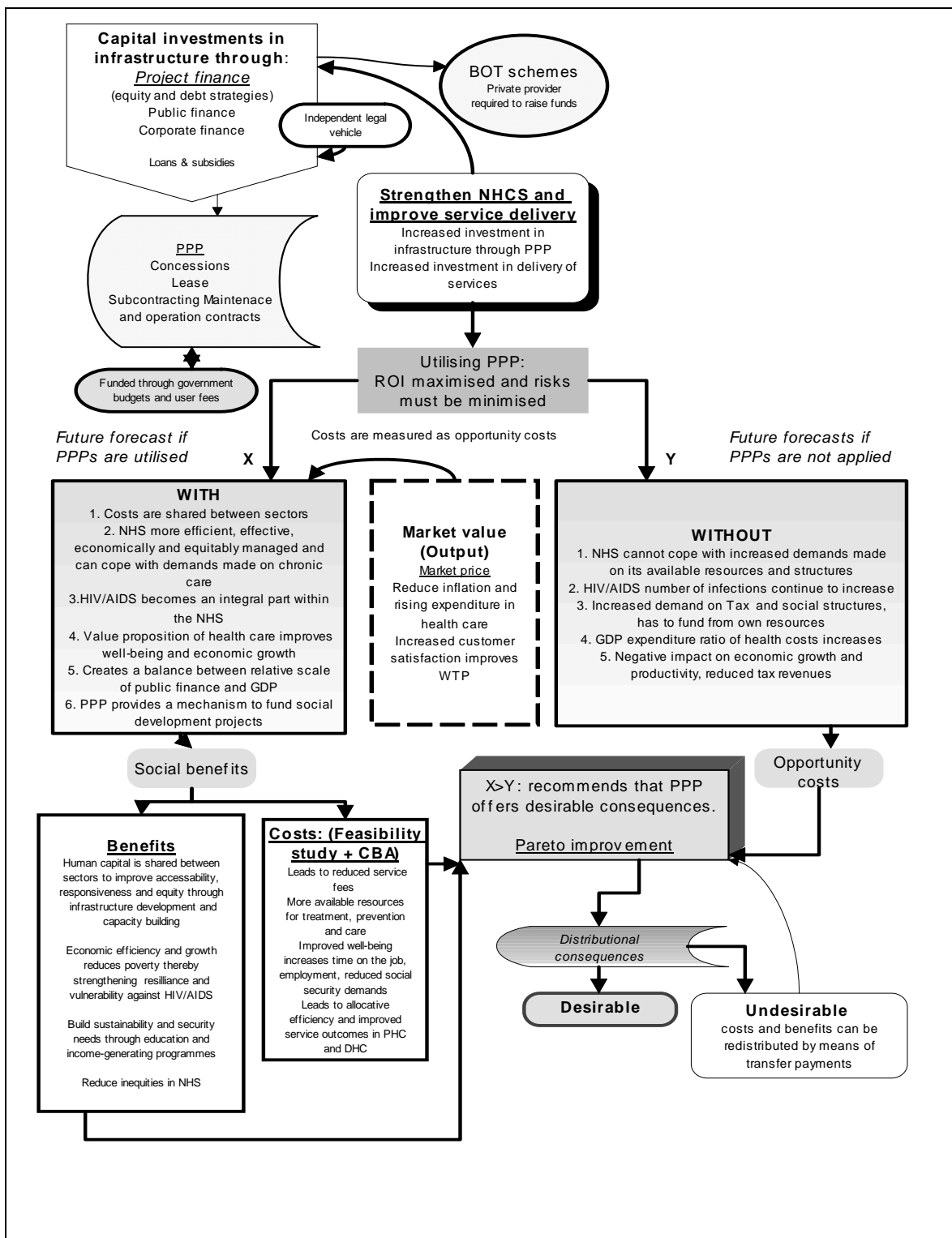
Source: Adapted from Brent (2003:5); Campbell and Brown (2003:2,3).

Integrating the three types of costs that influence health care in the design of efficient supply and demand functions (direct costs, indirect costs and the intangible cost) identified in Table 6.2 clearly shows that the negative costs of HIV/Aids interventions have a direct impact on profits, NPV and ROI and the interest of shareholders. When PPPs are established these factors become a determining point in the approaches taken to HIV/Aids in health care interventions. The NPV and ROI also determines if PPP is a viable option. Strengthening the health system and building capacity can only be achieved if HIV/Aids interventions become an integral part of the overall health strategies (applied within a NHS) and must not be seen as a separate entity in the attainment of goals in health care and service delivery.

A social cost-benefit analysis determined the effect of improving efficiency of public sector investment through the utilisation of PPP in health care, as well as its direct impact on the future value of roll-out plans for HIV/Aids intervention. Good investment provides value for money benefits to the economy as a whole. Utilising PPP as a mechanism that provides good investment has a carry-through effect on all sectors of health care. The with-and-without approach used in Figure 6.4 forms the pivotal point for the cost-benefit approach and measures the difference investments made in providing health care and social development opportunities. Likewise, the concept of opportunity costs underlines the value of services and goods. The benefit is based on the increased value of future supply (NPV).

The generic PPP model defined within the PFMA does not include PPI within its framework. The rigidity of the PPP model, absence of skills in the Department of Health to manage PPP relationships and the complexities surrounding the model when it is applied to health interventions, prevented the health sector from utilising PPPs as an effective mechanism. A strong resistance against the PPP model meant that alternative models were developed in competition to PPP, instead of identifying the social costs and benefits the model offers in health care and mitigating the risk factors that turned the PPP model into an unfriendly and complex model.

Figure 6.4: Social cost-benefit analyses for PPP applied in NHS: Case Study 5



Source: Adapted from Campbell and Brown (2003:3-5); Brent (1998:5).

Figure 6.4 showed that PPPs offer desirable consequences for Case Study 5. In establishing the type of social costs and benefits that are created through the application of PPP, it is recommended that the PPP model should take a broader focus. PPP intervention is a value-creating instrument as it forms an important part of procurement and becomes a macro and microeconomic development tool if it is used with skill.

6.5 Conclusion

Chapter 6 provided an in-depth discussion of the key issues and key performance indicators that underscored HIV/Aids strategies within the international and national environment. It measured outcomes against benchmarks that explored the influence of ideologies on the approaches that each country took to improve well-being and the public good. Business and management instruments supported by interviews and a literature review framed the core problems associated with policy-making in health care, HIV/Aids and the PPP environment. The outcomes of the systematic exploration presented best practices in building capacity and strengthening policy capacity within the government. Exploring the value of PPP as a mechanism to improve efficiency in service delivery within a framework of 4Es applied to health care and HIV/Aids became a core issue in addressing the research question.

The next chapter compares the results of the case studies and highlights issues, trends and options derived from each analysis as these outcomes are steered by the NPM movements in developing fiscal reforms that increased state capacity. The fiscal reforms reduced costs in health care spending, thereby establishing the extent to which strategies have impacted on the roll-out plans for HIV/Aids policies in South Africa.

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

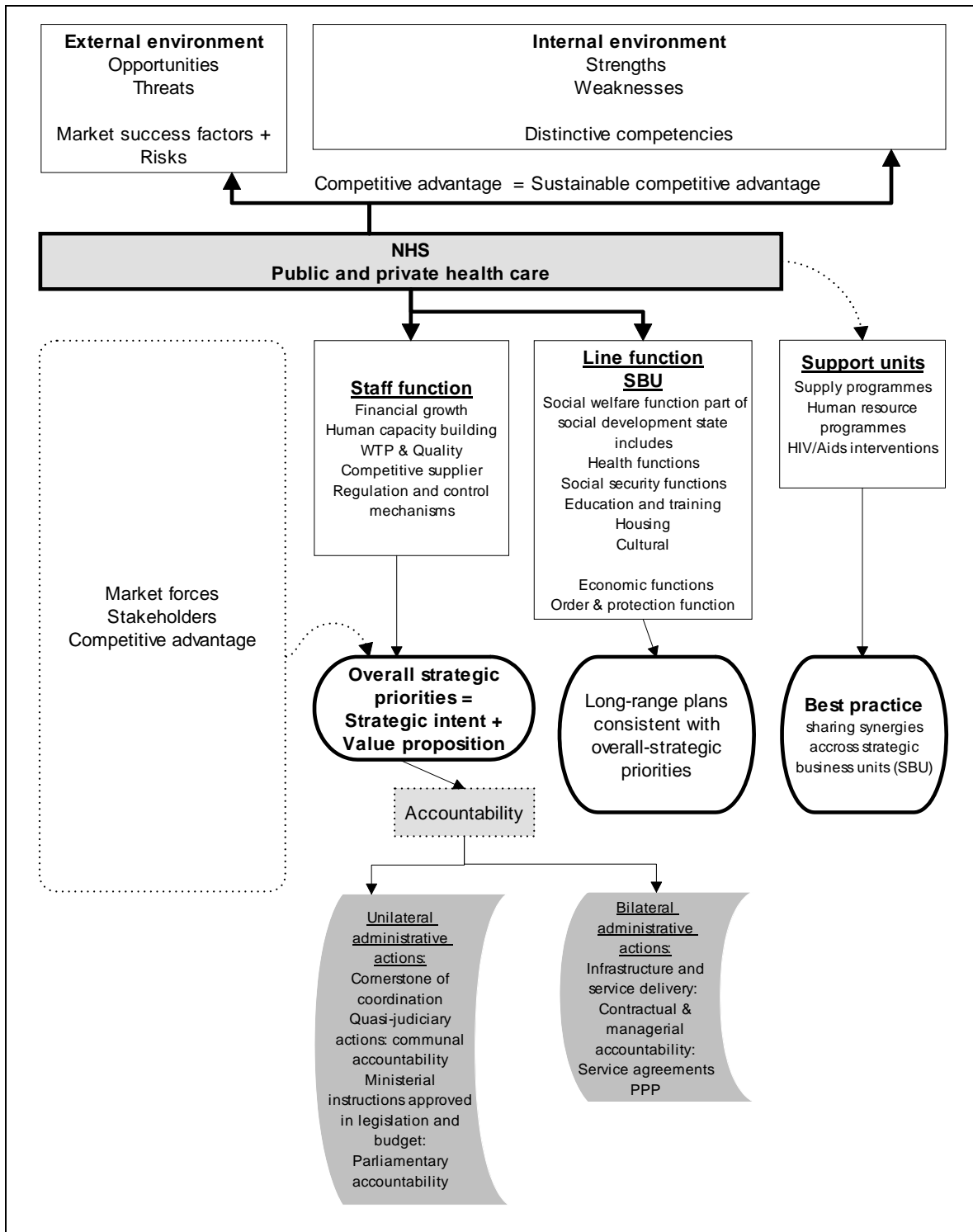
The main issues, trends and patterns in the data with reference to the research question are broadly discussed in this chapter. Options are therefore linked to trends and patterns to provide for new and alternative approaches that solve the problem statement by questioning the extent to which the overall 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. Gildenhuis (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 (Quality). 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 nineteenth-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 (Schechter, 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 off 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 control 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:	<p>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.</p> <p>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.</p>
Implications for public finance:	<p>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.</p> <p>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.</p>

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 outsourcing 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 fiscally 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 too 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 utilising 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.

CHAPTER 8: CONCLUSIONS AND RECOMMENDATIONS

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

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

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

8.1 Introduction

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

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

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

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

8.2 A summary of the main results

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

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

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

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

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

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

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

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

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

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

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

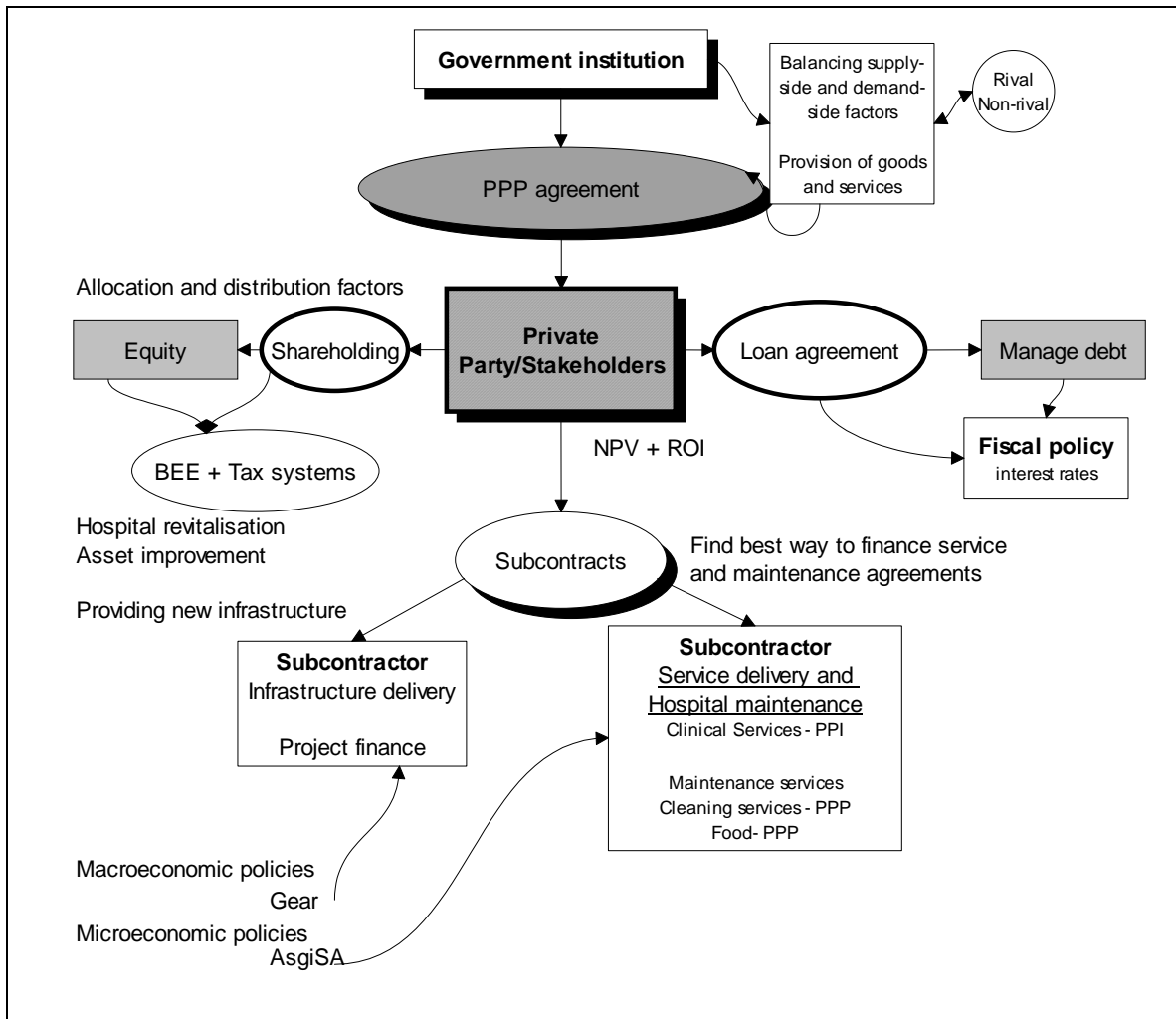
In short, the advantages of utilising PPPs in health care have shown both strengths and weaknesses. Focusing only on the negative outcomes, thereby resisting the use of PPP, is short-sighted as it does not enforce fiscal responsible mechanisms in health care interventions. Similarly, refusing to look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

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

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

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

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



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

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

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

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

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

8.3.1 Policy implications

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

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

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

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

8.3.2 Alternative options

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

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

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

8.4 Future research

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

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

8.5 Conclusion

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

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

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

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

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