

PUBLIC-PRIVATE PARTNERSHIPS – A MECHANISM TOWARDS FISCAL RESPONSIBILITY. AN OVERVIEW OF ISSUES, TRENDS AND OPTIONS FOR HIV/AIDS INTERVENTION STRATEGIES IN SOUTH AFRICA

*Prof. D.J. Fourie
Ms L. Schoeman
University of Pretoria*

ABSTRACT

Public-Private Partnerships are seen as mechanisms that offer the promise to strengthen government's policy implementation capacity and its ability to deliver services efficiently, effectively, economically and equitably (4Es) to communities. HIV/AIDS-related problems add to the complexities associated with building partnerships and networks as it demands a shift towards horizontal and broader based policy issues that show no respect to boundaries or do not fit neatly into areas of jurisdiction. Traditional models that described public and private relations have become obsolete, forcing governments to revisit their role and the type of outcomes they want to achieve. The symbiotic relationship between the economy, society, political philosophy and public finances increase the difficulty of finding a balance between the relative sizes of public and private health sectors steered by supply and demand functions, against a background of political performance which focus on finding the correct inputs for political, governmental and administrative systems to deliver quality outputs.

In this presentation the authors take a critical look at the key issues necessary to ensure that accountable and fiscal responsible measures are in place when PPP networks are built in the health care sector. Their views are supported by the outcomes of a comparative research study that investigates PPP as a mechanism for public finance management in the macro- and micro-economic planning through the application of four international case studies. These case studies are benchmarked against the national situation to identify the best practices and find a best value for money approach to address the core issues, trends and options available to HIV/AIDS intervention strategies in South Africa.

INTRODUCTION

Public administration is a fundamental manifestation of governmental power and has profound implications for the effectiveness and efficiency of government. It defines the conduct of democracy and shapes the relationship between government and its citizens. Most importantly, public administration provides a dominant base for values and practices that must be pursued with regard to good governance and the way powers are exercised. These theoretical underpinnings support a “hypothetical model” that explores key issues surrounding collaboration between public-private actors in a national health care system and form an integral part of the discussions that follow. The issues presented are part of the findings of a comparative and qualitative research study conducted at the University of Pretoria in the Faculty of Economics and Management Sciences at the School of Public Administration and Management. This doctoral study investigates four international case studies (United States of America, United Kingdom, India and Uganda). The international key issues identified are benchmarked against the national situation. The paper questions whether public-private partnerships can be utilised as a mechanism for fiscal responsibility and as a value-for-money approach and thereby successfully address the core issues, trends and options available to HIV/AIDS intervention strategies in South Africa.

The question is addressed in two phases. First the authors focus on the key issues that have a significant influence on the development and concomitant accountability of PPP networks in the national health care system of South Africa. Secondly, the authors take a critical look at the interventions needed to strengthen policy capacity and accountability and as such improve government’s ability to deliver quality services.

IMPACT OF PPP ON PUBLIC ADMINISTRATION

Throughout history reformers drew a sharp distinction between politics and administration. Within the politics/administration dichotomy reformers wanted to clarify the roles of public administrators so that they could find ways and means to work more efficiently. The impact of industrial management on the role of public administrators blended together to form a science and a businesslike approach to government based principles. The theme “economy and efficiency” prevailed while reformers gradually came to agree that politics and administration are inseparably linked to the outcomes of service delivery (Goodnow and with a new introduction by Rohr, 2003; Kettl, 2003).

In order for health services to be more flexible and efficient one saw a gradual move towards adhocracies or network-based organisations (Roux and Schoeman, 2004). Considering that Public administration has been built on a theory of hierarchy and authority, new approaches, such as “adhocracies and networks” have challenged existing hierarchical and authoritative structures in a quest to find ways and means to address and cope with increased capacity demands and the rising costs of service delivery. The newspaper article by Shevel and Keeton (2005:9) highlight concerns faced by the public-private sectors related to the growing costs, staff shortages and rise of HIV/AIDS patients and their

subsequent impact on value-for-money services in South Africa. Finding ways and means to cope with these growing demands made on the national health system has no quick fixes or shortcuts. It requires a holistic approach on all sectors involved and an intense scrutiny of the supply and demand functions that steer the health industry together with its impact on government's allocation and distributional functions.

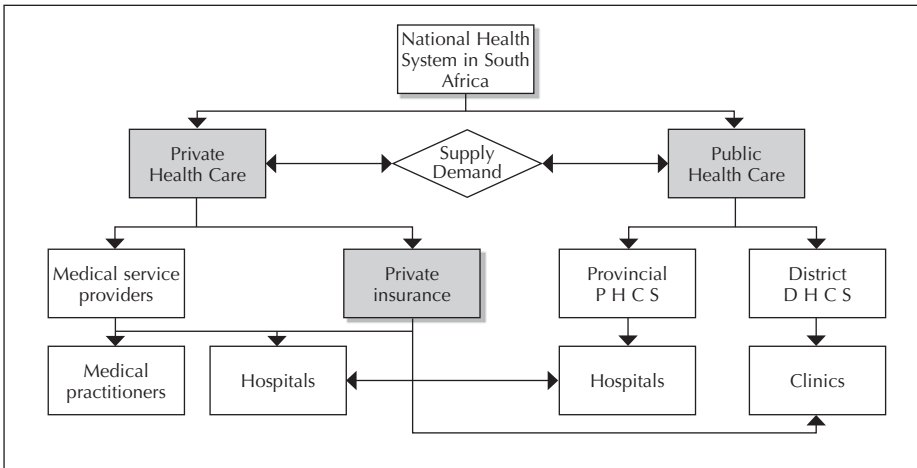
In the New Public Management movement public-private partnerships and networks are seen as mechanisms to strengthen government's policy capacity and administrative systems that support service delivery outcomes. Through public-private partnerships and networks, the responsibility for implementing public programmes is more broadly shared in intricate contract-management and coordination strategies that are tied up in partnership agreements between the public, private and NGO sectors. However in this environment, authority became less effective as a mechanism in problem-solving, decision-making and accountability (Peters and Savoie, 2000; Goodnow and with a new introduction by Rohr, 2003; Kettl, 2003).

The main reason being that the challenges faced by management in positions of authority became more complex as health and HIV/AIDS policies became broader-based and more horizontal. "Fuzzy or blurred boundaries" confused managers as they are required to manage less through vertical authority and more through horizontal authority and a wide variety of other strategies. While public servants find themselves delegating authority in traditional ways they are discovering that the old mechanisms for ensuring accountability are ineffective and fail to address the real issues and needs (Kettl, 2003). Being that government relies more on partnerships with the private and NGO sectors, the problems faced by building value-for-money strategies are multiplied as public servants need to devise new techniques and new strategies for securing democratic accountability (Kettl, 2003). This is further complicated by a shift in service delivery planning that requires public servants to "listen" and "serve" rather than "tell" and "steer" the governance process (Denhardt and Denhardt, 2003).

Authors argue that theorists questioned more and more which approach offered the best outcome while social scientists became increasingly impatient with the trade-offs that occurred between PPP and traditional public administration. An emerging gap between public and private relations and governance emerged. Tensions developed between the demands made on government and their capacity to do the job effectively, efficiently, economically and equitably (Kettl, 2003). These tensions are more pronounced when they are applied to HIV/AIDS-related problems and efficiency. Measuring health care efficiency is complex because asymmetric information increases consumer dependency and introduces the possibility of opportunistic behaviour, deception, over-servicing and fraud as well as the risk of excessive health outlays by medical practitioners (Hillman, 2003; Shevel and Keeton, 2005).

No health system can be perfect. Securing and providing enough resources to cope with the demands made on health care, is impossible (Brent, 2003) Added to this, health care is entangled in ideologies, personal values and are in synergy with social conditions depending in part on developments well outside the health sector (Barr, 1998). These emotional polemics are tied to aspects of distributive justice and procedural justice and

Figure 1: National Health System in South Africa

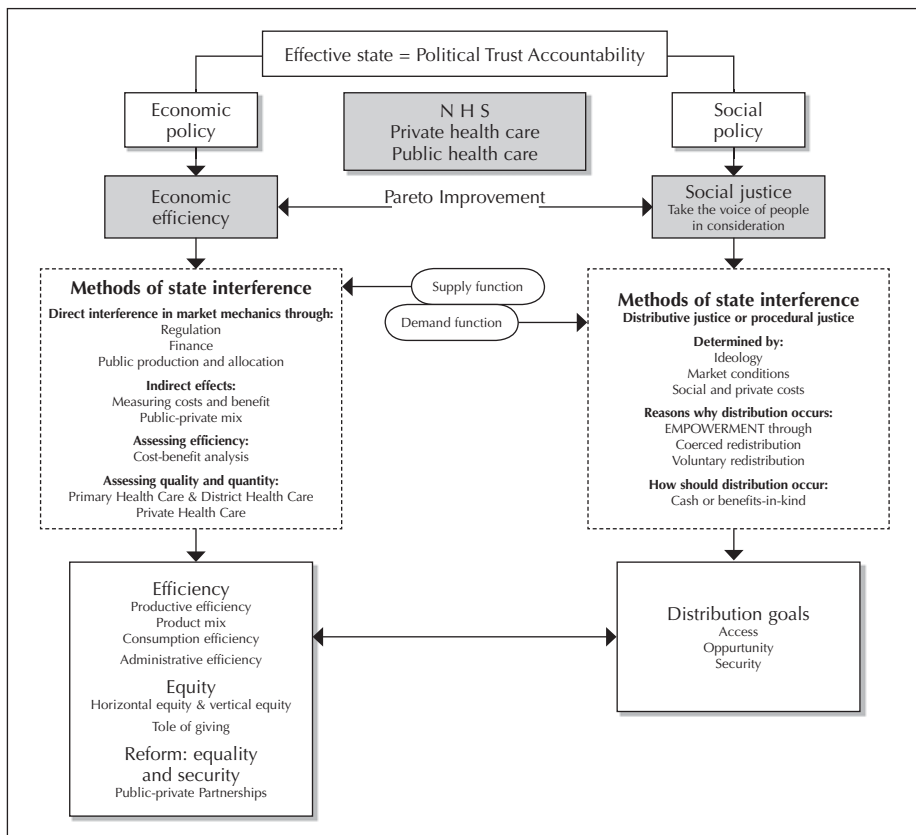


relates to each person’s perception of distributive fairness (Barr, 1998; Hillman, 2003). The symbiotic relationship between health, social care systems and economic development can therefore not be ignored as the compounded impact of their outcomes influence employment figures and wealth creating initiatives. Steering the tensions in the national health care system are the supply and demand functions and their impact on delivery. 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 is not only a key issue in policy-making, but also forms the pivotal point in accountability, responsiveness and finding fiscal responsible mechanisms in health care service delivery (Reich, 2002). By taking a closer look at health care in South Africa the NHS can be illustrated as follows:

Own interpretation (2005)

An effective state and a stable political environment are vital elements for the provision of goods and services. It is also an essential ingredient for wealth creating initiatives and supports the creation of well-being. Health and well-being are interwoven into the fabric of sustainability, equity, security in livelihood and the creation of opportunities. Without an effective state sustainable development both economically and socially are not possible (van der Velden, van Ginneken Velema, de Walle, van Wijnen, 1995; World Bank, 1997; Barr, 1998; Adamolekun, 1999). Achieving good governance through effective state interventions is a critical determinant that achieves economic success and encourages social development. The following “hypothetical model” points out the key issues necessary to achieve effective interventions in a social welfare state and provides a background against which the relationship between “efficiency and social justice” in policy strategies, delivering a NHS and PPPs are applied effectively.

Figure 2: Key issues to achieve effective interventions



Own interpretation (2005) adapted from (Szirmai, 1997; Barr, 1998; Pieterse, 2001; Rothstein and Steinmo, 2002; Kettl, 2003; Przeworski, 2003)

One can thus conclude that the core issues that steer the process of delivery, the development of administrative systems and organisational structures in health care are based around the principles of economics and social justice. Hence, the supply and demand functions set the boundaries for efficiency, competition and value-for-money approaches. It also has a significant impact on how allocation and distributional policies are put together.

HEALTH MARKETS VERSUS PRIMARY HEALTH CARE

Worldwide, lucrative health markets are created in health care through Public-Private Partnerships (PPP) agreements (Sen, 2003; Labonte and Schrecker, 2004). Building accountable, responsive and fiscally responsible PPP networks

in the health care sector offers government the promise to strengthen their policy capacity as well as administrative systems and thereby improve their ability to deliver value-for-money services to its customers (Peters and Savoie, 2000). The validity of this argument is questioned as there is growing evidence that contractual relations of PPPs have led to the weakening of the traditional notions of accountability (Mohr, 2004). This is further complicated by changes in traditional models that described public-private relations.

During the 1990s the promotion of health care became an active part of global governance systems (Kennedy, Messner Nuscheler, 2002; Lee, Buse Fustukian, 2002). The process started with the Alma-Ata Conference held in September 1978 when a plea was made for a system of primary health care (van der Velden, van Ginneken et al., 1995; Szirmai, 1997). The United Nations Assembly endorsed the Alma-Ata and the WHO adopted the Alma-Ata in its *Global Strategy for Health for all by the Year 2000* (WHO, 1981). Primary health care was accepted as a basic human right that must be accessible, affordable and socially relevant (van der Velden, van Ginneken et al., 1995; Szirmai, 1997). This view and the MDG had a significant impact on shaping government's role within its ideological framework, its capacity to deliver and providing adequate funding mechanisms to support its strategies. As government accepted responsibility for reducing poverty and its subsequent impact on health they found themselves pulled into matters that had less to do with economics and more with social policy. The demands on the welfare state grew as well as the governmental institutions and administrative systems to support these 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.

Neo-liberal policies and the growing interrelationship between the private and public sectors gradually moved the state into the position of enabler who regulates and privatises funding and the provision of public services through the General Agreement on Trade in Services (GATS). The GATS is an integral part of the WTO arrangements that covers health, education, public utilities, social welfare, financial services and transport (Sen, 2003; Labonte and Schrecker, 2004). It encourages trade and regulates the tender procedures in the service industry between the public and private sectors. GATS used as a facilitator for global governance, competition and partnerships, and turned health care into health markets. Health care markets are becoming more and more of central importance in health care provision. Multi-national and trans-national corporations especially the pharmaceutical industry, are lobbying to capture large segments of the gross domestic products (GDP) and government's spending on public health services (Scheil-Adlung, 2001; Sen, 2003). Internationally pharmaceutical companies have become major players in the formulation of PPPs and are also actively involved in health care reforms (Lethbridge, 2002; Sen, 2003; AVERT, 2005). Evidence of these movements are visible within the new approach, the "President's Emergency Plan for AIDS Relief, 2003 (PEPFAR) in which a focused use of expanded resources and years of technical and medical expertise of multi-national and trans-national corporations are used to implement integrated prevention, care and treatment programmes to ease the suffering of millions infected (AVERT.ORG, 2005).

The improvement of supply and production of drugs for HIV/AIDS was supported in the strengthening of network systems and the Supply Chain Management System (SCMC) contract funded through PEPFAR (AVERT.ORG, 2005).

This means that the supply and production of drugs for HIV/AIDS is highly controversial. Against this background the WHO has moved health systems towards the concept of “new universalism” which means that essential services are defined on cost-effective criteria to the population as a whole (Sen, 2003). HIV/AIDS has increased the value of these markets. Sadly the more HIV/AIDS spreads, the more lucrative the health markets become and the more difficult it becomes to regulate accountable and responsible fiscal structures. Conflicts in interest are arising where government has to prioritise the interest and rights of the patient who cannot pay for services against the interest of the pharmaceutical industry, health insurance and private practitioners who are guided by market forces (Committee, 2005).

CAPACITY BUILDING: PURSUING EFFICIENCY IN PPP

Market-orientated reforms especially in developed countries such as the UK and USA are associated with service-orientated enterprises and Public-private partnerships that aim at making the public sector more business minded. Poor performance in the public sector and the absence of resources to cope with the growing demands made on government in health care saw PPP as an acceptable alternative to privatisation, corporatization or contracting-out (Wettenhall, 2003). 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. PPPs became a mechanism in which government achieved effective state interventions through the accelerated delivery of infrastructure renewal and thereby improving the quality of service delivery (Partnerships UK, 2005).

Economic reasons alone cannot determine why the private or public sectors must provide certain goods or services. Tomkins in Farnham and Horton (1996:28) strengthened the supply-demand debate by pointing out that the:

“... focus should be on the appropriate form of management for each activity rather than the ideological support for its location in either private or public sector”.

Building state capacity through PPPs ensure that these mechanisms are effectively, efficiently and economically applied and require that administrative reforms are simultaneously aligned with the political demands and economical factors of existing administrative structures. Administrative reforms adopted decentralised policies in pursuit of efficiency and effectiveness. It is important to note that although decentralisation is a key characteristic of PPPs as it gives power to local authorities and improves decision-making and democracy, the success of decentralised structures still depends on a strong centre that provide a supporting role through its administrative design framework. This framework determines how accountability is established and how funding and monitoring support

distribution and allocation of goods and services (Cohen and Peterson, 1999). PPP networks challenge existing hierarchical and authoritative structures due to broader-based policies and a demand for flatter and more flexible structures (Kettl, 2003; Roux and Schoeman, 2004). Budgeting, procurement, value-for-money, risk, affordability and competition are all key issues in PPP creation. It is these same key issues that complicate accountability in health care and therefore need further discussion.

The monopolistic structures of public service markets, the absence of valid indicators of organisational performance and large government departments increased the lack of efficiency and effectiveness (Farnham and Horton, 1996). This lack in governmental efficiency and effectiveness in managing partnership relations saw the development of monopolies, (especially in developed countries) as businesses and medical services are steered by profits, dividends and shares instead of focusing on quality services and addressing the needs of citizens (Skelcher, 1998; Goetz and Jenkins, 2005). In cases where government was not involved in establishing regulations on quality and pricing of medical care, health markets are dominated by profit maximisation instead of quality (Panda, Chatterjee et al., 2002). Similarly, the expansion of the private health sector in South Africa showed strong negative net effects on the public sectors. These effects are of particular concern in the private hospitals that operate largely in unregulated environments (Moorman, 2001; Shevel and Keeton, 2005). All of these market-failures shift the role of government towards that of a regulatory agency as it becomes an integral and important part of public administration to control the power of privatized monopolies. As reforms regulate competition on the supply-side against the quality of service outcomes, it also means revising the criteria by which performance is assessed rather than enforcing compliance on financial and technical rules (Goetz and Jenkins, 2005).

KEY ISSUES THAT ENSURE ACCOUNTABLE AND FISCAL RESPONSIBLE PRACTICES IN HEALTH SECTOR PPPS

Looking back at the hypothetical model the concept of voice, social justice and accountability do not only dominate development discourse but it is seen as ethical and helpful to improve performance (Goetz and Jenkins, 2005:8). Social justice must take the voice of the citizens into consideration (Goetz and Jenkins, 2005). Accountability is described as a relationship of power that calls for answerability and enforcement by the key actors entrusted with the responsibility to implement specific activities (Pauw, Woods, van der Linde, Fourie, Visser, 2002; Goetz and Jenkins, 2005). In the PPP environment answerability and the enforcement of power to act in an accountable and responsible manner constitute actions that support value-for-money, affordability and transfer of risk.

Co-ordination forms the cornerstone for value-for-money approaches in public administration and management. It determines how leaders pull resources together to address service backlogs, accelerate infrastructure renewal and improve public finance management. Through partnership agreements in PPP, government is able to share the costs of service delivery with the private and NGO sectors. When partnerships are not structured adequately it weakens authority and brings on vicious cycles of monitoring and distrust

between partner organisations (Mohr, 2004). As PPPs are an integral part of the budgeting and procurement process and assist in building co-ordinated efforts to solve complex problems, the concerns as to whether PPPs have negative consequences for accountability in terms of services provided become more pronounced. The linkage of distribution and allocation policies executed through governmental budgets and their supply and demand relationship are central issues. A major concern with accountability in PPPs are based on the extended periods of concessions that weaken the capacity of the electorate and their representatives to influence policy direction (Mohr, 2004).

It is argued that by transferring risks associated with public finance to the private sector, value-for-money services offer affordable options and conform to quality standards for performance in specific enforceable terms negotiated in legally binding agreements (Demirag, Dubnick, Khadaroo, 2004). Pursuing efficiency or responsiveness becomes far more difficult with broader-based policy demands and fuzzy boundaries (Kettl, 2003). Therefore, managing PPP programmes effectively depends on bridging the boundaries as well as separating those who created the partnership from those who share the responsibility to implement it. When partners share the responsibility for managing programmes the outcomes depend on how well agreements are coordinated and managed to achieve the desired end results. In the end the programme is as strong as its weakest link.

CONCLUSION

Service delivery outcomes are the product of perceptions, values and previous experiences that do not only shape political preferences but also impact on the willingness to pay (WTP) for services. PPPs are used as a development tool in the fiscal policy to increase growth, reduce unemployment, increase equity (BEE) and efficiency, thereby strengthening government's policy capacity and improve its ability to deliver quality services. Through its successful application social spending is reduced, making more revenue available for increased investment and strengthening government's capacity and resources.

Although the concepts behind the utilisation of PPP as a fiscal tool for strategic development in the health environment is sound, the emotional disputes and tensions between the supply and demand functions tied to the distributional and allocation mechanisms in the public, private and NGO sectors makes the application of PPPs in the health care sector a highly complex environment. These complexities are increased by blurred boundaries between public and private sectors and between politics and administration. Intergovernmental structures impact on governance outcomes. Governance perspectives took a wider view of the role of the state as it brought heterogeneous networks of interdependent actors into policy-making and implementation. The sharing of responsibility and risk has emphasised problems in achieving public accountability as the very nature of interdependency amongst public, private and NGO sectors adds to the complexities of achieving successful outcomes.

One can conclude that PPPs utilised as a fiscal responsible mechanism within HIV/AIDS intervention strategies challenges transparency and the wider issue of

accountability. It is a complex environment with no quick fixes or easy answers to solve capacity and resource problems. It needs a holistic approach that takes a wide angled look at the interplay and synergy between issues that underscore the public-private mix and the supply and demand functions and its cause-and-effect impact on service delivery outcomes.

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