



The record of proceedings

Section 2D

Public-Private Interactions

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Discussion paper

Public-private interactions

Introduction

This document outlines key issues that require consideration in relation to Public-private interactions (PPIs) within the South African health sector. The term PPI is used to indicate that all forms of interaction between the two sectors should be considered, rather than merely focussing on specific public-private partnerships (PPPs). This approach recognises the complexity of existing inter-relationships between public and private health sector financing mechanisms and providers in South Africa and the need to contextualise individual PPPs and other public-private initiatives through broader consideration of the way in which the two sectors interact.

In developing an equitable, efficient, coherent and high quality health system in South Africa, there is considerable potential for constructive engagement (collaboration and co-operation) between the public and the private health care sectors.

However, such engagement can in some instances undermine health system goals. It is, thus, necessary to develop a set of principles to guide consideration of public-private interaction, with these principles being based on the vision and goals of the National Health System. In this way, PPIs will serve as a mechanism for the achievement of health system goals, rather than as an end point of the process of health system development.

The structure of the document is as follows:

- A review of the vision and goals of the South African health system is undertaken.
- An overview of the range of PPIs is provided.
- A set of principles that could guide decision-making about PPIs are then presented.
- The potential role of government and the private sector in terms of meeting health system goals through PPIs are considered.

- A series of questions that can be considered in small group discussions during the summit are presented.

The vision: A health system for the future

The vision and goals of a future National Health System (NHS) for South Africa are outlined in key policy documents such as: The Reconstruction and Development Programme (1994), the White Paper for the Transformation of the Health System for South Africa (1995) and the Health Sector Strategic Framework, 1999-2004 (1999). The vision and goals provide insights into the respective roles of the public and private health sectors and inform the principles for PPIs.

The 1999-2004 Strategic Framework indicates that the mission of the Department of Health (DOH) is:

“to consolidate and build on the achievements of the past five years in improving access to health care for all and reducing inequity, and to focus on working in partnership with other stakeholders to improve the quality of care at all levels of the health system, especially preventive and promotive health, and to improve the overall efficiency of the health care delivery system”.

The Strategic Framework also indicates that: “Our vision is a caring and humane society in which all South Africans have access to affordable, good quality health care.”

A more detailed explanation of the vision guiding the overall development of the South African health system is that, over time, it will:

- *Move **towards** a coherent, unified health system offering financial protection for all the population in accessing a nationally affordable package of health care, at the time of need*
- ***and away** from a segmented and inequitable health system that burdens the country with its unaffordable cost.*

This health system will benefit the population as a whole by developing *a coherent, fair and effective health system that represents the core values of the new South African society, and in which all the population can take pride.*

This vision explicitly recognises the necessity to address the major problems currently facing the health sector, these problems being a reflection of the health system’s current structure and management practices within it. The development of PPIs in the future must contribute to tackling these problems, rather than making them worse, in pursuit of the health system’s overall goals.

Recent health policy documents all stress four key goals – equity, coherence, quality of care and efficiency – which provide a useful basis for decision-making about public private interactions (PPIs). Table 1 provides a description of each of these goals, highlights the major health system problems that these goals need to address and

outlines some pre-requisites for meeting these goals, in line with the overall health system vision.

Table 1

Goal	Description	Existing problems	Requirements to meet goal
Equity	Ensuring access to a nationally affordable package of health care for all the population of South Africa, where health care entitlement is not based on ability to pay	<ul style="list-style-type: none"> • Growing mal-distribution of financial, human and other resources between the public and private sectors, relative to the populations they serve • Mal-distribution of the health care resources available to different socio-economic groups within the population • Mal-distribution of all health care resources between and within provinces, which has been increasing over the past few years 	<ul style="list-style-type: none"> • The resources available within the public and private sectors are used for the benefit of the whole population, wherever they live • The healthy, younger and more wealthy population groups cross-subsidise an adequate level and quality of care for the sick, elderly and poorer groups
Coherence	The development of a health system which is co-ordinated and unified across the diverse public and private agents involved in provision and financing health care	<ul style="list-style-type: none"> • Fragmentation of the health system, based on separate financing and provision arrangements for different socio-economic groups, that prevents the development of efficient cross-subsidisation arrangements, and co-ordinated service delivery 	<ul style="list-style-type: none"> • The population uses a co-ordinated and unified provider system for all levels of care • Public health system is the provider of choice for most people (all levels of care)
Quality of care	Good quality care is care that meets acceptable technical standards as well as the needs and expectations of users and communities	<ul style="list-style-type: none"> • Decline in the (perceived) quality of care of public hospitals • Drain of health professionals from the public to the private sector • Poor quality of care provided by private practitioners and in some private hospitals, in terms of understaffing, unnecessary investigations etc. 	<ul style="list-style-type: none"> • Health professionals choose to work in the public sector and are motivated to provide caring and technically good quality care • Private practitioners and hospitals provide good quality care for defined services (all levels of care)
Efficiency/ cost-effectiveness	Technical efficiency: Maximising health service outputs at the lowest possible cost, while maintaining quality of care Allocative efficiency:	<ul style="list-style-type: none"> • Mal-distribution of resources between levels of care relative to the health needs of the population • Inefficient use of resources within the public sector due to poor management • Increasing levels of cost-inflation in the private sector due to over-servicing 	<ul style="list-style-type: none"> • Adequate levels of resources are invested in health services, especially primary care services • Resources are used efficiently in the public and private sectors • Cost-escalation in the private sector

	Distribution of limited resources between different types of services to maximise health outcomes (health status improvements)		is controlled
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An overview of the range of PPIs

The range of public-private interactions that may support or constrain the South African health system's development are set within the overall public/private mix of the country. Table 2 provides a brief overview of currently important policy issues concerning the public/private mix in South Africa.

Financing	Provision	
	<i>Public</i>	<i>Private</i>
<i>Public</i>	<ul style="list-style-type: none"> • Improved equity, efficiency and quality of care so that the public sector (especially hospitals) is provider of choice for most South Africans • Improved efficiency and access to PHC services through contracting other spheres of government to provide services 	<ul style="list-style-type: none"> • Reviewing existing public financing of private services (tax subsidies on scheme contributions; general tax funding of civil servants' scheme contributions; subsidised health professional training) • Reviewing existing and potential future for purchasing of non-clinical and clinical services (or other arrangements for purchasing private providers' services e.g. sessional appointments and PHC contracting) • Reviewing mechanisms to promote private provision of priority public health services (including preventive and promotive interventions)
<i>Private</i>	<ul style="list-style-type: none"> • Effective implementation of UPFS with revenue retention • Preferred provider contracts with medical schemes • Exploring potential to draw private finances to support quality public service provision (including through a Social Health Insurance mechanism and private financing for priority services including promotive interventions) • Evaluating the potential for improving efficiency of resource utilisation by leasing of spare public sector capacity to the private sector within co-location type arrangements (e.g. wards, equipment, etc.) • Evaluating the policy around 	<ul style="list-style-type: none"> • Effective regulation of private financing intermediaries (medical schemes and health insurers) and private health care provision (private hospitals; other facilities such as 'step-down' facilities, private clinics and HMOs; workplace health services; independent practitioners; equipment and technology; NGOs) to support achievement of national health system goals

¹ Please note that Table 2 is not an exhaustive list of existing or future PPIs. It is envisaged that it can be added to through consultation

	<p>Remunerative Work Outside the Public Sector (RWOPS)</p> <ul style="list-style-type: none"> • Evaluating the feasibility of Private Finance Initiatives (PFIs) 	
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Within this range of issues, this document focuses on PPIs that explicitly seek to draw on private resources or agents in support of what have previously been totally state-funded and state-provided activities (i.e. the public provision-private financing and the private provision-public financing quadrants in the above figure). It also indicates the need for consideration of existing and potential ways in which government resources are utilised within the private health sector.

However, the policy issues highlighted in the figure emphasise that managing PPIs within the South African health system over the long-term also requires the strengthening of all of the financing, provision and regulatory functions of government (i.e. the public provision-public financing and private provision-private financing quadrants).

Principles for decision-making around PPIs

In deciding whether or not to pursue any new PPI within the health sector, or in evaluating whether an existing PPI should continue or be revised, it is necessary to assess its merits in relation to the achievement of health system goals. Five sets of principles (summarised in the box below) are proposed for use in guiding these decisions, through careful and detailed assessment of whether the proposed or existing PPI will promote the objective embodied in the principle.

Guiding principles

A PPI should contribute to:

1. The overall sustainability of the entire national health system.
2. Promoting equity of access to primary care.
3. Promoting equity of access to affordable hospital care and strengthened public hospital care.
4. Promoting equity in financing of health services.
5. Promoting financial sustainability in the public sector.

In the application of these principles equal weight is given to the principles of overall health system sustainability/equity (principles 1 to 4) and of financial sustainability (principle 5). Therefore, in practice, every PPI should be assessed with respect to one or more of principles 1 to 4 *and* principle 5. The choice of which of principles 1 to 4 to use will be based on the nature of the proposed PPI, that is the element(s) of the health system to which it is addressed.

The motivation for this approach is that a PPI that only satisfies financial sustainability principles is very unlikely to be acceptable within the health sector. *Most critically, no PPI should be initiated that makes the existing inequities in access (to either primary*

care or hospital services) or in financing within the health sector worse, even in the short-term.

These principles should be reviewed periodically and revised as necessary in order to:

- Strengthen their support of the established health system goals.
- Facilitate their implementation.
- Enable their adaptation to changing health system needs.
- Enable their adaptation to changing PPI demands and possibilities.

The principles are:

A PPI should contribute to the overall sustainability of the entire National Health System.

This could be achieved by:

- Promoting cost containment in the private health sector, particularly with respect to the use of all health care technologies (including pharmaceuticals).
- Promoting the development of health care technologies (including pharmaceuticals) of greater cost-effectiveness than those currently available within the country.
- Promoting the development of health care technologies (including pharmaceuticals) that support the delivery of nationally affordable health care interventions.
- Promoting the efficient and equitable configuration of service provision in relation to highly specialised services that supports the long-term re-structuring of highly specialised services.
- Delivering demonstrable improvements in public sector management capacities (both skills and systems) that are retained within the public sector, at an acceptable cost (where cost considers the price of any related PP arrangement, the costs of any related system changes and the potential loss of skilled managers to the private sector etc).
- Strengthening health professional training by:
 - Consolidating and strengthening training capacity at all levels within the public sector.
 - Ensuring that health professional training at all levels is equally accessible to all those who have the required skills and qualifications, within the framework of employment equity.
 - Ensuring that the training of health professionals in all fields is maintained at adequate standards and remains wholly within the public sector's control.
 - Strengthening the training of health professionals in those specified fields deemed most important from a population health perspective and for the public sector.

A PPI should contribute to promoting equity of access to primary care.

This could be achieved by:

- Expanding access for all South Africans to a nationally affordable package of primary care services, of acceptable quality, with emphasis on those who currently don't have access.

- Strengthening access to, and the quality of, priority interventions provided by both public and private primary care providers (e.g. STI services, Integrated Management of Childhood Illness).
- Using the efficiency savings that may result from a new PPI mechanism to strengthen access to, and the quality of, primary care services.

A PPI should contribute to promoting equity of access to affordable hospital care and strengthened public hospital care.

This could be achieved by:

- Enhancing the provision of tertiary and secondary hospital services in under-served areas.
- Improving the quality of public hospital services for all patients, whilst allowing some differentiation in the amenity services offered to different groups of patients within public hospitals.
- Using the efficiency savings that may result from a new PPI mechanism to strengthen access to public hospital services and improve their quality.
- Attracting to and retaining in the public sector the full range of health care professionals, including managers, necessary to provide a nationally affordable and good quality package of public hospital services, especially in relatively under-served areas of the country.
- Encouraging greater use of public hospitals by a wider range of population groups, without undermining access to this care by the current users.

A PPI should contribute to promoting equity in financing of health services

This could be achieved by:

- Promoting cross-subsidisation (between healthy, younger and more wealthy population groups and the sick, elderly and poorer groups) in overall health care financing.

A PPI should contribute to promoting financial sustainability in the public sector.

This could be achieved by:

- Improving the efficiency of services currently provided within the public sector.
- Generating revenue for the public health sector that remains with the sector and can be used flexibly to support quality improvements.
- Not imposing an ‘unacceptable’ financial burden on the public purse (where the acceptable burden might be determined on the basis of its impacts on the budget available for other necessary activities and an assessment of the value/worth of the benefits gained).
- Securing a continuous supply of lower price and good quality drugs for the public sector and/or for priority public health conditions in both the public and private sectors.
- Using first the available under-used capacity within the public sector, without undermining access to public services by current users, and only after public sector capacity is exhausted, considering the construction of new facilities.

The role of government in the health system

Government has an important role in creating an enabling environment within which those PPIs that will promote achievement of health system goals can be developed. Some initial ideas on this potential role are presented here for consideration and discussion.

The draft National Health Bill indicates that the Minister of Health has the responsibility “To prioritise the health services that the state can provide taking into consideration health needs and resources available” (S4 (1)(e)) and to “Prescribe mechanisms to enable a co-ordinated relationship between private and public health establishments in the delivery of health services” (S56).

Government will have a set of core tasks in relation to its three main functions (i.e. financing, provision, regulation), which could include:

Financing:

- Maintain its role as a major financer of health care, with particular emphasis on the poorest groups.
- Strengthen its role as the overall co-ordinator of finance for health care provision, promoting equitable cross-subsidisation between population groups.

Provision and management:

- Strengthen its role as a provider of health services, especially within hospitals.
- Strengthen the institutional frameworks supporting management within the public health sector.

Regulation:

- Implement, and where appropriate strengthen, the regulatory frameworks governing the health sector in the following areas: Health professionals, health professional training and training institutions, private health care institutions, health care technology, the health insurance market, the quality assurance system for private and public providers.
- Strengthen its regulatory capacity through investment in the necessary skills and systems at all levels of government.

The role of the private sector in the health system

The private sector, especially the private health care sector, has definite roles to play in this partnership. Again, initial ideas on this role are presented for consideration and discussion. They may include:

- Ensuring efficient and effective provision of health services to their clients/patients.
- Assisting the Department of Health to ensure that affordable access to health care is progressively available in under-served areas of the country.

- Sharing management and clinical skills in the spirit of partnership that will improve the health of the populace.

Financing:

- Contribute to overall health care financing through pre-payment/insurance mechanisms that are: Equitable (ensuring appropriate cross-subsidisation and risk-equalisation within and between schemes) and affordable and efficient (incorporating effective mechanisms for controlling increases in benefit and contribution costs).

Provision:

- Contribute to equitable, efficient and coherent provision through supporting initiatives to avoid service duplication (particularly in relation to hospital beds and equipment) and promoting an equitable distribution of health services.
- Contribute to the development of efficient and effective health care technologies.
- Contribute to the development of an affordable and cost-effective health system

Regulation:

- Strengthen mechanisms for self-regulation, particularly in relation to peer-review of treatment practices and monitoring of quality of care.

Key issues for discussion

This background paper has:

- Reviewed the vision and goals of the South African health system, which should guide PPIs.
- Outlined the possible range of PPIs.
- Proposed a concrete set of principles to guide future decision-making on PPIs (both in reviewing existing PPIs and in evaluating proposed PPIs).
- Provided some initial thoughts on the role of government and the private sector in contributing to achieving health system goals through PPIs.

Questions for the Summit

Range of PPIs

- Does Table 2 adequately encompass the range of PPIs that exist or are under discussion in South Africa?
- If not, what other PPIs should be included to provide a comprehensive overview of the current range of PPIs?

Principles for decision-making

- Do the principles outlined fully reflect the health system vision and goals?
- Are there any other issues that should be incorporated into the set of principles to promote achievement of health system goals?
- Are there any other issues that need to be incorporated into the set of principles to ensure their relevance to the current range of PPIs?

Role of government

- What should the role of government be in ensuring that existing and future PPIs are in line with the principles guiding decision-making and thus, meet health system goals in line with the overall vision?
- What specific actions should the public health sector take in relation to health service financing, provision and management that will promote PPIs (e.g. to enhance fee revenue generation from private finance sources at public hospitals)?
- What specific regulatory mechanisms are necessary to ensure that PPIs meet health system goals?

[Note: It may be helpful to consider the role of government in relation to the range of PPIs that exist or could potentially exist, as outlined in Table 2.]

Role of the private sector

- What should the role of the private sector be in ensuring that existing and future PPIs are in line with the principles guiding decision-making and thus, meet health system goals in line with the overall vision?
- What specific types of PPIs could the private sector initiate/pursue that fulfil the guiding principles?

[Note: It may be helpful to consider the role of the private sector in relation to the range of PPIs that exist or could potentially exist, as outlined in Table 2.]

Action plan

- Based on the discussion of the questions above, what steps need to be taken to promote PPIs that meet health system goals?
- Who should be responsible for which aspects of this action plan, and in what time frame?
- What forms of monitoring and evaluation are necessary to ensure that emerging PPIs meet health system goals and do not make the existing inequities of the health system worse?

- Who should be responsible for which of these aspects of monitoring and evaluation?

Public-private interactions

Tough meat as sectors share a table

It was like a dog worrying a bone. Delegates gnawed at the issues, snapped at their differences of opinions, and extracted the splinters.

The Health Summit provided too many stark views around public-private interactions (PPIs), too meaty an agenda and too little time with the peppermints and bottled water in the vast chambers of the Sandton Convention Centre to find an appetite for consensus. In some of the sharper exchanges it wasn't clear if the two sides were yet ready to talk, at least over health financing.

Yet pragmatic solutions have been in place in South Africa for years and more are possible. And ultimately, in the four sub-groups debating this theme, delegates found enough in common for facilitators to extract a skeleton plan for future action.

The Summit billed itself as a means to address concerns over the gaps between policy frameworks and service delivery, not a response to a major crises. Professor Di McIntyre, Director of the Health Economics Unit at the University of Cape Town, facilitated the PPI breakaway sessions. Work began mid-morning on Monday 19 November with a presentation by the Department of Health's Dr Kamy Chetty of the PPI Background Paper prepared by a task team comprising academics and departmental officials. This was the bone served up for delegates to chew on, debating delegates the vision and principles spelled out in the document, the range of possible PPIs, and the roles of both government and the private sector.

Among those waiting to shake around the issues were representatives from the Financial Services Board, the Reserve Bank, the Treasury, medical funders, national and provincial health departments, local governments, hospital and pharmaceutical groups, the Board of Healthcare Funders, the Medicines Control Council, the USAID Equity Project, universities and professional associations. It was a broad group, but perhaps not broad enough.

Far from homogeneous

A first point to be raised was that the private sector is far from an homogeneous entity. Nor is it for profit only. The background paper might have had private practitioners, hospital groups, pharmaceutical manufacturers and medical financing companies in mind but it skipped out NGOs and community-based organisations. A range of these groups did attend the discussions and -- as Paul Davis, chairman for the Bureau for the Prevention of Blindness, explained -- they had important roles to play. The Bureau, for example, had been running PPIs for 40 years to help address backlogs in cataract surgery. This was a "quick win" arrangement which could continue and show others the way.

The background paper also did not reflect the diversity among corporate players: medical scheme Bankmed for example has helped develop a PPI in the Western Cape's Tygerberg hospital, while Discovery Health is still at odds with the Registrar of Medical

Schemes. Variations continue down to the individual level. “GPs in Katorus are professional, entrepreneurs and survivors – a mixture of missionaries and mercenaries,” observed Dr Nzapfurundi Chabikuli of the Centre for Health Policy, which presented a case study on improving the quality of private sector care for sexually transmitted infections:

Understanding objectives

Delegates in the PPI theme group were divided into four sub-groups and opposing viewpoints quickly emerged. In one sub-group – deftly chosen to square up facilitator and Council for Medical Schemes Registrar Patrick Masobe with delegate Shaun Matisonn, Discovery Health’s Principle Officer representing the Life Assurers Association – discussions opened with Professor Bill Haslam, deputy chair of the Financial Services Board. “The two parties are not talking, they’re coming from completely different paradigms,” he observed. “They have different agendas and are moving towards a situation which will have catastrophic results.” What was needed, he said, was for the two sectors to understand each other’s differing goals: Maximising profit and maximising the public good, respectively.

That group charged into a tussle over the terms of the background paper, which laid out a vision of a coherent, unified, health system offering financial protection for all in accessing a nationally affordable package of health care at the time of need.

Pat Masobe tabled his view: ‘It appears to be too Utopian and far-reaching – it gives the impression that anything less than (reaching people) ‘wherever they are’ and ‘for all levels of care’ is a failure”.

“It’s confusing,” said Mediclinic Chairman Dr Edwin Hertzog. “In some parts it appears to argue that the private sector should be strengthened, in others that a single national system should be in place.”

‘I don’t understand what a co-ordinated, unified health system means,’ was Mr Matisonn’s comment.

Fortuitously, the President explained the concept of “unified” in his address to the Summit that evening and it had nothing to do with the government nationalising the private sector. The unified health system to which Government had committed itself in 1994 meant, he said, organisational coherence across all spheres of government, an expression of common humanity, and an ability to “bring the public and private health care sectors within a common framework of social and professional values and objectives”.

The morning debate also chewed over the extent of cross- subsidisation and whether nationally affordable health care was based on total health sector expenditure. Equity, and its associated costs, was another issue which proved difficult to pin down in the space of minutes. “Halfway through the year everyone who is supposed to have the ability to pay is unable to pay,” growled Kgosi Letlape, Chairperson of the South African Medical Association and an ophthalmologist in private practice.

Dissent emerged on the question of whether partnerships were genuine, and trust between the two sides existed. “We’re forced to be reactive,” said Board of Healthcare Funders’ Deputy Chair Penny Thlabi. “Relationships are strained at best, and sometimes even hostile,” she said, speaking from her experience that input on legislation was not reflected in the final issues. The Department of Health barked back. “The principle of active participation is accepted, but we need to accept that Government has the final responsibility in determining policy,” said Dr Chetty.

Grinding on territorial themes

Several floors down, in a basement breakaway room, the other sub-groups were also grinding away on territorial themes.

In general, Government needed to stop being so defensive, lift the veil of secrecy over social health insurance and lead the way to an enabling environment by identifying its priorities, one group decided. They found the background paper’s guiding principles for PPIs thin on spelling out the possible roles and impact of the private sector.

For example, Professor Max Price, Dean of Wits Medical School, argued that training for health professionals should not remain “wholly within” the public sector, although care should be taken to ensure that training did not undermine public sector delivery.

At times delegates seemed to be stuck in a thorn patch, pitching ideologies without time to argue them through.

Departmental representatives and some of those who had drafted the background paper watched with concern. Yes, they said, in quiet asides, the document needed more clarity. But shallow readings and snap conclusions, compounded by the lack of trust between the two sectors, were leading to unfounded fears and misunderstanding.

The Summit did not yield answers. Questions remained on which side really knew its costs and could claim to be more efficient; whether the public sector could demand to be the provider of choice; whether the private a right to rely on Government to make provision for market failure; and whether equity could ever be achieved in the presence of a private health care system. The concept of a common health goal remained challenging, given that the private sector needs illness to boost profit, while the Government needs health to boost development and its WHO ratings.

Yet middle ground existed and was shaped by pragmatism. One small afternoon discussion group, for example, swiftly worked out how a private hospital could provide state funded emergency care to indigent patients. “The base would be a contract with very tight definitions, commitment from both parties and monitoring of care,” explained Dr Trevor Frankish of the Lifecare group.

It became clear was that measures were needed to build Government capacity to deal with the process. “Unsolicited bids from the private sector are difficult to evaluate and untenable. Government needs to be more proactive and procure and manage PPIs,” stressed William Dachs, Transaction Advisor in the Treasury’s Public Private Partnership Unit, which is already overseeing four health-focused PPIs around the country. Related to this was the need to clarify the roles of national, provincial and

local government. “For God’s sake tell us who is going to do what and get on with it,” pleaded Johan Kemp, Director of Health Services in the Garden Route Klein Karoo District.

Day One – extracting the flavour

The job of pulling together a presentation for the Summit’s Plenary session was accomplished through a two-hour report from facilitators and rapporteurs for the four sub-groups. They agreed to identify broad, commonly expressed issues rather than dwell on specific viewpoints and to recognise the underlying tensions between the two sectors.

It was with not a little pride that overall rapporteur for the PPI theme group Dr Yogan Pillay put forward the conclusions to the Plenary: “The PPI discussion were the most interesting and robust of the Summit,” he grinned, conceding that it had been difficult to put together a presentation with diverse opinions and not enough time to get consensus.

The PPI theme group found the vision for PPIs contained in the background paper mostly acceptable, provided that a “unified” health system only meant acceptance of a common overall objective for this system and subject to clearer definition of the concept of national affordability.

Dr Pillay also explained that the underlying approach to equity was that it was not to be viewed as an event or a once-off achievement, but a state that should be constantly aimed at and reinforced. He also pointed out that quality of care, a subject addressed by a different theme group within the Summit, was critical to PPIs if collaborative efforts were to yield desired results.

In principal the theme group decided to accept and use the background paper as a guide to evaluate if, on balance, any planned PPI was likely to yield a positive outcome. The “on balance” view of PPIs would allow the development of some that might have a negative short-term effect on access – for example, private wards in public hospitals - because of their longer term potential to generate capital for upgrading other public facilities in the hospital. The public sector, however, should not cross-subsidise the private sector through PPIs and the principles of accountability and non-duplication of services should hold.

Given the robustness of discussions, the theme group found it had to confront the need for various parties to work of building genuine partnerships, based on transparency and trust.

A tentative division of roles was also proposed for this partnership, in terms of which Government should provide core services, should outsource “non-core” activities (the concept was not clearly defined) and should take a leading role in developing PPIs.

The private sector has a role to play in monitoring quality, helping train health workers and influencing health policy. Although it was not optimally efficient – the reason put

forward was lack of competition – this sector should be allowed to innovate, invest and, in short, make profits. “How much profit?” asked the Minister. “We’ll take that back to the group!” Dr Pillay responded.

Theme group members took the view that the private did need to play a greater role in prevention, research and data collation. It also needed to assume more responsibility for risk in the provision of health services and more actively engage with government to build trust.

Pillay gave a sense that PPIs were still at an early stage and that further definition of concepts and role as well as a shared understanding of what makes PPIs successful would have to evolve. “This is part of a process,” he pointed out – adding the parting shot that PPIs were certainly not “a panacea for all the ills of the health system”.

It was this summary of ground covered in the first few hours of engagement that made the discussions of Day Two far easier.

Day Two – a plan of action

The task on the second day was to develop a plan of action*. This time, there was no shortage of ideas. But these ideas often raised new questions. For instance, how to reconcile intellectual property rights and unsolicited bids with constitutional requirements for good and fair procurement. And how to tackle the issue of public sector officials’ reluctance to take risks and responsibility. Action-oriented discussions also raised frustrations. Lamented Paul Davis of the Bureau for the Prevention of Blindness: “How do you open people’s eyes to the lack of depth in existing infrastructure?”

The short answer to all the above questions is: Step by step. And, despite its limitations, the Health Summit did achieve a sense of what steps would edge the two sides closer together.

First on the list of priorities presented by Yogan Pillay to the Plenary on the second day was to build trust and create an enabling environment by holding a national PPI lekgotla within three months. This meeting could contribute to an audit of existing PPIs.

The next priority was to create forums at each level of government to engage with the private sector.

Also on the action list was a proposal that the Department of Health should build its PPI capacity through establishing a unit headed by a “champion” of the PPI approach and with dedicated staff. This should begin within the first quarter of 2002.

This should enable the Department to explore the state of play and financing options of health care with its partners, like the Board of Healthcare Funders, in the second quarter of 2002.

Finally, the recommendation was made that PPIs should embrace and strengthen existing health strategies, such as the HIV/AIDS and TB programmes and initiatives on

rural development. Those offering a promise of quick success should be fast-tracked.

Anyone for dinner?

Janine Simon-Meyer

* Refer to the Summary of discussion for the PPI Theme Group for further details.

Public-private interactions

Summary of discussion

Introduction

This presentation looks at:

- Reaction to the proposed vision and principles
- The range of PPIs
- The role of government
- The role of the private sector
- Other issues

Vision, goals and principles

Vision

- Mostly acceptable to participants
- “Unified” health system understood to mean bound by common overall objective
- “Nationally affordable” requires definition

Goals

- Equity: The feeling was this should be phased in over time
- Coherence: Some queried the need for “unified” system
- Quality of care
- Efficiency and cost-effectiveness

Principles

- Overall sustainability of national health system
- List of issues to be used to evaluate if, on balance, positive outweigh negatives
- Need to ensure sustainability of both sectors
- Equity of access to primary care and hospitals
- Balance short and long term benefits of PPIs
- Equity in finance
- What is the appropriate level of cross-subsidisation between groups?
- PPIs must not be route for public sector to subsidise private sector
- Financial sustainability of the public sector
- Need to consider sustainability of private sector too

Add the following principles

- Accountability
- No duplication of services
- Quality of care

- Efficiency
- Capacity building
- Partnership as a relationship of trust, transparency and communication

Role of government

Government's role was seen as follows:

- To develop capacity to enter into PPIs – and reduce inertia in decision-making
- To provide core services and outsource non-core services
- To take a leading role in PPIs – as unsolicited proposals are difficult to manage
- Create mechanisms to ensure compliance (for instance, the Patients' Rights Charter)
- To have plans in place in case of market failures
- To create a forum to share PPI lessons
- To empower communities
- To clarify roles of national, provincial and local government

In addition the view was taken that:

- There was a need greater consultation on social health insurance
- Policies and legislation should be reviewed to create an enabling environment for PPIs

Role of private sector

In relation to the role of the private sector the following points were made:

- Monitoring quality could be a joint activity, strengthening partnership
- The private sector could assist with training health workers
- It has a part to play in influencing health policy
- It would undertake innovation, investment and capital outlay – while making profits
- The private sector should provide low cost products
- And it should encourage competition to ensure efficiency
- Furthermore, it should play an increased role in preventive health programmes

Other private sector responsibilities were:

- To provide accurate data
- To share risks – not just reap profits
- To contain costs to ensure sustainability
- To engage actively with public sector to build trust

Other issues

The following issues were raised:

- The need for clearer definitions, including the concept of affordability
- The inclusion of not-for-profit NGOs and CBOs in PPIs
- The role of sessional doctors
- The need to understand success factors of PPIs

- The need for research on costs of service provision in both sectors
- The cost of capital in PPI ventures
- Use of principles in World Health Report of 2000 as an evaluation tool

Conclusions

- Participants in the PPI discussion concluded:
- Much work needs to be done to build trust
- The Summit should be seen as part of a process
- PPIs are not a panacea for all ills of the health system

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