

**REPORT OF THE “PUBLIC-PRIVATE
INTERACTIONS” LEKGOTLA**

11-12 JULY 2002

KOPANONG, GAUTENG

INTRODUCTION

Public-Private health sector Interactions (PPI) are on the increase in South Africa. However, there are few mechanisms for the two sectors to routinely engage with each other. Such mechanisms are necessary to allow all stakeholders to understand better the motivations of, and the challenges that face, each sector and are a key part of the process of building trust between the sectors. The overall purpose of PPIs, and therefore of engagement between the public and private sectors, is to strengthen the overall health system for the benefit of all South Africans.

The PPI Lekgotla was a follow-up to the discussions on PPIs initiated at the National Health Summit held in November 2001. The Lekgotla was seen as one step in an ongoing process of strengthening the relationship and communication between the public and private health sectors.

The Lekgotla was planned by a PPI working group, which was established by the national Department of Health in early 2002 to take forward the recommendations of the National Health Summit. This Working Group comprises individuals from the public and private health sectors as well as academics. Members of the Working Group were invited to participate in their personal capacity (i.e. this group was not envisaged as a representative forum). It is co-chaired by Prof. Di McIntyre (Health Economics Unit, University of Cape Town) and Dr Kamy Chetty (Deputy Director-General, National Department of Health). This working group was tasked with very specific activities, in particular to ensure that mechanisms for ongoing interaction between the public and private sectors were established. The working group has initiated the collection of information on existing PPIs, has supported the national Department of Health in developing a proposal for a PPI unit within this department and has attempted to facilitate the establishment of PPI fora in each province. One of its key tasks was to organise the Lekgotla; the groups invited to participate, the agenda and other organisational aspects were all agreed by the working group.

The Lekgotla was held over two days, 11-12 July 2002. It was attended by over 60 participants, representing the following groups:

- National, provincial and local government health departments
 - National Treasury
 - Academics (Deans of medical schools) and CEOs of central hospitals
 - Statutory Councils
 - Medical Schemes
 - Private hospitals
 - Pharmaceutical groups
 - Medical professional groups (SAMA and SAMDP)
 - Trade unions
- In addition to the above-mentioned groups, a number of non-governmental organisations were invited but were unable to attend.

The key objectives of the Lekgotla were:

1. Sharing information on the context within which PPIs occur (both in relation to government policy and regulations, as well as challenges presently facing the private sector and efforts to address these challenges);
2. Strengthening the relationship and communication between the public and private health sectors to build a strong health system in South Africa; and
3. Developing clear mechanisms for facilitating ongoing communication between the public and private sectors, including PPI fora in each province.

The first morning of the Lekgotla was devoted to three plenary presentations and discussion of these presentations (see Agenda in Appendix A). The purpose of these presentations was to provide contextual information for the PPI discussions. This included:

- Perspectives from the national Department of Health, including the likely implications of the draft National Health Bill for PPIs (Dr Ayanda Ntsaluba, Director-General, National Department of Health);
- The National Treasury’s Strategic Framework for Delivering Public Services through Public-Private Partnerships (Mr William Dachs, PPP Unit, National Treasury); and
- The South African health system, the need for PPIs and the need for engagement about PPIs (Prof. Lucy Gilson, Centre for Health Policy, University of the Witwatersrand).

The rest of the Lekgotla was devoted to small group discussions, plenary report-backs and plenary discussions. The purpose of these small groups was to ensure that each group had adequate opportunity to express their views and to allow for detailed consideration of relevant issues.

This report provides an overview of all the discussions at the Lekgotla, and summarises the key conclusions reached on the way forward.

PLENARY PRESENTATIONS

The Lekgotla was opened with a keynote address by the Director-General of the national Department of Health, Dr Ayanda Ntsaluba (see Appendix B for the full text of this address). He highlighted the importance of addressing disparities in the public-private health sector mix in order to improve the overall performance of the South African health system, and that it was on this basis that the issue of PPIs had been adopted as a key theme at the November 2001 National Health Summit. Since the summit, there has been a process of reviewing the PPI policy framework, drawing on discussions at the summit. Other activities have also been initiated to take forward the summit recommendations.

Dr Ntsaluba stressed the importance of reaching a common understanding of the nature of the challenges that face the South African health system, as a basis for discussions about PPIs. It is non-negotiable that PPIs should be consistent with the fundamental policy thrusts of government.

He also referred to the National Health Bill, which will be considered by parliament in the near future. Specific sections of the Bill, such as that on health establishments and the certificate of need process, will have implications for PPIs. The intention of the Bill is to enforce a framework on the public sector that is consistent with government expectations of the private sector. Dr Ntsaluba assured Lekgotla participants that all comments on the draft Bill had been given serious consideration and indicated that stakeholders would have a further opportunity to comment on the Bill during the public hearings of the Parliamentary Portfolio Committee on Health.

Finally, he re-iterated his Department’s commitment to engaging in discussions on PPIs. “We need to tackle the task at hand as partners, as true partners, and we need to depend on the integrity of everybody who sits around the table to have these discussions. ... We should all approach this discussion with the understanding that all of us are trying to, as best we can, build a viable health sector.”

Mr William Dachs, who is responsible for the health sector within the PPP unit of National Treasury, then provided an overview of the Treasury regulations on PPPs (see Appendix C for a copy of his presentation). He stressed that while PPIs refer to the full range of inter-relationships between public and private health sectors, PPPs refer to a very specific set of activities. Treasury defines PPPs as: “A *contractual arrangement* between the public sector and a private entity where the *private sector performs a departmental function OR uses state property for own commercial gain* in accordance with *output specifications* for a significant *period of time*, in return for a *benefit*.” This means that only PPPs that meet the specifications in the above definition have to go through the process of obtaining Treasury approval. He stressed that any such PPPs that did not go through this process were not legally enforceable. It was suggested that if there was any doubt about whether a PPP required Treasury approval or not, the PPP unit should be contacted and could provide a response within a short period of time.

Mr. Dachs indicated that the criteria used by Treasury for evaluating any proposed PPP were:

1. Affordability;
2. Value for money;
3. Appropriate risk transfer. Treasury goes through a detailed process of evaluating whether these criteria will be met through the proposed PPP. This includes an initial feasibility study, which particularly focuses on the affordability of the PPP and provides an initial indication of whether it will provide value for money. Value for money is then further assessed before a Request for Proposals (RFP) is issued as well as after proposals have been received. A period of contract negotiation and approval ends this Treasury Authorisation process.

Prof. Gilson then provided some insights into why PPIs may be helpful in the South African context, drawing on the World Health Organisation’s (WHO) rating of the SA health system and the findings of the recently completed National Health Accounts project (see Appendix D for a copy of her presentation). She highlighted the fact that, in terms of the WHO’s evaluation of health systems in a large number of countries, South Africa performed very badly in comparison to many other low- and middle-income countries. It is clear that we receive very poor value for money from the South African health system; despite devoting considerable resources to health care, we have extremely poor health status (e.g. average life expectancy at birth of 48). In addition to the role of HIV/AIDS, a key reason for the low average health status indicators is the massive health inequalities in South Africa (e.g. Black South Africans have infant mortality rates that are 5.5 times greater than that of White South Africans; and there is a three-fold difference in infant mortality between the richest and poorest South Africans).

A key contributory factor to these health status inequalities is the existing public-private health sector mix, with significantly higher levels of health care resources found in the private than public sector **relative** to the population served by each sector. The rapid escalation in medical scheme expenditure, and hence in contributions, is contributing to a growing financial resource gap between the two sectors. This suggests that there is considerable scope to use total health system resources (both public and private sector) to better meet the needs of all South Africans.

These presentations provided a useful context for the first set of small group discussions.

FIRST SET OF SMALL GROUP DISCUSSIONS

Participants were divided into three small groups. The first group contained representatives of private hospitals, medical professionals, local government and public hospitals (the academic or central hospitals); the second group included medical schemes, provincial government and the Deans of Health Science Faculties; and the final group comprised representatives of the pharmaceutical sector, the national Department of Health, statutory councils and trade unions. It was felt that this structure would allow each stakeholder group adequate opportunity to fully express their views.

The questions posed for discussion in the first small group session included:

- What is the purpose / goals of PPIs:
 - Why do you think PPIs are worth pursuing in South Africa and how do you think PPIs will help in addressing the challenges facing the South African health system?
 - *From the perspective of your organisation*, how would PPIs help to meet *your own objectives*? (What does your organisation hope to achieve for itself from engaging in PPIs?)
- What are the key challenges to taking forward PPIs:
 - What constraints are there to PPIs, or what obstacles exist to being able to achieve the broad objectives of PPIs, as well as those of your own organisation?

Appendix E contains copies of the report-backs from each small group. The key issues raised in relation to the purpose and goals of PPIs include:

- To share resources between the public and private sectors (resources include people, skills, equipment, facilities, spare capacity)
- To avoid duplication in service provision
- To obtain better value for money (to provide health care cover at lower cost, to improve overall health status with the available resources)
- To redress the large disparities in health services and health status, and thereby promote equity
- To improve the retention of skilled health professionals in the country
- To promote revenue generation within the public sector and thereby reduce the heavy reliance on tax funding for these health services

There was considerable agreement on the broad objectives of PPIs, particularly that it was a way of promoting transformation of the existing health system to improve overall health status for South Africans and to redress existing health inequalities. While there were some differences in the specific objectives of individual stakeholder groups, it was apparent that PPIs could facilitate achieving some of these different objectives simultaneously. For example, the medical schemes' objective of being able to purchase health services for their members at lower cost and the public hospitals' objective of generating revenue could both be met through a preferred provider arrangement between schemes and public hospitals which provided differentiated amenities.

However, while there was a high degree of commonality in views on the overall objectives of PPIs, concerns were expressed that there may not be as much commonality about the overall vision of the future of the health system in South Africa. In particular, it was not clear what health system transformation different stakeholder groups would like to see and what end points different groups want to reach. It was suggested that without an explicit vision to drive the day-to-day development of PPIs,

we may not be able to address the health system challenges that face the country (e.g. achieving value for money, addressing inequalities).

The key issues raised in relation to the constraints and obstacles to PPIs include:

- There remains considerable uncertainty and lack of clarity about government policy on PPIs, for example, which kinds of PPIs does government wish to pursue and what is the possible impact of the Social Health Insurance proposals;
- There is also a lack of clarity on the role that government sees itself playing in the health sector (should government purely be a funder of health services or should it also be involved in health care provision; there is some confusion because sometimes the public sector is a purchaser of health (and support) services – through contracting out or outsourcing services – and sometimes a seller of health services – through preferred provider arrangements with medical schemes);
- The current processes for initiating PPIs are seen as bureaucratic and slow;
- There is a lack of capacity to negotiate, implement and monitor PPIs, both within the public and the private sector; and
- There remain some concerns about a lack of trust and possibly conflicting motives between the public and private health sectors.

It was clear from the discussion of these constraints and obstacles that there remained considerable confusion about the difference between PPIs and PPPs. It was stressed that PPPs are a small subset of PPIs; *PPPs only refer to specific contractual arrangements* where the private sector performs a government departmental function or uses state property for commercial gain. In contrast, *PPIs refer to any form of interaction* between the public and private sectors, where the activities of either sector impact on the other sector, or where the activities of another body may impact on both the sectors simultaneously. PPIs include such diverse issues as: government legislation that impacts on the private health sector; private financing of publicly provided health services (such as preferred provider arrangements between medical schemes and public hospitals); tax deductibility of medical scheme contributions; the distribution of health care resources between the two sectors relative to the population they serve and how this impacts on health status differentials in South Africa; skills retention which may affect the public sector where professionals move into private practice and affects both sectors when there is international migration; the need for minimum data-sets on both public and private sector health care financing, expenditure and service provision. The need for a focus on PPIs, rather than very specific PPPs, was reinforced by the earlier discussion of the importance of discussing various stakeholders' perspectives on a vision for a future South African health system.

Key steps that need to be taken arising from these discussions include:

- Urgently need information on past PPIs to learn 'good' and 'bad' lessons;
- Need clear guidelines on what PPIs are encouraged by government and on the process for approval (particularly for those PPIs lying outside of the Treasury regulations);
- Devolution of authority and revenue retention need to be implemented in public sector; and
- Need ongoing dialogue, not only about technicalities of PPIs, but most importantly to consider common strategic vision for the South African health system.

SECOND SET OF SMALL GROUP DISCUSSIONS

Participants were once again divided into three small groups, but each group contained representatives of each of the stakeholder groups. The questions posed for discussion in this small group session included:

- Do you think that establishing provincial PPI fora would be useful, and if so, in what way? What would you/your organisation hope to achieve through such fora? What should the goals of these fora be? What organisations should be involved in provincial PPI fora?
- Should there also be a national PPI forum? If so, what would the purpose of this forum be? How would the goals of a national forum differ from the provincial PPI fora? What organisations should be involved in a national PPI forum?
- Are there any other ways in which engagement around PPIs can be facilitated? If so, how, and with what purpose (and how does this purpose differ from the provincial fora and the national forum)?

The key issues raised in relation to the mechanisms for ensuring continuing engagement between the public and private health sectors include:

Provincial PPI fora:

- There was widespread agreement that there was a need to establish a PPI forum in each province as a matter of urgency. This will be spearheaded through the Provincial Health Restructuring Committee (PHRC) which includes the heads of health departments at the national level and from each province. PPI fora already exist in two provinces already (Western Cape and Free State) and valuable experiences can be shared by these two provincial fora with other provinces.
 - Provincial PPI fora should involve as many of the stakeholders as possible. As a minimum, each provincial forum should include representatives from the Provincial Department of Health (DoH), medical schemes, private hospitals and SAMA/medical professional organization. It would also be valuable to include representatives of local government, NGOs, the pharmaceutical industry and trade unions where relevant.
 - These provincial PPI fora should meet regularly (e.g. the Western Cape PPI forum meets on a monthly basis).
 - These fora should be co-ordinated by the respective provincial health departments, and there should be a senior official in each provincial DoH to 'drive' the process of engagement about PPIs. It would be desirable to have a PPI unit of some form in each provincial DoH.
 - The major focus of provincial fora should be on information sharing between the sectors and dealing with 'technical' issues relating to PPIs (such as service delivery and implementation issues).
 - However, provincial fora should also discuss other issues of common interest to feed forward to the national forum.
 - It was seen as important to have some co-ordination between the different provincial fora. There was a perceived need for a national co-ordinator, who could disseminate information to the provincial fora (thus promoting some consistency across provinces) and suggest issues for discussion in all the provincial fora as a mechanism for obtaining 'bottom-up' inputs to the national PPI forum. National PPI forum
- Again, there was consensus that a PPI forum should be established at the national level.
- The size of this forum should be kept reasonably small (e.g. 20 people), but there should be representation from all key stakeholders. It was suggested that there should be representatives from the national DoH, from each provincial PPI forum,

and one representative from each of the key stakeholders, particularly those that are nationally-based.

- The national PPI forum should meet possibly every 3-6 months (although it may be necessary to set up task teams or working groups that meet frequently in order to undertake specific activities).
- This forum should have more of a focus on strategic issues. In particular, it should explore the possibility of developing a common vision of the South African health system and the role of PPIs in a transformed health system. (One group suggested that there should be a Health CODESA to rapidly come up with recommendations for health system transformation). It should also focus on issues coming from the provincial fora that are of national relevance.
- Given the constraints on government resources, some suggested that there should be co-funding of the expenses of the national PPI forum by stakeholders.
- This forum can make recommendations to policy-makers; i.e. it is not a policy-making body as policy is ultimately made by government, through cabinet approval.
- The national forum needs a strong ‘policy champion’, i.e. a senior national DoH official who will take forward PPI issues. There should also be a PPI unit within the national DoH.

There was limited discussion of these issues in plenary, partly due to the considerable degree of agreement between the three groups.

CONCLUSION

Dr Chetty concluded by indicating that there are some activities that need to be undertaken immediately. In particular, it is critical to draft and disseminate very simple, clear document on the questions that were raised frequently during the summit (e.g. what are PPIs and PPPs and what is the difference between them; how to go about establishing a PPP, what’s the best way of establishing whether it falls within Treasury regulations, etc.). It is also necessary to develop a clear and explicit policy framework on PPIs and PPPs.

In addition, there is a need for considerable capacity building and information sharing. For example, it would be important to make copies of the National Health Accounts report and other relevant documents available to the various stakeholders.

The initiation of a national PPI forum needs to occur very rapidly. It was suggested that, in order to take forward the Lekgotla discussions, a meeting with one representative from each of the stakeholders be called, in order to concretise the key issues for consideration by this forum. This will not preclude the National Department of Health calling *ad hoc* meetings to discuss some of the key issues that have been raised at the Lekgotla, such as the proposed Social Health Insurance and the migration of health personnel.

Dr Chetty ended by noting: “From the National Health Summit to where we are right now, I can definitely feel a very visible and tangible difference. Some of the discussions at the Summit were acrimonious and there was a lot of distrust. We haven’t necessarily worked through all of that distrust, but the most important thing is that we have been able to establish a very strong foundation for dialogue. I think that the more we start talking to each other and understanding our different points of view and agreeing to disagree - of course, we’re going to have different view points - but at least we will be able to communicate that view point, talk around it, and get a better understanding.”

APPENDIX A: AGENDA FOR LEKGOTLA ON PUBLIC-PRIVATE INTERACTIONS

Thursday 11 July 2002

9h00 – 10h30 Plenary session (Chair: Dr Kamy Chetty)

- ◆ Welcome and background to the Lekgotla
- ◆ Keynote Address: Perspectives on PPIs from the National Department of Health
Dr Ayanda Ntsaluba
- ◆ Discussion

10h30 – 11h00 Tea

11h00 – 12h30 Plenary session (Chair: Prof. Di McIntyre)

- ◆ Presentation: The National Treasury's Strategic Framework for Delivering Public Services through Public-Private Partnerships
Mr William Dachs
- ◆ The South African health system: Why do the public and private sectors need to interact
Prof. Lucy Gilson
- ◆ Discussion
- ◆ Brief introduction to afternoon's small group discussions

12h30 – 14h00 Lunch

14h00 – 17h00 Small group discussions (Facilitated by Prof. Gilson, Prof. McIntyre and Mr Dachs)

Purpose and goals of PPIs and key challenges to taking forward PPIs, including:

- ◆ General perspectives on how PPIs can assist in addressing the challenges facing the South African health system;
- ◆ How PPIs can contribute to achieving the objectives of individual organisations represented; and
- ◆ Constraints and obstacles to achieving objectives of PPIs.

Friday 12 July 2002

8h30 – 10h00 Plenary session (Chair: Prof. Di McIntyre)

- ◆ Feed-back from small groups
- ◆ Discussion of key issues arising from report-backs
- ◆ Brief introduction to small group discussions (to be held after tea)

10h00 – 10h30 Tea

10h30 – 12h00 Small group discussions (Facilitated by Prof. Gilson, Prof. McIntyre and Mr Dachs)

Mechanisms for ensuring ongoing engagement between the public and private health sectors, including:

- ◆ Purpose and possible composition for provincial PPI fora
- ◆ Should there be a national level PPI forum and if so, what should its purpose and composition be
- ◆ Goals and mechanisms for any other strategies to promote ongoing engagement

12h00 – 13h30 Lunch



13h30 – 16h00 Plenary session (Chair: Dr Kamy Chetty)

- ◆ Feed-back from small groups
- ◆ Discussion of key issues arising from report-backs
- ◆ Agreeing key steps to continue public-private sector dialogue

APPENDIX B: FULL TEXT OF DR. NTSALUBA’S KEYNOTE ADDRESS

APPENDIX C: PRESENTATION BY MR. DACHS

**Public Private Partnerships
TREASURY OVERVIEW**



William Dachs
PPP Unit
11 July 2002

1

WHY DOES GOVERNMENT SUPPORT PPPs?

- Cabinet endorsed PPPs as service delivery mechanism in 1999
- Public Sector funded economic infrastructure in the amount of some R23 billion in 1999
- Private sector investment has steadily grown since the 1970's and now exceeds public sector
- NIF estimated infrastructure backlog in 1996 as some R180 billion over all sectors
- Private Sector therefore no stranger to delivery

2

WHY DOES GOVERNMENT SUPPORT PPPs?

- Public sector skills shortage acute
- Over-expenditure on personnel
- Consistent under-expenditure on capital works
- Growing experience of private participation
- New financing sources and mechanisms
- Unprecedented technological change

3

ROLE OF TREASURY IN PPPs

THE CONSTITUTION (Act 108 of 1996)

Section 217 (1):

"When an organ of state ... contracts for goods or services, it must do so in accordance with a system which is fair, equitable, transparent, competitive and cost-effective."

4

ROLE OF TREASURY IN PPPs

PUBLIC FINANCE MANAGEMENT ACT of 1999

- Efficient and Effective Financial Management
- Accounting Officers -Responsible and Accountable
- Procurement becomes the Responsibility of the Accounting Officer
- Applies to all Departments, Public Entities, Constitutional Institutions
- Each Department is responsible for PPP procurement and implementation in terms of PFMA

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ROLE OF TREASURY IN PPPs

TREASURY REGULATIONS MAY 2000 (REVISED MAY 2002)

- Rigorous Approval Process by Treasury
- Key Elements are:
 - ① Affordability
 - ② Value for Money
 - ③ Appropriate Risk Transfer
- Exemptions on basis of institutional capacity
- Does not apply to local government, does apply to Schedule 3 Public Entities

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ROLE OF TREASURY IN PPPs

A PPP DEFINED

"A contractual arrangement between public sector and a private entity where the private sector performs a departmental function OR uses state property for own commercial gain in accordance with output specifications for a significant period of time, in return for a benefit.

It involves a substantial transfer of all forms of project life cycle risk to the private sector. The public sector retains a major role either as main purchaser of the services or as main enabler of the project."

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ROLE OF TREASURY IN PPPs

- PPPs are sound commercial arrangements based on:
 - a thorough feasibility study
 - a comprehensive project agreement
 - a fair procurement process
- PPPs are not:
 - a panacea for service delivery failures
 - always the preferred option
 - Abdication of responsibility for service delivery
- All large capital works should be subjected to the same rigorous feasibility studies and procurement procedures as PPPs

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ROLE OF TREASURY IN PPPs

Guidelines Available

A Introduction
B Strategic Framework
C Treasury Regulations
D Project life-cycle – the steps in the PPP project process
E Project Finance – various aspects of managing project finance
F Transaction Advisor Guidelines – obtaining and managing transaction advisers
G Feasibility Study Guidelines – for the format and content of feasibility studies
H Request for Proposals Guidelines – guidance in the preparation of RFPs
I Unsolicited Proposals Guidelines – handling unsolicited proposals from potential private partners
J Departmental Budgeting Guidelines – integrating PPPs into departmental budgets.
X Glossary – major terms used in PPPs

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ROLE OF TREASURY IN PPPs

Provincial PPPs

- At present Chapter 16 powers not delegated to Provincial Treasuries
 - Building of capacity in provinces
 - Newness of PPPs
 - Co-ordinated rational approach = consistency
- PPPs do not happen in isolation to provincial budgeting and infrastructure planning
- Close co-operation between treasuries
- All approvals issued via the provincial treasury
- Good relationships forged and extended

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ROLE OF TREASURY IN PPPs

Treasury Authorisation I- feasibility study

- **Demonstrate Of Affordability**
Is approximation of private sector proposal less than available project budget?
- **Indication Of Value For Money**
Is private sector proposal likely To provide more value than departmental procurement? Determined from Public Sector Comparator
- **Identification Of Risks To Be Transferred**

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ROLE OF TREASURY IN PPPs

Treasury Authorisation II - value for money

Ta II has two parts:

1. Treasury approval of RFP document prior to issue
 - Check RFP structured for value for money
 - Check model contract
 - Check risk transfer
 - Check evaluation process is clear
2. Treasury approval of the process after proposals received
 - Check value for money test
 - Check the actual affordability
 - Check the qualifications in the proposals haven't compromised risk transfer

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ROLE OF TREASURY IN PPPs

Treasury Authorisation III - contract

Ta III Precedes Financial Closure.

- All Budgetary Commitments Attendant To The Agreement Must Be Approved

The Final Contract Must Be Approved

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DEALING WITH UNSOLICITED BIDS

- Most unsolicited bids are in the form of concepts
- Some have feasibility work done from private perspective, but usually risk averse.
- Govt. seldom receives fully-developed unsolicited bids for a PPP that will meet Treasury standards.
- Difficult to reconcile with competitive procurement

So how should a department respond?

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DEALING WITH UNSOLICITED BIDS

- Determine if proposal has merit. If yes, get it into PPP project life-cycle ASAP [*Affordability, Value-for-money, Risk Transfer* remain the central requirements];
- Usually, a Dept can take up the idea and begin the life-cycle, without betraying intellectual property;
- If idea is unique and intellectual property is at stake, Scheme Developer " status can be awarded through a SD agreement which re-pays SD for work to TAI and bid goes public as per PPP project cycle.

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IMPORTANT ISSUES

- Benefits of PPPs are not automatic
- Benefits include
 - efficiency gains
 - risks transferred
 - budgetary certainty
 - innovation
- Changes role of government from implementing to procuring and monitoring service

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“Public-private interactions” Lekgotla, 11-12 July 2002

ROLE OF PPP UNIT

- Regulatory: Formal Treasury Authorisations I, II, III
- Technical Assistance to Depts through Project Cycle
 - Form part of project teams;
 - Assist in appointing and monitoring Transaction Advisors;
 - Review all draft feasibility studies and bid documents to minimise time for formal Treasury approvals.
- Produce PPP Guidelines and Contract Standardisation
- Run training courses, disseminate information

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CONTACT DETAILS

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Go to the PPP icon to find:

- **PPP Guideline Manual (including PPP Regulations)**
- **PPP Quarterly publications**
- **Active PPP project list (updated monthly)**

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National Health Accounts

- Higher levels of financial & human resources in private than in public sector, *relative* to population served
- 1999-2000, annual expenditure per medical scheme beneficiary 4.7 times that spent per person dependent on public sector (R3905 vs. R814)

Cost Escalation - medical schemes

- Contribution increases routinely outstrip CPI (e.g. average of 20% increase in 1997)
- Increases in expenditure on administration and managed care expenditure greater than on 'claim' expenditure (average of 26% p.a. increase 96/97-98/99)
- 1996-98, highest expenditure increase was for private hospitals (now biggest single expenditure item)

Impact on public sector

- Scheme membership falling – higher proportion of population dependent on public sector
- A quarter of medical scheme members are civil servants and their dependants
- Government pays about R800 per civil servant *per month* covered by a scheme yet spends only R814 per person dependent on public sector services *per year*

NHA key issues

- Need to use total resources (public and private) to better meet the needs of all South Africans (including addressing geographic disparities)
- In both private sector and government's interests to bring cost spiral under control

APPENDIX E: REPORT-BACKS FROM FIRST GROUP WORK SESSION

Group 1: Session 1
Purpose

<p>Private hospitals :</p> <ul style="list-style-type: none"> • Sharing of resources • Building efficiencies • Avoiding duplication • Increase patient base/training • Planning & policy-making • Stretch the health care rand 	<p>Local Government:</p> <ul style="list-style-type: none"> • Share resources • Improve QOC, equity, efficiency • Enable focus on own core competencies • Assist with managing own burden
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Purpose

<p>Medical professionals:</p> <ul style="list-style-type: none"> • Use spare capacity of either sector • HR retention • Avoid duplication • Benefit professionals • Benefit patients 	<p>Public Hospitals:</p> <ul style="list-style-type: none"> • Use finite resources for all • HR retention and training • Avoid duplication & wastage • Improve outcomes • Broaden pat. base • Build one health system & prevent total collapse
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Obstacles

<p>Private hospitals:</p> <ul style="list-style-type: none"> • slow dng process • need to empower management within frameworks • lack of trust (motives) • public sector makes policy w/o process • review regulations • balance cur & prev 	<p>Local government:</p> <ul style="list-style-type: none"> • no incentives for PPIs • lack frameworks/structure • dependent on provinces • limited capacity • political interference • PPIs new/uncertain
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Obstacles

<p>Medical professionals:</p> <ul style="list-style-type: none"> • need more certainty in policy • need to measure/monitor • lack of success to review • lack of clarity on gov roles (funder/provider) • low pay for profession • SHI 	<p>Public hospitals:</p> <ul style="list-style-type: none"> • slow d-mkg • need for trust (motives) • not if but when& how • clarify processes for spending
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Open debate: questions

<ul style="list-style-type: none"> • are PPIs seen as a lifeline for system? • what partnerships should we encourage? • what are HR retention plans? • can there be full revenue retention • what is role of labour: when/how engage? 	<ul style="list-style-type: none"> • what PPIs have to go to Treasury? • what profit/business practices are acceptable? • where start? • does govt see sense of urgency?
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Open debate: constraints

<ul style="list-style-type: none"> • government personnel turnover • competition in core services • capacity to monitor contracts • no/bad past PPI experience • experience not reviewed • private sector not affordable 	<ul style="list-style-type: none"> • no clear policy on PPIs • mis-match responsibility & authority • lack of revenue retention • unclear who in govt can tackle known problems
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Open debate: purpose and needs

<ul style="list-style-type: none"> • PPIs allow both sectors to participate in system transformation • Use/build on enabling framework within govt 	<ul style="list-style-type: none"> • Need for dedicated driver • Treasury role important • There is revenue retention • Frameworks must empower managers • Learn from other experiences
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Open debate: purpose and needs

- Involve labour
- Greater clarity on govt regulations
- Need major change in way services are delivered:
 - clarify govt roles/private roles/PPI roles
 - not just small initiatives

Group 2: Session 1

Medical Schemes
Provincial Administration
Academic Health Complexes

Objectives

- Broad - was broad consensus:
 - Support Treasury principles (affordability, value for money, risk transfer)
 - Bridge the gap between public and private sectors / redress disparities
- Medical Schemes:
 - Purchase health services at lower cost
 - Extend cover through low-cost options (PMB - hospitalisation, chronic medicines)

Objectives continued

- Academic Health Complexes (AHCs):
 - Income generation to address resource constraints (staff - recruitment & retention; equipment etc)
 - Broader pathology for training
- Provincial administration:
 - Address personnel & skills shortages
 - Address capital funds shortages
 - Improve efficiency and effectiveness

Challenges and obstacles

- Policy not adequately transferred down to provincial level, or to provider level
- Red-tape and resulting delays
- Lack of capacity for structuring, implementing and monitoring PPIs
- Academic Health Complexes:
 - Dual lines of responsibility and accountability
 - Lack of legislative framework
 - Insufficient protection of intellectual property

Challenges and obstacles

- Debate about role of private sector in training health professionals in hospital context, but access to GPs for PHC training
- Unclear role of government: Both a purchaser and seller - needs to define markets and products
- Current PPIs not addressing broader needs (the unemployed, uninsured)
- Conflict of interests: Should rather identify needs & find best way to deliver

Key issues from discussions

- Need to move from view of schemes as funders only of private services
- Main focus of PPIs should be on the 'employed, uninsured', and to some extent on currently insured wanting lower cost schemes

Key issues from discussions

- Clear role for public hospitals in low-cost options, but need:
 - Accurate cost information
 - Real decentralisation of responsibility
 - Revenue retention
 - Improve services and address perceptions

Key issues from discussions

- Need integrated approach:
 - Primary health care (gatekeepers) as well as higher levels of care
 - Public and private sectors - consider financing mechanisms in integrated fashion and establish a coherent, integrated legislative framework

GROUP 3: SESSION 1

- Pharmaceuticals
- Unions
- National DoH
- Statutory Councils

SUMMARY

- Endorsement of the concept of PPIs, although with some concerns.
- Primary goal: Improved healthcare for all.
- Second goal: Sustainability, accessibility and equity.
- Service providers: Skills retention is an urgent priority issue - on-going skills development is equally important; with sharing of resources
- Bridging the gap, by sharing between the academic and private sectors.

SUMMARY

- Retention of professional skills, adequate resources being made available.
- Each stakeholder sector emphasised the benefit of PPI's for their specific requirements

SUMMARY

- e.g. Unions - Staff retention, skills development, improved administrative systems, improved social benefits, access to private funding but with due cognisance to sustainability and caution regarding the impact of social restructuring without an adequate budget with possible retrenchments and loss of other social benefits - (what happens if all funds are depleted?)

SUMMARY

- Statutory councils - Performance monitoring of PPI's to be improved upon.
- Adequate and effective dialogue must be pursued with to ensure success of PPI's.
- Resource allocation must ensure the best outcomes for patients and providers, whilst emphasising the importance of remaining within all ethical parameters and guidelines.

SUMMARY

- Pharmaceuticals - Dialogue essential
- NDOH - Common goal and trust must exist between stakeholders.

CONCLUSION

The broad concept of PPIs is endorsed, noting that all such interactions will not result in actual PPP's. All such initiatives will be thoroughly researched prior to implementation, with proper monitoring mechanisms in place to ensure success and to ensure that the noble goals are achievable.