Public-Private Partnerships

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This chapter draws on the experience of one provincial Department of Health in implementing public-private partnerships[a] (PPPs) and the challenges experienced. One overriding challenge was the timing of a new and risky initiative in the light of competing priorities. Although PPPs were seen as a potential strategy to overcome service delivery problems of the Department, managers are faced with many challenges and are working in a transforming health service, the scale of which is unprecedented. These challenges relate to the evolving policy, regulatory and institutional framework, capacity in skills and systems, buy-in from management and organised labour and many competing priorities.

Public-private partnerships require strong managerial systems and expertise and considerable buy-in from all stakeholders. The analysis suggests that changes at national, provincial and institutional level have led to a much more enabling environment to support implementation. Specific recommendations to support implementation are the appointment of a dedicated project manager, the establishment of a PPP forum with all relevant stakeholders, building capacity of management and staff, marketing of the strategy and an adequate monitoring and evaluation framework.

a The information contained in this paper originates from work done in the Gauteng Department of Health. In putting this paper together, I have relied heavily on the collaborative work undertaken with colleagues from the Gauteng Health Department, in particular Laetitia Rispel and Ahmed Valli who developed much of the earlier conceptual framework on public private partnerships.

Introduction

South Africa continues to face numerous challenges in addressing inherited public service delivery and infrastructure backlogs. It has been argued that the elimination of backlogs, while maintaining sound fiscal policies, requires greater efficiency in the delivery of public services.[1] Public-private partnerships (PPPs) are *one* component of the public sector's overall strategy for the provision of public services and public infrastructure. This does not imply that public-private partnerships are the preferred option for improving the efficiency of services but are one of a range of possible service delivery options available to government. In this paper a PPP is broadly defined as a contractual arrangement whereby a private party performs part of a government department's service delivery or administrative functions, receives a fee according to predetermined performance criteria and assumes the associated risks of the function.[2]

In 1997, the White Paper on the Transformation of the Health Sector stated that 'the activities of the public and private health care sectors should be integrated in a manner that makes optimal use of all available health care resources. The public-private mix of health care should promote equity in service provision'.[3]

There are various reasons why public-private partnerships are being explored in the health sector. One major reason is that the historical interaction between the public and private sectors has not been positive, and indeed has a strong negative net effect on the public sector.[4] Firstly, the rapid expansion of the private hospital sector in recent years has undermined public provision by draining large numbers of highly skilled staff and paying patients out of the public hospital system.[5] Secondly, the private health insurance system also exploits public hospitals by dumping expensive cases once insurance benefits have been exhausted in private hospitals. Thirdly, insured patients frequently claim to be uninsured and do not pay for care at public hospitals. Together these factors translate into a fairly substantial subsidy from the public to the private sector. An inadequate regulatory environment exacerbates the situation. PPPs are therefore seen as one way to tap into the concentration of resources to the benefit of all citizens.

Another reason why PPPs are being explored is that the special characteristics of the health care sector do not lend itself to market determination, and that dual systems of health care provision is promoting or exacerbating inequities in access to care.[6,7] Government therefore has an overall stewardship role to ensure that these inequities are attenuated or removed. In addition, the private sector does not focus on public health issues such as prevention and often provides inappropriate services and distribution of facilities.

For the public sector the anticipated benefits of public-private partnerships are improved efficiency, improved customer service and improved revenue generation. A key prerequisite is that services should cost less as a result of

the collaboration. Closer interaction with the private sector may contribute to the introduction of new management styles in the public sector and facilitate the development of new skills, especially related to cost accounting, contracting, project management and competitive negotiation. Strategically, it is envisaged that partnerships should enhance accountability by clarifying responsibilities and focusing on the key deliverables of a service.

Gauteng Department of Health: A Case Study of Public-Private Partnerships

In 1997, in line with a national emphasis on public-private partnerships, the Gauteng Department of Health drafted a policy on public-private partnerships.[b] In Gauteng there was urgency to resolve some issues in the public-private relationship, as a major plan for hospital transformation was released towards the end of 1996. Although there were developments at national level, clarity was generally lacking. The national Department of Health policy documents were only distributed in 1998.

The main objectives of public-private partnerships (PPPs) are, as given in the national Department of Health policy document:

1. Improved efficiency – either by reducing the cost of the service or increasing the quality and effectiveness of the service
2. Improved access to health services for under-served populations and access to under-provided services, by using the most cost-effective means of service delivery and by using private sector resources
3. Generate additional resources and revenue for the public sector by leasing facilities/equipment or expertise to the private sector at a reasonable cost. The number of higher income and insured patients was steadily declining and improved billing systems alone would not compensate for the declining numbers of private patients.

This policy document identified four types of partnership: purchased services, outsourcing, private finance initiatives and joint ventures (See Box 1).

b The discussion excludes the experience of outsourced in-patient services for tuberculosis and chronic psychiatric care, as well as the experience of service delivery via Non-Governmental Organisations.

Box 1: Types of Public-Private Partnership

Purchased services	The simplest form of a PPP. The Department awards a private party the right and obligation to perform a specific service, within well-defined specifications, for a period of time. The government retains ownership of all facilities and capital assets and properties. Services may be clinical, management or support. Examples might be: · Contracts with private doctors for primary care sessions · Contracts for clinical equipment maintenance · Contracts for hospital beds in private hospitals · Contract with NGOs for community health programmes · Contracts with private hospitals for specialised treatment, diagnostic services and beds.
Outsourcing	The private sector assumes full operating responsibility for a specific function/service previously provided by the public sector. The contractor should provide the service of similar quality at lower cost than the public sector. The contractor may have the skills, capacity or resources that are not available in the public sector, or the service to be contracted out may not be a core competency of the government.
Private finance initiatives	The private sector is involved as a provider of the capital asset as well as a provider of services. The public sector becomes a procurer of services rather than a direct provider of services to the public. Improved value for money is achieved through private sector innovation and management skills delivering significant performance improvement and efficiency savings.
Joint ventures	Joint ventures involve a sharing of resources between public and private partners. Joint ventures should contribute to lower costs, improved access and quality and/or public sector revenue.

In 1997, the national Department of Health appeared to be predominantly interested in pursuing joint ventures. It was acknowledged that the private sector had paying patients, state-of-the-art yet under-utilised equipment and investment opportunities that could benefit the public sector. In turn, the public sector had beds, specialists and could provide services at a lower cost than the private sector.

The advantage of 'joint ventures' as opposed to a 'service contract' was the notion of 'community benefit'. It was perceived that such ventures would benefit the public sector in social (improved quality of health care delivery, enhanced equity, cooperation between the public and private sectors) as well as purely monetary terms (more efficient use of resources and reduced overall cost of care).

Box 2: Opportunity for joint ventures[8]

	Private Sector	Public Sector
Needs	· Access to additional beds · Lower rates for low income patients · Specialists	· Additional revenue · Additional staff at affordable rates · Improve quality of service · Retain qualified staff · Raise capital · Increase equity between public and private staff
Resources	· Patients · Equipment · Ability to pay for services · Ability to generate capital · Ability to invest	· Beds · Specialists · Lower/competitive prices to private sector

According to the Gauteng Department of Health policy document, the three main objectives of public-private partnerships – improving access to services, increasing efficiency and increasing revenue generation – would lead to 'social' benefits, equity between the public and private sectors, improved quality of care, improved clinical and management skills and the retention of certain categories of health care workers in the public sector.

Against this background, the Gauteng Department of Health published a request for proposals (RFP) in 1997. The RFP was also to deal with the large number of unsolicited proposals that had been received by the Department, thereby ensuring that every potential bidder had an equal chance of being selected. The intention was to enter into a select number of pilot partnerships with the following aims:

1. To pilot public-private partnerships
2. To inform provincial policy on public-private partnerships particularly the risks and benefits for the Department of such partnerships
3. To consider the impact on the public sector of such partnerships
4. To identify any unintended consequences of the policy.

Numerous proposals were received (both detailed as well as letters of intent). A short-list was developed and oral presentations were requested. Specific criteria were used in order to determine the suitability of these proposals. The criteria used to select proposals were:

- The impact of the proposals on equity in terms of geographical distribution, and for staff and patients
- The likely impact of the proposal on administrative efficiency. In particular the costs to the province, the potential for increasing revenue and whether implementation will achieve real cost savings.

- Whether the proposals will result in improved quality of care for public patients
- Whether simpler options are available to the province, which will produce the same results
- The likely impact of the proposals for different groups of stakeholders, particularly patients, doctors, nurses, administration staff, unions and head office management
- Whether the proposals address the need for services
- Whether the proposals will result in the retention of key services
- Whether there are barriers to implementation – required legislative changes, administration changes
- Whether the partnership ties in with the long-term vision of the Gauteng Department of Health.

The table below shows the initial set of pilot projects selected at the end of 1997/ beginning of 1998.

Box 3: Description and status of proposals selected

Partners	Outline of partnership	Motivation for partnership
Independent Practitioners Association	· IPA would upgrade and staff a "private ward" in a public sector hospital · Doctors would admit private patients to this ward · Hospital would be paid hospital tariffs by the IPA · Additional daily 'allowance', which would be used to benefit the whole district · Doctors undertook to do sessions in under-staffed casualty unit	· Improved service delivery in historically disadvantaged area · Increased number of doctors in Casualty Department · Revenue generation
Medical aid for a large parastatal	· Medical aid would increase cover to low income members at affordable prices · Members would be offered private Primary Health Care cover and hospitalisation in public sector hospital · Medical aid charged preferential rates by public sector hospitals and guarantee payment · Capitation payment method discussed to facilitate administration by the public sector	· Revenue generation · Patients currently using public sector but not paying fees
Private hospital	· Under-utilised private hospital · No public sector hospital in the area and patients transported by ambulance to nearest hospital · Public sector leases 15 beds · Daily rate per bed paid · Support services/medication additional	· Improved access to level 1 hospital services for semi-rural community · Improved efficiency – cost of ambulance services equal to cost of leasing beds from private sector
Private ward in tertiary hospital	· Private ward with differentiated amenities at tertiary hospital · Linked to additional income for doctors	· Revenue generation by increasing the number of fee-paying patients · Some control over doctors doing private work · Retention of academic staff

Partners	Outline of partnership	Motivation for partnership
Specialist unit in tertiary hospital	· Specialist services of high quality in the public sector · Services offered to private sector at competitive prices · Services rendered to 'private' patients at times when they are not offered to public sector patients (evenings and weekends) to ensure that public sector not compromised in any way. · Linked to additional income for doctors · Income split between specialist unit and hospital	· Income generation by increasing the number of fee-paying patients · Retention of academic staff · Specialist unit could become 'self-funding'
Private sector provision of chronic renal dialysis	· Private sector complementing provision of public sector chronic renal dialysis services	· Improved efficiency · Clear national protocols · Increased access to service

Gauteng Province has a large, well established private sector and following the selection of pilot proposals many other unsolicited proposals were received from the private sector.

These unsolicited proposals included *inter alia*:

- Private Finance Initiatives – to build new facilities or replace existing ones
- Private provision of Primary Health Care services, casualty services and emergency medical services
- Private sector management of public sector hospitals
- Leasing of institutions, beds, services to the private sector. Proposals were received from both new and established medical schemes and managed care organisations to use public sector hospitals for low-income clients. Some medical schemes required comprehensive hospital services and some required access to certain specialised services such as radiotherapy and renal dialysis.
- Proposals from public sector specialists to use public sector equipment to treat private sector patients as a way of generating income for their clinical departments – such as renal dialysis, oncology services and radiotherapy services
- Outsourcing a number of non-core services such as linen, and catering
- Leasing of highly specialised imaging equipment from the private sector
- Private sector provision of certain treatments/operations not readily available or poorly provided in the public sector, such as cardiothoracic surgery.

Progress has been made with three of the six pilots: one was fully implemented, while two were partially implemented. The section below explores the lessons learned from these initiatives.

Lessons learnt in Gauteng

The purpose of this section is to analyse the main challenges for implementation of public-private partnerships and make recommendations for the future.

An effective and supportive institutional framework is necessary to support implementation of PPPs

Public service delivery through more aggressive pursuit of PPPs is relatively new in South Africa. At the time, an enabling environment in the form of greater coherence and consistency in government policy was lacking. A formal policy from the Departments of Finance would have provided clarity about the legal capacity of the various spheres of government (or the relevant officials) to create binding commitments as well as about the roles and responsibilities of the Treasury, the Tender Board, and the Department of Public Works. The evolving national policy and regulatory framework was developed much later than the proposals were being considered.

When the first proposals and pilot projects were being considered, a draft provincial policy document had been written. The responsibility for public-private partnerships lay with the Directorate: Policy and Planning and the intention of the pilot projects was to inform and consolidate this policy document. However, the objectives of the pilot projects were broad and the implementation of certain projects required clarity about what is acceptable in terms of gains from public-private partnerships (financial or 'community gains') and under what circumstances other provincial policies could be waived or amended in order to promote income generation and improve access to care.

In the absence of a strong institutional framework, proposals that were received by the department were assessed on an *ad hoc* basis. There was no forum to deal with them with representation from all stakeholders, in particular from the provincial Treasury. The Public Finance Management Act came into effect on 1 April 1999 and the PPP Unit was established in National Treasury almost 2 years after the Public Finance Management Act.

PPPs must recognise and be aligned with equity considerations

The ethos of the Department was, and is, to provide a high quality health care to all patients, regardless of their ability to pay. In 1997 a number of equity considerations were paramount. Two of the proposed PPPs involved tertiary/academic institutions at a time when the Department's structural transformation process emphasised the need to strengthen district and regional hospitals. The historically disadvantaged institutions, due to their geographical location, available facilities and condition of their institutions would be less able to attract private patients and generate revenue.

Specialists would have a strong incentive to remain in large institutions and patients would have an incentive to go to these tertiary institutions for primary

and secondary care. Several proposals did not consider institutions at all levels of care and ignored district services altogether.

Many of the proposed projects, especially those aimed at generating income, required attracting fee-paying patients into the public sector and giving incentives for them to pay. This implied some differentiated amenities given that in the absence of any clinical knowledge, patients' are attracted to services by their *perceptions* of the quality of care – the physical environment, the length of time that they wait and the attitude of the staff that looks after them - rather than the actual care that they receive. Even though differentiated amenities imply only differentiation of food services, linen, televisions etc, and not *clinical medical* care, within the Department there remained significant opposition to the notion of providing different amenities to different people, based only on their ability to pay for these services. This idea was in conflict with the principle of equity. In addition, the international experience suggests that there is often a thin line between differentiated amenities and differentiated services. Providing dedicated wards for 'private patients' can lead to subtle differentiation in the clinical services.

Furthermore, at an institutional level, there was considerable concern amongst institutional managers about dedicating space to private patients in already overcrowded hospitals.

The issue of paying health sector staff for the treatment of private sector patients must be resolved first

Generating income for the Department of Health requires treating private or insured patients in the public sector. A major concern was that these public-private partnerships were in conflict with a policy decision to terminate limited private practice. Medical doctors had for some time augmented their public sector salaries by seeing private patients in private sector institutions. Poor monitoring of this practice had led to gross abuse and, in the interest of public sector patients, good management practice and value for public monies, the Department abolished the practice. A new policy, Remuneration for Work Outside the Public Sector (RWOPS) was implemented. This policy required all provincial employees to formally apply for permission to undertake private work. Permission for RWOPS would be granted for 12 months at a time provided that the proposed work would not result in a conflict of interests between the province and the work to be done, and would be done entirely outside the hours for which the applicant would be paid. State facilities were not allowed to be used for RWOPS except under special circumstances for which permission had to be obtained.

A number of proposals received from the private sector proposed that staff involved in treating fee-paying patients be allowed to retain some of the income from these partnerships. Although theoretically all categories of staff could get permission to do RWOPS and see these patients, the reality is that only doctors can bill medical aids on an individual basis for their time.

The objections to some of the partnerships were firstly that health care workers would be individually remunerated for seeing private patients when income should actually go to the institution, and secondly that this would give an unfair advantage to doctors.

Although it is possible to implement some of the partnerships without remunerating individual staff members, there was always a concern that staff would not participate in the partnership unless there was something in it for them. Attracting private patients was seen as an increase in workload for which they expected to be compensated.

The conceptualisation, development and implementation of PPPs requires considerable financial, legal, technical and management skills and systems

The skills required for entering into public-private partnerships are considerable. At both Head Office and institutional level, the implementation of the pilot projects was hindered by inadequate capacity, both skills and systems. This experience is also borne out by the international literature.

At the time that the Department of Health was considering the implementation of the pilot projects, there was no legal capacity or support for the negotiation of contracts within the Department of Health. Any contract with financial implications for the Department had to be seen and authorised by the State Attorney. The overwhelming workload of the State Attorney's Office meant that seeking a legal opinion was extremely time consuming and delayed negotiations with the private sector. It was impossible to secure the State Attorney's time to negotiate directly with the private sector partner, who frequently arrived with their own lawyers putting the Department at a considerable disadvantage. Contract management and financial management skills were also limited.

In contrast to the public sector, private sector companies and organisations generally employ accountants and lawyers who have much more experience than the public sector in contract management and are much more flexible and less bureaucratic than the public sector. The people who came to meetings with the Directorate were able to make immediate decisions and respond quickly to proposed changes, whereas Departmental staff had to consider public sector rules and this often put the Department at a disadvantage.

It was not only the lack of skills that hindered the implementation of PPPs. The skills required are often not those normally required in the operations of a government department. It became increasingly evident that the implementation of PPPs required the support of people who were prepared to consider new and innovative ways of delivering health services and overcoming the overwhelming bureaucratic administrative processes. Several projects just never happened because there was rigid adherence to administrative processes and an inability to 'do things differently'.

Strong managerial and administrative systems are required to ensure that the public sector is not compromised during negotiations

The private sector is aware of weaknesses in public sector systems and capitalised on this fact. The nature of many of the proposals received from the private sector demonstrated the private sector view the public sector as bureaucratic, inefficient and poorly managed. There was a tendency for the private sector to propose partnerships that replaced rather than complemented and supported public sector systems on the assumption that private sector information, managerial and administrative systems were automatically superior to public sector ones. Knowing that the public sector has problems with billing patients and recovering bad debt, the private sector frequently offered quite unacceptably low rates for public sector services assuming that these would be accepted on the premise that 'something is better than nothing'.

Although the development of cost centres is underway, the centres are not yet sufficiently developed to assist with the costing of services. The private sector, aware of this fact, assumed that they provided services at a lower cost than the public sector. They also assumed that the public sector would accept their rates without question.

The implementation of public-private partnerships requires strong institutional management and buy-in

The Head Office's Policy and Planning Division co-ordinated the proposed pilot projects. Although this Directorate supported implementation at institutional level, the motivation for the projects came from Head Office rather than the institutions themselves. Ideally, institutional managers should identify problems that they have and constraints to service delivery and, having considered their options to overcome these constraints, may propose a PPP as a viable option. In many instances, the initiatives were not identified by institutional managers. If the private sector contacted the institutions directly there was a tendency for the institution to send the proposal directly to the Central Office without any attempt to analyse the project, or even indicate whether it was something that they would wish to pursue. This was not only because PPPs were a new idea but also because institutional managers did not have the capacity (skills and systems) to move forward. There are many competing priorities facing institutional managers and at the time that the pilot projects were being developed, none of the hospitals had Chief Executive Officers. There were a number of institutions without full time Superintendents and a high turnover of senior medical managers. Faced with overwhelming challenges, the development and implementation of PPPs was not a priority for many of the staff. Although most Superintendents were interested in the notion of PPPs and the idea that a PPP 'would solve some of their problems' the implementation required a great deal of time, which they did not have. Implementation required negotiations with unions, academics, clinicians and all professional groups, all of whom had their own demands and points of view. In addition, clinicians were sceptical about the quality of

clinical care in private hospitals and reluctant to sanction the private sector provision of services. They were concerned that this would mean that academic hospitals would lose the ability to teach certain specialties and that their own jobs would be threatened.

Although the decentralisation of certain financial and human resources functions is in progress, this initiative is not yet complete and hindered negotiations with interested parties.

Lastly, PPPs was but one initiative among a range of other very important health care transformation initiatives that had to be implemented.

Early Union involvement and co-operation is essential

Although the impact on staff varies, outsourcing and contracts with the private sector do have a substantial impact. The Unions are reluctant to accept partnerships that involve increasing the workload for public sector staff, involve transferring staff to the private sector, or result in redundancies. Negotiations with the Unions around all proposed PPPs were difficult and long. Negotiations were hampered by lack of dedicated capacity and not bringing the Unions on board in the planning stage.

Considerable management information is required

Several projects required substantial management information and costing of services. Instances whereby the public sector provided services on behalf of the private sector as part of preferred provider agreements required the negotiation of tariffs that would ensure full cost recovery for the public sector, and instances whereby the private sector provided services on behalf of the public sector required extensive costing of the service in the public sector to ensure that the Department was getting value for money. This costing of hospital and emergency services was problematic. The information required is not always available, and the Department has to make assumptions about the financial viability of projects. Unknown risks involved in such partnerships made it difficult to approve certain projects.

Lack of accurate data on the utilisation of public sector services also placed the Department at a disadvantage when it came to negotiating capitation fees with certain managed care organisations.

Procurement procedures need to be supportive

The new procurement reform initiatives are due for implementation in April 2002. Existing procurement legislation and regulations are geared to conventional procurement activities such as the purchase of equipment and services. The existing procurement procedures require that any services be tendered for unless an exemption be granted. The procedures are neither designed to address the complexities of PPPs nor provide a basis for ensuring that the key dimensions (e.g. affordability, value for money and efficient risk allocation) are appropriately evaluated. In addition the tender procedures are long and time consuming.

Existing regulations need to be supportive

Existing public sector and Treasury Regulations require that all monies generated by public sector hospital be paid into a provincial account. Although the Gauteng Department of Health had negotiated a revenue retention policy with the Gauteng Department of Finance, which allowed institutions to retain a proportion of the income that they generated, this money was only returned to the institution in the appropriation budget of the following year, and on condition that the institution reached an agreed-upon revenue target. This arrangement made it difficult for institutions to budget for any start up costs that the partnership might require and any additional expenditure that might be incurred in the first year.

Recent changes to support Public-Private Partnerships at national level

The national Department of Finance has undertaken a number of initiatives in order to confirm and reinforce government's commitment to make PPPs a viable option for delivering public services.

In 1997, an Interdepartmental Task team was appointed by Cabinet to explore ways in which to make PPPs a viable option for service delivery in the public sector. This Task team published three key documents:

1. **A Strategic Framework for Delivering Public Services through Public-Private Partnerships.**[9] This document proposed a strategic framework to support provincial and national departments in identifying, procuring and implementing PPPs.
2. **Treasury Regulations** in terms of section 76 of the Public Finance Management Act, 1999 (Act No. 1 of 1999),[10] which set the minimum requirements for PPPs entered into by provincial and national governments.

3. **Guidelines for Public-Private Partnerships.**[11] These guidelines were published in April 2000 and are intended to assist national and provincial departments in applying these Treasury Regulations.

These documents define public-private partnership as 'contractual arrangements whereby a private party performs part of a department's service delivery or administrative function, and assumes the associated risks. In return the private party receives a fee, according to pre-defined performance criteria, which may be entirely from service tariffs or user charges, entirely from a departmental or other budget or a combination of the above'.

The Treasury Regulations for public-private partnerships apply to national and provincial government departments for the development, procurement, and management of PPP projects. All aspects of the PPP life cycle, from project identification through to post-contract management and monitoring are regulated. The Regulations have shifted the focus of PPPs from being a 'sharing

of resources' to a more cost-effective way of providing services. The above definition refers to services for which the public sector department might pay. Several of the 'joint ventures' considered by the Gauteng Department of Health do not fall into this classification. Therefore, instances whereby the Department of Health will enter into preferred provider agreements with the private sector are not, in terms of the above definition, public-private partnerships.

A Public-Private Partnership Unit has been established in the national Treasury to provide technical and financial advice to public sector institutions and governments to support the implementation of PPPs. The Unit staff has project management, economic, legal and financial skills to assist departments in establishing PPPs.

A significant development is that the Public-Private Partnership Unit now provides training for government departments in PPPs and several provincial senior managers have participated in this training.

National Department of Health Support for Public-Private Partnerships

A national Department of Health Task Team for PPPs was established in 1999 and meets on a bi-monthly basis. The team is now chaired by the Deputy Director General and consists of representation from the Chief Directorates: Financial Management and Hospitals Services, the PPP Advisor from the national Treasury PPP Unit and the appropriate person from each of the provinces. The objectives of this Task Team are to co-ordinate and support the development and implementation of partnerships, develop implementation guidelines and tools, facilitate the sharing of experiences, provide technical support and report to and take instructions from the PHRC.

The Task Team has produced several policy documents: Public-Private Partnership in the Health Sector – Policy Framework, Implementation Guidelines for Public-Private Health Service Partnerships, Policy Guidelines for Joint Ventures, Certificate of Need Discussion Document and Performance Contracting Guidebook for Government Health Service Managers. There are four sub-teams which are looking at the issues of Certificate of Need, Service Partnerships, Contract Development and Management and Private Finance Initiatives.

Recent changes to support public-private partnerships at provincial level

Several recent developments at provincial level will greatly assist the implementation of PPPs. A Chief Financial Officer was appointed in line with the Public Finance Management Act. This appointment will strengthen the financial management skills for the Department. In the recent restructuring of the Department, a division of Revenue Support and Contract Management was established and will greatly assist the implementation of PPPs. The

establishment of this Directorate reinforces the Department's commitment to generating revenue and facilitates the development of a suitable PPP forum to streamline the process of negotiating PPPs.

Recent major advances in the decentralisation of certain human resource and financial management delegations will facilitate the implementation of PPPs.

An advocate was employed by the Department of Health two years ago and the appointment of her assistant has allowed the Department to go to meetings with the private sector with some legal expertise, placing the Department on a slightly more even footing with the private sector.

The reorganisation of the organisational structure has led to three geographical administrative regions in Gauteng, with integration of hospital, district and emergency services under one Chief Director. This will facilitate implementation.

Recent changes to support public-private partnerships at institutional level

The appointment of Chief Executive Officers in 1999 in all Gauteng hospitals is a very positive move forward. CEOs no longer have to be medically qualified people, which increases the scope for employing people from the business sector. The appointment of CEOs is linked to Performance Agreements, which will further encourage senior managers to consider innovative and challenging ways of delivering services.

Recommendations

The development of an explicit PPP strategy, linked to overall strategic objectives

The development of a PPP strategy should ensure that the objectives of PPPs are in line with the overall objectives of the public health sector. The strategy will ensure that systems are in place to support PPPs and that the public sector plays a pro-active, rather than reactive role in implementing PPPs. Departments should identify those areas in which a PPP is an acceptable and viable service delivery option and then actively research and engage the private sector market.

Appointment of a dedicated project manager and the establishment of a Provincial Public-Private Partnership Forum

A dedicated or designated project manager will go some way towards ensuring that efforts are co-ordinated. A provincial PPP Forum should be established with representation from relevant divisions in Finance, Human Resources, Procurement and Administration, as well as provincial Treasury, the Unions and Public Works. The establishment of this task team would bring together all key stakeholders and facilitate implementation. This Committee would review existing policies and legislation to identify potential constraints to

successful implementation of PPPs. Apart from supporting institutions in identifying cost-effective and affordable projects, the Committee would prepare advisory guidelines to assist departments in following suitable practices to implement their PPP programmes. Of particular importance is that this committee will ensure that negotiations with Unions occur upfront.

The Department's PPP strategy should be actively marketed and communicated to the private sector

Once the provincial Departments have a PPP strategy, this should be actively marketed and communicated to the private sector. This will ensure that the private sector will concentrate on developing proposals that they know are acceptable to the public sector and are in line with the Department's objectives. Although the public sector regulatory framework is perceived to be cumbersome and restrictive, it is important that the private sector appreciates that a regulatory framework is required to protect the public's interest. On-going communication between the two sectors is important. The two sectors need to fully understand how each other operate and what each other's expectations are.

Reduce the skills gap between the public and private sector

All institutional managers should receive the training that they require to consider, develop and implement public-private partnerships. This will include drawing up business plans as well as contract and financial management. The public sector needs to strengthen its ability to negotiate with the private sector and draw up and manage contracts. When the two parties do enter into negotiations, the public sector should not be at a disadvantage in terms of its ability to make decisions and provide the necessary financial and management information to substantiate their position

Explicit ways to provide staff and institutions with incentives to participate in and support PPPs

Innovative ways to provide incentives to staff should be considered both monetary and non-monetary. Possibilities are merit awards and academic incentives. It is also essential that all profits from PPPs directly benefit staff and are used to improve working conditions, such as the purchase of new equipment.

The development of clear performance criteria and a mechanism for ongoing monitoring and evaluation of partnerships

Linked to the overall development of a strategic framework is the need to agree upfront on what the performance criteria are and the measurement of these criteria. The monitoring and evaluation mechanisms and capacity required to examine the impact of the pilot projects need to be defined upfront. The Treasury has suggested that minimum contractual provisions for PPPs

should include:

- Duration of the contract
- Range of services and output levels
- Basis of payment in relation to service and output levels
- Relationships between the Department and service provider
- Use and retention of technology by the Department
- Accommodation of a Department's changing requirements over the duration of the contract.

Conclusion

This paper has reviewed the experience of the Gauteng Health Department in implementing a limited number of PPP pilot projects. Not all the projects were implemented, due to challenges experienced at the time of implementation. These challenges relate to the overall policy, regulatory and institutional framework, capacity in skills and systems, buy-in from management and organised labour and competing priorities in a transforming health system. The analysis suggests that changes at national, provincial and institutional level have led to a much more enabling environment to support implementation. Specific recommendations to support implementation are the appointment of a dedicated project manager, the establishment of a PPP forum with all relevant stakeholders, building capacity of management and staff, marketing of the strategy and adequate monitoring

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