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Abstract

South Africa has a large public health sector as well as an extensive, well-established private sector. This chapter explores the stewardship role of government in relation to the private sector, emphasising the cooperative working relationship needed to optimise the contribution from the public sector in transforming the health system. The chapter discusses the latest developments, challenges and the way forward in four main areas: legislation, finance and social insurance, public-private initiatives and human resources. The implications of the new Health Act of 2003, especially the Certificate of Need are discussed and the draft Health Charter is reviewed. The chapter concludes with a set of recommendations, highlighting the importance of a joint vision for transformation between the public and private sector, the need for a social health insurance system, the need for more guidance and evaluation of private-public initiatives and the need for a human resources plan that can apply to both the public and private sectors.

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Introduction

In South Africa (SA), which has a large public health sector as well as an extensive private health sector, government has a stewardship role to use national resources for the benefit of the entire population. Stewardship refers to "the careful and responsible management of something entrusted to one's care" and in the health sector, this means, "establishing the best and fairest health systems possible".[1] The stewardship role involves three areas:

- Running an equitable, effective and efficient public health sector.
- Regulating the private health sector to ensure private organisations act responsibly. 'Regulation' can be defined as actions to influence distribution, quality and costs of products, usually through legislation restrictions or incentives.[2]
- Facilitating a cooperative working relationship between the public health sector and the private sector that is beneficial for the health of the population as a whole.

Though the first two stewardship roles are well established and well documented, the government's role in facilitating a cooperative relationship has not received equal attention. This chapter focuses on the main issues involved in the government's facilitation of a cooperative public-private working relationship.

Over the last 10 years, the relationship between the private sector and government has received considerable focus in SA with the private sector often seeing this relationship as one where government unfairly regulates the private sector. While regulation has sometimes been successful in achieving its stated goals of fair access, it has also been a source of bitter conflict between government and the private sector.

Several parallel developments are contributing to urgency in the search for a more collaborative public-private working relationship. Although SA spends a relatively high proportion of its Gross Domestic Product on health care, its health status ranks poorly compared to other middle income countries that spend the same or less.[3] One of the main contributory factors is inequity and inefficiency associated with the segmentation between the public and private sectors.

The financial disparity in health spending between the two sectors has widened, with the private sector spending approximately seven times more per capita than the public sector, on less than 20% of the population. The public sector serves 84% of the population (mainly the uninsured and poor), spending approximately 41% of total health funding.[4]

Although the public sector has become more equitable with narrowing of interprovincial per capita expenditure, it does need to become more efficient and funding needs to be more sustainable. Increases in real expenditure in the public sector in the last ten years have been absorbed by growth in the uninsured population and wage increases. Hence there is need to explore whether cooperative relationships between the two sectors can contribute to improving overall public sector health performance and funding.

- Rapid expansion of the private sector and dramatic escalation in costs and stagnation in growth of the medical insured are calling into question the efficiency and the sustainability of the private sector. One option is for the private sector to increase the number of insured people, but unless significant changes are affected to the private health sector, this is unlikely given that medical insurance has become less affordable for lower income

members.[4] Another option is for the private sector to explore partnerships with the public sector that may be mutually beneficial.

- The overall shortage of health personnel affects both the public and private sectors and, more specifically, the migration from public to private sector is an increasing concern for government. This is adding impetus to the move towards greater public-private cooperation.

Against this background and based on a review of the literature, the following four areas emerge as key elements in the relationship between the public and private sector:

1. Legislation
2. Finance and social insurance
3. Public-Private Partnerships
4. Human resources.

In this chapter, 'private sector' will refer to the for-profit business and commercial sector. (Although medical schemes are not considered for-profit entities, they are a key component of the private sector). Some of the partnerships we discuss in this chapter also apply to non-profit organisations.

Legislation

When the first democratic South African government was elected in 1994, the problems in the health sector reflected the broader inequalities in South African society. There was a large, fragmented, under-funded and racially inequitable public health sector serving the majority of the population and a well-established, well-funded private sector serving a small minority of the population.[1] The private sector had moved to limit the package of care offered, to increase insurance fees and co-payments, and to exclude high risk members from cover.

Over the last ten years, despite consistently high profits in the private sector, the costs of private care have escalated at a rate above the inflation rate and there has been little growth in the number of people who are medically insured.

Government's response has been to regulate against these kinds of private sector developments. A range of legislation has been enacted over the past ten years to control unfair business practices and to ensure fair access to private health services. In particular, the Medical Schemes Act (1998) as amended, has ensured that medical aids offer an expanded minimum benefit package and that they are not able to use age and risk as barriers to membership. Similarly, the Medicines and Related Substance Control Amendment Act (2002) was designed to provide a more affordable supply of medicines and to reduce irrational prescribing habits that may be driven by financial incentive.[5] Government's efforts to regulate medicine prices were opposed, first by international drug manufacturers and later by local dispensing organisations, including legal challenges that delayed implementation of the legislation.[6] For more details refer to the Health Legislation chapter in this Review.

A major gap in legislation has now been filled with the enactment of the long awaited National Health Act of 2003.[5] This Health Act is applicable to the public and private sector, although there is more focus on the public sector. The facilitating role of government, to provide the framework for collaborative public-private relationships, is acknowledged in the preamble of the Health Act when it sets out to:

"Promote a spirit of cooperation and shared responsibility among public and private health professionals and providers and other relevant sectors within the context of national, provincial and district health plans."[7]

Even so, one particular provision in the Health Act, the Certificate of Need (CoN) has met with considerable opposition from the private sector.

Certificate of Need

The Health Act requires that every new and existing medical establishment obtain a CoN from government to be allowed to practice in a particular geographic area.[7] Government plans to use the CoN to help correct the skewed urban-rural distribution of health care resources and health technology by influencing the distribution of private health establishments. This means that a private hospital or a general practitioner can be prevented from opening a health establishment in areas of their choice if the Department of Health (DoH) assesses this to be inappropriate. The decision to grant a CoN or not, will be based on criteria that include:[7]

- "The need to promote an equitable distribution and rationalisation of health services...and the need to correct inequities based on racial, gender, economic and geographical factors."
- The need for an appropriate mix of public and private services and the availability of human resources.
- The demographic and epidemiological needs of the target population.
- The quality of care offered.

- The financial viability and sustainability of the business.
- Employment equity considerations.

Non-compliance with the CoN is an offence that is punishable with a fine and / or imprisonment.

The private sector response to the CoN has been largely negative. The main objection to the CoN is that it interferes with the individual's constitutional right to live and work in a place of their choice. There are also concerns about the scope and duration of the CoN as well as the mechanisms for appeal.[8]

- The CoN has a wide scope as it applies not only to the licensing of new, but also existing establishments, and it includes the modification of these establishments, (e.g. increasing the number of beds or acquiring new health technology).
- Although the Health Act states that the validity of the CoN 'may not exceed 20 years', the DoH is free to regulate that it be valid for a much shorter period. Objections have been raised about a proposed 5-year period that is deemed to be too short.
- The mechanisms for appealing a refusal to grant a CoN are considered too limited, as it does not contain the right to appeal to the courts.

The antagonism and mistrust in any potential court challenge to the CoN indicates that there is a lack of common vision and strategy about how to transform the South African health sector in a way that is satisfactory to both the public and private sectors. To create a framework for collaboration, the conflict stemming from this legislation would have to be resolved in a constructive way.

Way forward

When legislation is being drafted that affects the private sector, there is a need to consult at an early stage, to find common ground and, failing this, to find more constructive mechanisms to resolve conflict.

Regulation through legislation is not enough to improve the contribution of the private sector to the health system as a whole. Internationally, there is a tendency to see regulation through legislation as the response to various problems associated with the private sector.[2] A set of operational principles for effective regulation of the private sector has been suggested.[2] These include:

- the importance of the timing of legislation;
- understanding the political processes and developing alliances that will promote successful implementation;
- strengthening the role of consumers and patients;
- judicious use of incentives, such as using governments' purchasing power;
- phasing in of legislation to manage the expected challenges along the way; and
- recognising the limitations of what regulation can achieve.

Government capacity also needs to be strengthened to implement regulations effectively as well as to monitor whether the regulations have the intended effect. Effective implementation and monitoring will be enhanced if there is a common vision for a national health system and a good public-private sector working relationship. A series of government-private sector talks and forums, such as the Private Public heath sector Interations (PPI) Lekgotla in 2002, have been addressing this need for dialogue between the two sectors.

Financing and Social Health Insurance

The public sector is funded mainly from taxation and the private sector is funded through voluntary health insurance and out-of-pocket payments. The financial disparities between the public and private sector that are a major source of inequity in the health system have been well documented.[4] The World Health Organization (WHO) and other health systems experts advise that one way to address such dramatic financial disparities is to have cross-subsidisation between those who can pay for services and those who cannot.[1] Social Health Insurance (SHI) has been proposed as the most effective way to achieve this.

The aim of SHI is to reduce the financial disparity between private and public financing by enabling a nation-wide medical insurance scheme for all employed people based on their ability to pay (using a sliding scale). Those who are uninsured would be entitled to the standard (but now better funded) care in the public sector. Those who have social insurance would be entitled to a range of (mostly public) health services that are 'differentiated' (e.g. upgraded hotel services). Private care would be available to those who can afford to purchase additional medical insurance. In effect, the SHI would allow for a portion of current private medical aid funding to be re-directed towards a national fund, thereby

reducing the wide disparity in public-private funding, but still leaving a viable for-profit public sector.[9]

The post-1994 South African government has expressed commitment to SHI as a means of addressing the inequity in health financing, but there have been delays in determining what the most appropriate form of SHI should be and what funding mechanisms are required.

Government has renewed its commitment to the original goal of SHI and has developed recommendations on the form, content and phased implementation of a SHI system. The SHI will be based on 'universal contribution', where all employed people contribute towards medical insurance and where a common set of benefits are provided to all citizens via the public and private sectors.[10] Current SHI proposals envisage the continuation of choice between existing medical schemes (along with the Basic Benefit Package, risk equalisation and income-based cross-subsidy). The proposed SHI framework would include the following key elements:

- A mechanism for achieving risk-related cross-subsidies or risk solidarity (i.e. eliminating extreme variations in the costs faced by people with different risk profiles for a common set of health benefits).
- The Risk Equalisation Fund (REF) would provide the mechanism to eliminate these variations and improve risk solidarity.
- The establishment of an improved standard minimum essential benefit to which all contributors are entitled.
- A mechanism for achieving income cross-subsidies or income solidarity through the restructuring of current tax expenditure subsidies for health care.[10]

The plan is for a phased in development of a social health insurance system, alongside a regulated private insurance system. Through the Medical Schemes Act, government has already started to implement preparatory reforms that promote fair access and prescribed minimum benefits among medical schemes. The revitalisation of public hospitals is also intended to prepare for the public sector to become a preferred provider for certain medical schemes.

Work has already started on how to eliminate the income variations between medical schemes that result from selecting clients based on age. The establishment of a 'risk equalisation fund' is suggested as a means of balancing adverse risk pools. In the first stage of the REF, some medical schemes will have to pay into the REF and others will be paid by the REF to ensure risk-related cross-subsidisation between schemes.[11] Government is preparing for the Council of Medical Schemes to test the risk equalisation formulas starting in 2005, after which the implementation of risk equalisation will commence.

The second component of establishing a SHI is to implement mechanisms that will enable cross-subsidisation to compensate for income disparities between those contributing, and to ensure the unemployed are subsidised. The Minister of Health has appointed a ministerial task team to give priority to this issue. The team will need to finalise outstanding issues as well as get the buy in from National Treasury and the labour sector regarding the restructuring of tax expenditure on health care.

Way forward

The DoH seems to agree that a SHI system is the most appropriate mechanism to reduce the wide disparity in health financing between the private-public sectors and to improve the sustainability and quality of the public sector.

Government should build on their renewed efforts to implement a SHI and proceed with its plans to systematically test out each component of the SHI plans first before implementation. This is a medium to long-term strategy that will need extensive consultation with a range of stakeholders with competing concerns, and the importance of building cooperative working relations should not be underestimated. Ongoing monitoring is required to determine whether preparatory legislation and each phase of the implementation are indeed achieving more fair access to medical insurance and good quality health care.

Public-Private Interactions

An important aspect of the stewardship role of government is that of facilitating a cooperative working relationship, be it formal or informal, with the private sector, to the benefit of the health system as a whole. Public-Private Interactions (PPIs) are on the increase in SA, "but there are few mechanisms for the two stakeholders to understand better the motivations of, and the challenges that face each sector and (these) are a key part of building trust between the two sectors."[12] At a PPI Lekgotla, the meeting called for a "clear and explicit policy framework on PPIs that will clarify what are Public-Private partnerships (PPPs) and PPIs, how to go about establishing a PPI and that will provide guidance based on lessons learnt from best practice".[12]

According to the South African Treasury department, PPIs refer to a full range of interrelationships between public and private health sectors, whereas PPPs, refer to a specific set of activities. A PPP is a contractual agreement in which a private party delivers a service or performs a function for the public sector, with the private sector assuming the risk associated with the delivery of the service or function.[12] The DoH, therefore prefers to use the term 'public-private interactions' as it more accurately describes its full range of activities.[3]

Within government, and between government and the private sector, there are different understandings of the objectives, the value, and the pitfalls of engaging in PPIs. A common motivation for using PPIs is to increase efficiency but there may be different perspectives on how to achieve this. The Treasury department prioritises efficiency (defined as 'value for money') as among its main criteria for entering into PPIs, and the private sector focuses on curtailing costs and ensuring profitability in a shrinking market. PPIs in health are complicated by the fact that health is considered a service and not a commodity, so it is not always easy to define 'value for money'. In the health sector, the need for equity, to increase fair access based on need, is considered as important a factor as efficiency and revenue. This view on equity, however, may not necessarily be shared by the private sector. However, all the parties seem to agree that PPIs can be an opportunity to strengthen the health system, to reduce fragmentation in service delivery and to build trust between the public and private sector.[3]

Types of PPIs

PPIs in SA differ widely in terms of their objectives and the range of activities they engage in. There are those PPIs that are about managing relationships through exchanging information, consulting about policy and reducing conflict. For example, informal liaison or formal meetings to address problems of patient transfers from private to public sector, or informal clinical consultations between private and public sector doctors. The more common PPI is the 'service delivery' model, where the private sector is delivering a service on behalf of the public sector or some form of service or goods are being exchanged. Table 1 shows the wide range of types of PPIs with current and emerging South African examples.

Problems and challenges of PPIs

Internationally and locally, public-private partnerships in health are seen as inevitable and as offering considerable positive opportunities, but they also hold significant risks. Within the WHO, there has been demonstrated success with several PPIs. These include the Global Alliance for Vaccines and Immunisations and the Global Polio Eradication Initiative that have achieved positive results against infectious diseases.[13]

Concerns have been raised about the appropriateness of PPIs and that there are not enough precautions taken to prevent some of the negative effects of PPIs.[13] These include fears that:

- equity could be undermined;
- PPIs could signal a slow form of privatisation;
- government could use PPIs to shirk responsibility for its public role;
- priorities could shift from the less poor (as PPIs are often used in more developed areas where they have a better chance of working) and away from building capacity in the public sector more broadly (by outsourcing instead of developing internal management capacity); and
- there is not enough empirical evidence to accept the value of PPIs.

In SA, an added concern is that there is no adequate management capacity required to effectively implement PPIs and that there is not yet a common vision for a national health system between the private and public sector.[12]

Table 1: Classification of Public-Private Interactions in South Africa[a]

Category	Example
Joint Ventures ✧ Sharing of resources predominantly on a lease or service basis. ✧ Using private finance to support public sector delivery. ✧ Using public sector personnel to provide private sector services. ✧ Joint health promotion campaigns.	✧ Under-utilised space or equipment is leased to the private sector. (E.g. Universitas and Pelonomi hospitals in Free State). ✧ Leasing out of radiology equipment at a lower cost in exchange for a private radiologist providing service to the public sector as well. ✧ Differentiated services where public sector offers upgraded services to private sector clients. ✧ Remunerated Work Outside Public Sector (RWOPS) allows public service personnel to earn additional income as an incentive to remain in the public sector. ✧ A national DoH campaign to screen for hypertension and diabetes involved both the public and private sectors in selected provinces.
Purchased Services ✧ Public sector purchasing clinical services from the private sector. (The most common PPI)	✧ Outsourcing clinical care to for-profit (and non-profit) organisations or individuals. E.g. Lifecare for psychiatric and TB care, state aided hospitals, TB service by South Africa National TB Control Association (SANTA) and home-based care services for HIV and AIDS services. ✧ Contracting human resources on a sessional basis, especially doctors and nurses and contracting specialist medical services where there is no alternative.
Outsourcing non-clinical services ✧ Operations and maintenance functions outsourced with or without renting of assets.	✧ Range of hospital and clinic services are outsourced e.g. catering, cleaning, laundry, patient transport and security. ✧ Contracts for maintenance support for facilities and (usually high-tech) medical equipment and information technology systems. ✧ Contracting management expertise where private management consultants provide mentoring support to public sector management. (E.g. in the Eastern Cape).
Private Finance Initiatives (PFI) ✧ Using privately generated funding to support public sector service delivery.	✧ Raising capital on private money markets to build or revitalise facilities or to provide the latest medical and non-medical technology. (E.g. the Nkosi Albert Luthuli hospital in KwaZulu-Natal).
Other *Swapping assets* (Different from PFI in that it is a once-off swap with no capital outlay from the public sector) *Public subsidy of private services* *Lobbying for services*	✧ Private investor is offered a public asset in return for a service or asset that is more needed by the public sector. For example in the Western Cape where the non-health sector is considering swapping prime property in return for the private party building, upgrading and equipping facilities in areas of greater need. ✧ Tax breaks to employers providing medical aid coverage. ✧ Organisations lobbying for services in specific areas of need. (For example advocacy for access to HIV services.)

Joint Civil Society Monitoring Forum (JCSMF)

The stewardship role of building partnerships need not be limited to formal contractual relationships with private organisations. It can also involve voluntary joint monitoring of government's implementation of important policies. The JCSMF is a forum established in 2004 consisting of a wide range of organisations from the non-governmental, civil society, academic and business sectors for the purpose of jointly monitoring progress on the implementation of the Operational Plan for Comprehensive HIV and AIDS Care, Treatment and Management (Operational Plan). The JCSMF meets quarterly to assess the ongoing progress of the implementation of the Operational Plan. At their February 2005 meeting, they reviewed the progress of children's access to ARV treatment, highlighting successes and calling on government to address specific areas of weakness. The last meeting in May focused on nutrition.

Key among their recommendations were the need for health information systems that can provide adequate health surveillance information, the need for a national human resources plan that includes both the public and

a Adapted from Wadee H, Gilson L, Blaauw D, Erasmus E and Mills A, 2004. Pg. 22.

private sectors, and the need to monitor if current HR interventions achieve their purpose of reducing inequitable staff distribution.[14]

Health Charter

In September 2004, a joint task team of the public and private sector as well as civil society and non-governmental organisations, was appointed to draft a Health Charter. They issued a preliminary discussion document, describing the purpose and scope of the Health Charter:

"The Charter is intended to strengthen the health system as a whole and will be used as an instrument to measure the degree and rate of transformation in the health sector in the following areas: access to health care services, equity in health care, quality of care, sustainability and efficiency, public-private interactions and black empowerment".[15]

Finalising the Health Charter is a complex process as the contents and terrain are highly contested. A note of caution was sounded by a private sector CEO involved in the Financial Charter, when he asked "how an industry where key players have taken government to court can expect to sit down and draft a Charter together".[8] Nevertheless, the Minister of Health in her latest budget speech was hopeful about what the Charter could offer:

> *"I hope that the Charter will provide the basis for a consensual approach to eliminating inequities both in the allocation of resources and the provision of health services in our country."*[16]

The latest draft of the Health Charter became available, as this South Africa Health Review chapter was being concluded, providing us with a useful glance of this important document. The Charter starts off by setting out the 'fundamental principles', that is, to 'facilitate and effect transformation in the health sector' and to ensure sustainability and efficiency in the following key areas:[17]

1. Access to health services;
2. Equity in health services;
3. Quality of health services; and
4. Black economic empowerment.

For each of these four areas, the Charter outlines the main challenges, focusing on human resources and financing. Among the challenges identified are the difficulties with production, recruitment, distribution and retention of health personnel, the problem of inequitable health funding between the public and private sectors, inadequate quality assurance (including failure to measure health outcomes), problems with staff-patient relationships and the low levels of black representation and ownership within the health sector.

Many of these challenges and the wide range of solutions that are proposed are not new to policy analysts or health personnel. The value of this document lies, however, in the fact that the Health Charter represents an opportunity to get the private and public sector to agree on what the priority problems are, how these problems should be tackled and what the role of the private sector is in contributing to the transformation of the health system as a whole. The human resource solutions that are proposed include the need to increase efforts to train, recruit, retain and equitably distribute staff. Staff development and support are considered important, as is a 'zero tolerance' approach to unfair treatment of patients. The need for a minimum package of services to be widely available is re-emphasised. Public-private initiatives will receive renewed attention as a way to access both health services and health financing (although no direct reference is made to a national social insurance system). The Charter spells out what is meant by black economic empowerment in the health sector and sets a target of 35% black ownership of private sector business by the year 2010.

A special Health Charter Committee will be appointed to monitor the implementation of the Charter goals, starting with setting parameters for evaluation of progress.

Way forward

The need for an overall common vision for a South African Health System is fundamental for effective PPIs. This vision should include the development of capacity and skills within the public sector so that it can:

- identify the needs that can best be met by PPIs;
- develop briefs;
- select appropriate partners;
- negotiate appropriately detailed contracts;
- monitor and evaluate the outcomes of these partnerships; and
- choose not to implement PPIs when it is deemed to be inappropriate or where capacity for effective monitoring does not exist.[3]

There is an ongoing central role for the DoH to support the coordination of PPIs across provinces especially around monitoring and evaluation. The DoH needs to assess the effectiveness of various PPIs and provide evidence of 'best practices' that can guide and improve future implementation of PPIs and provide a clear framework for a PPI policy.

Human resources

SA, like other developing countries is experiencing an overall shortage of health personnel as well as an inequitable distribution between urban and rural areas and between the private and public sectors. This has been well documented throughout this Review.[17] Although the overall shortage of personnel affects both the public and private sector, the public sector is disadvantaged by the migration of staff from the public to private sector within the country. This issue was given prominence when at the 2002 PPI Lekgota, two key issues were raised for further discussion, social health insurance and the migration of personnel.[12]

Although we do not know enough about the specific reasons for migration from public to private sectors, general reasons for migration have been identified. Factors that encourage staff to move away from the public sector to other countries or the private sector ('pull' factors) are higher remuneration reduced workloads and improved professional resources. Factors that encourage staff to leave the public sector ('push' factors) are public health systems and management problems including poor infrastructure, remuneration, working conditions, workload and despondency about the effects of the HIV and TB epidemics on the health system.[18]

More information is needed about the 'pull' and 'push' factors of this internal public-private migration if we are to formulate creative plans to address the problem. For example, little is known about the impact of a peculiar type of migration known as 'moonlighting' where public sector staff, especially nurses, work in the private sector in their off-duty time.

Human resource planning and management

It is in the interest of both the public and private sectors to produce more of the required health personnel, to retain health personnel in the country and to collaborate on plans that will address these problems. There have been calls for a National Human Resources Plan that will address both the needs of the public and the private sector, including finding ways to reduce the internally skewed distribution of human resources.[14] The DoH has committed itself to producing such a human resources plan and its release is imminent.

Government has taken up the challenge by introducing a range of measures geared towards recruiting and retaining staff in the public sector. The community service requirement for doctors and other health personnel is one such intervention that provides a steady supply of professionals. The rural and scarce skills allowance is another, using monetary reward as an incentive to attract staff that may otherwise have gone to the private sector.

Several of the PPIs mentioned in this chapter involve a sharing of human resources between the public and private sector. On a PHC level, TB DOTS supporters and contracting NGOs to provide home-based care services are examples of non-profit organisations providing human resources for the public sector. Further examples are contracting GPs to deliver services at public facilities and short-term contracts for doctors and nurses to fill vacancies. However, given that PHC is one of the areas of greatest need, more drastic measures will be required to attract staff.

Human resource development

Government is the main source of producing trained health personnel for both the public and private sectors, but the majority of health professionals work in the private sector (e.g. 75% of medical specialists). In effect, government is indirectly subsiding the private sector. It is in the long-term interest of the private sector that a critical mass of specialists be retained in the public sector so that their training roles are maintained. Government introduced RWOPS as an incentive to retain specialist personnel by allowing them to add to their income. The success of this measure has not been assessed.

All doctors are now required to pursue continuing professional development (CPD) that requires them to attain education credits in order to remain registered. This has presented an opportunity for closer collaboration to improve quality of care and to promote PPIs in training. For example, the private sector plays a large role in the treatment of sexually transmitted infections (STI) in the general population, so seeking to improve quality of care, a CPD-accredited training course was offered to general practitioners.[b] This is a creative PPI that addresses the needs of both the public and private sector in improving STI management.

b Personal Communication, Dr Rita Sonko, Health Systems Trust 2004.

Way forward

Ongoing investigation is needed into the shortage in human resources and especially the internal migration to the private sector, as it is a complex problem with multiple underlying factors. A good human resource information system is essential to monitor both needs and shortages as well as to monitor whether the relevant HR policies are contributing to more equitable distribution of health personnel in the medium and long-term. A national HR plan is needed that will provide solutions to address not only overall shortage, but also the public-private migration, including creative ways of sharing human resources.

Recommendations

Joint vision and strategy for transformation in health

The DoH should exercise its stewardship role of facilitating a cooperative working relationship between the public and private sector. The draft Health Charter is a significant step forward as it represents a common framework for transformation of the health system. The Charter will facilitate the contribution that the private sector can make to transformation and this will hopefully contribute to more cooperation between the parties when it comes to government regulation of the private sector.

Finance and Social Health Insurance

Social Health Insurance remains a key strategy to reduce the funding disparity between the private and public sector and to offer an opportunity to build an improved public health system. The DoH should build on the renewed impetus and develop a SHI policy and continue with a systematic testing out and implementing of a phased approach to SHI, together with ongoing monitoring to assess if the aims are achieved. This is a medium to long-term strategy that will need extensive consultation with a range of stakeholders with competing concerns. SHI should therefore be one of the key issues on the agenda of the Health Charter, as this reform will require the cooperation and goodwill of all the stakeholders.

Managing Public-Private Interactions

The draft Health Charter indicates that PPIs are an important mechanism for strengthening the health system. The DoH has a central role to play in coordinating PPIs. One way to do this is to establish a national PPI unit that will have the resources to coordinate PPIs, to build management capacity for the implementation of PPIs and to monitor and evaluate PPIs. A PPI policy is required that has evidence-based knowledge about the effectiveness of PPIs in order to guide future collaborations between the public and private sectors.

A National Human Resources Plan

The DoH should develop a national human resource plan that offers solutions to the overall shortage and the skewed human resource distribution in SA. The national DoH released its Strategic Framework for Human Resources for Health Plan on 3rd August 2005, for discussion by all stakeholders. It is hoped that the private health sector will participate in these discussions and contribute to the development of the National Human Resources for Health Plan.[20]

A routine human resource information system is required as a first step to be able to monitor the needs and to inform the Human Resource Plan. For more details see chapter 14 on Information for Human Resources Management in this Review.

References

1 World Health Organization: The World Health Report 2000 - Health systems: Improving Performance. How is the public interest protected? Geneva: WHO; 2001.
URL: http://www.who.int/whr/2000/en/whr00_en.pdf

2 Kumaranayake L. Effective Regulation of Private Sector Health Service Providers. June 1998. London:Health Policy Unit, London School of Hygiene and Tropical Medicine; 1998.

3 Wadee H, Gilson L, Blaauw D, Erasmus E and Mills A. Public-Private Interactions in the South African Health Sector: Experience and Perspectives from National, Provincial and Local Levels; 2004 Centre for Health Policy, University of Witwatersrand and Health Policy Unit, London School of Hygiene and Tropical Medicine; 2004. p.7.
URL: http://www.healthlink.org.za/uploads/files/ppi.pdf

4 Blecher M and Thomas S. Health Care Financing. In Ijumba P, Day C, Ntuli A, editors. South Africa Health Review 2003/04. Durban: Health Systems Trust; 2004.
URL: http://www.hst.org.za/uploads/files/chap20_03.pdf

5 Forman L, Pillay Y and Sait L. Health Legislation 1994 – 2003. In Ijumba P, Day C, Ntuli A, editors. South Africa Health Review 2003/04. Durban: Health Systems Trust; 2004.
URL: http://www.hst.org.za/uploads/files/chap2_03.pdf

6 Gray A, Matsebula T. Drug Pricing. In Ntuli A, editor. South African Health Review 2000. Durban: Health Systems Trust; 2000.
URL: http://www.hst.org.za/uploads/files/drugs.pdf

7 National Health Act of 2003, No.61 of 2003, Government Gazette, Republic of South Africa, Cape Town; July 2004.
URL: http://www.info.gov.za/gazette/acts/2003/a61-03.pdf

8 Bisseker C. Doctors go to court. HST News; 9 October 2003.
URL: http://www.hst.org.za/news/20031015

9 Doherty D, McInityre D and Gilson L. Social Health Insurance. In Ntuli A, editor. South Africa Health Review 2000. Durban: Health Systems Trust; 2000.
URL: http://www.hst.org.za/uploads/files/chapter7_00.pdf

10 Department of Health: Committee of Enquiry - Health Chapter. Inquiry into the various Social Security Aspects of the South African Health System; Department of Health; 14 May 2002.
URL: http://www.doh.gov.za/docs/reports/2002/inquiry/

11 Department of Health: Consultative Forum on Risk Equalisation: The Context for Health Financing Reform in South Africa; Department of Health, July 2003.
URL: http://www.doh.gov.za/search/index.html

12 Department of Health: Report on the "Public-Private Interactions " Lekgotla; Kopanong, Gauteng 11-12 July 2002.
URL: http://www.doh.gov.za/docs/index.html

13 Buse K and Waxman A. Public- Private Partnerships: A Strategy for WHO. WHO: Bulletin of the World Health Organization 2001; 79(8).
URL: http://whqlibdoc.who.int/bulletin/2001/issue8/79(8)748-754.pdf

14 Joint Civil Society Monitoring Forum, 3rd National meeting, 18 February 2005. Durban 2005.
URL: http://www.hst.org.za/uploads/files/jcsfm_180205.pdf

15 Department of Health: Strengthening the Social Contract: Partnership and the Health Charter - A Discussion Paper (draft) December 2004. p.6

16 Department of Health: Budget Speech - Minister of Health, 8 April 2005.
URL: http://www.doh.gov.za/mediaroom/index.html

17 Department of Health: Draft Charter of the Private and Public Sectors of the Republic of South Africa, July 2005.
URL: http://www.doh.gov.za/docs/charter-f.html

18 Day C and Gray A. Health and Related Indicators. In Ijumba P, Barron P, editors. South Africa Health Review 2005. Durban: Health Systems Trust; 2005.

19 Padarath A, Chamberlain C, McCoy D, Ntuli A, Rowson M, Loewenson R. Health Personnel in Southern Africa: Confronting maldistribution and brain drain. Equinet Discussion Paper 3: Equinet 2003.
URL: http://www.equinetafrica.org/bibl/docs/healthpersonnel.pdf

20 Department of Health. A Strategic Framework for Human Resources for Health Plan: draft for discussion. Pretoria: Department of Health; 2005.