Evaluating Support Service Co-operation in the Netcare-Settlers Public Private Partnership, Grahamstown, South Africa

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ABSTRACT

The neo-liberal restructuring of state assets and facilities, which has taken place internationally over the past three decades, as well as in South Africa, has been a matter of great controversy. Privatisation, in particular, has been a polarising issue, especially when applied to fields like healthcare. Supporters of privatisation view it as cutting costs, mobilising funding, expertise and innovation, resulting in improved delivery, and opening possibilities for a spread of ownership. Critics claim the process involves retrenchments, declining services for the (poorer) majority of people, and a focus on the elites as citizens become transformed into customers, and with any economic empowerment going to the already prosperous.

This thesis examines these issues by looking at the privatisation of hospitals in South Africa, with a case study of the Netcare-Settlers Public Private Partnership (PPP) (also known as the Settlers Private Hospital) in Grahamstown, South Africa. Netcare is South Africa's largest private hospital company, and also has substantial operations in the United Kingdom. The thesis sets out the context: a highly inequitable healthcare system in the country, the rise of privatisation in the apartheid and post-apartheid eras, and healthcare privatisation.

In terms of the Netcare-Settlers PPP, the thesis examines how the PPP was structured and developed, focusing on the impact of the PPP on non-clinical operations. The thesis argues that the results of the PPP are mixed, that it has greatly improved areas like facilities, maintenance, cleaning and catering, performed less well in increasing the doctor/ patient ratio or in attracting specialists, and is associated with the widespread and problematic use of outsourcing of service workers like cleaners and security. Overall, the PPP has improved healthcare, with some effective sharing of resources between the public and private parts of the hospital, but also relies on a pool of relatively low waged, under-unionised, labour.

In terms of the general debate over privatisation, the Netcare-Settlers PPP shows that both supporters and critics have some valid points, and that privatisation in practice is not an either/ or, black/ white, good/ bad proposition, but something more complex. The success and failure of PPPs depend on the details of the contracts, and these can be used to maximise the performance of both the public and private partners. Better contracts may help avoid the uneven results seen at institutions like the Netcare-Settlers PPP.

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This thesis is for Sesethu Nosimphiwe Mahote…..!

ACRONYMS

ANC	African National Congress
BOO	Build Operate Own
BOT	Build Operate Transfer
CBOs	Community-Based Organisations
COSATU	Congress of South African Trade Unions
DA	Differentiated Amenities
DBFOT	Design Build Finance Operate and Transfer
DCPPHS	Draft Charter of the Public and Private Health Sectors
DoH	Department of Health
EC	Eastern Cape
ECDoH	Eastern Cape Department of Health
ENT	Ear, Nose and Throat
GEAR	Growth, Employment and Redistribution Strategy
GNP	Gross National Product
NDoH	National Department of Health
NDP	National Drug Policy
NEHAWU	National Education, Health and Allied Workers Union
NGOs	Non-Governmental Organisations
NHI	National Health Insurance
NP	National Party
NPM	New Public Management
PDoH	Provincial Department of Health
PFI	Project Finance Initiatives
PFP	Privately Financed Projects
PPI	Public Private Interaction
PPP	Public Private Partnerships
PWN	Private Ward Network
RDP	Reconstruction and Development Programme
SA	South Africa
SACP	South African Communist Party

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CHAPTER ONE:

INTRODUCTION

Introduction

The democratic post-apartheid government inherited a highly fragmented healthcare system that needed urgent restructuring: there was a historical legacy of inequitable and racially discriminatory health services; low levels of healthcare have numerous negative effects on society more broadly, including on economic productivity and growth; the new government was mandated by voters and by law to improve healthcare (Hirschowitz and Orkin, 1995). The post-apartheid government has undertaken a series of reforms to the system, as a means of increasing access and public benefits, including Public Private Partnerships (PPPs).

This thesis examines the outcomes of the PPP at the Netcare-Settlers Hospital (or the Settlers Private Hospital), in Grahamstown, a university town in the impoverished Eastern Cape province, as a means of examining the effects of health PPPs: does collaboration between the "public" (or state) and private entities benefit the South African citizenry? It locates this discussion in the larger controversies about the effects of neo-liberal state asset restructuring – above all, around privatisation. This chapter introduces the topic and the context, as well as the research methodology. The next chapters provide a larger discussion of the history and development of healthcare in South Africa, its current challenges, the rise of PPPs, and my findings and conclusions.

In 1987, South Africa spent R9.2 billion on healthcare: this amounted to 5,8 % of the Gross National Product (GNP), but the private sector accounted for 44% of this spending, despite only servicing 20% of the population; the rest of the population depended on the public sector where a mere 56% of expenditure was undertaken (De Beer and Broomberg, 1990:1). By the end of apartheid, in the early 1990s, the private health sector employed half the doctors, 80-90% of dentists, and nearly 20% of nurses, and absorbed half of the money spent on health (Greenberg, 2006:88).

By 2000, private sector healthcare covered around 16 per cent of the population at a cost of R36 billion annually, as compared to R32 billion spent by the state health sector on the other 84 per cent (Naidoo, 2001). By 2009, it was reported that there was a substantial difference in

resource availability between the public and the private sectors: less than 15% of the population were members of private sector medical schemes but 46% of all healthcare was attributable to these schemes; a further 21% of the population used out-of-pocket spending for primary level care but generally depended on the public sector for hospital (tertiary) care; the rest depended on state facilities (Coodavia, Jewkes, Barron, Sanders and McIntyre, 2009:826). Tied to this was the rapid expansion of private hospital groups, which played a role in centralising private healthcare: three companies dominated by 2001, with Netcare having a market share of 30%, Mediclinic, another South Africa-based multi-national having 22%, and Afrox Healthcare – now called LIFE – at 26% (*Financial Mail* in Greenberg, 2006:88).

Under apartheid, the state healthcare system was highly discriminatory on racial grounds, with more *per capita* spending on whites than on other races, and with African (and rural Africans in "homelands") receiving the lowest spending. Besides the major gap between spending in the main ("white") South Africa and the homelands, there were stark inequalities within the main South Africa. This is supported by data provided by Giliomee, that show the life expectancy for other races was much lower than that of whites, despite improvements due to increased state expenditure: under apartheid, African life expectancy rose from 38 to 61, from 55 to 68 for Indians, from 46 to 62 for Coloureds and from 66 to 73 for whites (2010:596). Although this might show improvement in life expectancy and a closing of the gap, it still underlines sharp disparities under apartheid between the different races in terms of service delivery, living conditions and access to education. Unequal resource allocations under apartheid are evident from the statistics provided by De Beer (1984:37): in the (white) Johannesburg Hospital R107 was spent on each patient in 1980, compared to R37 in the (black) Baragwanath Hospital in Soweto. In addition, the then-Transvaal province where both were located was short of 25% of the required number of nurses and this led to a sharp drop in the quality of healthcare provided.

While the post-apartheid health public healthcare system has been formally de-racialised, with the removal of separate facilities, as well as expanded in some respects, it has not been possible to finance *per capita* spending at the level previously enjoyed by whites-only facilities. Besides funding problems, there are important capacity issues: total South African healthcare expenditure equals those of many developed countries, but is far less effective and efficient (Stevens, 2012).

Many state hospitals, post-apartheid, have a degree of administrative crisis, as a report to the Presidency noted: "nursing procedures were no longer followed consistently, recording of data

was inconsistent, discipline had broken down, inexperienced or underqualified staff were taking responsibility beyond their scope of practice, infection control procedures had broken down, essential drugs were absent from pharmacies, linen shortages were endemic, to name only a few indices of hospital malfunctioning" (in von Holdt, Smith and Molaba, 2010: 4).

Even some pro-ANC writers have suggested that a "decline" in the functioning of state hospitals, post-apartheid (von Holdt, 2010: 10). This has been attributed to many factors, including a breakdown of the older apartheid management system, rapid staff turnover in the new state, problems in the post-apartheid management model including fragmentation and ill-advised appointments, misleading reports and excessive centralisation, racial divisions amongst staff, deep-rooted morale and labour problems, and funding shortfalls (von Holdt, Smith and Molaba, 2010; von Holdt, 2010).

The state cannot completely overhaul the system through a massive expansion of the state sector, as it lacks both adequate revenue and administrative capacity. Therefore the state has looked to other methods to ease the burden and address the problems in the strained state healthcare sector. With some exceptions (see e.g. von Holdt, Smith and Molaba, 2010), the main approach has been to try to harness private sector resources for improve state healthcare.

The government has introduced various collaborations with the private sector for the provision of public services, including in the health sector. Central to this have been various forms of Public-Private Partnerships (PPPs) (Hemson, 1998:1). PPPs have been used for the provision of a variety of services in the health sector, with, for example, Department of Health (DoH) hospitals working with private sector partners to provide secondary and tertiary services. PPPs are a form of Public Private Interaction (PPI) and should include:

- Innovative healthcare delivery models and business models for health services;
- Models aimed at skill retention and the effective distribution and utilisation skills;
- Use of public assets for the provision of health services by the private sector;
- Use of private assets for the provision of health services by the public sector.

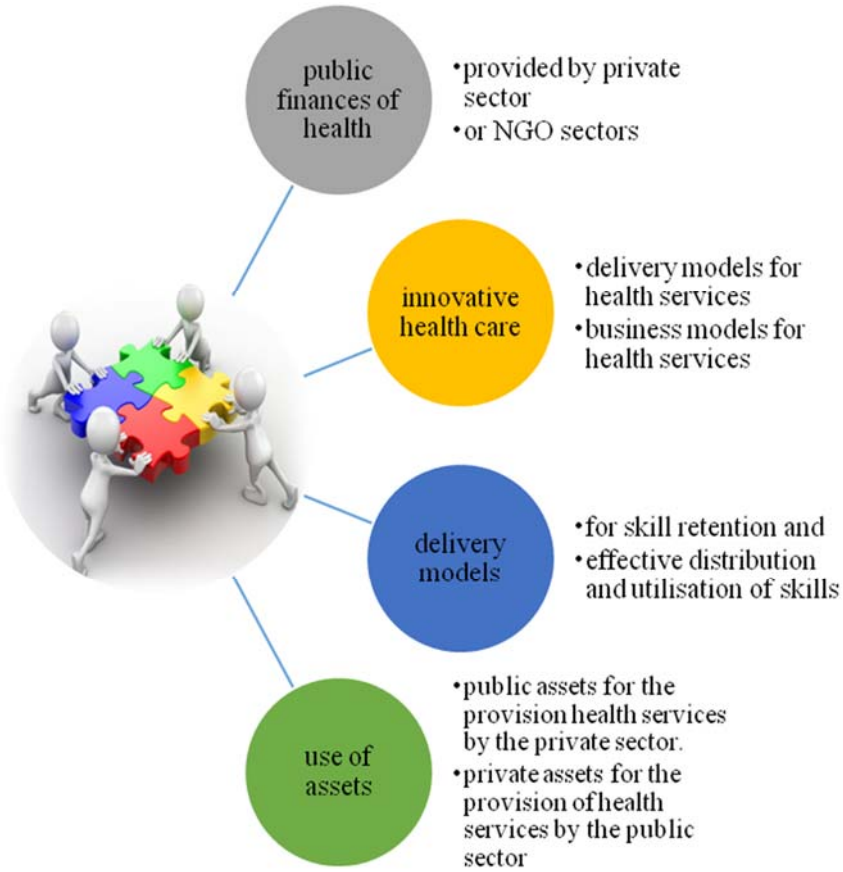


Figure 1.1. Illustration of the different PPI strategies used for the provision of private and public healthcare services by various stakeholders, the private entity, NGOs and the public sector entity. SOURCE: Wadee, *et al*, 2004.

The PPP model of privatisation has been subject to substantial controversy, linked to larger debates about the effects of neo-liberal forms of state asset restructuring, including of commercialisation, corporatisation and privatisation more generally. A substantial private sector role in the South African health sector is, however, nothing new. The country's healthcare system, historically and currently, has a deep divide between state and private provision. The state sector, including primary, secondary and tertiary healthcare, provides for the working class and poor majority: it is mainly funded by the government through taxation (Price 1988; Stevens, 2012; van Rensburg, Fourie and Pretorius, 1992). In contrast, the private sector is indirectly funded by insurance or medical aids, or directly funded out-of-pocket (van Rensburg *et al*, 1992: 88-89) and caters mainly for higher income earners, including the upper levels of the working class.

Research Problem

The enormous role of private healthcare must be understood against the backdrop of both inadequate state healthcare, and the introduction of neo-liberal policies by the National Party (NP) government from the late 1970s: this accelerated the already substantial role of the private sector role in the provision of services. The post-apartheid government has, in many ways, continued thus neo-liberal trajectory. Thus, the *Financial Mail* (of 2001, cited in Greenberg, 2006:88) argued that the growth of private healthcare was closely linked to subsidy cuts to state hospitals, which meant the state's level of service was lower than that available in private facilities.

The system of medical aids (medical insurance) reinforces privatisation by providing a means of accessing expensive private healthcare. Access to medical aids is, however, closely linked to race and class. Many workers have historically not had access to medical aids (Price and Tshazibane, 1989). While the Black, Coloured, Indian and White middle and upper classes, as well as a more affluent layers of the working class, currently have access to medical aids, the main users of under-funded and poorly performing state hospitals today are the working class, and more especially, the majority of the black working class. About half of healthcare spending goes to the minority of the population that uses private healthcare, with 84 per cent receiving the remainder: this majority carries a higher burden of disease, but receives one sixth of the spending per capita, despite widespread poverty and inequality (Mooney, 2012:81, 133). The disparity between state and private healthcare is so stark that demands for better access to medical aid schemes were made by state workers, including nurses, in the big state sector strikes of 2007 and 2010 i.e. these state workers themselves wished to escape the state healthcare they themselves helped provide (see Bekker and van der Walt, 2010:142).

In this sense, the current private/ state split reflects older inequities in access to healthcare on the lines of race as well as class. Initially the government of the African National Congress (ANC) adopted the Reconstruction and Development Programme (RDP). The RDP's main objective was redressing the legacy left by the apartheid government, including by establishing more effective, efficient, inclusive and accessible services. In health this meant proposing an intersectoral approach, including the introduction of a National Health Insurance (NHI) scheme along with private healthcare (Gilbert, Selikow and Walker, 1996: 185). This was indicated within the RDP document which advocated "programmes designed to restructure the healthcare services in South Africa with the aim to ensure that all citizens get infinitely better value for

the money spent in health, and that their mental, physical and social health improves both for its own sake and as a major contribution to increasing prosperity and the quality of life for all" (RDP, 1994: 43).

The RDP leaned towards an expansionary Keynesian model, but was soon overshadowed by the RDP White Paper, and was replaced two years later by the Growth, Employment and Redistribution (GEAR) policy. In 1995, President Nelson Mandela stressed the need to maintain fiscal discipline, reduce state debt, resist overspending and reorganise government assets in a manner calculated to produce revenue in order to reduce state debt and ease taxpayers' burdens (Mahadea, 1995:97).

Both of the RDP White Paper and GEAR were identified by many scholars as a move to the right, in favour of neo-liberal market-led solutions (Marais, 1996; Padayachee, 1997; Greenberg, 2006). Lehulere (1997:73) argues that GEAR was *not* the start of the ANC's slide into neo-liberalism but rather represented the "aggregate of drifts" already taken towards neo-liberalism in social, economic and political policy in the preceding two years – and that there was a basic continuity in economic policy between the NP and ANC.

GEAR, as adopted by the ANC government, aimed to enforce fiscal restraint in order to eliminate rapidly the government's large, inherited deficit, while simultaneously restructuring and reprioritising the existing national budget to meet social needs, and implementing liberal economic reforms, such as lifting exchange controls and restructuring state assets, and a flexible labour market to facilitate a globally competitive, export-led, growth path (van Niekerk, 2003:371).

Thus GEAR (1996) was informed by both neo-liberal theory and aims: wage restraint and the deregulation of labour markets, privatisation and other forms of market-oriented state asset restructuring, budget and tax cuts, and measures allowing money to move in and out of the country more easily (Lehulere, 1997:75). The shift to neo-liberalism by both the NP and ANC was part of a larger trend. Globally neo-liberalism gained ground following the economic crisis of the 1970s; Western countries abandoned the Keynesian economic philosophy and other countries moved away from economic protectionism (van Rensburg *et al*, 1992:79).

South Africa experienced many of the same economic challenges, compounded by problems specific to the apartheid economic model. Neo-liberalism did not start with the ANC: the NP government adopted privatisation in the 1980s (van Rensburg *et al*, 1992: 79), including the

partial privatisation of state oil company SASOL from 1979-1981, and the privatisation of state steel company ISCOR from 1987-1989 (Greenberg, 2006: 10).

The neo-liberal model has important implications for the health sector and healthcare delivery: health privatisation becomes government policy and an increase in public demand for private healthcare strengthens privatisation (Price and Tshazibana, 1989:103). The South African government remains committed, in the GEAR era, to improving access to healthcare both in the private and state spheres by harnessing all resources, including those of the private sector.

Even prior to the adoption of GEAR, the ANC engaged in some privatisation of services in the healthcare sector. Besides allowing the ongoing expansion of medical aids, the ANC endorsed pharmaceutical partnerships and outsourcing. This is the context in which PPPs in hospitals have been implemented, despite controversy. As of February 2013 (National Treasury SA, 2013) there were seven signed PPPs between the DoH and the private company Netcare (Netcare Report, 2010:50); this included one in the impoverished Eastern Cape, covering the Port Alfred Hospital and the Settlers Hospital (the latter in the university town, Grahamstown).

PPPs in health include a range of partnerships, co-management arrangements, joint ventures, and private ward arrangements. The latter can take different forms, but the most notable is co-location (Wadee and Gilson, 2005: 256). This is where a state asset is concessioned or leased to a private company for a specific period of time, with some of the services and equipment shared between the public and the private locations, and with a distinct private set of services for private users. Wadee and Gilson (2005: 265) argue that in South Africa, private wards are used as a means of generating revenue and enabling retention of personnel for the broader pool of lower- income public-hospital users.

From PPPs to NPM

Neo-liberal state asset restructuring does not just involve spending cuts and a greater private sector role. It also involves a new approach to management, in the form of the New Public Management (NPM) model that has been widely used since the 1970s by governments in developed and developing countries alike. The neo-liberal inclination of the NPM is reflected in its adoption of organisational principles, leadership styles, and corporate models from private business (Gruening, 2001). NPM is used in both corporatisation and commercialisation, and is also introduced through PPPs that place private firms in control of state facilities.

NPM proposes a polycentric administrative system in which the provision and production and financing of services are separated; also, its main principles include market competition, a business-management model, a customer-service orientation, and value-for-money. This also requires granting the public a choice of services and products, and, specifically choice between different state and private services, as a means of disciplining (competing) providers and producers.

This model has been widely applied in South Africa, where the notion of the citizen as a "customer" has been increasingly used (e.g. Hemson, 1998). The citizen is supposed to be no longer passive in service provision, but to take initiative and demand quality in the services received, especially by choosing services to use. With the adoption of various models of corporatisation, commercialisation and privatisation, the "good of the customer" comes first, with the service provider held accountable, rather than being able to rely on state monopoly, or hide in the bureaucracy of the state (Haque, 2000). In terms of health PPPs, the idea is to offer the public options, as hospital PPPs allow users to choose between private and public healthcare (often at the same location); employees also a chance to opt for employment with the public or the private healthcare centre in which they will provide services.

This means, according to NPM, that citizens-as-customers enforce responsiveness and efficiency in the state sector, and this relies on the freedom of individuals to make informed choices without the interference of the government (Gruening, 2001). NPM tends to view states as "bureaucratic" organisations, and to claim bureaucratic organisations have serious deficiencies, such as a strong tendency towards the accumulation of tasks and resources, excessive conservatism, and an inability to accomplish certain tasks. Thus, public choice and NPM is seen as creating innovation and efficiency and adaptation (Gruening, 2001). Also, politics and administration get separated, and finance models like cost-centres enable budget cuts through savings, require user fees, and improve regulation.

Other Developments: Price Control and NHI

There have been moves towards other forms of health restructuring under the ANC: besides stricter regulation of medicine costs, which benefits consumers, medical aids and state spending, moves towards a NHI continue. New legislation includes the Choice on Termination of Pregnancy Act (1996), which provides for pregnancy termination upon the request of a women during the first 12 weeks of gestation; the Medical Schemes Act 1998 regulating the

private sector; and a suite of legislation pertaining to regulation of professions, occupational health and safety and the private sector (Schneider, Barron and Fonn, 2007:296).

To date, NHI has not been implemented: the government has assigned a task team to research on the probable impact and a White Paper on its financing is still promised. Both price regulation and a mandatory NHI are partly in contradiction to the corporatisation, commercialisation and privatisation of healthcare services, and, as Price and Tshazibana (1989:104) foresaw, the power of the private health industry creates obstacles for the development of an egalitarian national health service, including a powerful lobby against a redistributive NHI. It seems clear today that the NHI currently proposed by the AC government will not replace the private sector, but involve a mix of state and private healthcare (Ruiters and van Niekerk, 2012:4; Bauer, 2011).

The original RDP envisaged a unitary state-centred National Health System (NHS), and came against a backdrop in which it was anticipated that statutory NHI would likely be politically feasible (De Beer and Broomberg, 1990:14) By 2007, however, the ANC spoke of NHI in terms of a means of achieving universal *access* to healthcare, so addressing South Africa's extreme health system inequities; this version of the NHI would mean a large pool of public funds that could be used to purchase health services from both state and private providers (Ruiters and van Niekerk, 2012: 4). So, even if NHI was implemented, it would not mean a nationalised health system (Ruiters and van Niekerk, 2012: 4). The NHI would co-exist with the private health system, and enable more PPPs, including bringing private sector management capacity into state health delivery (RSA, Medium-term Budget, 2010 in Ruiters and van Niekerk, 2012:4).

Thesis Objectives

This thesis aims to investigate the effects of PPPs on healthcare delivery post-apartheid South Africa, as a way of examining the larger impact of privatisation on what is considered basic service delivery, through a case study. It looks at the Eastern Cape PPP between the Nalithemba Netcare Consortium (led by Netcare) and Eastern Cape Department of Health (ECDoH), looking at Settlers Hospital (today, the Netcare-Settlers Hospital) in Grahamstown, with a focus on the non-clinical side, including the support side of operations: cleaning and catering, security and laundry services.

In healthcare services provided in hospitals, clinical treatment is provided by doctors and nurses, which in turn requires the support of other clinical services such as radiology and laboratory (Reiss, 2005:13). The non-clinical operations of the hospital are sometimes called "non-core" or "support" services, but, strictly speaking, non-clinical operations include functions like administration and information systems that are "core". These should be distinguished from "ancillary" services that are non-clinical services: the term "ancillary" literally means subordinate and generally, the largest portion of hospital ancillary expenditure is accounted for by six areas or divisions: building maintenance, catering, cleaning, engineering, gardening and laundry services (Ascher, 1987:172; Reiss, 2005).

This study is undertaken noting that there is a substantial controversy over the benefits of privatisation, including of PPPs, which also applies to healthcare. Naidoo (2001) for example, argued that privatisation does not benefit the poor, as it excludes them from essential services through higher prices, and promotes casualisation and retrenchments. Hemson (1998) argues that there are negative spin-offs from all PPPs, including corruption in the tendering and allocation of contracts, rising prices and a tendency to worsen labour conditions. The choice of the public is undermined by inequalities (not all citizens can afford to choose between state and private services), the reality of private monopolies; also, treating citizens as customers, rather than as universally entitled by right to certain goods and services, can mean that only the citizens with money get high quality services. Regarding health, some argue that privatisation can only exacerbate problems since it consolidates inequality (also see Greenberg, 2006; ILRIG, 1999; Marais, 1998; Naidoo, 2001).

However, there is a counter argument from proponents like Netcare (2009) which insists that a partnership with a private company can help ensure better access to affordable, quality healthcare, lower costs, and a better service including better staffing (also see ILRIG, 1999); the ECDoH, in adopting a PPP, with this company, clearly agrees. The main objective of the Netcare-Settlers PPP agreement is to widen access to affordable healthcare services.

This is a complicated set of debates, but one way to decide on which set of positions is more convincing is through evidence-based discussions e.g. case studies. To make this more concrete, the main goal of the thesis is to investigate and analyse the extent to which the Settlers partnership between the Netcare Consortium and the ECDoH has contributed towards improving state healthcare, by upgrading the non-clinical operations at Settlers; it will also look at the effects of the PPP on support service workers. This case study will allow this debate

over benefits to be evaluated by reference to a concrete example. In order for the main goal to be realized, secondary goals include:

- Outlining the core arrangements, responsibilities and goals of the Settlers Hospital PPP, with a focus on non-clinical operations;
- Examining the means that this PPP uses to provide and manage non-clinical operations;
- Investigating whether this PPP model has led to improvements in access, service quality and overall costs for the hospital, with specific reference to the non- clinical services;
- Examining labour relations in the non-clinical operations.

The aim is to examine the effects of the Netcare-Settlers PPP over a period of five years.

Research Methodology

This section outlines the research methodology used throughout the study, including the research design, data collection methods and data analysis methods and lastly the research challenges on the field.

A research design is an outline of the ways in which the research study will be conducted (Babbie and Mouton, 2002). The main objective of the thesis is to examine the effects of the Netcare-Settlers PPP over a period of five years. Thus requires engaging various stakeholders and key informants, to create a better understanding of PPPs as a strategy to improve state hospitals.

In-depth interviews were undertaken with clinical service personnel (nurses), non-clinical personnel, hospital management (the Netcare General Manager) and users of services provided at the hospital. The author also intended to interview representatives from the ECDoH but these, along with Netcare-employed nurses, these were unavailable for interviews. Representatives from the ECDoH refused to participate on the grounds that their jobs might be at stake (this despite proof of approval from the district office being produced). An attempt was made to get permission from the Netcare Nursing Manager to access the Netcare-employed nurses but she refused: she stated that they worked in high pressure, stressful situations, and permission to interview these nurses was thus denied.

Interviews were eventually conducted with 15 participants. The interviews were guided by questions derived from the main aim of the thesis (evaluating the effects of the PPP), and its

secondary goals (like mapping the core arrangements of the PPP, and examining labour in non-clinical operations). The stakeholder interview questions differed according to the cluster in which the respondent was identified. The respondents were from different clusters and their views about the Netcare-Settlers PPP also varied; it was also necessary to modify questionnaires.

Hospital Stakeholders	Employed		Unemployed		Permanent		Contracted		Total
	F	M	F	M	F	M	F	M	
Service Users	3	1	2	1					7
Netcare					0	3	4	0	7
Department of Health					1	0			1
Total	4		3		4		4		15

Table 1.1. Respondents' statistics and categorisation.

It took a great deal of time to line up the interviews and to secure access and permission. It was only in August 2014, for example, that all permissions were granted both by Netcare and its contracted companies at the hospital, as well as the ECDoH. Respondents for the -user cluster were volunteers, both from those that used the state side of the hospital and those that used the private side of the hospital.

In addition to interviews, use was made of primary documents like DoH and Netcare annual reports and related materials, which provided a means to assess the PPP over time. Press releases were also used, as were National Treasury PPP Unit materials, and a Risk Management in Public Private Partnership Presentation: Public Sector Risk Management Forum (06 March 2014) report.

The ECDoH annual reports provide, for example, detailed information on the process undergone by the ECDoH during the bid of contracting out PPP tender and the specifics of the

agreement between the ECDoH and Netcare as concessionaire. The Netcare annual reports offer a detailed account of how the agreement has been implemented in the years since the contract came into operation. The ECDoH and Netcare annual reports also provide updates on progress (or lack thereof) towards the goals of the PPP. The two sets of annual reports do not contradict, but rather complement, one other. National Treasury documents provide the basic guidelines and requirements for PPP agreements, and indicate the manner in which PPPs should operate.

Together these primary documents help explain the aims and regulations of PPPs in post-apartheid South Africa, and their application to the Netcare-Settlers PPP. Other useful materials include documents from the ANC, including its National Health Plan for South Africa (NHP), and from the DoH, such as the Health Charter. These documents help fill out the picture of the aims and objectives of the current government for the development of and access to healthcare in South Africa. They provide an overview of the strategies that the state envisions as needed to improve the healthcare system in South Africa.

Research Ethics and Challenges

The proposal to this study went through the Rhodes University Higher Degrees Committee and ethical received clearance. This study adhered to the rules and guidelines of the Rhodes University Ethics Protocol on ethics. It is important to maintain honesty with regards to the aims of the research. The confidentiality and anonymity of respondents was respected where requested, and where people refused to participate, they were obviously allowed to do so. In the event, all respondents who participated request that they remain anonymous when quoted. All the necessary company and DoH representatives were contacted, and management was made aware of the research. None of the research work involving Netcare-Settlers employees was conducted during working hours, to ensure that my presence on the field did not interfere with service delivery at the hospital.

There were a number of challenges encountered. One was the need to secure permissions. It took almost six months to secure access, in some cases. Netcare also restricted the number of workers I could interview: two workers per section (catering, cleaning, laundry and security). The IT people were said to be unavailable for interviews as they were busy working between the Port Alfred PPP Hospital and Netcare-Settlers PPP hospital. Some workers volunteered to do the interviews (security guards in Hi-Tec, a company contracted to Netcare) but did not

keep their promises. The Netcare Nursing Manager refused to allow any Netcare-employed nurses questioned via in-depth interviews, as noted above.

Thesis Outline

The first chapter introduces the research problem and objectives of the thesis project. Chapter two provides a historical overview of the development of healthcare policy in South Africa against an international background and changing economic policies. The third chapter context contextualises the application and practise of privatisation in alleviating state sector challenges in service provision with specific reference to the use of PPPs in healthcare, hospitals in particular. The fourth chapter brings forth an analyses of a specific contract between the Department of Health and Nalithemba Netcare Consortium; the Netcare-Settlers PPP in Grahamstown. The following chapter outlines the general effects of the strategy(ies) used by the private partner, and the impressions of service users whether the PPP concession agreement has served its purpose and if the PPP should be used in the long-term in hospitals in the state sector. The sixth and final chapter concludes on the findings and offers recommendations based on the limited study conducted at Netcare-Settlers Hospital PPP.

CHAPTER TWO:

THE ROAD TO HEALTH AND HEALTHCARE DEVELOPMENT IN SOUTH AFRICA

Introduction

This chapter provides an overview of the history and problems of the healthcare system in South Africa, focusing on the period from 1910 to the early 1990s. It is important to understand this context in order to contextualise ongoing efforts at economic and social reforms, including in healthcare, in the 1990s. The next chapter takes up these issues again, looking at the rise of neo-liberal approaches, like PPPs, and their application to healthcare. It is argued in thus chapter that the post-apartheid government inherited an inequitable, under-resourced and fragmented healthcare system, with a struggling state healthcare system alongside a massive private health system covering a wealthy minority of the population.

Healthcare under the Union government

While the bio-medical model assumes that all diseases and illnesses can be traced to viruses or bacteria, and can thus be resolved via medicine, medical skills and knowledge, the psycho-socio-environmental model broadens the definition of health to encompass social and emotional elements rather than restricting the definition to clinical criteria (Gilbert *et al*, 1996: 5). The latter model does not deny the biological elements of illness and disease, but draws attention to the social context of health, and directs attention to the importance of understanding the social and historical context of South Africa's current healthcare challenges. Dynamism was always obvious in South African healthcare, but this dynamism, for the greater part, reflects a clear healthcare in the same direction, and ongoing structural problems.

The 1910 unification of South Africa inevitably had significant implications for healthcare, especially as a unified political framework created the possibility of a unified healthcare system. When South Africa became a Union, a separate Department of Health was part of the planned new state, but there was long an entrenched fragmentation of authority over health matters (van Rensburg *et al*, 1992: 57). The responsibility of the previous four polities (Cape, Natal, Orange Free State, and Transvaal Republic) with regard to healthcare was simply transferred to four new provincial administrations, while local authorities continued with the tasks entrusted in them in republican and colonial days (van Rensburg *et al*, 1992:56).

A shift in emphasis towards primary, preventive, and community health, which was propagated continually and from various quarters – among others, by the Loram Committee in 1928, the Gluckman Commission in 1944, the National Health Service Facilities Plan of 1980 and the Brown Commission of the same year, and the 1986 National Health Plan – was time and again abortive (van Rensburg *et al*, 1992:57). Segregation on basis of race was entrenched, exacerbated by the rejection of the proposals of the Loram Commission in 1928 of training black doctors, and by the rejection of the Gluckman Report of 1944's emphasis on a non-racial, state-run, national health service for South Africa (van Rensburg *et al*, 1992:57).

The Public Health Act 36 of 1919

The Union of South African Act of 1909 united the four "white" polities (two colonies, two republics, which became provinces) and around ten "black" polities (mainly kingdoms, which became "native reserves", later "Bantustans" or "homelands") but did not contain any directives that unify the healthcare or other services; the new Union government did not initially dismantle the fragmented colonial and republican legislation relating to healthcare (van Rensburg *et al*, 1992:59). The healthcare system in the early years of Union was not comprehensive, and it lacked uniformity and co-ordination.

The disastrous global influenza epidemic of 1918 was responsible for the fundamental changes in the South African healthcare system. The influenza epidemic demonstrated the poor co-ordination and organisation of the health system and indicated that the national state had to assume more responsibility for healthcare services (van Rensburg *et al*, 1992:59).

The epidemic threatened the whole South African society; it did not stop at provincial or racial or class boundaries (van Rensburg *et al*, 1992:59). In response, a new dispensation and health policy came about, with the Public Health Act 36 of 1919, which aimed to reformulate and amend health laws. In addition, a national Department of Public Health was established, to coordinate the network of health services provided by the local authorities as the first tier of government, and be responsible more generally for public health services in South Africa (van Rensburg, 2012: 82). The second tier set up was provincial administration, with the third tier as the local authorities. The local authorities were now responsible for the control of contagious diseases and for environmental health in their respective areas of jurisdiction, but the costs were recoverable from the new Department of Public Health (van Rensburg *et al*, 1992: 60).

However, the three tiers did not work in unison: each aimed instead to achieve its objectives by promoting its own interests and autonomy above that of others, and often did so at the expense of the broader system (van Rensburg, 2012:83). The new Department of Public Health was responsible for aid and advice to provincial as well as local authorities, and was also ultimately responsible for the control of contagious and other diseases, the advancement of environmental health, for extra hospitals and institutional services (principally, district surgeon services), for control of institutions for the mentally ill, and for tuberculosis and leprosy patients (van Rensburg *et al*, 1992: 59). But the provincial administrations retained responsibility for the establishment, maintenance and management of general hospitals and charitable institutions, and as such were also henceforth associated with curative services in South Africa.

The new legislation had, however, two significant implications: on the one hand, it legitimated organisational fragmentation in the public health sector, and on the other, there was no reference to the place, and the role, of the rapidly growing private health sector. The latter could continue, unhindered, to expand as a separate and independent, market-based, system of health provision and financing (van Rensburg, 2012:83).

The systems inherited by the 1910 Union government were also normally racially segregated, and discriminatory, and this was also carried through in 1910s Union legislation. The health professions were themselves also segregated, with different training facilities, with black, Coloured and Indian staff not permitted to work with white patients, and with black hospitals run by white managers (von Holdt, 2010: 12-13).

The 1919 legislation etched the lasting contours of a deeply fragmented health system; it did not so much create a unitary health system as provide additional scope for fragmentation. Thus, fragmentation, existing before Union, continued despite reforms by the Union, from 1919 onwards.

In short, fragmentation was destined to remain a major characteristic of and a fundamental problem in South African healthcare. Elements of the system in place from 1919 remain in place today. The three-tier authority structure in the public health system, the divided control of different sectors of healthcare, the divide between the curative and preventive services, and the divide between state and private healthcare, have to this day remained the core features of South African healthcare (van Rensburg *et al*, 1992:60; van Rensburg, 2012:83). Although racial segregation has been formally removed under the present democratic ANC-headed

government, deep inequities and divisions, and the heavy legacy of past discrimination, remain important features of the South African healthcare system.

During the Union period there were, however, attempts by different groups and Commissions, with more forward-thinking approaches, to overhaul the healthcare system, notably the 1925 Vos Commission into public hospitals and related institutions, and the 1928 Loram Commission of enquiry into medical training for blacks, both of which reflected concerns with the deteriorating conditions of the urban and rural black population. The Loram Commission, for example, recommended state subsidised training of black doctors and nurses similar to that provided to white people, to cope with spread of communicable diseases and deterioration of labour within the black population; the establishment of a State Native Medical Service; and more and better hospitals for black people and rural health units (van Rensburg, 2012:84). The recommendations were rejected by the Union government. The 1936 Commission on National Health Insurance (known as the Collie Committee) investigated the feasibility of introducing a national health insurance scheme, but again, nothing materialised.

The problems did not disappear simply because of state inaction. Further requests for reform were made by the medical profession, notably the South African Medical Association, as well as by the Chamber of Mines, concerned with the health conditions of the black population. Meanwhile, Afrikaner nationalists were anxious about the health of poor whites (van Rensburg, 2012:84).

These pressures contributed to a renewed awareness of the need for greater state responsibility for healthcare. Deteriorating social conditions, growing political tensions and labour unrest, and a greater willingness in the government circles to bring about reform, led to the appointment of the National Health Services Commission in 1942, also known as the Gluckman Commission, which reported in 1944 (van Rensburg, 2012:84-85).

The 1944 Gluckman Commission Report

The National Health Services Commission was tasked by the Union government to investigate the case for a state-run national health service and to report on the administrative, legislative and financial measures required for such a service. It was chaired by a Dr Gluckman, thus it was also known as the Gluckman, Commission.

The Gluckman Commission's fundamental philosophy was that health services should be planned to ensure each person access to the best possible care, according to their specific needs

(van Rensburg *et al*, 1992:61). It proposed to do this by consolidating all health services, and by establishing a NHS that would be within reach of all sections of the population, regardless of race, colour, means or station in life.

The Commission argued that many elements of the existing health system were problematic: the lack of coordination; haphazard healthcare development, with a fragmented, unplanned system with different parties responsible for its administration; and a shortage of services, with personnel and facilities in limited numbers, specifically with regards to hospital bed distribution, with ratios varying from 1:304 for whites to 1:1198 for blacks (van Rensburg *et al*, 1992:60; Torkington, 2000: 8). Private practices had further problems, notably an unequal distribution of doctors and qualifying medical personnel, as doctors established their practices where paying customers lived, and not necessarily where the ill and desperate lived: this meant doctor/ population ratios were unequal, ranging from1:308 for the white population in Cape Town, to 1:22 000 in Zululand to 1:30 000 in Northern Transvaal (Torkington, 2000:8).

There was also a problem of inappropriate emphasis and priorities. The Gluckman Commission criticised inadequate environmental measures, and a critical shortage of medical services needed for preventing illness, because the emphasis was on cures, curative services and institutional care (van Rensburg *et al*, 1992:60-62). The Gluckman Commission argued that vast improvements in nutrition, housing and health education were necessary steps (De Beer, 1984:24). Without these, the burden of disease would escalate (Torkington, 2000:8).

With regards to the black population problem and disease, the Gluckman Commission stressed the social and economic factors causing illness. Thus, the Gluckman Commission's Report argued for an inter-sectoral approach towards combating healthcare challenges, with an equitable and nationalised healthcare system that would benefit the whole citizenry. But, since it was as unreasonable to expect the health services to make good the deficiencies of the socio-economic system, the Commission argued that health needed to be a long-term goal of economic policy as well (De Beer, 1984:24). Further, the Report noted that the health challenges of the time threatened the economy, since the main sources of labor (blacks, Coloureds and Indians) were threatened by ill-health and a shortage of reasonable and healthy living conditions.

The Commission also devised a detailed programme to implement the recommended NHS: a single central health authority responsible for planning; the coordination and effective use of health services; the state taking responsibility for all personal health and preventive services;

the phasing-out of private practice; a chain of referral of both service and hospitals stretching from general medical practice to specialised and academic hospitals; and the training of more health personnel, and the adaptability of service according to local needs (De Beer, 1984:25; van Rensburg *et al*, 1992:62-63).

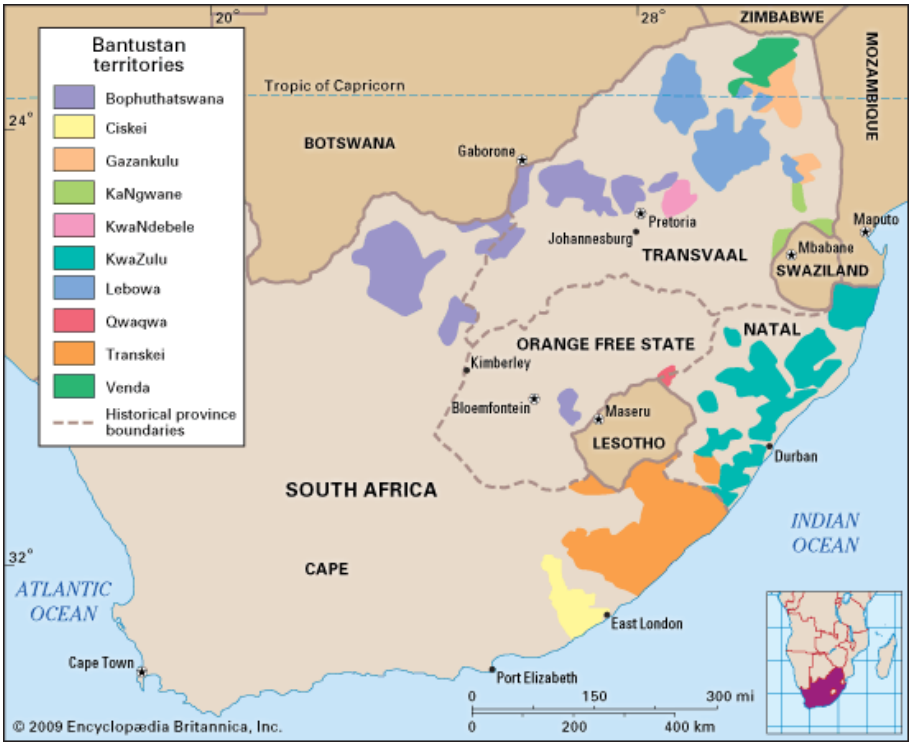
Healthcare and the Apartheid Era in South Africa

Most of the Commission's recommendations were not adopted, although a few influenced the National Health Act of 1946 (van Rensburg *et al*, 1992:63). This was due to a lack of political will from the Smuts government, opposition from the South Africa Medical Association, and the resistance of the provinces, curative institutions and hospitals (De Beer, 1984:27; van Rensburg *et al*, 1992:63). The few proposals that were accepted were viewed only as "a series of measures" and not as "a single step" to overhaul the whole health system (McIntyre, 2010:146).

The 1948 coming to power of the NP, whose programme of increased segregation was at odds with the approach of the Gluckman Commission, finally removed the possibility that the Gluckman Commission's programme would be revived after the War. Of course, the NP's coming to power cannot be taken as the sole reason for racial segregation and inequity in healthcare in South Africa (van Rensburg *et al*, 1992:64). Unequal treatment for the different races, revealed through unequal provision for and access to care, differential availability and quality and the disproportionate distribution of human resources, service and facilities according to race and colour, was in place long before 1948.

However, under the NP, *apartheid* was declared official state policy, was legitimised through new legislation and was implemented on a much grander and more systematic scale (van Rensburg, 2012:88). Apartheid healthcare policy saw the healthcare system further segmented into four separate healthcare services for the four races, with further fragmentation between the services in the main ("white") South Africa, and those in the different black homelands. The role and functions of these "Bantustans" were expanded, in an attempt to control, and reduce, the black presence in white areas. Most African men already carried passbooks by 1948; under apartheid, the system was to be expanded to African women, with all pass-bearers tied (by descent) to distinct "tribal" homelands where they were to have permanent residence and political rights (van Rensburg *et al*, 1992:65). Under apartheid, a huge number of people were moved back to the homelands, which had few facilities or employment (Torkington, 2000:9).This did not hinder the movement from the homelands to nearby "white" cities, in the

form of migrant labour, but it entrenched abject poverty in homelands and townships, which explained a high mortality rate among blacks (Torkington, 2000:10).



Map 2.1. Historical boundaries of the homelands and the four provinces: Transvaal, Natal, Cape and Orange Free State. SOURCE: Encyclopedia Britannica, 2015.

Population growth in the homelands reflected the success of the measures taken by the NP government to restrict black influx to the "white" cities. In the 1960s, about 37% of blacks resided in the homelands; 20 years later 54% of blacks resided in homelands (van Rensburg, 1992:66). The homelands were wracked with poverty, overpopulation, unemployment, low wages, famine, inadequate sanitation, crime and violence (De Beer, 1984: page). Over time, all ten homelands developed their own Departments of Health (Gilbert, Selikow and Walker, 2009:158).

Between the Bantustans themselves, healthcare provision and other basic public services varied drastically in quality and coverage, but these were generally worse than those for blacks in "white" South Africa: in 1975, for example, the Transkei had the highest incidence of tuberculosis with 489/100 000, compared to 256/100 000 for South Africa as a whole (van Rensburg *et al*, 1992:66). Within "white" South Africa, inequities were marked between the

areas set aside for different races: for example, while infant mortality rates for the Transkei were 130/1000, for Soweto they were 26.5/1000 but for South African whites a mere 12. 3/1000.

Healthcare service provision in the homelands was very limited, and certainly insufficient to accommodate the majority of their population; personnel, services and facilities were of poor quality (van Rensburg *et al*, 1992:66). Per capita healthcare expenditure varied by province (see Figure 2.1.) and by homeland, so that in 1983/84 per capita spending on curative care was highest in the Cape Province (at R127) and lowest in the Orange Free State (at R79), while in the homelands, per capita expenditure on all healthcare was highest in Ciskei (at R45) but lowest in Lebowa (at R16) (van Rensburg, 1992:67).

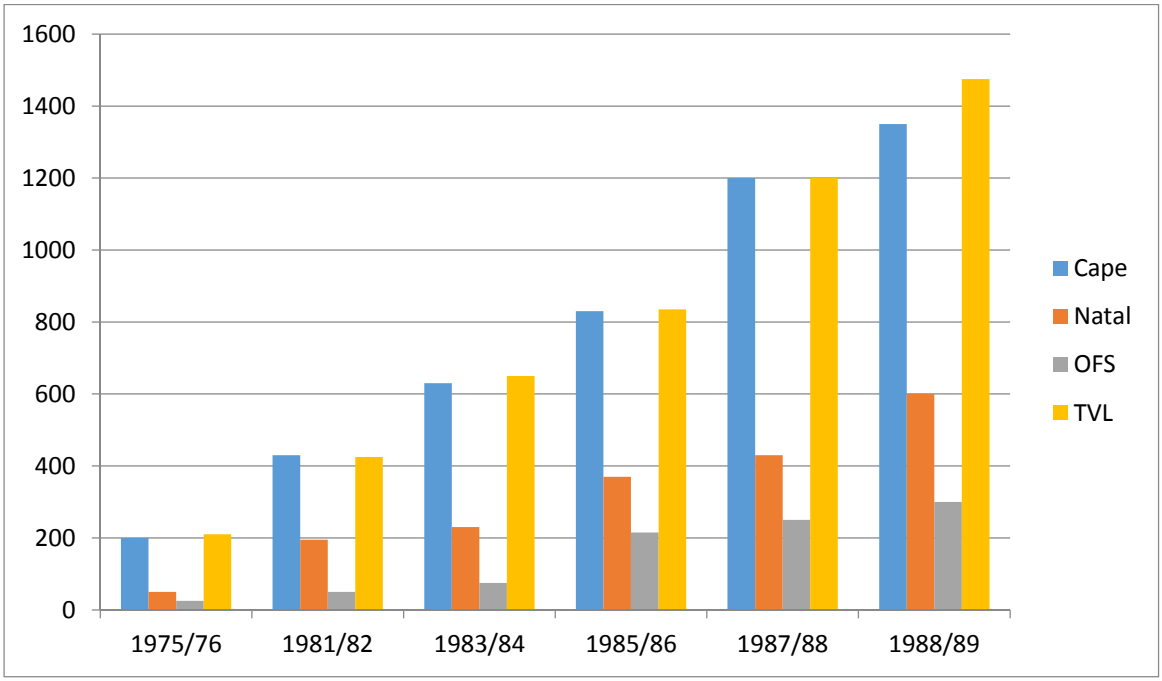


Figure 2.1. The trends in health expenditure by the four provincial administrations in South Africa, 1975/76-1988/89. SOURCE: van Rensburg *et al*, 1992:212.

Although general life expectancy and health improved for all races under apartheid (for example, African life expectancy rose from 38 to 61: Giliomee, 2010:596), the system remained extremely inequitable. From the 1970s, it also entered into a severe crisis, leading to various reform initiatives. Political reforms, including the reform of the industrial relations system, the creation of elected Black Local Authorities (BLAs), and of the Tricameral Parliament (with Houses for Coloureds, Indians and whites) were part of the process.

But while labour relations law was largely deracialised in the 1980s, the BLAs and the Tricameral Parliament entrenched the racial fragmentation of the system. BLAs, as local government institutions, were responsible for the first tier of health, but were heavily reliant on funding raised locally from (mainly poor) communities, and met fierce resistance when raising rates and rents.

The Tricameral Parliament saw the development of three more health authorities (in addition to the 11 that had already established). Curative services for whites, Indians and coloureds would be under their "Own Affairs" Departments of Health and preventive services will fall under their "Own Affairs" local authorities. Then a "general affairs" Department of Health (DoH) would be responsible for the health services provided for blacks (in "white" South Africa). The homelands would continue to operate their own separate health departments. Further complicating the system, the Departments of Health and Population Development controlled all academic hospitals, while provinces continued to administer the hospitals on behalf of all the "Own Affairs" and "General Affairs" departments of health (Gilbert *et al*, 2007:158). An outline of the various state departments involved health and healthcare development in South Africa is presented below as Figure 2.2.

There were, however, some efforts at comprehensive healthcare reform during the reform period of late apartheid, beginning with the Brown Commission in 1980, the National Health Service Facilities Plan of the same year, and the 1986 National Health Plan (van Rensburg, 2012:102). The objective of the National Health Plan was to help unify health services in South Africa, and to achieve the national objectives and priorities recommended by the 1980 Brown Commission: central responsibility for overall planning and policy; the optimal use of available resources by means of the elimination of fragmentation and duplication; a rectification of the divide between preventive and curative care; and – significantly – encouragement of more private sector initiative in the health sector, with private organisations and practitioners being seen an important part of a comprehensive health plan (van Rensburg, 2012:102).

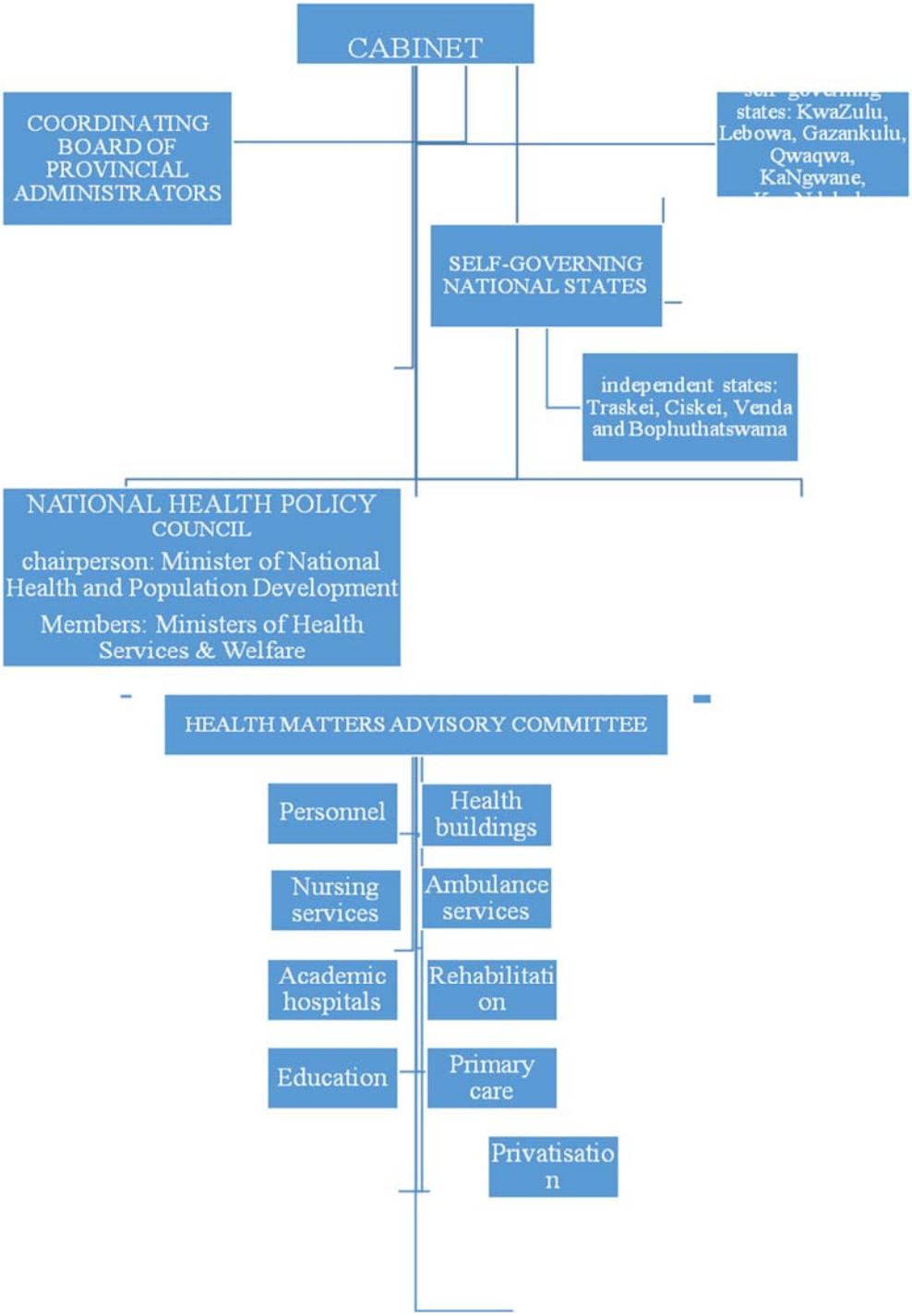


Figure 2.2. The complicated system of healthcare in late apartheid South Africa (1986). SOURCE: van Rensburg, 2012:103.

The National Health Plan took more consideration of socio-economic impacts on healthcare than earlier policies, and spoke in terms of four areas: the provision of basic subsistence needs, health education, primary healthcare and hospitalisation. The key objective was to bridge the gap between the availability of curative and preventive services: the existing healthcare services were concentrated on curative services and not preventive services; very little attention was paid to clinical services; huge amounts were paid as grants by the government to state hospitals. With hospitals so expensive, hospital-based healthcare could not be made easily available to everyone (De Beer, 1984:38). Yet in practice, only limited provision was made for expanding preventative care: this would have required massive improvements in the conditions of the black, Coloured and Indian majority, which was not economically or politically feasible at the time.

In the 1970s, privatisation became one of the later apartheid government's main policy reform instruments, and following the crisis that affected the world's economy and the growing problems in South Africa, healthcare was identified as a site for this reform. Privatisation, as government policy in South Africa, was influenced by and in line with international trends towards an increasing role for the private sector (Coodavia *et al*, 2009:826). Thus, South African health and healthcare privatisation took place in the 1980s (van Rensburg *et al*, 2012:104).

Privatisation was seen as a way of improving services, was also viewed as a means of shifting welfare burdens off the state and allowing cuts in spending on whites. Service privatisation was also a strategy to shift responsibility from the state to the market: the government could then claim that decision regarding health services was no longer "political" (Price, 1988:704). There were several factors that encouraged privatisation: first, state expenditure levels were becoming unsustainable, and it seemed unlikely that spending, including in healthcare, for all could be equalised at "white" levels; the economy was undergoing severe problems, which affected state revenues, while political problems meant escalating spending on military and policing functions; it was also increasingly believed that the large-scale state involvement in the economy in place since the 1920s as part of an import-substitution-industrialisation strategy, was in itself undesirable, with the free market seen instead as the solution (van Rensburg, 2012:105; also Community Resources and Information Centre / CRIC, 1989).

Given the neo-liberal and privatisation policies of the 1980s, the last decade of apartheid saw increasing privatisation of healthcare, which helped contribute to expenditure in the private healthcare sector growing faster than state health expenditure (van Rensburg, 2012:105). The long-standing gulf between private and state healthcare was deepened. Strain on the state reinforced the drive towards privatisation in healthcare – the government had previously viewed private health services with some suspicion (Price, 1988:705).

The growth of private provision reinforced an existing trend that saw, by the early 1970s, large number of whites moving over to private healthcare. By 1972, two-thirds of doctors were employed in the private sector, with the provision of medical care starkly inequitable within the white population as well as between the races. While the state continued to provide subsidised public healthcare for poorer whites, wealthier whites opted increasingly for private healthcare options, including through state-run medical aid schemes for the better-paid state employees and workers.

It is important to note that the apartheid state always targeted its social service interventions for whites in the area of education, and the state never assumed as prominent a role in healthcare as it did in education (Natrass and Seekings, 2006:136). The government viewed education as enabling whites to occupy better jobs, and thus earn higher salaries as well as avoid competition from other races: as the white population moved upwards, its ability to move from state towards private services increased. That is, state investments in education provided a growing part of the white population labour market advantages, which enhanced their capacity to get private healthcare and pensions. This eased the burden of state expenditure, and initially allowed public healthcare expenditure to remain steady at between 50 and 60% of the total despite growing spending on blacks, Coloureds and Indians (Natrass and Seekings, 2006:155). By 1992-93, public health expenditure had fallen to 30%, as the use of medical aid schemes increased to account two-thirds of healthcare spending, with another fifth accounted for by private out-of-pocket payments (Natrass and Seekings, 2006:156).

The decrease in public healthcare expenditure and increase in private healthcare expenditure also entailed rising medical costs: although the private sector was more expensive per capita, a growing proportion of the population, especially of whites, was covered by medical aid and related schemes. Fees charged at private facilities differed sharply from those charged at public facilities: fees at public facilities were determined by household income while those charged by private practitioners were determined by medical schemes and business considerations

(Price, 1988:704). In the 1970s, 59% of the white population was covered by medical aids but by 1980 the number had escalated to 79%, while in the total population about 11% was covered, rising to 16% by 1980 (Natrass and Seekings, 2006: 155-156).

Although this meant that more resources were made available for healthcare, the beneficiaries of private healthcare were a very small part of the population, and the problems of limited resources, fragmentation and so on in healthcare persisted. In 1982 about R3 750 million (in 1982 values) was spent on healthcare, a total of 4.9% GNP, of which .2% was financed publicly by taxes and deficit financing; a further 25.1% was spent by medical schemes whose income was derived largely from employer and employee contributions; the rest of the 21.4% was paid by means of user-charges to patients (Price, 1988:704). So, this approach really meant that while some of the burden on state hospitals, notably of services for whites was reduced, it did not really solve the problems facing most of the country's population, or the deeper inequities and inefficacies in the overall healthcare system.

According to Price (1988: 703) the structural changes that went with this privatisation created long-term problems in the provision of more egalitarian healthcare. The major cost drivers in the private sector were hospitals (over 35% of medical scheme's expenditure) and specialists (nearly 21% of schemes' expenditure). The growth of the private health sector usage was routinely associated with sharp cost escalation, which was partly driven by the fee-for-service system (Price and Tshazibana, 1989:100-101).

Although most black, Coloured and Indian people were outside of the growing private healthcare system, an increasing number were covered by medical aids in the 1980s, partly this because of reforms in labour relations, and the rise of a new wave of unions demanding equality, plus capital's interest in developing a core of permanently urbanised, well-educated and skilled black, Coloured and Indian workers (Price, 1988:703-704).

Politically, the NP government was also interested, after 1976, in winning support from the black middle class (and from better-paid workers), and one means was to give these groups better state services and improved urban environments (Price, 1988:704). The slow removal of the "petty apartheid" segregation of state facilities, which in principle meant that people of colour could access previously whites-only facilities, including hospitals, was part of this project. It was partly enabled by the fact that that whites relied less on the old whites-only facilities.

But major reforms in the system were prohibitively expensive, and both the National Health Service Facilities Plan (1980) and the National Health Plan (1986) had little potential to remedy some of the challenges of the time. The system remain deeply fragmented: as Figure 2.3. shows, the proportional allocation of funds in the state health sector in the year 1987/88 saw 14.2 % (R749 million) allocated to the national Departments of Health and Population Development, 14.4% (R762 million) was allocated to the homelands, 2.2 % (R118 million) to "Own Affairs" administrations, 4.3 % to local authorities (R225 million), 7.5% to other state departments (R 399 million), with 57.3 %(R3 029 million) to provincial administrations (van Rensburg *et al*, 1992:208).

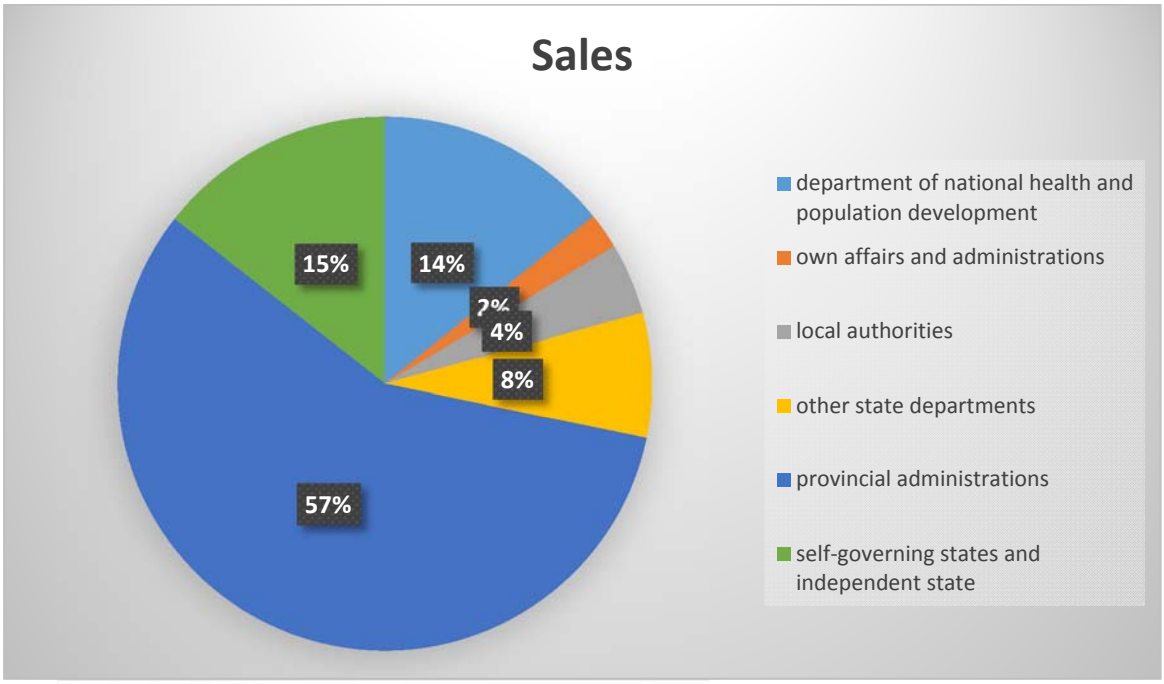


Figure 2.3. The proportional allocation of financial resources in the public health sector in South Africa, 1987/88. SOURCE: van Rensburg *et al*, 1992: 208.

So, the 1980s saw commitment by the NP government to reforming the healthcare sector, including privatisation, but there was no real sign of bold reform strategies that could address the long-standing distortions and inequalities linked to the larger socio-political order (van Rensburg *et al*, 1992:83). Efforts were relatively feeble, and failed to penetrate to the roots of the problem: as van Rensburg *et al* (1992:83) note, they failed to address structural problems like segregation and unequal distribution services throughout the country. Various policies and systems structured society according to race, gender and age-based hierarchies, and this influenced of social life, including access to the most basic healthcare (Coodavia *et al*, 2009:817).

ANC National Health Policy and the RDP

The ANC-led government thus inherited a country infested with stark socio-economic and healthcare disparities: income distribution was racially skewed, and the country one of the most unequal in the world, one where lavish wealth and abject poverty co-existed (RDP, 1994:2). Segregation with inequity existed in all sectors, including education, healthcare, welfare, transport and employment, leaving deep scars of inequality, economic inefficiency, racism and social conflict. For example, the education system of apartheid South Africa provided deficient training for blacks, Coloureds and Indians, contributing to low labour productivity and endemic skills shortages (Giliomee, 2010:537).

Discrimination, migrant labour, the destruction of family life, vast income inequalities, and violence formed part of South Africa's troubled past, and inexorably affected the healthcare system (Coovadia, *et al*, 2009). The healthcare system faced many challenges when apartheid ended in 1994, and many of these challenges persist (Coovadia *et al*, 2009). The state healthcare sector, overshadowed by the private healthcare sector, was marked by inequitable distribution, especially in rural areas, and a lack of access, but also problems of a lack of transparency and openness, responsiveness and sensitivity, and discourteous staff.

The ANC-led democratic government set out to correct these problems, also being bound by the Constitutional provision that the state provide basic services to those unable to provide for themselves and their dependants. The Constitution of the Republic of South Africa (Act 108 of 1996) stated specifically that everyone had the right to access healthcare services, including reproductive healthcare, to sufficient food and water and social security, and to social assistance if they were unable to support themselves and their dependents (SA Constitution, 1996:8). Thus, the imperative to take reasonable legislative measures to ensure that everyone has access to healthcare service was constitutionally entrenched (Forman, Pillay and Sait, 2004). Further, the ANC had accepted the Declaration of Alma Ata of 1978, adopted by the World Health Organisation (WHO), which affirmed that access to basic health services was a fundamental human right (Hall and Taylor, 2003:17). (The conference held at Alma Ata expressed the urgent need for governments, health and development workers to promote and protect the health of all people).

Health policy was not envisaged by the incoming ANC government of 1994 in isolation: like the Gluckman Report of fifty years earlier, the incoming ANC stressed that health improvements, in the long run, required improved social and economic conditions for the

majority. As noted by Gilbert *et al* (1996: 111) healthcare equity required that attention be given, not only to changing healthcare services, but also to improving the socio-environmental circumstances of the majority of the people, in order to improve their health status. The RDP was envisaged as an integrated and coherent socio-economic policy, including social services (RDP White Paper, 1994:7), to mobilise all "our people" for the final eradication of apartheid and a democratic, non-racial and non-sexist future (RDP, 1994:1; also Torkington, 2000:15). This included redressing inequalities from the past, including in health (Torkington, 2000:16).

The RDP base document listed six core principles (RDP, 1994). First, it was to be an integrated and sustainable programme, rather than one made of piecemeal, uncoordinated policies, and to be implemented at all levels of government, as well by business and organisations within civil society. For healthcare, this meant a single National Health System that would harness all resources and coordinate public and private healthcare (RDP, 1994:3).

Secondly, it was to be a people-driven process, one that relied on the "people's" energies, active involvement and growing empowerment, with the state committed to maximum transparency and inclusivity. For healthcare, this stressed primary healthcare, centred on "community health centres", providing promotive, preventive, rehabilitative and curative care, as part of a district health system (RDP, 1994:3). Primary healthcare was defined as essential healthcare based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and their families in the community and country through their full participation, and at a cost that the country could afford to maintain, for every stage of their development, in the spirit of self-reliance (RDP, 1994:20). While the state was expected to address healthcare needs throughout society, its primary obligation was to meet the basic needs of those living in great poverty and experiencing immense vulnerability (RDP, 1994).

Third, the RDP spoke of promoting peace and security, and combating the endemic violence faced by communities and women, with demilitarised, professionalised and representative security forces and a National Peace Accord (RDP, 1994:45). This was a prerequisite for health development, and for reconstruction and socio-economic development.

Closely linked to this was the principle of nation-building, based on a single country, with a single economy, a unifying Constitutional framework that established clear powers, respect and protection for minorities, and co-operation. For healthcare, this meant building a unified health system, involving all key stakeholders, including employer, labour, professional, medical aid, and health insurance organisations.

The next RDP principle was linking reconstruction, development and reconciliation, especially through an expanded infrastructural programme that would provide access to modern and effective services, and improve productivity and human resources. In terms of healthcare, local and equitable healthcare and infrastructure development in both rural and urban areas was highlighted (RDP, 1994:43).

The sixth and final RDP principle was that of a thoroughgoing democratisation of South Africa, where people participated in decision-making, including between periodic elections. For healthcare, this included removing the apartheid legacy with better public-private collaboration and some rationalisation, as well as more transparency, openness and choice in the healthcare system.

The health plan in the RDP (1994), the subsequent ANC's 1994 National Health Plan (NHP, 1994), and the 1997 White Paper for the Transformation of the Health System in South Africa, elaborated the government's approach to achieving the removal of the apartheid legacy and operationalising a universal right to access to equitable healthcare (Forman, Pillay and Sait, 2003/04:14). This was to be achieved through a health sector that was to draw together all role players and services into a comprehensive health system (Torkington, 2000:18).

The White Paper on the Transformation of the Health System set the objective of developing a unified health system capable of delivering quality healthcare to all (Forman, *et al*, 2004:14). Its core principles were unifying the fragmented health services at all levels into a comprehensive and integrated NHS; reducing disparities and inequities in health service delivery and increase access to improved integrated services, based on primary healthcare principles; giving priority to maternal, children's and women's health; and mobilising all partners, including the private sector, NGOs (Non-Governmental Organisations), communities and Community-Based Organisations (CBOs) (White Paper on the Transformation of the Health System, 1997:2).

Administration was to be condensed into one single system under national, provincial and local administration, but (as in the apartheid era), health services were to be provided by both the state and private sectors. Some of the racial disparities in the state system were removed easily, by merging the many Departments of Health into a single DoH, divided into nine provincial administrations (in line with the nine new provinces), while removing all remaining formal and informal racial restrictions on access to facilities. The ANC government quickly achieved the objective of consolidating the 14 health administrations of the homelands and the rest of South

Africa into one national health system with nine provincial departments (Coodavia *et al*, 2009: 828).

Primary healthcare was strongly emphasised by the ANC at this time. Long neglected, primary healthcare in South Africa was now an idea "whose time had come", and finally "mainstreamed" (Kautzky and Tollman, 2008:18). The ANC stressed primary healthcare, rather than tertiary services, and preventative rather than curative approaches, aiming at a network of free clinics, community health centres and mobile clinics (NHP, 1994; RDP, 1994:20; Torkington, 2000:19).

Primary healthcare, as the cornerstone of the healthcare system, was to be funded via allocations by district health programmes, divided into three main areas: the district office, facility-based care, and community-based services (Bletcher, Day, Dove and Cairns, 2007:187). Although the system stressed community involvement, one of the major changes from earlier healthcare arrangements was that primary healthcare now fell under the provinces, with the district health system under provincial DoHs (Makana Annual Report, 2012:33). Primary healthcare is now provided in communities, through healthcare centres and through fixed and mobile clinics which helped cover far-flung rural areas. In addition, for health purposes, each of the nine provinces was also divided into regions, with each region having its own comprehensive primary healthcare team.

These changes were in line with the model of primary healthcare promoted at Alma Ata, which envisioned a system based on community health centers, with facilities providing children younger than 6 years and pregnant mothers with free treatment, an approach also reviving some of the recommendations of the Gluckman Commission 50 years earlier (Coovadia *et al*, 2009:12). While some categories of patients were to be given free state services, payments by others would be means-tested; medical aid users would be charged in full at state facilities, as a subsidy, but the main income would be from tax revenue; further, staff were to be retrained as needed; a "charter" of patient rights was adopted; the emphasis was placed on poor and rural areas, and on ensuring an equitable allocation of staff across territory.

Primary healthcare was seen as necessarily community-based and socially acceptable, in line with ANC promises of democratic governance (see Gilbert *et al* 2010: 360). As De Beer (1984:38) had said many years before: "preventive medicine and health education work best when people see that health is not only about going to the doctor. It is important to involve communities in their own healthcare". The White Paper on the Transformation of the Health

System also envisaged communities being drawn in to help achieve the goals set at various levels of care (1997:3). Since primary healthcare was envisioned as part of a comprehensive, transparent and people-driven healthcare system, involving the family and community in the social, economic and mental well-being of members was imperative if the system was to be successful (Dennill and Rendall-Mkosi, 2012:59).

Effectively, the ANC government opted to divert resources from curative care to focus on preventive and promotive healthcare, stressing primary healthcare facilities. The stress on primary healthcare meant a shift from the historic emphasis on high-technology, curative, hospital-based and doctor-oriented services driven by the interests of professionals and the market, to preventative, primary and community healthcare services (van Rensburg, 1999:3). Hospitals are very expensive compared to clinics, and thus cannot easily be made available for free or at low prices to everyone; further, many of the issues that hospitals address could be avoided by creating better awareness about how good health can be maintained.

So, "In the health sector, political change has aimed to reduce inequalities in health and health services into one South African health-care system and re-orientate services towards primary healthcare": user fees were removed for some categories, abortion was legalised, and a massive clinic building programme (Chopra, Lawn and Sanders, 2009:1023). With primary healthcare delivered through a district health system, the district health system became the core of healthcare provision, and a clinic infrastructure programme saw 1345 new clinics built and 263 upgraded (Coodavia *et al*, 2009: 828).

By 2000, primary healthcare was provided by the state for free to all children under six, and to pregnant and nursing mothers, the elderly, the disabled and some categories of the chronically ill (Torkington, 2000:19). Secondary healthcare was provided by the government through state hospitals under the responsibility of the DoH. All tiers of the state healthcare system, dealing with primary, secondary and tertiary health services, were funded primarily through tax revenue (as noted later, PPPs would also be seen as a way of mobilising private resources for state facilities).

The primary healthcare system, as understood by the ANC, was envisaged as working closely with state hospitals: the White Paper on the Transformation of Health had a whole chapter dedicated to the improvement of hospitals in association with the primary healthcare system. It recognised that the primary healthcare system could not operate in isolation, and it could not meet to all patients' needs and demands without the backup of hospitals (van Rensburg,

2012:562). At the same time, the primary healthcare system took some of the burden off state hospitals (many of which had been neglected for years, with the standards of of care and service varying widely) (White Paper on Health, 1997:100). Many demands on hospitals could be reduced through a referrals system that directed patients to clinics. The different facilities were seen to be complimentary, not contradictory.

Service provision in democratic South Africa (*Batho Pele* and Healthcare)

Meanwhile, the 1995 White Paper on Transforming Public Service Delivery (WPTPS) (and the subsequent legislation: Government Gazette, 1997) stressed a "people first" (*Batho Pele*) ethos in all state services, and aimed at providing a policy framework and practical implementation strategy for the transformation of state services provision. It argued that decent and dignified services were not a privilege in a civilised and democratic society, but a legitimate expectation (Government Gazette, 1997:10). This approach marked a break with the authoritarian and racist approach of the apartheid state bureaucracy (see von Holdt, 2010). Detailed principles and practices were outlined (see Table 2.1).

The 1997 White Paper on Transforming Public Service Delivery called on national and provincial departments to make service delivery a priority and to develop concrete "service delivery" strategies (Government Gazette, 1997:10). This required mission statements for service delivery, service guarantees, financial plans that linked budgets directly to service needs and personnel plans, a culture of customer care and approaches to service delivery that were sensitive to issues of race, gender and disability (Government Gazette, 1997:11).

This was in direct contrast to the policies and practices of the NP government, which even in the 1980s reform period acted according to socio-economic inequities in terms of race, gender and class, and which operated from a generally authoritarian ethos. As such the White Paper on Transforming Public Service Delivery was intended to bring about a fresh approach to service delivery that put pressure on systems, procedures, attitudes and behaviour within the state sector to put people first (*Batho Pele*). The White Paper on Transforming Public Service Delivery outlined eight specific principles, which are summarised in Table 2.1.

Principles	Explanation
Consultation	Citizens should be consulted about level and quality of the public services they receive and, wherever possible, should be given a choice about the services that are offered.
Access	Citizens should be told what level and quality of public services they will receive so that they are aware of what to expect.
Service Standards	All citizens should have equal access to the services to which they are entitled.
Courtesy	All citizens should be treated with courtesy and consideration.
Information	They should be given full, accurate information about public services they are entitled to receive.
Openness and Transparency	Users should be told how national and provincial departments are run, how much they cost and who is in charge.
Redress	If promised standard service is not delivered, citizens should be offered an apology, a full explanation and a speedy and effective remedy, and when complaints are made, citizens should receive a sympathetic, positive response.
Value of money	Public services should be provided economically and efficiently in order to give citizens the best possible value for money.

Table 2.1. The White Paper on Transforming Public Service Delivery's eight principles for the transformation of service delivery: SOURCE: Government Gazette, 1997:15-16.

Fiscal and Managerial Constraints, and Private Partnerships

However, like the NP before it, the ANC faced severe fiscal constraints and economic challenges. The principles of the RDP stated that all levels of government must pay attention to "affordability", fiscal discipline and achievable goals and goal eight of the White Paper on Transforming Public Service Delivery was "value for money". When the RDP (1994) argued for a merger of the fragmented state, it did this partly on the grounds that this would allow cost-

cutting; the RDP White Paper and GEAR were also explicitly committed to fiscal austerity (Lehulere, 1997). There was an ongoing commitment in ANC policies to reducing unnecessary government consumption (including the duplication arising from segregated services), to allow the release of resources for productive investment, based on prioritising the areas of greatest need (Government Gazette, 1997:10).

Budgetary reform was thus identified as a primary strategy to improve access to social services, in particular reprioritisation within the (limited) health and education budgets (GEAR, 1996: 9). For healthcare services, this restructuring meant an emphasis on universal and free access to (cheaper) primary care (GEAR, 1996:14), in line with the RDP's stress on primary care and strict spending limits (RDP, 1994:3).

GEAR noted that nearly half the government budgetary was dedicated to welfare and services, and it argued that this situation required spending prioritisation, with the emphasis (for healthcare) on free access to comprehensive primary care (1996: 8, 14). This meant stressing basic services and education at the primary level (Torkington, 2000:19), and strict limits (even some cuts) on or in hospital services, administration, and emergency services, while moving a number of professional nurses from hospitals to primary care facilities.

Fiscal constraints also posed severe challenges to the primary healthcare programme centred on clinics. These were worsened by problems arising at the administrative level, such as confusion and delays in defining district boundaries, and a lack of standardisation of the roles, training, and supervision of "community carers" who also now worked at the clinics (it was unclear, for example, if "carers" were to be paid, or were volunteers), as well as new pressures from the HIV/ Aids and tuberculosis epidemics (Coovadia *et al*, 2009).

Both clinics and hospitals faced problems like securing regular medicine supplies, partly because of poor practice, maladministration and corruption (Dennill and Rendall-Mkosi, 2012:61), and partly because of fiscal constraints. The problem was not just one of money, since total South African healthcare expenditure equals those of many developed countries (Stevens, 2012). The apartheid-era healthcare system was highly fragmented, but held together to some extent by an authoritarian and racist approach to administration (see von Holdt, 2010). The post-apartheid healthcare system has removed the apartheid fragmentation and segregation, but did not succeed in developing an effective alternative to the old administration systems. The post-apartheid healthcare administration is marked by a toxic mixture of

excessive centralisation, racial tensions, poor reporting and administration, and morale, labour and discipline problems (von Holdt, Smith and Molaba, 2010; von Holdt, 2010).

This is the larger context in which some clinics are still under-resourced (Dennill and Rendall-Mkosi, 2012). Another effect has been that the expansion of primary healthcare has seen a number of tertiary facilities (for example, the Hillbrow Hospital in Johannesburg) downgraded to clinics. Many clinics and hospitals also have severe human resource problems, with staff demotivated due to difficult working conditions and resource problems. One result has been recurrent strikes by nurses and porters, who have sometimes demanded medical aids in order that they need *not* themselves use the state healthcare facilities in which they themselves work (see Bekker and van der Walt, 2010: 142).

Shortages in healthcare personnel continue to place severe pressure on South African healthcare. Not only is the geographical coverage of healthcare personnel very uneven, but the total numbers of skilled medical personnel are also relatively low. According to Netcare, SA has about 55 doctors per 100 000 of population, which is far worse than other middle income countries like Brazil. In 2008, South Africa had less than half the number of doctors prescribed by international standards for developing countries (Bauer, 2011).

Moreover, poor working conditions and wage complaints in the state sector, plus the attractions of the far better-resourced private healthcare sector, mean that state healthcare struggles to attract doctors (Netcare Annual Review, 2010:40):

> 49% of general practitioner (GP) posts and 44% of specialist posts in the public sector are vacant. There is a dire shortage of doctors in both the public and the private sectors and South Africa is currently not producing enough doctors to maintain the status quo… at current capacity SA only trains 1400 GPs and 820 specialists…

From 1994 up to 2007 there was actually a reduction in the number of professional registered nurses, from 149 nurses in every 100 000 population in the state sector to 110 nurses in every 100 000, largely due to out-migration to private sector and jobs abroad (Coodavia *et al*, 2009:830). Skilled medical staff are concentrated in the private sector, as shown in Table 2.2.

	General Practitioners (%)	Medical Specialists (%)	Nurses (%)
Public	27.4	24.8	58.9
Private	72.6	75.2	41.1

Table. 2.2 Overview of public and private health personnel distribution, 1998/1999. SOURCE: Wadee and Farzana, 2007: 143.

The private healthcare sector has far more doctors than the state sector, and almost the same number of nurses, despite serving a much smaller part of the population: inequity in terms of human resource distribution is illustrated in Table 2.2. When the two sectors are further disaggregated, the problem becomes even starker: see Table 2.3. Even so, the private sector argues that it is under-staffed (Wadee and Farzana, 2007: 143).

	Private sector	Public sector
Population per general doctor	(243) 588*	4 193
Population per specialist	470	10 811
Population per nurse	102	616
Population per pharmacist	(765) 1 852*	22 879
Population per hospital bed	194	399

Data in brackets represent only medical aid scheme members (approximately 14.8% of the population).

Table 2.3. Distribution of human resources for health between the public and private healthcare sectors in 2007. SOURCE: HEARD, 2009:21.

Many factors contribute to the shortages and misdistribution of health personnel in South Africa, from brain drain to the private sector, brain drain to other countries, and low production due to problems in training colleges for nurses and medical schools. The state has tried to address these problems, by attracting skills back to South Africa (a substantial number of medical personnel work abroad on contracts), by investing in higher education to increase the

numbers of personnel and by proposing that recent medical graduates undertake compulsory "community" service (Wadee and Farzana, 2007: 144; also Bauer 2011).

Simply increasing the supply helps but does not solve the problem, because the distribution of medical personnel in South Africa is strongly shaped by market conditions. Although labour costs are a major expenditure item in the state sector, state sector wages often lag behind those of the private sector, especially for professional jobs (see Hemson, 1998:5). With more financial resources, and more attractive working conditions and wages, the private sector can employ more staff than the state sector. The problem is also not just an absolute shortage of human resources in state healthcare sector, since both the state and private healthcare sectors in smaller centres struggle to attract and retain professional, especially specialist, staff who are instead attracted to the larger metropolitan areas.

As noted earlier, the RDP spoke of partnerships between the state and society, including business, a theme continued in other policy documents. Even before 1996, and the adoption of GEAR, there was a growing interest in partnerships between the government and private healthcare providers as a possible solution to resource constraints and ongoing disparities in the delivery of healthcare services in South Africa. Running alongside the stress on customer care in the White Paper on Transforming Public Service Delivery was an explicit mandate to investigate potential partnerships with the private sector, NGOs and CBOs for service delivery (Government Gazette, 1997:11).

PPPs were an obvious option for the ANC, as they would partially overcome the divide between private healthcare and state healthcare by establishing joint facilities, but still allow the state a measure of real control through the terms of the contracts established. By contrast the NP largely saw the private sector role in healthcare and other areas largely in terms of expanding the private sector to draw pressure off the state. PPPs, as noted in chapter one, can take a range of forms, and in healthcare, often involve co-location, which can be a concession or a lease. In this, a state healthcare asset (e.g. a hospital) is concessioned or leased to a private company (e.g. a private hospital group) for a specific period of time, with some of the services and equipment shared between the state and the private sector (e.g. state and private wards might use the same cleaners), and a distinct set of private facilities (e.g. private doctors treating private patients in private wards).

There is no current plan to create a single state-run healthcare system. The White Paper on the Transformation of the Health System (1997:2-3) supported the GEAR vision of an integrated

– and cheaper – healthcare system, including partnerships with the private sector, NGOs, CBOs and communities (White Paper Transformation of the Health System, 1997:2). GEAR spoke of partnerships between the DoH and private entities as a means of addressing the problems of the vulnerable, especially in under-serviced areas, and of freeing resources from expensive institutionally-based services (GEAR, 1996:14).

In this context, *Batho Pele* was easily (re-)interpreted in terms of NPM notions of citizens-as-consumers, acting in a competitive service environment (see Hemson 1998). From around 2002, for example, local governments adopted *Batho Pele* "customer" charters, including in commercialised, corporatised and privatised utilities (Bond, Chitonge and Hopman, 2007:135). Evidently, creating customer charters instead of citizen charters involves creating customers out of citizens, undermining possibly more universalistic public services ethics. These more universalistic public services ethics might refer to a set of values that include accountability to the political process, acceptance of bureaucratic norms of honesty, professional integrity and a stress on altruistic, rather than pure financial, motivations from state officials (Bond, *et al* 2007:135). All citizens are equal but not all customers are equal. For example, poor customers often end up relying on lower-quality state services, while wealthier customers can opt out of using state services altogether, even if they still pay for them indirectly through taxation.

For McDonald and Pape (2002) treating citizens as "customers" also implies that should "customers" not be able to pay for services, they must either forfeit them completely or be reduced to receiving low-end minimalistic lifeline services within fiscal austerity constraints. This means that *Batho Pele* doctrine can become a means of applying the neo-liberal principles suggested by GEAR (McDonald and Pape, 2002:2). McDonald and Ruiters (2005) argue that a market-based society entrenches disparities, lack of accountability and linking rights to income in practice. In a way, these measures "depoliticise" services, since they are run like businesses, and often by private companies (CRIC, 1989). This allows politicians to avoid responsibility and protests.

A National Health Insurance (NHI) Scheme?

In 1994, the ANC also proposed a NHI scheme, as part of the strategy to refurbish the healthcare system into one that would benefit people of all races. This was never implemented, and the new National Health Service has retained a clear distinction between state and private healthcare (Marais, 2011:314). NHI policy remains in some limbo, even at the time of writing: various proposals brought forward by the government before 2007 lacked a precise plan on

how the various proposals would be funded and how taxation would be affected, although they recognised NHI could be important (Ruiters and van Niekerk, 2012, 143). The 2007 ANC Policy Conference took a resolution on NHI, but to date, progress has been at a snail's pace. By the end of 2014, a White Paper on NHI had not been produced. But, as noted in chapter one, current government thinking on NHI assumes that this would be a single insurance scheme, which could be used for private facilities as well i.e. not NHI as part of a single state-run NHS, but NHI as a centralised medical aid scheme servicing both state and private facilities.

Conclusion

In South Africa, as this chapter has shown, healthcare development and systems have been influenced by a number of factors including the policies of the government of a particular time, and the state of the economy. The period of 1910-1994 saw healthcare development in South Africa marked by severe problems and inequities (van Rensburg, 2012:81). After Union, in principle the whole country was united but healthcare administration remained the sole responsibility of the individual provinces, and racial and class divisions were entrenched in various inequitable ways.

Healthcare reform was not part of the initial political agenda (at Union) although a united political framework created a platform for the possibility of a united healthcare system. Only the influenza disaster of 1918 spurred reforms, but these were limited. Various subsequent recommendations for a major overhaul of the system were made, but the government did not adopt them. For example, the ambitious Gluckman Report (1944) was considered, but was not implemented as a whole, and the onset of apartheid from 1948 under the NP saw racial and homeland legislation further exacerbate healthcare fragmentation and inequity, and perpetuate social and economic conditions that had severe health outcomes. Despite some real improvements in life expectancy, health administration was fragmented and health services and spending were highly unequal, with the state focussing on good healthcare for whites. It was only in the 1980s that the NP government began some health reform measures with the Brown Commission (1980), the National Health Service Facilities Plan and the National Health Plan (1986). These did not remove the basic problems in the system.

The post-apartheid ANC government, inheriting the fragmented and inequitable system, vowed to overhaul it, and successfully created a single national healthcare administration, with nine provincial departments and a focus on primary healthcare. But severe fiscal constraints and

inequities persisted, including a major divide between the state and private health systems. An emphasis on “people first” (*Batho Pele*) practices has run alongside staff and supply problems and neo-liberal measures. In line with a range of government policies, PPPs were seen as a possible solution, along with NPM. The next chapter will examine PPPs, including health PPPs, and the controversy around this model, laying the basis for the subsequent chapter, which examines PPPs in practice with a case study of Netcare-Settlers in Grahamstown, in the impoverished Eastern Cape Province.

CHAPTER THREE:

FROM PUBLIC VS. PRIVATE HEALTHCARE PROVISION TO COMMERCIALISED COLLABORATIONS IN HEALTHCARE SERVICES

Introduction

The previous chapter provided the historical context to contemporary South African health problems, pointing to an entrenched system of fragmentation, inequality and policy problems. The 1994 ANC government brought in, for the first time, a single health ministry (the DoH) and policy framework, with a strong emphasis on primary healthcare, but there was a continuation of the divide between an under-resourced state health sector (used by most people), and a very well-resourced private health system (used by a minority of people). Like the NP before it, the ANC faced serious economic problems and fiscal constraints, which contributed to it, also like the NP, adopting neo-liberal policies and privatisation. This included a growing interest in the use of PPPs in health. This chapter examines post-1994 health privatisation, including PPPs, and the debates around the use of privatisation by governments as a means of achieving economic and social objectives. The following chapter will examine a concrete PPP – that of Netcare-Settlers in Grahamstown, the Eastern Cape – and use this to consider the effects of health PPPs. This provides an evidence-based way to intervene in the debates around privatisation, including health privatisation.

Restructuring the state sector

From the 1920s to the 1970s, South Africa had a fairly closed economy, the state making extensive use of import-substitution-industrialisation and market controls. Faced with pressure by various social movements and unions, as well as severe economic problems, the NP government moved to economic and political reforms from the late 1970s. It saw in privatisation a key to solving many problems (CRIC, 1989). Large sections of big (white) business also supported privatisation, which they hoped would open up new areas for profitable operations, and help revive South African capitalism. Increasingly, the government of the time believed that large-scale state involvement in the economy plus poor state investments had contributed to the economic problems that plagued South Africa, with neo-liberal policies viewed as the solution (CRIC, 1989).

Privatisation was not just seen as a quick solution to economic as well as political problems, but as part of a larger policy package to undo what were now seen as fifty years of economic policy mistakes. The ANC, then in opposition (and illegal) was against the NP's 1980s privatisation and neo-liberalism, and leaned towards a mixed-economy model. However, the ANC did not have a formal economic policy when it was unexpectedly unbanned in 1990; suddenly it needed a strategy to repair the economy, reassure business, and deal with the realities and challenges of the 1990s – and it also operated in a world in which neo-liberal policies had become dominant, with mixed and state-led economies discredited.

However, in the early 1990s, the ANC still leaned towards state management of the economy, with a policy of growth-through-redistribution. In 1994, under pressure from its ally, the Congress of South African Trade Unions (COSATU), it adopted the RDP which leant towards Keynesianism (despite stressing fiscal discipline). The RDP viewed state investment in social and physical infrastructure as a major means of redistribution, as well as of boosting growth by stimulating aggregate demand and private sector profits (Nattrass, 1994:519).

Once in office, the ANC's growth-through-redistribution / Keynesian approach was quickly but silently replaced by a neo-liberal redistribution-through-growth model, the idea that private sector investment would drive improvements in living conditions and job creation, and that this required economic deregulation and a smaller state role. Growth would lead to better conditions, rather than better conditions lead to growth. This was implicitly a trickle-down approach to solving social and economic inequities (Marais, 2012:310).

This continuity with the neo-liberal policies of the last years of the NP has been explained in a range of ways. Some highlight that growth-through-redistribution carried significant dangers of inflation and macroeconomic imbalances: it was simply not viable (Nattrass, 1994: 518). Others stress national and international pressures, including by big business, the international financial community, and the emerging black capitalist class (Lehulere, 1997).

Internationally, ideas like Keynesianism and import-substitution-industrialisation were on the retreat and "Thatcherism" was on the rise (e.g. Greenberg, 2006; Marais, 1996). Globally neo-liberalism gained ground following an economic crisis in the 1970s, which discredited the Keynesian economic philosophy (van Rensburg *et al*, 1992:79). South Africa's transition in the 1990s was not a revolution, but a compromise, and "Sunset Clauses" (September, 1992) and an Interim Constitution (November 1993) guaranteed job security for five years for apartheid-era civil servants and security officials, including in the homelands (Mangcu,

2003/04: 106). There was an unofficial compromise between incoming black and outgoing white elites around neo-liberal economic policies (Ruiters and Bond, 1999).

The 1994 RDP White Paper, released within five months of the ANC taking office, recast the RDP in neo-liberal terms (Padayachee, 1997). In mid-1996, the ANC adopted GEAR, which aimed to use free markets to achieve the goals of the RDP. Lehulere (1997:73), as noted earlier, argued that GEAR was not the start of the ANC's slide into neo-liberalism, but its conclusion, since many neo-liberal policies had already been adopted by this time by the ANC.

Neo-liberalism, as in GEAR or the RDP White Paper entails unregulated markets including the deregulation of the labour market, and a rolling back of the state from the economy and welfare, including healthcare, with the belief that unregulated markets are of advantage to efficient economic outcomes and attract foreign and local private investment, with positive outcomes (Campbell and Pedersen, 2001:251; also Lehulere, 1997:75). Neo-liberal forms of state asset restructuring, which are commercialisation, corporatisation and privatisation, are central to these goals, and mean, respectively, running state assets on a commercial (for-profit) basis, administering state assets with the managerial techniques of the private sector, notably NPM, and moving state functions or assets to the private sector.

Privatisation and PPPs

Privatisation is often understood simply as the outright sale of state assets to the private interests (with a partial or a complete sale), which is divesture, but in fact it includes *any* measures that transfer state functions or assets to the private sector (Greenberg, 2006:3). Thus, privatisation could involve the selling of state-owned assets. But other types of privatisation include outsourcing or contracting out, which could mean contracting out services (for example, management contracts, or service contracts, taking forms like leases and concessions), or the actual transfer of assets for a limited period (Greenberg, 2006:4). Naidoo (2001) argues that privatisation includes the contracting out of government functions, or promoting private substitutes for state activities through closing or running down state facilities, to push people to use private ones, are therefore also forms of privatisation.

A "lease" is a form of privatisation entailing a transfer of the management and operation of state facilities to the private sector; depending on the agreement, concessions can be short-term or long-term (Greenberg, 2006:4; also Grimsey and Lewis, 2007:11-12). A "concession" is similar, except that the lessee is also responsible for new investments. Both leases and

concessions go well beyond contracting out a few functions from a state facility: complete day-to-day control is moved to a private party. The contract regulates the obligations of both sides, and there are many possible contracts. In both leases and concessions, the state is freed of many costs and, in some cases, is paid a regular fee or "rent" by the private partner.

Besides leases and concessions, there are models that involve creating completely new facilities. A Build Operate Transfer (BOT) contract sees a private party take primary responsibility for building and operating a facility, which is then transferred to the state party when the contract expires. A Build Own Operate (BOO) contract sees the construction, control, operation and ownership of the project remain with the private entity, but under state regulation. A joint venture entails the public and private parties jointly financing, building and operating a new facility (Grimsey and Lewis, 2007:11-12). BOT and BOO are usually long-term contracts, with a fixed customer base built in. A joint venture is not the same as a partial privatisation by sale, where the state remains a part-owner, since it involves a new facility being created rather than an existing asset being sold.

Service outsourcing by the state usually involves the segmentation of functions in an entity into core and non-core functions, usually with the last (e.g. security) placed on tender and then contracted out. However, core functions can also be contracted out. For example, management contracts (outsourcing) usually involve bringing in outside managers to restructure a state entity over a set period, introducing commercialisation, or corporatisation, or preparing it for some form of privatisation. Low-end service outsourcing is usually done to reduce costs, and high-end services or management contracts are usually done to bring in expertise and are expensive (Adler, Bezuidenhout, Buhlungu, Kenny, Omar, Ruiters and van der Walt, 2000).

Table 3.1. (below) explains various mixes of between the state sector and the private sector. All of these models – service contracts, management contracts, leases, concessions, BOTs, BOOs and joint ventures – involve private companies competing for the contract, following a call for bids for a tender. PPPs, as defined by Yong (2010:8), are long-term contractual arrangements for the delivery of public services where there is a significant degree of risk sharing between the state and private sectors; they can include concessions, leases, BOTs, BOOs and joint ventures. Grimsey and Lewis (2007:2) emphasise another feature: PPPs are arrangements whereby private parties participate in, or provide support for, infrastructure development: a PPP agreement results in a contract for a private entity to deliver public infrastructure-based services.

However, these are just the broad outlines: it is possible to include a variety of more specific goals and obligations into any one of these contracts. For example, the state could specify that a BOT applies means-testing in its billing, providing "lifeline" services to the indigent cross-subsidised by payments by the better-off, while a co-location concession or lease could involve sharing certain services and equipment between public and private locations, although with a distinct private set of services for private users (Wadee and Gilson 2005: 265).

	Private production	Public production
Private finance	A	B
Public finance	C	D

A: symbolises a total privatisation of a public entity/ denationalisation or a staff and management buy-out.

B: represents a publicly provided service, for example municipal museums or cleaning at public hospital being leased or contracted out.

C: denotes contracting out.

D: state-owned enterprises where goods and services are both publicly provided and financed.

Table 3.1. Privatisation explained in terms of taxonomy of the public-private mix of good production and finance: SOURCE: Mahadea, 1995: 88.

So, the term "PPP" covers privatisation that does not involve divesture (sales), closure or running down, or contracting out only limited functions. It is also important to note that PPPs are not simply about the private sector state financing the public sector infrastructure, as the finance element is only one part of the agreement. The essence of a PPP is that the state does not sell an asset but rather that the private sector purchases a set of services and rights under specific terms and conditions (Grimsey and Lewis, 2007:6).

The terms for these partnerships between the state and the private sector differ from country to country: in the United Kingdom they are often referred to as Project Finance Initiatives (PFI),

in Australia as Privately Financed Projects (PFP); the term PPPs is used in South Africa (Haarhoff, 2009:2). Regardless of these different names, the objective has been *combined* service delivery between the private and state sector (Osborne, 2000:14 in Haarhoff, 2009:2).

PPPs could involve the transfer of state property to the private party for the contract's duration; a private entity building or renovating a state facility according to the terms of the contract; or a private entity providing services previously in state hands for a specified amount of time; or a private entity creating a new facility; in all cases, the private party eventually transfers the facility back to the state as per terms of the agreement (Grimsey and Lewis, 2007:2). So, unlike divesture, the state retains ownership here, and sometimes increases the size and scope of the asset it owns (where the private partner has to provide investment through concession, BOT or BOO). However, the state's actual responsibilities, in terms of management, financing, staffing and innovation, are greatly, sometimes completely, reduced.

A partnership is "a relationship based upon agreements, reflecting mutual responsibilities in furtherance of shared interests" (Mitchell, 2001: 1-2). Emphasis is both placed on transparency and accountability and on a common understanding between the parties of what is expected. The details and nature of the partnership differ in each case, and the difference is further influenced by the sector which is being privatised (Haarhoff, 2009:2).

PPPs include a "policy-level" dynamic, in that the private entity and the state jointly design and formulate the policies, as well as a "project-level" dynamic, focussed on specific sites or situations (Grimsey and Lewis, 2007:7). The PPP models that have been developed in Australia, Canada, the United Kingdom and South Africa have the following features: the state sector defines the services it requires over a given long-term period (e.g. 15-30 years) with reference to clearly set outputs; no payments are made before the asset is delivered and working; subsequent payments are subject to reduction if service performance standards are not met; the design risk in terms of the decision of the appropriate facility that is required for the delivery of the needed services rests with the private entity ("risk transfer"); the state sector provides no funding during the construction phase (except in certain concessions or leases); the risk of cost overruns rests with the private entity; and the state transfers control to the private sector over the assets and resources needed to deliver the service to such an extent that the private sector bears the risks and receives the rewards of effective ownership (Grimsey and Lewis, 2007:6-7).

PPPs cover a range of types of privatisation, and involve infrastructure, partnership contracts, and overall state regulation combined with daily operations operating under the private partner. In South Africa there are hundreds of PPPs, at the national, provincial and local levels: these include in eco-tourism, information systems, roads and transport, trade and industry, agriculture, conservation, environmental and land affairs, schools, pension management, and in medicinal and healthcare services (National Treasury: PPP Unit, 2013). The governing policies are based in the national Treasury, which also has a dedicated PPP Unit. For PPPs to succeed there must be a clear framework under which they will operate, and in South Africa the legislation governing PPPs is vested in the National Treasury (2009:7). This enables the National Treasury and the provincial treasuries to regulate and promote PPPs, with consistent policies, while the National Treasury also provides technical assistance to state institutions entering PPPs, and facilitates PPP deals (National Treasury: PPP Unit, 2013).

Privatisation, PPPs and Healthcare

A drive towards privatisation in healthcare emerged in Western countries in the 1970s, with the move away from the Keynesian welfare state (van Rensburg *et al*, 1992:79). PPPs in the health sector are also promoted by the WHO and the United Nations as means of counteracting the burden of disease and improving access and service delivery, especially in poorer countries (Reich, 2002:8). PPPs have been used in a variety of sectors internationally, including in health and medical services. There has been a significant global growth of PPPs in health in the past two decades (Reich, 2002:2). These have tended to involve long-term contracts for service provision and investment, with the state receiving a fee (Grimsey and Lewis, 2007:14).

South Africa had, as previously noted, always had a strong private sector role in healthcare: even through most South Africans rely on state healthcare, with most hospitals, environmental and immunisation services, clinics and ambulance services in the state sector, the private sector dominates healthcare resources (van Rensburg *et al*, 1992:80). Furthermore, dental and blood transfusion services, the pharmaceutical industry, were always principally in the hands of private entrepreneurs. By the early 1990s, private healthcare expenditure was larger, and growing faster, than public healthcare expenditure (van Rensburg *et al*, 1992:80).

The use of PPPs to solve South Africa's healthcare problems was increasingly accepted in the 1990s. Reinforcing this: healthcare privatisation started before the 1990s. Besides the growing medical aid industry, and spread of private healthcare institutions, there were healthcare privatisation initiatives by the late 1980s in mental facilities, tuberculosis clinics and homeland

hospitals (McGregor and McGregor, 1987:31). The RDP, the NHP, GEAR and the 1997 White Paper for the Transformation of the Health System all argued for some form of partnership between the state and the private sector in healthcare.

In 1999 a healthcare PPP task team was established by the DoH, and it released its first draft report in March 2000 (Health Systems Review, 2008:228). The task team considered four major roles for PPPs: joint ventures; private finance initiatives; purchasing services to obtain specialised skills; and outsourcing some non-clinical operations such as cleaning, catering and data processing.

The National Health Act (61 of 2003) then empowered the Minister of Health to prescribe mechanisms to enable co-ordinated relationships between the private and state health establishments for the delivery of health services. It stated that national, provincial and local health authorities could enter into agreements with private practitioners and private health establishments to achieve a national health system that provided the population of the Republic with the best possible health services that resources could afford, while protecting, respecting, promoting and fulfilling the rights of vulnerable groups DoH objectives for such partnerships included consistently improving healthcare delivery by focussing on access, equity, efficiency, quality and sustainability (Shabalala Report, 2006:2), outcomes the government argues benefit from harnessing the, expertise and resources from the private sector (Mahao, 2011:11-12; van Rensburg, 2012:179).

PPPs were viewed as a way of overcoming the state/ private divide to benefit all people. According to the *South African Health Review* (2008:247), by 2007 at least eleven provincial PPP projects were healthcare related. These included Life Esidimeni, part of the Life Healthcare Group, which managed a tuberculosis hospital and two district hospitals; the Clinix Hospital Group, which had a hospital care contract with Gauteng; and various Netcare contracts (2008:232). All these were approved by the PPP Unit of the National Treasury. These healthcare PPPs generally involved the transfer of responsibility to private parties for aspects of the supply, financing and regulation of healthcare (van Rensburg, 2012:106).

Netcare played a leading role, and by 2010, was involved in seven PPP projects across South Africa (Netcare Report, 2010:50). The company described its aims, in undertaking PPPs, as addressing the challenges faced by the South African healthcare system through partnerships with the government. Specifically, it said that it would share resources between the state and the private sectors, avoid duplication in service provision, enable better value for money,

redress disparities in health services and health status, improve the retention of skilled health professionals in the country, promote revenue generation within the state sector, reduce state healthcare's heavy reliance on tax funding, and create a "win-win" solution with tangible benefits for both the state and private sectors (Netcare Report, 2010/2011:5).

The Larger Debate over Privatisation in South Africa

Since its inception in South Africa in 1979, with policies that enabled the privatisation of SASOL, privatisation has been a source of controversy. The NP government published a White Paper on Privatisation in 1987 which set out guidelines and argued for a continuous privatisation process (Mahadea, 1995:96). The NP government was driven by a number of factors that saw it adopt privatisation of some state-owned enterprises, including rising unemployment, growing political unrest, debt payment problems, balance of payment constraints, and low economic growth (CRIC, 1989; Mahadea, 1995).

Some of the debate that took place at the time, over privatisation, dealt with concerns specific to the 1980s. The NP argued that privatisation would help in the reform of apartheid, while its critics, including the ANC, saw privatisation as a means of quietly transferring wealth to white corporations, "selling off the family silver" (CRIC 1989; also McGregor and McGregor, 1987). The NP government also wanted to depoliticise large areas of the state's operations, removing the state from the frontline of the protests over basic services such as health and housing. This also meant the state could spend less money. So, the NP used the privatisation of state assets as a response to the fiscal problems and to the wave of political and labour unrest starting in the 1970s (van Rensburg, 2012: 104; also CRIC, 1989).

Many facilities were prepared for privatisation by the late 1980s, including not only major state organisations (like ISCOR, which was sold off, and state electricity utility, ESKOM, and state transport company, the South African Transport Services / SATS, which were restructured but not sold in the end), but also small regional state corporations and parts of the state-provided services in health, education, housing, road maintenance and refuse disposal (Mahadea, 1995:88).

NP privatisation was quite slow and incomplete, outside of the divesture of SASOL and ISCOR. The government wanted to retain control over some enterprises for political reasons, like ARMSCOR, which produced weapons the government used (CRIC, 1989:61). South Africa's turbulence in the 1980s also frightened investors, and despite some commercialisation

and corporatisation into the 1990s, privatisation largely stalled. It also seemed likely that NP would be excluded from power in the post-apartheid administration, and the ANC threatened to re-nationalise any privatised industry once in office (Mahadea, 1995:97). This also worried private investors and stalled privatisation.

However, in office, the ANC continued with privatisation. The semi-Keynesian RDP actually helped open the door, because it suggested the possibility of privatisation on a case-by-case basis and stressed fiscal austerity (Greenberg, 2006:95). So, more than 20 years later the controversy over the application of privatisation on state facilities and assets is still ongoing, although some 1980s-specific parts of the controversy have fallen away. A key difference is that it is the ANC now championing the policy (ILRIG, 2009; also Greenberg, 2006; Lehulere, 1997; McDonald and Pape, 2002; McDonald and Ruiters; 2005; Naidoo 2001).

Many of the main arguments for privatisation that are made today can be found in the NP's 1987 White Paper on Privatisation, as well as in a range of ANC and other documents. The arguments include (Bond *et al*, 2007; CRIC, 1989; Dieltiens and van der Walt, 2000; GEAR, 1996; Greenberg, 2006; Hemson, 1998; ILRIG, 2009; Lehulere, 1997; McDonald and Pape, 2002; McDonald and Ruiters; 2005; McGregor and McGregor, 1987; Naidoo 2001; National Treasury: PPP Unit, 2013):

- Economic considerations: privatisation is seen by supporters as part of a larger neo-liberal programme to revive the South African economy. It is also seen as a means of creating a truly free South African economy in which state control of the economy and regulations governing economic activity gets reduced, where economic growth leads to job creation, more opportunities for everyone, and more revenue for the state.

- Resource mobilisation considerations: this argument for privatisation sees it as assisting with better services and products. Maximising competition (including through competitive tenders for state contracts and partnerships) helps ensure at least the same standard of service as provided by state facilities, at no higher cost. Instead of the state having to spend large amounts of money, it could draw on private sector finance, expertise and techniques to cut costs, improve performance and reduce its commitments. The state would get value for money, while also moving many financial, design, technical and operational risks to the private sector. This also allows fiscal discipline, along with some quick money from sales of assets, and sometimes revenue from fees paid to the state in certain types of lease or concession.

- Empowerment considerations: proponents argue here that privatisation removes state monopolies and excessive control, and provides opportunities for ordinary people to own or run companies, or at least choose between services. Users would have more options, and services would improve through private sector involvement and more competition. There would be a spread of ownership and new areas for investors, allowing a "popular" capitalism and a "shareholder society". Privatised entities should provide the public with at least the same standard of service at no higher cost. Under the ANC, this has normally meant viewing privatisation as a means of Black Economic Empowerment (BEE), through sales of shares, or contracts to black-owned or black-partnered firms (here "black" is used to include Africans, Coloureds and Indians).

Critics of privatisation have made a range of arguments against its use, many of which also go back to the 1980s (Adler *et al*, 2000; Bond *et al*, 2007; CRIC, 1989; Dieltiens and van der Walt, 2000; GEAR, 1996; Greenberg, 2006; Hemson, 1998; ILRIG, 2009; Lehulere, 1997; McDonald and Pape, 2002; McDonald and Ruiters; 2005; McGregor and McGregor, 1987; Naidoo 2001; National Treasury: PPP Unit, 2013):

- Economic considerations: critics see privatisation and the larger neo-liberal programme as against the interests of working class and poor people. As users of services, they would face rising prices, as goods or services will be provided on a cost-recovery basis, with subsidies removed (in many cases, including divesture) or only limited subsidies or cross-subsidies (in the case of certain PPPs) provided. Cost savings due to privatisation would be based on lowering conditions and wages for workers, and on retrenchments. Unions would be undermined, since there would be a break-up of large units into smaller companies, with decentralised bargaining, and communities will be divided between those who pay and those who cannot, in both cases disorganising the working class. From a Keynesian (or RDP) perspective, these measures would also reduce aggregate demand, hurting economic recovery.

- Resource mobilisation considerations: the private sector could provide expertise, critics agree, but this would be tied to profit-making, which is not appropriate for many state facilities. Money generated through divesture would be quickly used up, so the state would have quick windfall but lose a major assets. Private investors would profit from buying facilities paid for by the public through tax. Cost-savings to the state from private contractors or owners taking over state facilities would be made possible from the pockets

of users, who will now pay user-fees as well as taxes. Privatisation would also fragment facilities between competing owners and contractors, and departments, leading to less efficiency in that administration and communication can become very difficult and likely less efficient.

- Empowerment considerations: the private sector's main aim is profit, meaning that a privatised asset would treat people as customers, not as citizens. Public service ethics of political accountability, bureaucratic, professional integrity and altruistic considerations will be replaced by profit-making considerations. Poor customers would receive worse (or no) resources. Good services will be accessible to the privileged few. BEE will take place, but will only benefit a small black (including Coloured and Indian minority), which would operate in the same profit-seeking, anti-working class way as its white counterparts.

Privatisation and PPPs in Post-apartheid Healthcare

The South African ANC government faces a difficult situation, which forms the background for these debates: much of the state sector is grossly underfunded and overworked, while the private sector is grossly inefficient and inequitable (Rispel and Moorman, 2013:339). In this context, privatisation including PPPs has been seen as a means to an end, and not an end in itself, the government arguing that for the state sector to function effectively it must work alongside and with the private sector (Greenberg, 2006:95). Accordingly, privatisation is seen as a strategy to redress inequities in access, availability and provision of healthcare in South Africa. The intent is to harness resources from both the state sector and the private sector, including funding (finances), infrastructure, and specialised personnel, and to do so in a way (through PPPs) that avoids complete segmentation into distinct and unequal sectors (Wadee and Gilson, 2005).

PPP advocates argue that neither sector can accomplish its objectives alone, therefore collaboration is inevitable (Reich, 2002:8). Many also argue that PPPs avoid many of the problems of divesture, since the state still retains overall regulation and ownership. The ANC has largely steered away from divesture, and from the 2000s stressed PPPs and the interdependence and mutual needs of the state and private sectors (Mitchell, 2001: 4). Since neither the state nor the private organisations can resolve major problems on their own, partnership is essential (Reich, 2001:2).

Globally, PPPs are argued by some to unavoidable and imperative (Nishtar, 2004:5). In the more developed countries, PPPs have been pursued to reduce the operating cost of state service and to achieve higher levels of service quality and customer satisfaction (Haarhoff, 2009:2). In emerging markets like South Africa, Malaysia, Thailand and Argentina, governments have been involved in PPPs to access new sources of long-term investment capital as well as management expertise and new technologies (Haarhoff, 2009:2). For example, PPPs provide a means of putting in place NPM-type management models, with the private sector providing private sector-type management expertise.

Hospital PPPs are argued by supporters to be effective ways to enable collaboration between the public and the private sector. In essence, PPPs are meant to contribute to the overall strength, efficiency and the sustainability of the entire healthcare system. Specifically, they are meant to improve management efficiency and financial stability in the state sector (van Rensburg, 2012:179). If the state sector is unable to provide public goods on its own, in an efficient, effective, and equitable manner, because of a lack of resources and management issues (Nishtar, 2004:1), then partnerships in healthcare can help in product development, improving access to healthcare, management and quality (Nishtar, 2004:3).

Another reason for the prominence of PPPs in healthcare provision is the fact that health problems are being pushed to the international policy agenda (Reich, 2001:2), with individual countries adapting to the trends set on a global scale (Nishtar, 2004). Partnerships are embraced because they harness financial and human resources from both sectors to deal with inequity and inequality.

However, as in other sectors, the effect of privatisation on healthcare is controversial (Reich, 2001:1). The rise of healthcare PPPs has been complicated, with many models being tried (McKee, Edwards and Atun, 2006:894). Case studies of the impact, in South Africa, of healthcare PPPs, remain limited.

Conclusion

This chapter has shown that, just as the NP government before it faced global and local pressures, and sought a solution in neo-liberal policies, the ANC has also adopted neo-liberal measures in office. As leader of the first democratically elected, post-apartheid government, it was obligated to reform the healthcare system, but it soon concluded that the state public sector

needed assistance from the private sector, through privatisation. PPPs with contracts and set time periods were soon adopted.

One of the main purposes of these PPPs was to transfer responsibilities and risks to private entities, in order to improve the provision of goods or services, and to access additional resources. In healthcare, PPPs were seen by supporters as aiding both the private and state sectors, with the state sector seen as struggling to provide healthcare in an efficient, effective and equitable manner due to resource and management issues.

The use of privatisation, including PPPs, by governments all around the world has been subject to much controversy, with supporters highlighting successes and hopes, and critics stressing failures and inequalities. In South Africa, these debates go back to the 1980s. Under the NP, privatisation was used partly to assist apartheid in a period of massive unrest and economic crisis, while for the ANC privatisation has been seen as a way harness private resources to benefit the post-apartheid Republic, and address the apartheid legacy.

It is not easy to settle the debate over privatisation at an abstract level, especially when dealing with the complexities of PPPs. The solution to this is to examine the different views, for and against, in relation to an actual case study. This is done in the next chapter, which presents a case study of a major hospital PPP, the Netcare-Settlers Hospital in the university town of Grahamstown, in South Africa's poorest province, the Eastern Cape.

CHAPTER FOUR:

THE NETCARE-SETTLERS PUBLIC PRIVATE PARTNERSHIP: A CASE STUDY

Introduction

This chapter provides a case study of the Netcare-Settlers PPP (also known as the Settlers Private Hospital) in the university town of Grahamstown, in the impoverished Eastern Cape province of South Africa. The first section focuses on the context, providing background information on the province, and the town; the second section discusses the emergence of the PPP, including Settlers Hospital before the PPP; the third looks at the structure of the PPP, including the role of subcontractors brought in by the private partner; and the final section examines the outcomes of the PPP, which began in 2007, with a focus on non-clinical operations.

This PPP involves co-location, with the private clinical facilities of Settlers Hospital fully operational from 2009, although Netcare personnel started occupying the premises before then (Interview: Netcare Catering Manager, 07/08/2014). The Netcare PPP includes both the Port Alfred and Settlers district hospitals (DoH Annual Report, 2008), but the study here presented looks only at the Netcare-Settlers Hospital in Grahamstown.

The aim of this discussion, which is based on primary research, is to provide an evidence-based means of evaluating the impact of PPPs in South Africa in order to intervene in the larger controversy over the use of privatisation. PPPs in healthcare provision are endorsed by the WHO and the ANC-led post-apartheid government as means to improve healthcare, and privatisation, more generally, has been presented by its supporters as an effective way to boost economic growth, mobilise resources and empower ordinary people (see last chapter). Critics have argued, however, that privatisation undermines working class and poor people, communities and unions, and only benefits a small elite of users and owners while having other negative effects (also see last chapter). This chapter examines these positions in relation to the Netcare-Settlers case.

PPPs, Health and the Eastern Cape

Post-apartheid South Africa has several hundred PPPs. By 2007, there were at least eleven healthcare related provincial PPP projects (South African Health Review, 2008:232), and by 2010, Netcare was involved in seven PPPs (Netcare Report, 2010:50). Netcare is the leading private hospital group, with a 30% market share in private healthcare by 2001 (*Financial Mail* in Greenberg, 2006:88). The Eastern Cape DoH has PPP agreements for Humansdorp district hospital (with Metro Star Hospital Life Healthcare Ltd, signed in 2003), and for the Port Alfred and Settlers district hospitals (with Nalithemba Netcare Consortium, signed in 2007).

Netcare has a majority stake in this consortium, at 50%, with the other half owned by Nalithemba, which is a BEE consortium (Malan, 2011). The consortium comprises Netcare Limited and Nalithemba Hospitals Limited, which is made up of local black investors Vestline, Pro Health and Qapela Women's Group. The contract was signed in 2007 for 15 years (see below for details). This means that this research was done roughly halfway through the contract. At this stage, it is clearly evident that the PPP has been successful in BEE, in that black investors have been party to the contract and benefited from the profits (bearing out some of the case for privatisation as a means of empowerment and BEE) as well as in improving services, but was associated with serious problems for workers and unions.

The Eastern Cape is the poorest province in South Africa, partly because it incorporates two impoverished former homelands plagued by poor governance and low investment, the Transkei and the Ciskei, both of which were "independent states" under apartheid. In 2011, it had a population of 6.6 million (12.7% of the total population of South Africa), and contributed 7.5% of GDP (Statistics South Africa, 2014). However, its unemployment rate exceeds 50% (using an expanded definition that includes discouraged work seekers), and the province has a continual outflow to others, as people leave to search for jobs. The unemployment rate is far higher than the national average, and the province is marked by severe problems in service delivery in a range of sectors and high levels of poverty and rural underdevelopment (Hodgskiss, 2009: 11).

In this context, PPPs have seemed an ideal solution to current healthcare problems, with co-location viewed as a key step: state hospitals would be made attractive to private fee-paying and medical aid-using patients, enabling cross-subsidisation between private facilities on the premises, and onsite state facilities. For supporters of privatisation, this is an example of how privatisation can mobilise private resources for public benefits.

Efforts have also been made to increase the number of healthcare personnel. For example, the Eastern Cape DoH has given out more than 100 bursaries to student from the Eastern Cape for study in medical programmes in Cuba (ECDoH Annual Report, 2012/13:17). It has also allocated R13.5 million to the Lilitha nursing college for improving the quantity and quality of nursing education in the province (DoH Annual Report, 2008/09:22). The college has a number of campuses, and a relatively high pass rate: see Table 4.1.

Campus	Year 1	Year 2	Year 3	Year 4	Total	Overall pass rate
EL	42/113	42/69	131/182	88/88	305/452	63%
Mthatha	102/147	101/163	93/103	59/61	355/474	75%
PE	90/107	30/82	89/112	56/64	295/365	81%
Queenstown	90/118	80/126	90/109	83/87	343/440	78%
Lusikisiki	61/74	54/81	45/64	71/71	231/290	80%
Total	385/559	337/521	448/570	357/371	1527/2021	75%

Table 4.1. Number of Graduates produced and overall pass rate at Lilitha Nursing College distributed by year of study. SOURCE: ECDoH Annual Report, 2012/13:193.

However, the various Lilitha Nursing College campuses have continued to struggle with a shortage of nurses' residences, classrooms, education material, machinery and equipment. Allocations by the provincial government have partly eased the situation, but, since the allocation of nurses to facilities is heavily linked to market forces, there are still problems in ensuring that graduate nurses work in state hospitals and clinics in the long-term (several "community engagement" years are required after completion of studies).

The Eastern Cape has several industrial cities with a substantial automobile industry and harbour system, a tourist industry, and several universities. Grahamstown, part of the Makana Municipality in the Cacadu District of the Eastern Cape, hosts the province's research university, Rhodes University. Grahamstown is the only significant urban centre in Makana Municipality, which stretches 4 376km^2 (Alebiosu, 2005 in Hodgskiss, 2009:13). It is divided into Grahamstown West and Grahamstown East (*iRhini*); the west represents the wealthier,

more suburban and historically white part of the town, including the university; on the contrary, iRhini comprises the poorer "location" or township areas.

The 2011 census reported 80 390 residents in Makana Municipality, concentrated in Grahamstown (STATS SA, 2011:1). People of working age comprised 69.4%, with the elderly 6.2%, but the unemployment rate (using the narrow definition, excluding discouraged work seekers) was at 32.5% out of 28 494 economically active people, with the youth unemployment rate at 42.3% (STATS SA, 2011:1). Household incomes were generally low, with 12.7% having no income, those earning less than R5 000 making up 10.1%, those earning between R10 000 and R100 000 at 59.2 % and those earning above R100 000 18.1%.

The PPP at Settlers Hospital: Core Aims and Terms

Since around 89.4% people of the Makana population are living in urban to semi-urban areas (STATS SA, 2011:1), most people are not far from healthcare facilities, and ambulances can also reach different areas without much difficulty. The main population centre, Grahamstown, has a single hospital, Settlers Hospital, funded by the provincial DoH: it was founded in 1922. Healthcare provision is not part of Makana Municipality service responsibilities, since healthcare is provincialised (Makana Annual Report, 2012:33). Here, as elsewhere in South Africa, health services are provided by the District Health System under the provincial DoH.

Although Grahamstown has grown very rapidly over the past two decades, it is not viable to operate a completely private hospital in the town, which struggles to even retain medical specialists, most private practices consisting of GPs. Specialists prefer to work in bigger and better paying centres like Port Elizabeth, if they stay in the province at all. For example, Grahamstown does not have a single resident gynaecologist at the time of writing.

By the late 1990s, Settlers Hospital was serving a large and expanding population, and faced the typical challenges of a post-apartheid state hospital, compounded by the specific problems of the Eastern Cape: funding issues, staff and resource shortages, and administrative challenges. By the mid-2000s, patients who could afford services elsewhere avoided the hospital, which one user described as "a dirty place, with blood on the floors, rude nurses and one doctor for hundreds of patients" (quoted in Malan 2011).

The Eastern Cape DoH is a supporter of PPPs, arguing that these arrangements enable the private sector to assist in meeting infrastructure and other needs, as well as the beautification and face lifting of healthcare facilities (ECDoH Annual Report, 2006/07:169). Netcare also

argues that health institutions' infrastructures can be improved through PPPs, to the benefit of both private and public patients (Netcare Annual Report, 2010:50). It argued that PPPs were effective (Netcare Annual Report, 2009), but, rather than a traditional BOT, favoured co-location healthcare PPPs based on concessions that included investment in facilities and the provision of clinical services to strengthen and support government healthcare infrastructure and delivery (Netcare Annual Report, 2008:16).

The healthcare PPP at Grahamstown was proposed as early as 2004, with an application for approval submitted to the Treasury (ECDoH Annual Report, 2005/06). The project was registered with the PPP Unit of the national Treasury, which designated an advisor to assist the Eastern Cape DoH in complying with relevant regulations. A feasibility study was undertaken, and it was argued that the project should centre on the upgrading and refurbishment of the Port Alfred and Settlers Hospitals respectively (ECDoH Annual Report, 2008/09).

A call for tenders was issued, and the Nalithemba Netcare Consortium was the successful bidder. A contract was signed on 7 May 2007, in terms of which the private partner was to upgrade the existing building and equipment, and develop and run private hospital facilities, over a period of 15 years, after which all facilities revert back to provincial DoH. The PPP is regulated by the Treasury regulations and the Public Finance Management Act (No 1 of 1999) (DoH Annual Report, 2008).

The Settlers-Netcare PPP concession includes not just the Settlers Hospital but also the state hospital in Port Alfred (DoH Annual Report, 2008). With the agreement in place, the Settlers Hospital also became known as the Settlers Private Hospital (ECDoH annual report, 2006/07:187), but this title is a bit misleading, because the hospital includes state facilities, and involves a co-location PPP. The co-location approach to PPPs had been used elsewhere in South Africa notably in the Free State province, at the Pelonomi and Universitas hospitals in Bloemfontein. In co-location, the state and the private sector share facilities and premises, and the private sector provides services to both sides (Shuping and Kabane, 2004:152; Wadee and Gilson, 2005). Co-location can involve a concession or a lease, to a private hospital company for a specific period of time, which then addresses challenges specified in the contract with the state.

In the case of the Netcare-Settlers Hospital, the contract was a concession, including requirements for new investment. Netcare was made responsible for financing and design, for the upgrade and refurbishment of the facilities, and for the provision of both clinical and non-

clinical operations, including facilities management and maintenance (ECDoH, 2008/09:302; also Netcare Annual Report, 2010).

The provincial government granted the concessionaire the exclusive right, during the concession period, to use and operate the project facilities, to carry out operations to combine the different strengths of both state and private sector healthcare facilities and capacities to enable more efficient utilisation of government resources, to increase existing resources through private sector investment, and to improve maintenance of existing resources through income-generating activities (ECDoH Annual Report, 2009).

The private partner was also to construct and install additional project facilities, but strictly in accordance with agreed design documents and construction requirements. This construction did not confer upon the private party any ownership or rights beyond those specified in the contract, and the concessionaire was not, upon expiry or termination of the agreement, entitled to any payments when the facilities reverted back to the state (ECDoH, 2008/09:303). There would be 30 private beds and 60 public beds added. as well as additional Netcare staff; the pharmacy at the hospital would be run by Netcare, which would also run general administration and non-clinical operations; an additional wing would be added to the building; there would be two private consulting rooms, and private wards, but shared facilities between the two wings including the labour ward, the maternity ward, radiology, casualty, the theatres, clinical storage and sterilisation (CSSD), kitchens, cleaning and other services, the mortuary, stores, linen areas, and the plant and workshop areas. The Netcare-led consortium would be paid a fee by the Eastern Cape DoH, or in simple form, the provincial DoH would purchase services from Netcare (ECDoH, 2008/09:302), but Netcare would pay a sort of “fee” through its spending on the PPP.

The Present Profile of Netcare-Settlers Hospital

With the PPP signed, both the Port Alfred Hospital and Settlers Hospital were to have state and private facilities operating side-by-side, with the private consortium responsible for managing both hospitals for 15 years, dating from 2007 (Netcare Operational Review, 2009:2). Currently, the Netcare-Settlers Hospital can be described as a privately-run state hospital with a private wing, consisting of 32 beds, a maternity ward, a neo-natal intensive care unit, and six ICU (Intensive Care Unit)/ high care units, all managed by Netcare.

Netcare provides a range of services to all parts of the hospital, including financing, the management, refurbishment and upgrades of facilities and selected equipment, including medical equipment, medical instrumentation and durables like furniture, the Information Management and Technology (IM&T) system, and non-clinical ancillary services like cleaning, laundry, catering, grounds and security.

The Netcare-Settlers Hospital was extensively refurbished and the equipment was upgraded (Netcare Annual Report, 2010:50). Netcare constructed a new wing of the building, opened in 2009 (Malan, 2011). According to most reports, medical or clinical services have improved substantially. Private fee-paying patients have the option of using a private doctor, or the government doctors. Permanent medical personnel staff divided between those employed by the provincial DoH, and those employed by Netcare, but management is in the hands of Netcare. Patients can choose between state or private facilities, and where medical employees of Netcare deal with state patients, these patients are charged government rates (Malan, 2011). Morale has reportedly substantially improved, repairs have been undertaken, with new equipment, such as wheelchairs for every ward (previously there was a shortage of wheelchairs).

But the hospital was still struggling in 2011 to attract specialists, and had a significant number of posts open (Malan, 2011). Although some specialists could be called in, one respondent stated:

> …you don't have to go to other places to get services that you need, unless now you want to see [certain types of] specialist. But you are still going to be referred by Settlers to see a specialist in PE [Port Elizabeth]. But most of the things? It is here (Interview: Settlers Hospital Midwife (name withheld), 18/09/2014).

Currently the hospital is able to provide a wide range of medical facilities and services, including general medicine, neonatal-intensive care, ICU, high care, general surgery, orthopaedic surgery, and Ear Nose and Throat (ENT) surgery. Other services include radiology, pharmacy, pathology, physiotherapy, audiology, and speech therapy (Netcare, n.d.). This wide range of medical services, far more extensive than previously offered, is seen as one of the major accomplishments of the PPP. According to Netcare, its "innovative partnership" with the Eastern Cape DoH "unlocked more health services for the local community; they no longer have to travel to nearby larger centres for most medical services" (Netcare Limited Annual Report, 2009:38).

Before the concession agreement, patients in the Grahamstown area were referred to Port Elizabeth due to a lack of services at Settlers. According to one staff member:

> We have to ensure that we have a healthy community hence we are having 'drives' … where we advertise our service and people know when they are coming to the hospital what they want and they know where to get it… so you don't have to go to PE, for example, for male circumcision because it's been done now here at Settlers. They don't have to go to PE if you want TOP because we have a women's clinic, now all those services are being provided here at Settlers for the Grahamstown community (Interview: Settlers Midwife (name withheld), 18/09/2014).

This improved range of services seems to bear out the claim that privatisation can mobilise the resources and expertise of the private sector to the benefit of the larger public. Since the new services at Netcare-Settlers are also available to state patients, there does not seem to be the danger of services being made exclusive to a small minority. According to the Netcare General Manager, Mr Mutle, the priority in the Netcare-Settlers PPP is improving service provision for both employed and unemployed people in the Grahamstown area (Interview: Mr Mutle (Netcare General Manager), 05/03/2014).

However, there is a definite disparity reported in terms of access to doctors. The majority of the respondents reported that, in spite of many improvements, there is a recognisable shortage of doctors in the state or public wing. The patients in the private ward can bring in their own private doctors that attend to them.

> The doctor? I'm expecting to be attended to by a specialist, not just a general doctor. Obviously, I'll talk to the nurse and tell her about my problem and they can verify and all that stuff … if it's a private hospital I'm not expecting to be attended to by a doctor who's been on duty for the past 24 hours, do you understand? So I'm expecting … there should be a doctor on call, if that's a right word, because I mean it's a private hospital as they put it (Interview: Ms Gwedla (Service-User; student), 23/07/2014).

In the state section, there can be quite a delay (outside of emergency or casualty cases). The hospital's management admitted this some years ago, stating that private patients "Using their

own doctor means they mostly don't have to wait for service and it takes pressure off the state doctor" (Malan, 2011). The disparity is clearly visible to patients in both wings.

This seems to confirm the argument by critics of privatisation that the system will tend to benefit wealthier people more than poorer ones. The PPP has also struggled in attracting an adequate staff of doctors and specialists. This is a problem facing the town more generally, its inability to attract and retain specialist medical staff, but it does mean that private patients can get a significantly better service than state ones in this regard.

Photograph 4.1. Settlers Hospital building prior to the 2007 PPP concession. SOURCE: Hwange Investments (Pty) Ltd, trading as 3C Construction Cost Consultants.

State hospitals and clinics provide free primary healthcare for young children and pregnant women, but pricing for the rest of the population that relies on state healthcare is set by a generalised means-test to determine the price or payment for services rendered per individual case (Torkington, 2000:19). The means-test determines whether an individual is eligible for government assistance using income, marital status and occupation, and, also, it is an evaluation that tests an individual's assets and income in order to determine whether the individual's means are below a stipulated amount. Those who can afford to pay for their own healthcare should do so, to take pressure off limited government finances.

Photograph 4.2. Netcare-Settlers PPP hospital after 2009. SOURCE: photo by the author, 2015.

This is applied to users of the state wing of Netcare-Settlers, while private patients in the other wing pay private rates, which can then be used to top up the hospital's funds, and get spent in various ways. There have been some complications with the practice of means-testing in the state section. Many users are students, but:

> ...they have a chart that they use to put people in certain brackets i.e. if you don't work you don't pay, if you work you pay a certain amount and then there's one for students, I can safely say Rhodes Students. All students pay the same amount but we might all be students but we are not the same; we don't come from the same families, I can tell you that probably half the population at Rhodes have medical aid (students) but some do not have medical aid, but they are treated the same way, there is a standard rate for everyone. In their language there is a standard rate for all students (Interview: Ms Gwedla (Service-User; student), 11/08/2014).

This means the means-test system, relying here on occupation (student), ignores the fact that students do not have the same background. In some cases the system benefits needy students:

> I don't pay hospital bills; I've never paid hospital bills, I just go to public hospitals where I don't have to pay. I did get a bill from Settlers when I went

> but I didn't have money to pay because I'm unemployed, so I'm yet to pay that bill (Interview: Mr Sipungu (Service-user; Student), 20/06/2014)
>
> … The fact that one is a student at Rhodes does not mean they can afford healthcare… (Interview: Ms Gwedla (Service-user; student), 11/08/2014).

But in some cases, the system operates in a way that does not assist the government:

> One of the disadvantages of being on medical aid there's that thing that some of your medical bills you have to foot … on your own. Sometimes it's an inconvenience for students like me, so by going to get medical services from the new merger, allowed me to get almost free services from Settlers (Interview: Ms Otieno (Service-user; Student), 20/06/14).

Some caregivers at the hospital agree that even medical aid patients refuse to use the private ward and opt for the state ward because they claim the services are basically the same. They see no need to pay high bills for services that are provided subsidised by the government – but these are the people that are meant to help subsidise the state wing by paying higher rates. Others who could pay do not pay their bills:

> I never pay my hospital bills, the government pays for me, and I never received an account (Interview: Mr Sokanyile (Service-user; municipal worker), 10/06/2014).

At one level, this seems to confirm Netcare's argument that meaningful partnerships with government go a long way to ensure that inequities in access to healthcare are addressed (Netcare, 2009). But since the private wing is meant to generate resources for the public wing, in part by generating income from fee-paying and medical aid-using patients, the use of the public wing by patients who can in fact, and should be, paying for facilities on the private side, means a loss of income or cross-subsidy.

Netcare-Settlers Hospital should be commended because it does not turn away patients needing help, but who cannot settle their bills. But it is also a fact that some user who can pay, do not, either because the hospital does not always follow-up accounts or because people with medical aids are sometimes able to access the free or low-cost state services. So, the administrative

systems of the private sector are not necessarily more efficient than those of the state, meaning that the argument that privatised operations are always efficient is not always true, and also meaning that the private sector wing does not always cross-subsidise the state sector wing as well as it could.

Admissions seem to run smoothly. Service provision priority is not rendered according to whether patients are on medical aid or not, or can pay or not, but rather, patients are categorised by need and the urgency of their cases, According to one user:

> … And then there's the system, your folder or your file. The nurses attend to you and then they assess your situation and rate you according to their stickers… There's the green which means you are an outpatient, basically you are treated like any other patient with flu for example… then there's yellow: these patients do need to see the doctor quick but their matter is not too urgent. And then there's the red… these are critical patients and they need to be attended to much quicker than the rest (Interview: Ms Gwedla (Service-user; student), 11/08/2014).

The Netcare General Manager confirms this:

> Treatment is given both to public and private sector patients… [The] PPP is instructed not to favour medical [aid] patients; those with emergencies are attended to first… The hospital prioritise with regards to needs… (Interview: Mr Mutle (Netcare General Manager), 05/03/2014).

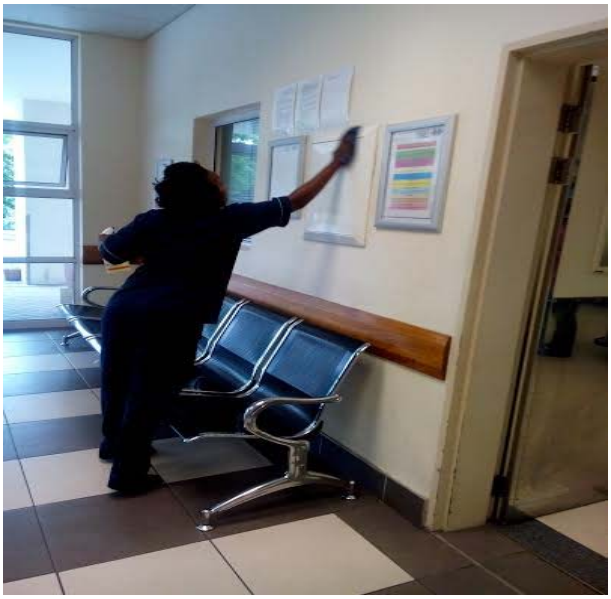
Waiting periods for state doctors for non-critical cases can be quite long, as there are not enough doctors. Once people are assessed by the Sisters in charge, or the Sisters on duty, the waiting period depends on the doctors; the nurses do not control it. The problem is that people do not expect to wait for hours in a "private" hospital, and Settlers is a public-private hospital in which some private wing facilities are used by both public and private patients. On the other hand, it cannot be said that Netcare-Settlers has massive queues of the type seen at some state hospitals. People still complain about the waiting hours, but the problems seem concentrated in certain times of the day. Several times I saw the waiting area empty, with only a secretary and a Royal Serve employee present and working.

Netcare-Settlers is also commended for its hospitality and courtesy towards service users of all types, by clinical and non-clinical staff alike. There has been a demonstrable improvement,

although the Netcare General Manager admitted that there is always room for improvement (Interview: Mr Mutle, 07/08/2014). He understood the core business of the PPP to be making the standard of state healthcare as good as the standard of private healthcare, so that a person could not to really see the difference between the private and the public wings and services. This not only refers to the clinical services but also to the non-clinical services: Netcare and ECDoH agree, in the PPP agreement, to open access to quality healthcare and services to all, even to those that cannot afford to pay. (As seen above, this success can itself create problems, as where clients who can pay take advantage of the cheaper or free state services, precisely because the quality is almost indistinguishable).

Generally, the hospital staff made a good impression, and during my site visits to the hospital I also noted that security has increased and improved since the PPP was implemented. There are security guards at the main gate, the boom gate leading to the staff parking lot, the main entrance to the building, and there are guards in the building itself. Some of the wards are occupied by guards that guard hospital property and ensure the safety of patients, visitors and employees. Security guards on duty also help with general queries in the hospital, like giving directions, or fetching patient record cards from the card room on request from the nurses.

Photograph 4.3. Hitec Security guard parading in the area near the main entrance. SOURCE: photo by the author, 2015.



Photograph 4.4. Royal Serve employee cleaning. Note: no long queues. SOURCE: photo by the author, 2015.

Photograph 4.5. Waiting Area 12 December 2014. Note: no long queues. SOURCE: photo by the author, 2014.

Management of Facilities and Services

Both the Port Alfred and Netcare-Settlers Hospitals were redecorated and repaired, and the upgrading included roof construction, rainwater systems, new walls and floors, and repainting, as part of the PPP (ECDoH, 2008/09:303). The general appearance of Netcare-Settlers, including the state wing, "reminds one of a private hospital. Framed paintings decorate the walls, every ward has a kitchen with wooden laminated cupboards and there are separate partitioned units for mothers in the maternity ward" (Malan, 2011). Judging from the exterior and interior of the building, the concessionaire has met the terms and spirit of the agreement. Lawns are mowed, the grounds are clean, and the buildings looks neat and maintained.

At this level, it seems clear that the PPP has indeed, as supporters of privatisation argued in the last chapter, leveraged resources for the state sector from the private sector. Since this is a concession, these improvements also remain the property of the state, so there is no danger of state resources being traded for quick money, easily used windfalls – as can be the case with divestures. The provincial government pays Netcare a monthly fee (R3.8-million in 2011) (Malan, 2011), and also retains responsibility for many medical staff, but seems to be getting value for this money.

The hospital seems to be well-run, using Netcare expertise, and this means it has private-sector-type management model close to the NPM that state departments increasingly use. The non-clinical services run by Netcare at Netcare-Settlers include catering, cleaning, linen and laundry, pest control, garden and estate maintenance, security and the maintenance and replacement of equipment in the hospital (Netcare Operational Review, 2010:18). "Ancillary" services centre on building maintenance, catering, cleaning, engineering, gardening and laundry services (Ascher, 1987:172), which helps explain why Armin (2005:13) calls them "accommodation" services; they are not too different from those in a hotel.

At Netcare-Settlers, most ancillary services are outsourced to subcontractors: refer to Figure 4.1. for details. The Netcare General Manager (Interview: Mr Mutle, 05/03/2014) describes it as follows:

> Here, at Settlers-Netcare PPP hospital, the workers in the auxiliary section are outsourced to different private companies. In this case, security is outsourced to Hitec Security Services, cleaning and catering are outsourced to Royal Serve,

and laundry services are contracted out to Montana Laundries–Bidvest Laundry Group….

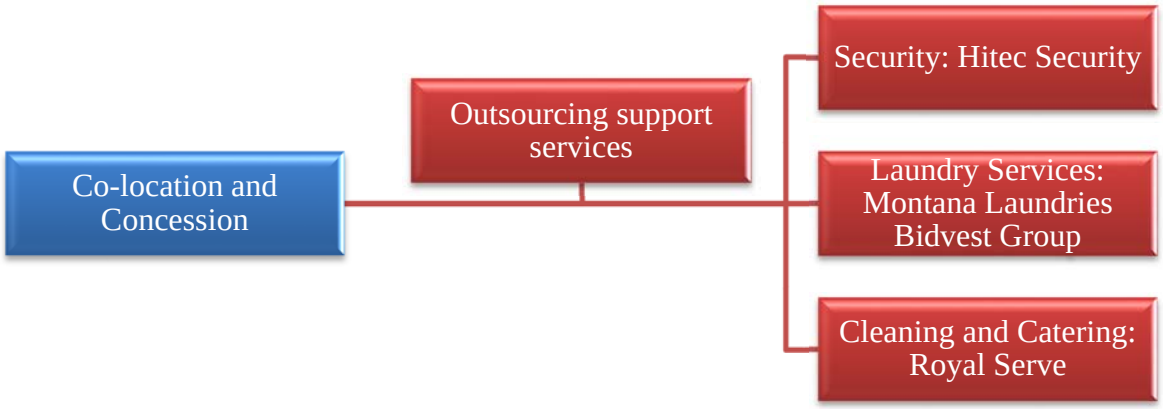


Figure. 4.1. Outline the web of relationships in the Netcare-Settlers PPP Hospital.

This was done as a cost-saving initiative that, together with reducing overtime, yielded positive results for the company (Netcare Limited Annual Report, 2009:51). This outsourcing seems to be in line with a general decision by Netcare to outsource a range of non-core operations and services in its operations across the country.

It means these ancillary services are not provided "in-house" but by other private companies, contracted to Netcare, and therefore, the workers are not directly employed by Netcare (Netcare Hospital General Manager, 05/03/2014). So, although Netcare recognises the importance of employee concerns and their rights to freedom collective bargaining, and has implemented training interventions while paying the highest minimum wage in the private sector (Netcare Annual Report, 2011:6), the outsourced workers are not actually employed by Netcare and so are not covered by these commitments.

The subcontractors and their workers provide a service for both the state and private wings, meeting the conditions of the PPP contract that the private entity provide support services to the whole hospital, at lower costs.

Have these actions helped create an environment that is welcomed by all? As seen in the previous chapter, one of the problems often seen as arising from privatisation is fragmentation, as big companies get broken up into smaller units, or as outsourcing takes place. This can potentially create serious administrative problems, as there is no longer a unified and coordinated system.

Photo. 4.6. Royal Serve employee sweeping near the main entrance at Settlers Hospital. SOURCE: photo by the author, 2015.

But from the research, it does seem that this problem has been avoided at Netcare-Settlers. The general impression is that the hospital runs very well, with all part, including subcontracted parts, fitting together. Patients expect to be treated in a clean, well-maintained and possibly air-conditioned building or environments, and the PPP seems to enable this. For example, one employee stated (Interview: Ms Bhani (Royal Serve Employee), 07/08/2014):

> I was employed in 2008 when the outsourcing was started, I was a cleaner, the hospital was very dirty. I was the one cleaning the hazardous ward. My, it was very very dirty then, so when we started cleaning here as the private company everything has changed.

Service users have also reported improvements in cleanliness (Malan, 2011), with one user stating that the hospital was dirty and disorganised as late as 2009, and not suitable for the treatment of patients.

A more senior employee claimed, however, that the improvements should not be overstated (Interview: Settlers Hospital Advanced Midwife (name withheld), 18/09/2014):

> Mmhmmmm before…. I won't say cleanliness *per se* because the hospital was clean before, it's just that the building is more attractive than it was before and ahhhh and what else? … Not a lot of things have changed for me, it's still the same, the people are the same, even the care is still the same as before we had the partnership.

Is this a contradiction? Not really, because the two employees worked in different parts or the hospital, and may have been commenting on different experiences. Other issues, like linen shortages, ensuring proper meals, and good service, had also reportedly been addressed.

The purpose and necessity of ancillary services is to create a positive environment for patients' care, as patients need to be in a clean and comfortable environment. As such, ancillary services are as important as clinical services, because they ensure, around the clock, that the facility is in excellent condition:

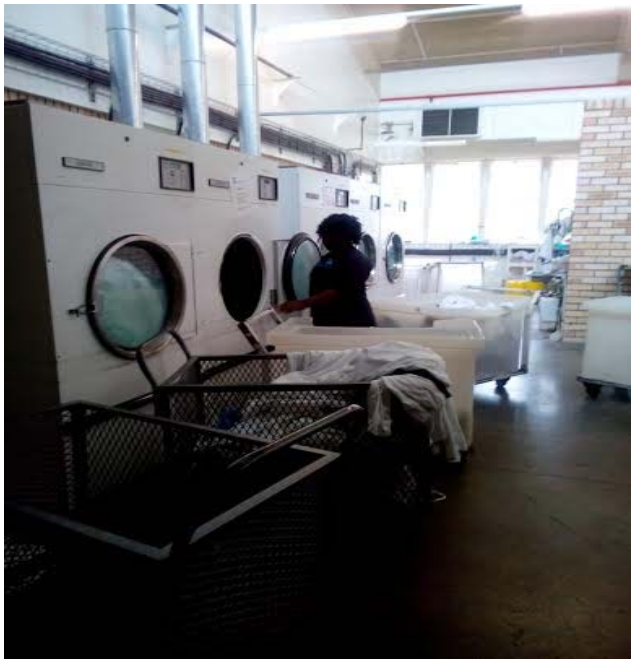
> Our contribution is just cleaning, just making our patient to stay in a clean environment…… we have to use our own chemical to disinfect the ward, because the hospital is the place whereby there is a lot of germs, there is a lot of contaminated diseases. So that we can clean the ward in a proper manner, so that a disease from another ward cannot be contaminated into another ward. We have to follow some safety precautions (Interview: Royal Serve Employee (name withheld), 07/08/2014).

Evidently, ancillary services staff is carrying a huge responsibility, which goes beyond just ensuring that the floors and sanitation facilities in wards are kept clean: for example, the linen that is used by the patients is changed every morning and every afternoon. Linen was a big challenge for Settlers Hospital before the PPP agreement, but according to one respondent:

Even the laundry services: we used to struggle with linen; we did not have linen but now we have. Everything is enough, everything is enough, sufficient enough… (Interview: Maternity Ward Sister (name withheld), 18/09/2014).

Photograph 4.7. Montana Laundries transports dirty linen from the wards in the hospital to the laundry room. SOURCE: photo by the author, 2015.

Photograph 4.8. On the left, two giant washing machines washing linen, and on the right dirty Linen on the floor sorted into different stacks; night gowns, bed sheets, bed covers etc. awaiting washing. SOURCE: photo by the author, 2015.



Photograph 4.9. Laundry services employee taking clean linen out of the tumble dryer to be folded and sorted by others. SOURCE: photo by the author, 2015.

Photo. 4.10. Linen neatly folded in the linen storage room. SOURCE: photo by the author, 2015.

The above four photographs lay down the sequence of events that the linen undergoes before it is sent back to the hospital for the nurses to change the beds. During an interview with the laundry services manager at Montana Laundries, Ms Nkohla, she explained the process that

took place, beginning with the company transport fetching the dirty linen from the hospital to their quarters (which are inside the hospital yard but in a separate building) until the linen is sent back to the hospital. She further emphasised the importance and value of the new system in the laundry, for the patients using the hospital.

Other staff and users acknowledged that everything that was needed to ensure service-user satisfaction for effective outcomes in service provision was readily available.

> I was never admitted before the year 2009 so I don't know what it was like then. But I can safely say it's good, effective and efficient. For example, linen is changed every day, the wards are cleaned every day (Interview: Ms Dibela (Service-user; contract worker), 30/05/2014).

Generally, there have not been negative complaints about the interior condition and environment of the hospital from service-users, or clinical and non-clinical staff. As such, in terms of cleanliness and facilities, the PPP has met its expectations even if there is always room for improvement.

Workers, Unions, Wages and Jobs

The overall picture so far is that of improvements in the hospital, which seems to confirm the arguments that privatisation can be an effective way of mobilising private sector resources, expertise, innovation and management for public benefit.

But what about the arguments by critics of privatisation, that it benefits wealthier people the most? Some of this is backed up as well by the material. The Nalithemba Netcare Consortium had a large BEE stake, and so, the PPP benefited black capitalists. Some of the worst problems of inequity were avoided by a PPP model that involved sharing medical and ancillary services, and a common private management. However, there is a disparity in access to doctors in the private and state wings of Netcare-Settlers.

What about the issues directly affecting non-medical workers, often black and Coloured, at the hospital? One of the objectives of the PPP was to create employment and improve the socio-economic conditions in Grahamstown. Worker respondents agreed that the PPP had contributed positively to job creation during the construction phase, in infrastructure improvement and renovation, and in the ancillary services:

> *Ja*, it's good because each and every year they employed new people up to now (Interview: Ms Mfecane (Royal Serve Employee), 07/08/2014).

> I can say when PPP came in, it gave us more jobs because when it was government, it was very few workers here. Now we are more than those workers … (Interview: Ms Mfecane (Royal Serve Employee), 07/08/2014).

It is clear from the above quotes that there has been an improvement in employment numbers over the years at Settlers hospital.

However, there was also clear evidence that some worker respondents felt unhappy with their wages and conditions:

> Now we are more than those workers but we are short of money, we are more but short of money, I can say that… (Interview: Royal Serve Employee (name withheld), 07/08/2014).

> I earn even less than the cleaner that was employed by the government used to have, because my salary is R3 000 but I am a supervisor; I am supervising 57 people alone: I said, alone! (Interview: Royal Serve Employee (name withheld), 07/08/2014).

It was also claimed that the employment of larger numbers was done through lower wages. One of the respondents alleged that ancillary staff employed by the government got better pay, as well as permanent employment with benefits, but that few people had jobs. Now, more people had jobs, but on worse conditions.

As seen earlier, the outsourcing to subcontractors was specifically done to cut costs (Netcare Annual Report, 2009:51). Netcare is obviously a profit-making enterprise, and profit-making enterprises that run hospitals work by a different logic to non-profit bodies that run hospitals, like governments and religious bodies (McKee *et al*, 2006:890). Private hospital and medical groups make continuous efforts to exit loss-making investments and non-core activities, and their interest in PPPs is driven by the same concerns with profitability. PPPs are a way through which such companies, which normally compete with state operations, can use co-operation with the state to actually expand their market and profit base (Wadee and Gilson, 2005:256).

Critics of privatisation also argue that splitting workers into separate companies, by outsourcing, undermines unions by decentralising bargaining into smaller companies. State

hospitals are strongly unionised since the early 1990s (von Holdt, 2010; also Bekker and van der Walt, 2010).

Workers in cleaning at Netcare–Settlers reported that they were in fact members of the National Education, Health and Allied Workers Union (NEHAWU), which is also the main union in state hospitals.

> Yes I am a member of NEHAWU…… NEHAWU are negotiating with our top managers… (Interview: Ms Bhani, N. (Royal Serve Employee, (07, 08, 2014).

But it should be noted that these workers refer to themselves as Royal Serve employees, which is true: Royal Serve is contracted to Netcare, and these workers are Royal Serve employees. In South African labour law, this means that NEHAWU must negotiate with Royal Serve, not Netcare, and NEHAWU members in Royal Serve do not form part of the same bargaining unit as workers in other companies subcontracted to Netcare-Settlers, or with Netcare employees at that hospital, or with state (DoH) employees at that hospital. The workers under each of these different employers cannot strike jointly. This is the sort of situation that NEHAWU, in a press release of May 2013, complained of, that privatisation sometimes brings "efficiency" by cutting labour costs through employing cheap workers with limited rights (NEHAWU, 2013).

The Netcare General Manager, Mr Mutle, at Settlers stressed that South African labour relations allow everyone to be unionised, with a union of their choice, and that Netcare had some unionised employees:

> Certain levels are unionised for example, managers are not unionised… Manager have to adhere to rules and regulations, protection is more internal… (Interview: Mr Mutle, Netcare General Manager, 05/03/2014).

But obviously in this situation of fragmented workers, many people who do in reality work at the Netcare-run facilities on a daily basis are not employees of Netcare, and so, they cannot negotiate directly with that company. Some outsourced workers state that their wage levels are not set by collective bargaining, but by minimum wages set by the government for the hospitality industry. According to respondents, the cleaners that worked at the hospital prior 2009 earned more than they do (R6000, as compared to R2000):

> What I can say is that when government was employing people it was better, it was better than the situation we have now. We are employed, as people can say in the location, we are working, as people can say. But, we are not happy according to money and according to benefits. We don't have benefits because we are cleaners, we earn a little bit of money. So that means that our children will be cleaners as well, because we are not benefiting from the private company that we are working for (Interview: Royal Serve employee (name withheld), 07/08/2014).

This does confirm the argument that privatisation does not benefit the poor, as it promotes low wages, weak unions and exclusion. What happened for the ancillary workers when the government was their employer, does not happen them now the hospital is under a PPP. As in many countries (Ascher, 1987:110), state sector arrangements for holiday and sickness pay, disciplinary procedures, pensions, wages and benefits are often better than those offered by private companies, especially subcontractors. Many worker respondents felt that it would be better to be permanently employed by the government instead of employment by the private subcontracting companies.

The worker-respondents did not complain about the working conditions although they admitted to working hard and had some issues around pay; the atmosphere in the workplace was not a problem for the employees as they enjoyed their work and ensured that they performed as best they could to maintain the required maximum standard.

In other words, their morale was actually quite good. This is better than the situation reported for some other state hospitals among state employees (e.g. von Holdt, 2010). But although the pay situation has not affected worker performance, it is not clear what the long term effects of low wages, with low (or no) benefits will drive the ancillary workers to do:

> …. give us some money and give us some benefit so that we can do this job properly. We can't do a job when we are hungry or when we are not happy. (Interview: Royal Serve employee (name withheld), 07/08/2014).

Being contracted out has also decreased job security for people in the ancillary services, as their jobs were dependent on the companies securing future contracts. In order to ensure competition, and good quality, contracts come up for renewal periodically. Those that are employed by the private contractor as a result of the competitive tendering process have less

security than many other private sector workers, and less than most state employees, as their livelihood depends on the renewals of the company's contract (Ascher, 1987:111). Some of my respondents expressed concern about what would happen when Royal Serve's contract expired:

> …according to my understanding we will stay at home until another cleaning company will … maybe … take over, Maybe that new cleaning company will take us we don't know... (Interview: Royal Serve employee (name withheld), 07/08/2014).

Some workers found themselves on terms that created more anxiety:

> … Sometimes as now I'm working as a hostess [in catering] because if someone is on leave or is on sick they usually hire me to work as a hostess in that place. I'm working as a hostess now. No I don't get paid [more]I'm working my shift for the same amount (Interview: Royal Serve employee (name withheld), 07/08/2014).

Obviously cost-savings have to come from somewhere, and in this case come at least partly from lower wages and low (or no) benefits to the outsourced workers. So while the government, Netcare, and Nalithemba investors all benefited, and while workers benefited with more jobs, there was also a loss in terms of income and job security and an impact on the prospects for the workers' children. So, this does seem to be a case where (among blacks), BEE has mainly benefited black investors, over black and Coloured workers.

Conclusions

The record of the Netcare-Settlers PPP is uneven, with both positive and negative effects existing at the same time. The next chapter will unpack this set of issues more fully, and link the findings to the larger debate in the literature on the case for and against privatisation.

PPPs are meant to improve state services, with finance, management, and innovation, and to shift costs and risks to the private sector (Wadee *et al,* 2004). It certainly seems that the Netcare-Settlers PPP has done very well in improving facilities and services and administration, to the benefit of users of both the private and state wings. This seems in line

with the claim by privatisation's proponents that the private sector can help achieve the goal of accessible, equitable and affordable services for the citizenry.

However, as Wadee and Farzana (2007) the workforce has a major impact on the production of healthcare within the health system. This PPP has increased the number of beds and services, but still struggles with the general problems of retaining specialist personnel and of too few doctors in the state wing. While it's medical and administrative personnel seem satisfied with conditions, and even subcontracted service workers at the site report good morale, it must also be stated that workers in subcontracted ancillary services do experience low wages, job insecurity and limited collective bargaining power.

CHAPTER FIVE:

CONCLUSION

Introduction

The South African healthcare system has, for a long time, been marked by haphazard, inequitable and inegalitarian developments under different governments, by deep race and class divisions and by a stark divide between a well-resourced private sector servicing a minority, and a resource-strained state / public sector, used by the majority. Although not all the problems and challenges encountered by governments after the collapse of the apartheid system can be accounted for by the NP period, apartheid certainly exacerbated an already unequal distribution of wealth and resources. With a new, post-apartheid government established in 1994, the mission to transform and change the status quo became a central goal of the ANC government.

In reforming the country, it became essential to change the state sector and meet basic needs, including in healthcare. Given constraints in funding and capacity, and a general shift to neo-liberal policies, the post-apartheid ANC state (like the NP apartheid state in its final years) has increasingly seen privatisation as a solution. Although divesture has not taken place on a large scale in recent years, hundreds of PPPs have been adopted, with a PPP Unit attached to the national Treasury providing technical and other assistance, and a set of regulations and policies by Treasury providing the basic framework. PPPs, especially concessions, have seemed, to the government, an ideal way to bring the private and state healthcare systems together, for public benefit.

The extensive post-apartheid use of privatisation has revived older debates about the advantages and disadvantages of this policy, especially regarding its impact on the economy, on resources and on workers and communities. For example, healthcare PPPs are often justified by arguments around the state sector's inability to deliver effective, efficient and equitable manner because of lack of resources and management issues (Nishtar, 2004:1), while critics argue (Hemson, 1998:4) you cannot assume that private sector performance is invariably better, and stress the injustices that can arise due to privatisation.

In this thesis, I used a case study of a 15-year PPP at Settlers Hospital, Grahamstown, in the Eastern Cape, which started in 2007, as a way to evaluate the different positions in this debate. This is a co-location concession with cross-subsidisation and investment into infrastructure,

facilities and equipment, as well as contracting out of large parts of the ancillary support services.

It seems clear that cases like Netcare-Settlers PPP show that the issues are more complex and less black and white than the polarised debate for and against privatisation might suggest. In the case of Netcare-Settlers, many circumstances have changed for the better since the implementation of the PPP. In terms of services provided at the hospital, there has been a positive change, with more facilities, better maintenance, and better ancillary service delivery in areas like cleaning, linen and security. Staff morale is also good, and the appearance of the hospital is impressive. One result of this success was that the PPP faces the problem of people who could pay for its private services, opting for the state wing of the facility on the basis that the service is almost the same – but is cheap or even free. This indicated that there are some administrative issues, which indicate some private sector inefficiency. However, other systems of management and administration, such as patient admissions, seem to work well.

There is, however, a shortage of state doctors, and of specialists for both wings. The shortage of skilled healthcare personnel remains a serious challenge that mars the positive outcomes at the PPP. The equipment might have improved, the environment in the hospital has improved, there are cleaners around the clock, but without the required number of doctors to respond to patients' demands and needs, the privatisation has definite limitations.

Since a major main factor pulling doctors and specialists away from Grahamstown is the massive size and resources of private healthcare, the problem is partly caused by the private health industry in the first place. With a deregulated labour market and a large private healthcare sector, many skilled medical personnel tend to move away from the state sector and small towns, to work for the private sector in large centres, due to the benefits they receive. There is competition between for human resources, which can even lead to emigration, as skilled healthcare staff seek better deals elsewhere.

On the other side, the ancillary services are outsourced, and while there are now more jobs, in many ways the effects of the Netcare-Settlers PPP on these workers are problematic. The outsourcing was done to save costs, the subcontractors' workers reporting lower wages, and fewer (even no) benefits. They generally reported being in a far less comfortable position than workers in state employment. Generally subcontractors are harder to unionise, and unionisation rates tend to be worse than in big employers, whether those are state or private. These workers are fragmented into different bargaining units: pre-privatisation, most workers would be in

NEHAWU, which could bargain at the hospital level, and also at national level. Now, each subcontractor, and the Netcare, and the DoH-employed staff, are in separate units, and even if NEHAWU represented them in each firm or division (which it does not) it could not negotiate for the workers in a common bargaining forum since these are separate employers. There is also anxiety for subcontracted workers, as to the long-term security of their jobs. Although these workers are satisfied with working conditions, if contract for outsourcing expire, they might lose their jobs.

General Implications of Findings

Innovative healthcare PPPs can play a vital role in upgrading state health infrastructure and services. In essence privatisation has the potential to build up and transform the provision of public services but it also has its own limitations. PPPs can be a useful strategy to harness the private sector to public ends, and to improve the efficiency and effectiveness of the state sector through providing financial and human resources, and improvements in infrastructure and equipment. PPPs provide a means of overcoming the divide between the private and the state sectors, through measures enabling co-operation in healthcare provision. Therefore some privatisation of state healthcare can provide better services and leverage private sector capacity and resources, while reducing the financial burden on the state.

However, for service / non-clinical workers, the story is often less positive, due to the use by PPPs of cost-cutting strategies like outsourcing. There needs to be a serious consideration whether this compromising of employees' conditions, wages and rights is an acceptable way to treat working class citizens. While there might some job creation, there is little job security and relatively poor conditions for support service / ancillary workers, whose efforts are essential to health facility operations. Furthermore, unions are weakened as different sections of the workforce are divided between different contractors, with different bargaining arrangements, further weakening workers' ability to change the conditions of insecurity and low incomes.

Conclusion

PPPs are as strong and as effective as the details specific to the contract. The private sector has its own weaknesses, and some of the problems faced by the state healthcare sector are experienced by the private healthcare sector as well. Unless PPPs are realistic about these

problems, the PPP agreements will not establish boundaries, goals and systems to overcome these problems.

The state sector can work with the private sector in ways that advance public interests, and secure many benefits. The fact remains, however, that private corporations are still profit-seeking even when involved in partnership with the state sector for service provision, and this is manifested in measures like cutting costs through reducing labour costs. Therefore, it is essential that the terms and conditions are set in a way that marries private profit-making with public concerns, rather than intensifies some of the existing problems and that future PPPs include adequate measures to protect workers against low wages, low or no benefits, limited collective bargaining power, and job insecurity. This is surely central to a preventative approach to healthcare.

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2. Mr Donovan, Netcare Catering Employee.
3. Mr Patrick, Netcare Catering Manager.
4. Ms Nokwethemba, Royal Serve Cleaning Services Supervisor.
5. Ms Zandile Montana Laundry Services Employee.
6. Ms Zanele Mfecane, Royal Serve Cleaning Services Employee.
7. Ms Ziyanda Nkohla, Montana Laundry Services Manager.
8. Sister Qototi, Department of Health Employee (Advanced Midwife).
9. Mr Mbulelo Sokanyile, Makana Municipality Contract Worker (No Medical Aid).
10. Mr Thoko Sipungu, Rhodes University Student (No Medical Aid).
11. Ms Anelisa Mente, Rhodes University Permanent Employee (Medical Aid).
12. Ms Lumka Dibela, Makana Municipality Contract Worker (No Medical Aid).
13. Ms Nanamhla Gwedla, Rhodes University Student (No Medical Aid).
14. Ms Ntombekhaya Fulani, Fort England Psychiatric Hospital Employee (Medical Aid).
15. Ms Sabina Otieno, Rhodes University Student (Medical Aid).

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Appendix 1

Interview Guidelines for support service workers

Background

- Gender (Male/ Female)
- Name, Age and Race
- Are you a Grahamstown "local"?
- If not, where is home?

Terms of employment

- Are you employed by Netcare or the EC Department of health?
- If by Netcare, is your job outsourced or inhouse?
- Are you a contract worker/ temporary/ or a permanent staff member?
- If you a contract worker, when does your contract expire?
- Do you have any idea what happens after the contract expires?
- For how long have you worked in the hospital? Do you think you and your team have the capacity to deliver the work that is expected of you and why?
- As a staff member what are your responsibilities?
- How many hours do you work per day?
- What is your remuneration package?

Trade Union Affiliation

- Are you a member of a trade union?
- Which one?
- Do you think the TU serves its purpose and why?

General understanding of PPP

- Do you understand the PPP arrangement between Netcare and the EC Department of Health?
- If yes, how has your service contributed to the achievement of the PPP goals?

Appendix 2

Interview Guidelines for clinical staff (Grahamston Community)

Background

- Gender (Male/ Female)
- Name, Age and Race
- Are you a Grahamstown "local"?
- If not, where is home?

Terms of employment

- Do you work for Netcare or the department of health?
- Are you permanent?
- How long have you worked in the hospital?
- Please give a brief description of your job?
- Please describe Settlers before and after 2009, differences and similarities? (have there been any significant changes that are visible?)
- What is your interaction with the support service staff?
- What new relations if any have been established between the clinical staff and the support service staff?
- What contribution do support-services for access to care and effective provision?
- Please described the main responsibilities of the Settlers – Netcare hospital towards the Grahamstown and surrounding areas

The effects of the PPP

- How has access to care and the services rendered improved?
- How has the Grahamstown community and surroundings been affected?
- How have labour relations transformed since the implementation of the PPP arrangement?
- What has been the overall impact of the PPP agreement?

Appendix 3

Interview guidelines for services-users (Grahamstown Community)

Background

- Gender (Male/ Female)
- Name, Age and Race
- Are you a Grahamstown “local”?
- If not, where is home?
- Are you employed?
- If not, how do you pay you medical bills?
- If yes, are you on medical aid or any form of personal health insurance?

General understanding of the ‘new’ hospital

- Have you ever visited the hospital before 2009?
- If yes, what was your experience like?
- Are you aware of the Netcare-Settlers arrangement?
- What do you understand about it?
- What are your expectations of the ‘new’ hospital?
- Have the changes undergone by the hospital affected your visits? If so how and why?
- Do you think the ‘new’ hospital has created employment opportunities?
- What do you think of the support service staff?
- What can be improved in the ‘new’ hospital?
- What is your overall impression?

Appendix 4: Letter of permission from Settlers Hospital CEO

Eastern Cape Department of Health

Enquiries:	Zonwabele Merile	Tel No:	040 608 0830
Date:	14th August 2014	Fax No:	043 642 1409
e-mail address:	zonwabele.merile@lmpilo.ecprov.gov.za		

Dear Ms T. Mahote

Re: Support service cooperation in the Settlers – Netcare Public Private Partnership (PPP), Grahamstown, 2009 - 2013

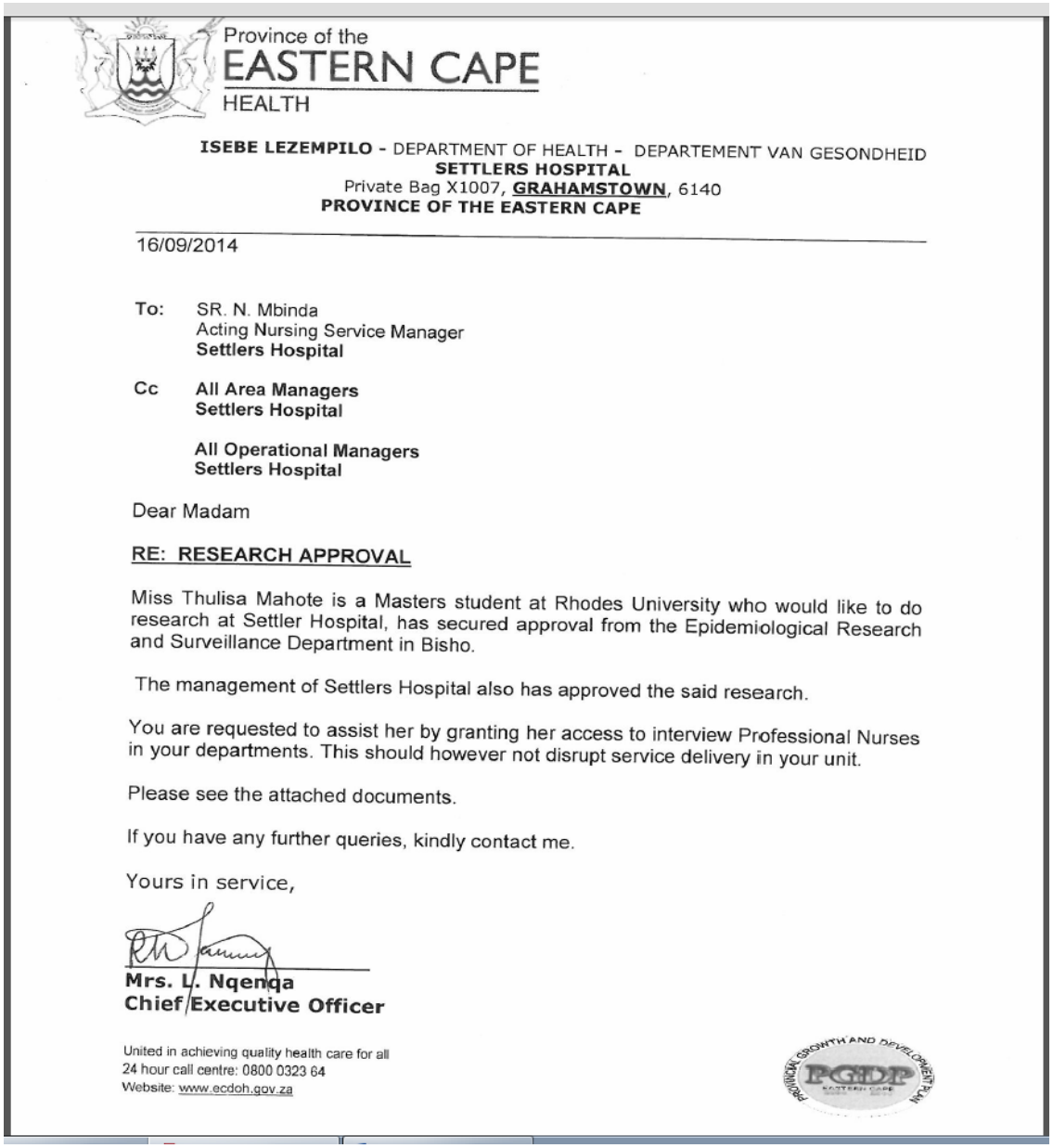
The Department of Health would like to inform you that your application for conducting a research on the abovementioned topic has been approved based on the following conditions:

1. During your study, you will follow the submitted protocol with ethical approval and can only deviate from it after having a written approval from the Department of Health in writing.
2. You are advised to ensure, observe and respect the rights and culture of your research participants and maintain confidentiality of their identities and shall remove or not collect any information which can be used to link the participants.
3. The Department of Health expects you to provide a progress on your study every 3 months (from date you received this letter) in writing.
4. At the end of your study, you will be expected to send a full written report with your findings and implementable recommendations to the Epidemiological Research & Surveillance Management. You may be invited to the department to come and present your research findings with your implementable recommendations.
5. Your results on the Eastern Cape will not be presented anywhere unless you have shared them with the Department of Health as indicated above.

Your compliance in this regard will be highly appreciated.

DEPUTY DIRECTOR: EPIDEMIOLOGICAL RESEARCH & SURVEILLANCE MANAGEMENT

Appendix 5: Letter of Permission from the Provincial Department of Health



Province of the
EASTERN CAPE
HEALTH

ISEBE LEZEMPILO - DEPARTMENT OF HEALTH - DEPARTEMENT VAN GESONDHEID
SETTLERS HOSPITAL
Private Bag X1007, **GRAHAMSTOWN**, 6140
PROVINCE OF THE EASTERN CAPE

16/09/2014

To: SR. N. Mbinda
Acting Nursing Service Manager
Settlers Hospital

Cc **All Area Managers**
Settlers Hospital

All Operational Managers
Settlers Hospital

Dear Madam

RE: RESEARCH APPROVAL

Miss Thulisa Mahote is a Masters student at Rhodes University who would like to do research at Settler Hospital, has secured approval from the Epidemiological Research and Surveillance Department in Bisho.

The management of Settlers Hospital also has approved the said research.

You are requested to assist her by granting her access to interview Professional Nurses in your departments. This should however not disrupt service delivery in your unit.

Please see the attached documents.

If you have any further queries, kindly contact me.

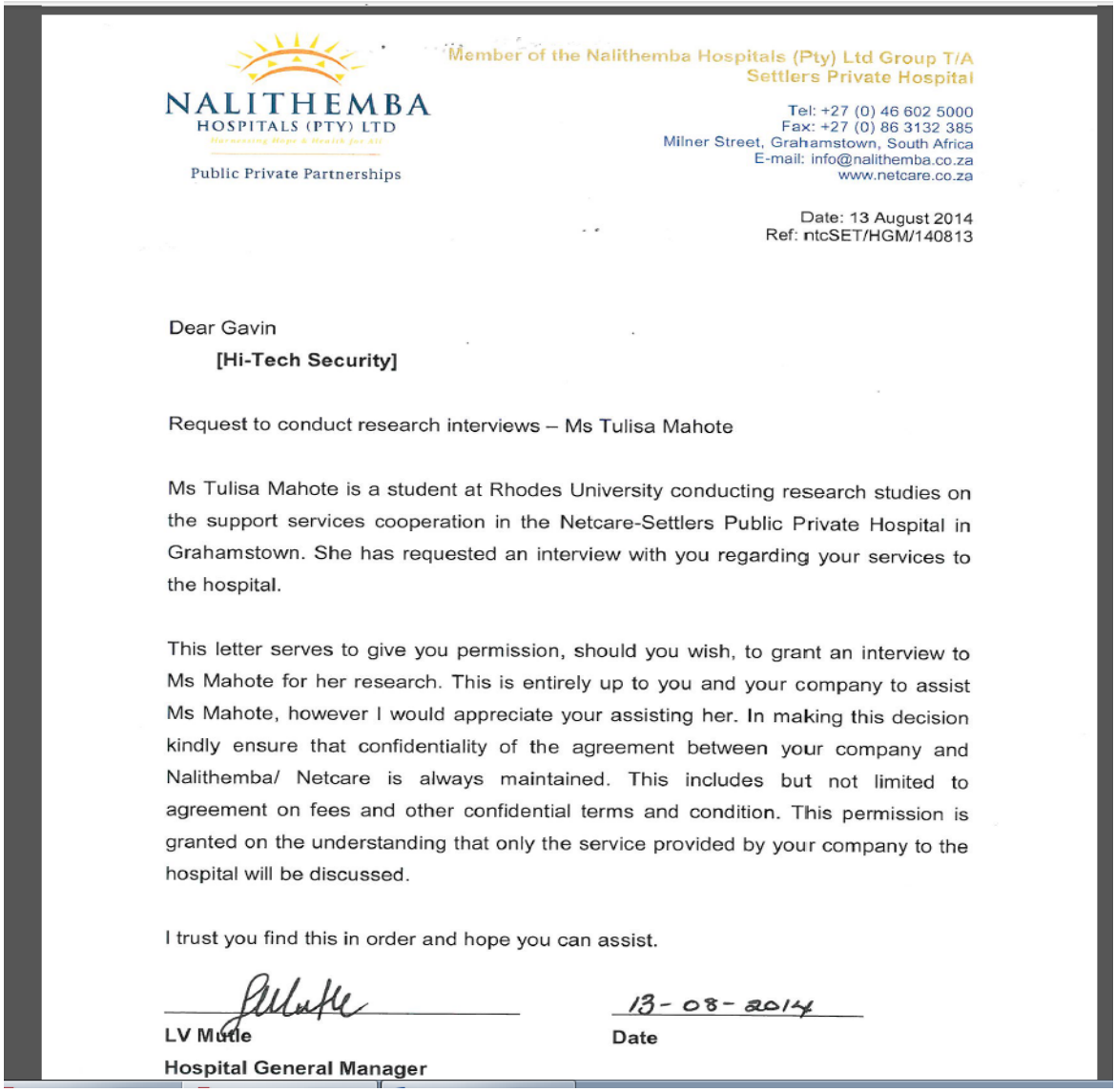
Yours in service,

Mrs. L. Nqenqa
Chief Executive Officer

United in achieving quality health care for all
24 hour call centre: 0800 0323 64
Website: www.ecdoh.gov.za

PROVINCIAL GROWTH AND DEVELOPMENT PLAN
PGDP
EASTERN CAPE

Appendix 6: Letter of Consent from Netcare to Hi-Tec Security



NALITHEMBA
HOSPITALS (PTY) LTD
Harnessing Hope & Health for All
Public Private Partnerships

Member of the Nalithemba Hospitals (Pty) Ltd Group T/A
Settlers Private Hospital

Tel: +27 (0) 46 602 5000
Fax: +27 (0) 86 3132 385
Milner Street, Grahamstown, South Africa
E-mail: info@nalithemba.co.za
www.netcare.co.za

Date: 13 August 2014
Ref: ntcSET/HGM/140813

Dear Gavin
[Hi-Tech Security]

Request to conduct research interviews – Ms Tulisa Mahote

Ms Tulisa Mahote is a student at Rhodes University conducting research studies on the support services cooperation in the Netcare-Settlers Public Private Hospital in Grahamstown. She has requested an interview with you regarding your services to the hospital.

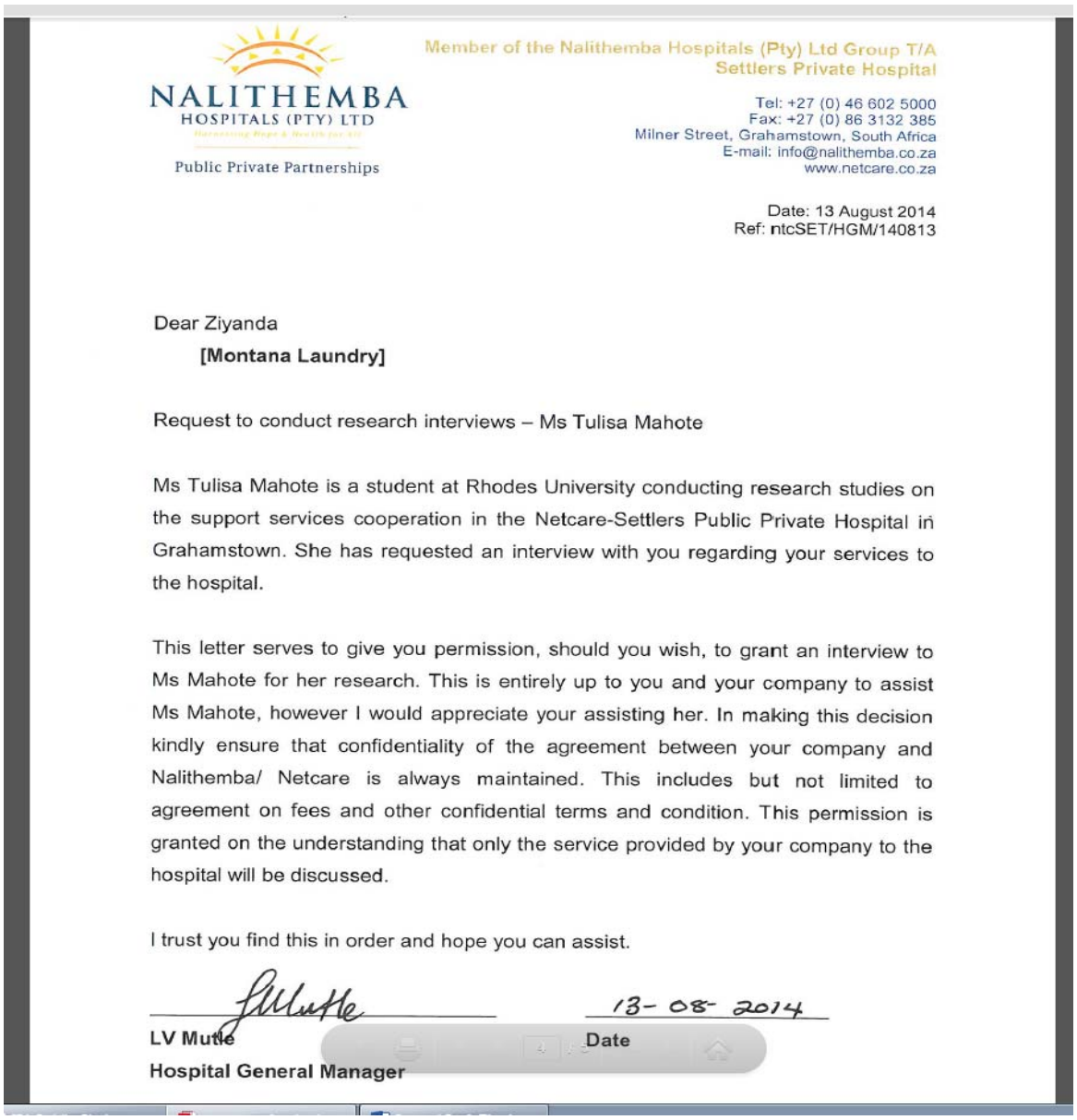
This letter serves to give you permission, should you wish, to grant an interview to Ms Mahote for her research. This is entirely up to you and your company to assist Ms Mahote, however I would appreciate your assisting her. In making this decision kindly ensure that confidentiality of the agreement between your company and Nalithemba/ Netcare is always maintained. This includes but not limited to agreement on fees and other confidential terms and condition. This permission is granted on the understanding that only the service provided by your company to the hospital will be discussed.

I trust you find this in order and hope you can assist.

13-08-2014

LV Mude **Date**
Hospital General Manager

Appendix 7: Letter of consent from Netcare to Montana Laundry



NALITHEMBA HOSPITALS (PTY) LTD
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Fax: +27 (0) 86 3132 385
Milner Street, Grahamstown, South Africa
E-mail: info@nalithemba.co.za
www.netcare.co.za

Date: 13 August 2014
Ref: ntcSET/HGM/140813

Dear Ziyanda
[Montana Laundry]

Request to conduct research interviews – Ms Tulisa Mahote

Ms Tulisa Mahote is a student at Rhodes University conducting research studies on the support services cooperation in the Netcare-Settlers Public Private Hospital in Grahamstown. She has requested an interview with you regarding your services to the hospital.

This letter serves to give you permission, should you wish, to grant an interview to Ms Mahote for her research. This is entirely up to you and your company to assist Ms Mahote, however I would appreciate your assisting her. In making this decision kindly ensure that confidentiality of the agreement between your company and Nalithemba/ Netcare is always maintained. This includes but not limited to agreement on fees and other confidential terms and condition. This permission is granted on the understanding that only the service provided by your company to the hospital will be discussed.

I trust you find this in order and hope you can assist.

LMutle 13-08-2014

LV Mutle **Date**
Hospital General Manager

Appendix 8: Letter of consent from Netcare to Royal Serve

NALITHEMBA
HOSPITALS (PTY) LTD
Public Private Partnerships

Member of the Nalithemba Hospitals (Pty) Ltd Group T/A
Settlers Private Hospital

Tel: +27 (0) 46 602 5000
Fax: +27 (0) 86 3132 385
Milner Street, Grahamstown, South Africa
E-mail: info@nalithemba.co.za
www.netcare.co.za

Date: 13 August 2014
Ref: ntcSET/HGM/140813

Dear Nolufefe
[Royal Serve]

Request to conduct research interviews – Ms Tulisa Mahote

Ms Tulisa Mahote is a student at Rhodes University conducting research studies on the support services cooperation in the Netcare-Settlers Public Private Hospital in Grahamstown. She has requested an interview with you regarding your services to the hospital.

This letter serves to give you permission, should you wish, to grant an interview to Ms Mahote for her research. This is entirely up to you and your company to assist Ms Mahote, however I would appreciate your assisting her. In making this decision kindly ensure that confidentiality of the agreement between your company and Nalithemba/ Netcare is always maintained. This includes but not limited to agreement on fees and other confidential terms and condition. This permission is granted on the understanding that only the service provided by your company to the hospital will be discussed.

I trust you find this in order and hope you can assist.

LV Mutle
Hospital General Manager

13-08-2014
Date