The Role of Private and Other Non-Governmental Organisations in Primary Health Care

Authors:
Gustaaf Wolvaardt
Jack van Niftrik
Brad Beira
William Mapham
Tienie Stander

Abstract

The private sector is playing an increasing role in the provision of Primary Health Care through both the for-profit and not-for-profit portions of the sector. In the post-1994 era, the relevance of this sector for the uninsured population has been markedly increased, due to corporate social investment and employee assistance programmes aimed at this population. A dramatic increase in donor-funded, health-related activities, in the HIV and AIDS and tuberculosis fields, has further expanded this sector’s involvement in providing Primary Health Care services to a larger proportion of the population. However, this sector has a relative over concentration of skilled human resources, a situation that appears to be immune to all policy attempts to reverse it. Given this reality, serious consideration should be given to finding mechanisms to leverage these resources, so that they can provide services to the larger community. Government proposals, such as those for a social health insurance system, would help better align the population with health care providers and should therefore be encouraged and fast tracked. A mechanism needs to be developed that would allow the contracting of the private sector, including the not-for-profit component, to address current unmet health service delivery needs among the South African population. Not utilising this resource while the public sector annually shows unspent budget allocations for Primary Health Care services makes little sense.

i  Foundation for Professional Development
ii  Medworx
iii  Aon South Africa (Pty) Ltd.
iv  Soul City
v  Health Econometrix
Introduction

This chapter reviews the role of the private sector, both the for-profit and the not-for-profit components, in Primary Health Care (PHC). Incorporating the review of both components into a single chapter has been a deliberate decision, seeing that it is becoming increasingly difficult to differentiate non-governmental health care providers purely based on their profit motive. Traditional not-for-profit organisations often level service charges for PHC services, while traditional for-profit organisations are increasingly involved in philanthropic health care provision. This approach is also in line with the definition used by the national Department of Health (NDoH).1

One of the major developments in the post-1994 period has been the increasing involvement of both components of the private sector in health care delivery at a primary care level. While the number of South Africans with medical insurance who access private sector care has been static since 1994, the number of uninsured people accessing care through the private sector has increased dramatically.2 The driving forces behind this increased response by the private sector to address the PHC needs of the uninsured population, include factors such as a growing awareness of the impact of the HIV and AIDS epidemic on the workforce, corporate social investment (CSI) and an increase in the number of the employed but uninsured population.

The explosive HIV and AIDS epidemic has created an unprecedented demand for health and welfare services. This has resulted in a massive injection of resources from donors, predominantly into the not-for-profit private sector (see Box 1). Employers have also responded to this epidemic by introducing various types of employee assistance programmes. As a result, both for-profit and not-for-profit health care suppliers, such as non-governmental organisations (NGOs), faith-based organisations (FBOs) and community-based organisations (CBOs) have increased their involvement in PHC.

It seems that CSI, whereby for-profit companies support charitable causes, became popular following the emphasis placed on the so-called ‘triple bottom line’ highlighted in the King II Report on corporate governance.4 This report defined good governance as extending beyond purely ensuring a profit (the bottom line), to also include companies supporting CSI and being environmentally friendly (the second and third bottom lines). The introduction of a CSI pillar in the Broad Based Black Economic Empowerment (BBBEE) Codes in 2007, created a further incentive for private sector companies to dedicate substantial budgets to activities that are often aimed at improving the health of uninsured South Africans.5 The draft Health Charter that has been a subject of discussion for a number of years, if adopted, would create additional incentives for international health

Box 1: Case study - The United States President’s Emergency Program for AIDS Relief (PEPFAR)

Over the past four years, PEPFAR has provided grants to the value of $856.8 million to support AIDS related prevention and treatment in South Africa.

The majority of this funding has been channelled through private sector organisations that often provide support to provinces through public-private initiatives (PPIs).

Since it started supporting country efforts in 2003, PEPFAR funding has supported the following services.

In 2007:
- 329 000 individuals were supported on antiretroviral (ARV) treatment;
- 984 500 HIV positive individuals received care and support;
- 365 000 orphans and vulnerable children received care and support;
- 1 742 300 people were tested for HIV; and
- 5 173 800 people were reached through community HIV awareness programmes promoting abstinence and faithfulness and 2 263 000 were reached with condom promotion campaigns.

What PEPFAR has shown South Africa is the capacity of the South African private sector (for-profit and not-for-profit) to absorb funding and to support the rapid expansion of health care services to underserved communities.

PEPFAR funding has increased over the past four years from $89.3 million in fiscal year 2004 to $397.8 million in fiscal year 2007. All of this funding was spent in a highly controlled environment, where strict adherence to complex financial rules is monitored through annual audits and where quarterly reporting of results are interrogated through data quality audits.

Source: PEPFAR, 2008.3
sector companies to provide such services in lieu of trying to meet the ownership criteria of the BBBEE Codes. The Charter creates a mechanism for international companies, who clearly would not have a 25.1% Black ownership, one of the targets of the BBBEE Codes, to still achieve points in this pillar of the BBBEE scorecard, through spending certain amounts on activities that can include the provision of health services to the uninsured population.

The dramatic change in the demographics of the employed population in South Africa, with the emergence of a Black middle class, has not resulted in any change in the racial composition of medical scheme members. As a result, there has been an increase in the number of people in the population who have the means to purchase health care services, but choose not to purchase medical insurance. This population is willing to pay out-of-pocket for PHC services from the private sector.

**Key findings**

In assessing the role of the private sector this chapter will try to answer two fundamental questions, namely, who are the private sector role players involved in PHC and what do they do?

**Private sector role players in Primary Health Care**

The private for-profit sector is involved in PHC through two mechanisms. The first is where services are provided at a fee, usually with a profit motive, as in the case of self-employed health care professionals. The second is where for-profit companies get involved in providing health care services with no intention of making a profit (i.e. by providing PHC services to their employees or to the community on a philanthropic basis).

The private not-for-profit sector encompasses a large number of organisations that either provide services for a service fee or at no charge. Included are NGOs, FBOs, CBOs and increasingly other role players, such as academic and research institutions. Currently, there are an estimated 60 000 to 80 000 not-for-profit organisations working in South Africa. Actual numbers are impossible to determine as reforms to the Nonprofit Organisations Act (Act 71 of 1997) lifted the mandatory requirement of registering with the Department of Welfare. The number of organisations, which are involved in health care is therefore also unknown. HIV911, a project of the University of KwaZulu-Natal, is busy compiling a series provincial directories of AIDS service organisations. While acknowledging that they have only scratched the surface of this sector, they have already identified 4 135 private sector organisations working only in the HIV and AIDS field. The provincial distribution of the organisations that they have identified is shown in Table 1.

**Table 1: Number of HIV and AIDS service organisations in South Africa, 2008**

<table>
<thead>
<tr>
<th>Province</th>
<th>Public sector</th>
<th>Private sector</th>
<th>Total (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>EC</td>
<td>284</td>
<td>429</td>
<td>713 (11%)</td>
</tr>
<tr>
<td>FS</td>
<td>77</td>
<td>124</td>
<td>201 (3%)</td>
</tr>
<tr>
<td>GP</td>
<td>237</td>
<td>1 125</td>
<td>1 362 (22%)</td>
</tr>
<tr>
<td>KZN</td>
<td>645</td>
<td>1 158</td>
<td>1 803 (29%)</td>
</tr>
<tr>
<td>LP</td>
<td>69</td>
<td>149</td>
<td>218 (3%)</td>
</tr>
<tr>
<td>MP</td>
<td>174</td>
<td>138</td>
<td>312 (5%)</td>
</tr>
<tr>
<td>NC</td>
<td>98</td>
<td>149</td>
<td>247 (4%)</td>
</tr>
<tr>
<td>NW</td>
<td>167</td>
<td>153</td>
<td>320 (5%)</td>
</tr>
<tr>
<td>WC</td>
<td>330</td>
<td>728</td>
<td>1 058 (17%)</td>
</tr>
<tr>
<td>SA</td>
<td>2 081</td>
<td>4 153</td>
<td>6 234 (100%)</td>
</tr>
</tbody>
</table>


**The role of the private sector in Primary Health Care**

In exploring the role of the private sector in PHC, it is important to look at service delivery in the context of the eight essential components of PHC namely:

- health promotion;
- food supply, nutrition, water and sanitation;
- family planning, maternal and child care;
- immunisation;
- prevention and control of locally endemic diseases;
- appropriate treatment of common diseases;
- promotion of mental, emotional and spiritual health; and
- provision of essential drugs.

**Health promotion**

Health promotion as envisaged in the Alma Ata Declaration was introduced in South Africa around 1990. Prior to that there were forms of health education. Since then, both the public and private sectors have actively embarked on health promotion activities, albeit in an uncoordinated way. Grey and Harrison described the recent collaboration between all sectors in the drafting of the latest HIV & AIDS and STI National Strategic Plan for South Africa, 2007-2011 (NSP) as, “an unprecedented example of cooperation between government and civil society”.

---

a HIV911 website: http://www.hiv911.org.za
The not-for-profit sector is currently the largest private sector contributor to health promotion, especially through activities by various NGOs focussing on HIV and AIDS, and the health promotion activities of medical schemes aimed at the 7.1 million insured South Africans. An interesting example is the Discovery Health Vitality Programme, that uses a classic affinity programme model of accumulating points and subsequent rewards to promote healthy living. 

Two other particularly high profile and innovative examples are Soul City and loveLife. Soul City has pioneered one of the most successful multimedia edutainment initiatives for health promotion, using a combination of a very popular prime time soap opera, inserts in newspapers and radio programmes to cover a wide range of health promotion topics. Soul City is known for its sound research-based approach. Furthermore, its effectiveness is partially attributable to the fact that it uses multiple intervention components (i.e. multimedia, advocacy campaigns and social mobilisation interventions) to impact synergistically on individuals, communities and broader societal processes. The focus of loveLife is on teenage sexuality and relationships, and the prevention of HIV infection and related conditions. Its mass media advertising campaigns are backed by a helpline. They also take a straightforward approach to addressing the underlying factors that fuel the spread of HIV, teenage pregnancy and sexually transmitted infections (STIs).

An interesting conduit for health promotion has been a number of large high profile AIDS conferences that have been organised in South Africa (e.g. the XIII International AIDS Conference held in Durban in 2000), and which have attracted massive media coverage creating a significant and sustained increase in media coverage about AIDS in this country.

Human rights and health rights issues, in relation to HIV and AIDS, have given rise to groups such as the AIDS Law Project and the Treatment Action Campaign (TAC), which pursue high-profile campaigns of activism, community mobilisation, civil disobedience and legal action in support of creating awareness of AIDS related issues amongst the public.

Another innovative example of leveraging CSI in support of health promotion is the annual MultiChoice Vuka Awards. This competition started in 1999 and is aimed at attracting South Africa’s top talent in the film making industry. Since its inception, it has generated 986 public service announcements, often covering health issues, and winning entries have received free airtime on television.

An important tenet of health promotion is to consider people, not as isolated individuals, but as part of a wider environment. This environment is the ‘setting’ in which people live and work, and has a profound effect on their health. Gold Fields’ response to the South African Mining Charter is a good example of the role that big corporations can play in support of health promotion. Gold Fields have set targets for improving the housing and living conditions of its employees. In 2007, Gold Fields spent R38.7 million on hostel upgrades. Many companies are also promoting employee wellness days to all their employees irrespective of whether they are insured or not.

**Food supply, nutrition, water and sanitation**

The right to access sufficient food is enshrined in section 27 of the South African Constitution and the government operates a variety of food security schemes such as, nutrition education, micronutrient supplementation, food fortification and feeding schemes. According to the Integrated Food Security Strategy for South Africa (IFSS), in July 2002 an estimated 35% of households were food insecure. This strategy placed great emphasis on public-private civil society partnerships as a basis for addressing household food security needs. Provision of meals and food has historically been a popular activity in which the private sector has been involved, through corporate philanthropy, or through the work of NGOs, CBOs and FBOs, who promote food gardens and other subsistence or commercial food production projects.

In 1994, an estimated 14 million people in rural areas of South Africa had inadequate access to safe water and some 21 million people did not have access to a basic level of sanitation. The Department of Water Affairs and Forestry (DWAF) actively pursued partnerships with not-for-profit organisations working for the provision of water and sanitation to rural communities to meet its policy objectives. In 1996, a partnership project was launched with NGOs and within 10 years has provided services to 10 million South Africans and created 400 000 jobs. NGOs were involved in educational activities, novel service delivery models, awareness campaigns and evaluation. The not-for-profit sector is also involved with projects aimed at increasing access to drinking water and reducing the economic time taken up with water gathering. This involvement was predominantly in response to a survey conducted by Statistics South Africa (StatsSA) in 1999, which estimated that 200 000 school children spent more than 24 hours per week carrying water for household needs. The Mvula Trust is the largest water and sanitation NGO in South Africa and has, over the last 14 years, disbursed over

---

b Discovery website: http://www.discovery.co.za  
c Soul City website: http://www.soulcity.org.za  
d loveLife website: http://www.lovelife.org.za  
e MultiChoice Vuka Awards website: http://vuka.multichoice.co.za
7. They have also rendered services to over one million South Africans who previously did not have access to either water or sanitation services.

The private for-profit sector traditionally played a role in water provision as a contractor to the government. Water security is however, becoming an area for CSI, as demonstrated by the Water for Humanity project of General Electric. This project, designed to promote access to drinking water is working with several communities surrounding the villages of Letsitele in Tzaneen, Limpopo. Nestlé in South Africa has also focused its CSI policy on improving nutrition and ensuring access to safe water.

Family planning, maternal and child care

South Africa’s total fertility rate is estimated to be one of the lowest in sub-Saharan Africa at fewer than three births per woman on average, and figures show that this is declining. These statistics testify to the success of family planning efforts in South Africa. As with so many of the components of PHC, health insurance status determines where people access family planning services. The insured population will access such services through private sector providers, predominantly medical practitioners, although there are also a number of family planning pharmacists who are licensed to provide contraception services directly to the public by the Pharmacy Council.

For the uninsured population, government and the not-for-profit sector are the providers of choice. Family planning has always been a popular activity area for NGOs and there are a number of large NGOs involved in various aspects of service provision. Family Health International addresses the family planning needs of women and couples with HIV, or at high risk of HIV infection. They also work with the NDoH on policy issues such as strengthening the integration of family planning and HIV services. The Population Council conducts research to improve policies, programmes and products in areas such as: HIV and AIDS; poverty, gender and youth; and reproductive health.

There are also a number of large South African academic projects that are directly involved in service provision around maternal and child health, the most prominent being based at the University of the Witwatersrand. Both the Reproductive Health & HIV Research Unit and the Perinatal HIV Research Unit have mobilised substantial donor funding, allowing them to move beyond a research focus into service provision.

According to United Nations Children’s Fund (UNICEF), only 780 000 of the 1.2 million South African women who visited antenatal facilities in 2006 were tested for HIV. Statistics also show that 27% of the women who were tested were found to be HIV-positive and only 59% of the known HIV-positive pregnant women received prevention of mother-to-child transmission (PMTCT) services. A large number of local and international NGOs therefore work in the PMTCT field, many on programmes designed to support public sector facilities through staff secondments and technical assistance. One of the more innovative programmes is the one of mothers2mothers (m2m). This programme focuses on supporting the expectant mother as opposed to the health care professional. The programme also employs HIV-positive mothers as ‘Mentor Mothers’. Mentor Mothers provide education and support to pregnant women and new mothers receiving care under the PMTCT programme. They also ensure that women get tested for HIV during pregnancy, that they understand how to take the ARV medications, select and adhere to an appropriate method of infant feeding, and learn to ‘live positively’ with HIV.

Numerous not-for-profit organisations are also responding to the 1.2 million AIDS orphans in South Africa. The Compass Project, which maps AIDS service providers, has seen a sudden increase in the number of these organisations in Tshwane in the last year. They are unsure if this increase is due to the availability of increased funding, or a symptom of the beginning of a collapse of the extended families’ ability to look after these children.

Immunisation

The role of the private for-profit sector is predominantly around service provision for the insured population and CSI. Private medical practitioners and private pharmacies provide vaccination services for children who are covered by medical schemes, and to adults and children who are travelling abroad as part of travel medicine services. There is substantial private sector provider involvement in vaccine trials. There are also a few examples of where private health care providers have been contracted by the State to provide vaccination for uninsured clients, as in the case of Ndlovu Medical Trust. Substantial CSI support is provided by the corporate sector to the South African AIDS Vaccine Initiative by companies such as Eskom, Transnet and Impala Platinum.

---

1. Mvula Trust website: http://www.mvula.co.za
2. General Electric website: http://www.zenon.com
3. Family Health International website: http://www.fhi.org
5. Compass Project website: http://www.compassproject.co.za
6. Reproductive Health & HIV Research Unit website: http://www.rhru.co.za
7. Perinatal HIV Research Unit website: http://www.phru.co.za
8. mothers2mothers website: http://www.m2m.org
Immunisation of the uninsured population against vaccine preventable diseases is predominantly a function of the public sector. The not-for-profit sector predominantly supports government through advocacy campaigns, often in the context of high profile vaccination drives such as the Rotarians campaign on polio eradication.\textsuperscript{n}

**Prevention and control of locally endemic diseases**

The private sector is predominantly involved in efforts to prevent high profile diseases such as HIV, tuberculosis (TB) and malaria. Given the dramatic increase of HIV prevalence in the South African population, as demonstrated by the increase of HIV prevalence in antenatal clients from 1% in 1991 to 29.1% in 2006, it is not surprising that the largest concentration of private prevention activities is in the field of HIV.\textsuperscript{21}

Voluntary counselling and testing (VCT) is a popular area for both components of the private sector. Numerous commercial VCT providers offer a service to companies as part of HIV workplace programmes. The not-for-profit sector has introduced numerous models in an attempt to supplement VCT uptake at public sector facilities. Some of the more innovative models of VCT currently in circulation are:

- New Start, a non-profit franchise, operated by the Society for Family Health, brings together several NGOs under the shared New Start brand.\textsuperscript{o} They aim to standardise service delivery protocols and develop quality assurance and training systems, as well as marketing strategies. This model has been designed to make HIV counselling and testing more accessible, removing it from a clinical setting and by offering walk-in services, which are open from early to late, to approximately 10 000 clients per month.\textsuperscript{p}

- Mobile VCT services are provided by organisations such as Foundation for Professional Development (FPD) and Right to Care (R2C). These organisations operate colourful mobile VCT sites, which appear to be extremely popular with the public as crowds gather as soon as these vehicles park. These organisations also partner with the public sector to strengthen VCT sites through the provision of additional staff. They also provide outreach into hospitals and TB treatment facilities to offer HIV testing to all patients in these facilities.

Screening for TB is another area where the private not-for-profit sector and academia have become heavily involved in service delivery. Most of these efforts are predictably aimed at the uninsured population, where government is still the first port of call for screening. However, as public services come under strain, there have been increasing efforts from the private sector. These include:

- Projects such as the South African Medical Research Council’s (MRC) ‘THAT’S IT’ (TB, HIV and AIDS, Treatment Support and Integrated Therapy) programme, a PPI aimed at strengthening the ability of public sector facilities to improve screening for TB in HIV-positive patients and HIV screening of patients who are being treated for TB. The project also aims at decreasing stigma by creating active community outreach programmes, positive branding, training and education both of health care workers and patients, as well as giving due attention to infection control principles in the areas where support is given.\textsuperscript{q}

- Ndlovu Medical Trust has had a contract with the provincial governments of both Limpopo and Mpumalanga dating back to 1998, through which they provide a comprehensive PHC model of TB services, including screening and contact tracing.\textsuperscript{r} This partnership is so well established that they are electronically linked into the National TB Register.

Malaria prevention is historically another area where prevention efforts were almost exclusively in the domain of the public sector, with the private for-profit sector limiting its role to the sale of malaria prophylactic drugs. One of the more spectacular private sector initiatives is that of the mining giant, Billiton. They initiated a joint project with the governments of Mozambique, Swaziland and South Africa in 2000, after a third of their employees at their smelter in Mozambique fell ill with malaria in two years (6 600 cases).\textsuperscript{22} This project has been lauded by the United Nations as a model of malaria eradication.

There are also a large number of South African NGOs involved in prevention of specific endemic diseases. The South African National Cancer Association (CANSa) is a good example of a local NGO that runs health promotion programmes, screening clinics and support groups.\textsuperscript{s} They have also played an active role in the detection of cervical cancer.

\begin{thebibliography}{9}
\bibitem{n} Rotary International website: http://www.rotary.org/endpolio
\bibitem{o} New Start website: http://www.newstart.co.za
\bibitem{p} Personal communication, S Billy, New Start, 25 May 2008.
\bibitem{q} Personal communication, M Uys, ‘THAT’S IT’ Project Manager, 20 August 2008.
\bibitem{r} Ndlovu Medical Trust website: http://www.ndlovu.co.za
\bibitem{s} South African National Cancer Association website: http://www.cnasa.org.za
\end{thebibliography}
Appropriate treatment of common diseases

Independent private health care providers (i.e. doctors, dentists, pharmacists, etc.) meet the primary care service needs for 7.1 million insured South Africans on a fee for service basis. In 2007, medical schemes spent R10.6 billion on such services. It is also estimated that around four million people who are formally employed, but uninsured, use this sector for ambulatory care on a regular basis, paying directly for these services. These private sector health care practitioners also often provide primary care to the uninsured population, through structures such as churches, service organisations (e.g. the Lions and Rotarians) or professional associations. A good example of the latter is the support from both the Optometric and the Ophthalmologic Societies for the ‘Right to Sight’ campaign, catalysing the private sector to perform 618 cataract operations for free during the October 2007 eye care awareness week.

Employers in South Africa show a distinct preference to structure remuneration packages on a total cost to company basis. This shifts many of the cost of living risks onto the employee. Medical scheme and tax legislation have limited the tax rebates for private medical scheme participation. Increases in private medical scheme premiums above both the Consumer Price Index (CPIX) and medical inflation, as calculated by StatsSA, have led individuals to purchase less expensive medical scheme cover with an option to self insure the payment gap. A consequence of this is that individuals have reduced their levels of medical cover and are seeking medical treatment later in their illness cycles. The direct impact on employers is an increase in the average duration of sick leave, from 2.4 days per sick leave event in 2004, to 2.7 days per sick leave event in 2007.

There is, therefore, an increasing trend for employers to establish health and wellness strategies for their employees, especially where they have a large uninsured workforce. These programmes offer a basket of health, lifestyle and wellness related services to employees. These services range from legislated occupational screening and health and safety services, to lifestyle consulting services, addressing financial challenges, legal needs and psychosocial issues.

Programmes addressing HIV and AIDS are often ‘ring-fenced’ and managed separately to primary health and occupational health services. Most medium to large employers have structured education, training and VCT programmes in place. These programmes are mostly procured from private for-profit and not-for-profit service providers. Employers with large work force populations make use of work site medical facilities to provide PHC and occupational health monitoring and screening. These facilities are, at times, self-administered but in most instances, are outsourced to third party specialist service providers. Occupational health and safety initiatives include, the screening of employees with exposure to high-risk environments on a six to 12 month rotational basis, either done on-site or via contracted off-site services. In the past, there has been the feeling that occupationally acquired illnesses and injuries should be managed by the employer, while socially acquired illnesses and injuries (all impairments not a direct or indirect consequence of employment) should be the responsibility of the individual concerned. Increasingly, the focus of corporate wellness programmes is now shifting towards providing an integration of essential occupational health, safety monitoring and screening, as well as provision of a minimum of psychological, physical and physiological primary health services.

It is in the field of HIV and AIDS and TB care where there has been a dramatic increase in the provision of care by private sector health care providers, often funded through donor funding. Various models are used for supporting the provision of HIV and AIDS and TB treatment to the uninsured population. Organisations such as the FPD focus predominantly on supporting scale-up of treatment at public sector facilities through a PPI model. They do so in the context of a memorandum of understanding, where facilities are strengthened mainly through the secondment of clinical and managerial staff. R2C, being another large NGO, uses a variety of models including, supporting government and NGO treatment sites to provide increased access to treatment for the poor.

Certain niche areas of practice, such as palliative care have long been the domain of private not-for-profit organisations, while FBOs such as the Salvation Army, are among the mainstays of hospice and home-based care for those infected and affected by HIV and AIDS. The Catholic Church has been involved in health care in South Africa since the 19th century. They currently operate three hospitals, 32 PHC clinics, many hospices, day centres and orphanages. Currently, a particular focus is on HIV and AIDS and they operate 150 service programmes for people living with HIV and AIDS; 20 of which provide ARV therapy to 15 000 people.

CBOs are becoming major contributors at grass roots level, especially in providing home-based care services and caring

---


---
for the terminally ill. There has been substantial investment in developing the role of these organisations by government and donors such as the European Union.

**Promotion of mental, emotional and spiritual health**

Mental health and emotional well-being seems to be a major area of neglect in South Africa. According to the South African Stress and Health Survey, released on World Mental Health Day in 2007, fewer than 20% of patients who experience a mental health disorder during their lifetime will get treatment. Even the insured population has limited access to private for-profit providers, as the number of psychiatrists has been steadily decreasing due to the ‘brain drain’. Currently, there are 1 188 psychiatrists in practice, with some provinces, such as Mpumalanga, struggling to attract any psychiatrists. The same scenario applies to psychologists, given that the country only produces 75 annually. In this environment, there is a plethora of non-medical institutions and organisations that are contributing to the promotion of mental, emotional and spiritual well-being including NGOs, FBOs and various patient support groups. Traditional healers play an important, if not well-documented, role in emotional and spiritual health, especially among rural and poor populations. In 1992, it was estimated that there were 200 000 traditional healers practicing in South Africa.

**Provision of essential drugs**

Essential drugs are provided by the private for-profit sector through privately owned pharmacies, dispensing doctors and hospital pharmacies. There are 2 400 active private pharmacies in the country, and these are defined as those who have ordered medication in the last three months. This is 442 less than the 2 842 still registered by the Pharmacy Council. The Council has not adjusted its register over the past four years to reflect the pharmacies that closed as a result of the government reforms on pharmaceutical pricing. Pharmacies and dispensing doctors provide access to essential drugs for both insured and uninsured patients. Annually, medical schemes spend R8.7 billion on procurement of drugs for insured ambulatory patients.

The private sector is also the source of procurement for all pharmaceutical companies for the public sector. Once the public sector has purchased these drugs, they usually distribute them through State facilities. However, in the Western Cape, the provincial government has contracted a private sector pharmaceutical company, IPM (Pty) Ltd., to distribute all chronic medication to stable chronic patients in the province. This company provides a service of daily collection of all prescriptions from clinics and day hospitals. They dispense around 90 000 prescriptions per month (average 5.1 items per prescription) back to these State facilities. Apart from customer care improvements with regard to waiting time, this project also provides the provincial Department of Health (DoH) with detailed disease management and stock control information.

The private not-for-profit sector is involved in improving efforts to provide essential drugs at various levels. A large number of NGOs are directly providing access to these drugs through AIDS treatment related activities, where they operate not-for-profit clinics, or contract private general practitioners to see uninsured HIV-positive patients. Other NGOs work specifically with the public sector to improve various aspects of service delivery. Management Sciences for Health (MSH), an international organisation, through the Rational Pharmaceutical Management Plus (RPM Plus) programme assists the public sector in strengthening systems for pharmaceutical management in support of HIV and AIDS scale-up activities. Their activities focus on strengthening the policy and legal framework and improving information management systems.

**Human resources for health and the private sector**

The discrepancies in human resource distribution, between the private and public sectors, have been an area of concern dating back prior to 1994. The relative over supply of health care professionals in the private sector has increased steadily since 1994, despite the private insured population remaining stable. Figure 1 shows changes in the percentages of health care professionals working in the private sector over a 14-year period.

**Figure 1: Percentage of health care professionals working in the private sector, 1990 and 2004**

The discrepancies in human resource distribution, between the private and public sectors, have been an area of concern dating back prior to 1994. The relative over supply of health care professionals in the private sector has increased steadily since 1994, despite the private insured population remaining stable. Figure 1 shows changes in the percentages of health care professionals working in the private sector over a 14-year period.

**Human resources for health and the private sector**

The discrepancies in human resource distribution, between the private and public sectors, have been an area of concern dating back prior to 1994. The relative over supply of health care professionals in the private sector has increased steadily since 1994, despite the private insured population remaining stable. Figure 1 shows changes in the percentages of health care professionals working in the private sector over a 14-year period.

**Figure 1: Percentage of health care professionals working in the private sector, 1990 and 2004**


---

y Personal communication, J Du Toit, IPM (Pty) Ltd., 27 May 2008.
z Management Sciences for Health website: http://www.msh.org
The actual numbers of health care professionals in selected categories working in the public and private sectors are shown in Table 2. Although the information is dated, it demonstrates the unequal distribution of human resources between the two sectors.

Table 2: Distribution of health care professionals between the public and private sectors, 2004

<table>
<thead>
<tr>
<th>Profession</th>
<th>Total No.</th>
<th>Public sector No. (%)</th>
<th>Private sector No. (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Practitioners</td>
<td>19 729</td>
<td>5 398 (27.4%)</td>
<td>14 331 (72.6%)</td>
</tr>
<tr>
<td>Specialists</td>
<td>7 826</td>
<td>1 938 (24.8%)</td>
<td>5 888 (75.2%)</td>
</tr>
<tr>
<td>Dentists</td>
<td>4 269</td>
<td>316 (7.4%)</td>
<td>3 953 (92.6%)</td>
</tr>
<tr>
<td>Pharmacists</td>
<td>4 410</td>
<td>1 047 (23.7%)</td>
<td>3 363 (76.3%)</td>
</tr>
<tr>
<td>Psychologists</td>
<td>3 808</td>
<td>222 (5.8%)</td>
<td>3 586 (94.2%)</td>
</tr>
</tbody>
</table>


Compounding this maldistribution between the respective health sectors are issues around production and retention of health care professionals. Using doctors as an example, one notices that the output of medical schools has been stable for the last 20 years at around 1 200 per annum, not matching an increase in demand for health care due to population growth and increasing morbidity due to AIDS. Emigration compounds this problem. Despite medical schools producing 19 500 graduates between 1990 and 2005, the register of the Health Professionals Council of South Africa showed only 9 304 new registrations during this period.

The fact that production of almost all categories of health care professionals (pharmacists are excluded for some unexplained reason) has to increase dramatically was acknowledged in the National Human Resources Plan for Health of 2006. This plan sets ambitious targets for doubling the production of most categories of health care professionals by 2014. The plan does not however explain how this will happen, and intake at tertiary academic institutions has to date not been increased in response to this plan. Unfortunately, the obvious solution of encouraging the private sector to contribute substantially to the production of health care professionals to offset this sector’s voracious appetite for skilled professionals is not addressed in this plan either. Despite South Africa having a large and dynamic private higher education industry, the private sector is, to a large extent, barred from producing health care professionals. Some hospital groups are involved in training nurses, but if anything, the plan takes a dim view of private training of health care professionals.

The private sector clearly absorbs a disproportionate number of the country’s highly skilled health care professionals and this trend is likely to continue, until the public sector pays serious attention to retention of clinical staff. A study by the South African Medical Association (SAMA) in 2003 showed that the way they were being treated, was the biggest reason why doctors left the public sector. Another study in 2007 by the FPD, looking at whether health care professionals doing community service intended to stay on in the public sector, again highlighted how important treatment of these professionals was in influencing their decisions to leave or to stay. The latter study showed that there were some hospitals where professionals were treated so poorly, that it was almost guaranteed that they would not only leave the public sector, but would leave the country on completion of their community service.

The not-for-profit sector also mobilises a substantial number of people in support of this sector’s contribution to PHC. Staff involved in this sector are employed either on a salaried basis or as volunteers. Volunteerism is an incredibly powerful contributor to economic development. For example, in 2006, Canada reported that the volunteer sector contributed over $75 billion to the national economy and represented 7.8% of its gross domestic product (GDP).

Traditionally, volunteerism was spontaneous, with individuals joining up with not-for-profit organisations for this purpose. In recent years, for-profit businesses have started employee volunteer programmes in South Africa. These programmes are designed to create conduits for employees to become involved in philanthropic activities. Programmes can include giving staff paid time off, while others set up structured programmes where staff can work as volunteers in the community linked to the companies’ CSI.

There are no national statistics available on the total number of volunteers involved in PHC. The Compass Project is working with organisational development and NGOs in the health sector in Tshwane, and has been mapping the AIDS service organisations in the city. In Table 3, results are shown from a survey that they conducted in Tshwane in 2007, highlighting the profile of people employed in AIDS related activities.
Table 3: Number of people working in various AIDS service organisations in Tshwane, 2007

<table>
<thead>
<tr>
<th></th>
<th>Full-time staff</th>
<th>Part-time staff</th>
<th>Volunteers</th>
</tr>
</thead>
<tbody>
<tr>
<td>NGOs</td>
<td>1 069</td>
<td>197</td>
<td>830</td>
</tr>
<tr>
<td>FBOs</td>
<td>88</td>
<td>8</td>
<td>33</td>
</tr>
<tr>
<td>Private sector</td>
<td>40</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>Public-private partnerships</td>
<td>53</td>
<td>5</td>
<td>43</td>
</tr>
</tbody>
</table>

Source: Compass Project, 2008.

As part of the expanded public works programme, government has been funding positions for community health workers (CHWs) who are usually employed by a NGO, which has a contract with provincial departments of health. This has created a large contingent of health care workers providing home-based care.

African Health Placements is an innovative private sector project aimed at addressing the severe health professional shortages in the public sector. This is a donor and corporate-funded project that actively recruits and fasttracks employment in the public sector of foreign qualified health care professionals from developed countries, as well as South African qualified professionals who wish to leave the private sector.

Public-private partnerships

Public-private partnership (PPP) as defined in the Treasury Regulation 16 to the Public Finance Management Act (Act 1 of 1999) entails a commercial transaction between a government institution and a private party. Through this transaction, the private party performs institutional functions, acquires the use of State property, assumes substantial risk (with regards to the institutional functions and use of State property) and receives a benefit for performing the institutional functions or the use of State property.

In the health care arena, a PPP Task Team was established in 1999 by the NDoH. They released the first draft report in March 2000 and considered four major categories for PPPs. These included: purchased services to obtain specialised skills; outsourcing non-clinical services (such as cleaning, catering or data processing); joint ventures; and private finance initiatives. The draft document focused mainly on public hospitals and expensive technology.

PPPs are increasingly viewed by governments in Africa as an efficient way of fostering development faced with the reality of insufficient investment and growing pressures on government budgets. Such PPPs create incentives for the private sector to mobilise investment capital, and bring managerial experience, to addressing priority areas identified by government. In South Africa, this is also seen as a mechanism to promote BBBEE objectives.

In health care, a number of examples of PPPs exist. The National Treasury PPP unit has indicated, that at least 11 of the 18 provincial PPP projects in preparation are health care related. Examples of existing PPPs are:

- The NDoH’s 40% shareholding in BioVac Institute (Pty) Ltd. In exchange for the shareholding, the NDoH transferred its staff and assets of the Directorate that housed the State Vaccine Institute to BioVac.
- A number of PPPs revolve around the management of hospitals. These include those of Life Esidimeni, part of the Life Healthcare Group who manage a TB hospital, and two district hospitals. The Clinix Hospital Group, which has a Level One hospital care contract with Gauteng Health, and Netcare who is involved in two PPPs in health in South Africa. Netcare also recently awarded a contract in Lesotho of a PPP, which includes the management of two PHC clinics as well as build-operate-transfer of a new referral hospital in Maseru.

PPPs in the preparation phase cover collaboration on issues such as:
- revitalisation of the pharmaceutical supply chain in the Eastern Cape;
- management of State hospitals or units in such hospitals; and
- renovations and upgrading of hospitals and residences.

The introduction of a social health insurance (SHI), pillar of health care funding, will create more opportunities for PPPs in such areas as the administrative processes involved in the management of a Risk Equalisation Fund (REF). Other anticipated areas of PPPs are, provision of services to SHI patients by private health care providers, allowing public sector facilities to be used by private sector health providers, to provide services to SHI patients and contracting private sector facilities and to provide services to public sector patients.

a African Health Placements website: http://www.ahp.org.za
Given the current focus on private hospital costs, the notion of competition to reduce price and increase quality, can also be achieved via PPPs to assure the transformation of State owned hospital facilities to competitive economic units in the private health care sector.

Although there are relatively few examples of PPPs, there are numerous PPIs, these being examples of cooperation between the public and private sector outside of the Treasury regulation definition. Especially in the field of HIV and AIDS and TB care, there are literally hundreds of organisations working in close partnership with government to improve access to services. Most of these initiatives are funded through donor-funded programmes such as PEPFAR, an international donor programme to support numerous high prevalent countries in the HIV and AIDS field.

**Conclusion**

The private sector, both the for-profit and the not-for-profit components, is progressively playing a larger and larger role in the provision of health care services at a primary care level. CSI, BBBEE and HIV and AIDS are all powerful driving forces changing the way this sector engages in health care provision. Traditional categorisation of various health care providers based on profit motive is naïve and does not reflect the evolution currently taking place.

Should the proposed Health Charter, with its provisions for international companies to make replacement offerings instead of taking onboard BBBEE partners be implemented in the near future, this will further enhance the incentive for the private for-profit sector to become involved in health care delivery for the uninsured population.

The potential of this sector to increase its activities rapidly has been demonstrated by the PEPFAR programme. This programme has demonstrated the ability of this sector to implement health care programmes, usually in collaboration with provincial departments of health, in a highly monitored and closely controlled environment.

Although a number of health sector PPPs have been established and are also in the pipeline, they have not really tapped into the large capacity and ability of the private sector to deliver PHC services. Given the fact that the majority of primary care providers still congregate in the private sector, despite numerous attempts by government to increase professional staff in the public sector, serious consideration needs to be given to outsourcing patients to the private sector. Not utilising this resource while the public sector annually shows unspent budget allocations for PHC services makes little sense.

**Recommendations**

The following recommendations originate from this chapter.

- The private sector, especially the not-for-profit sector, should take the initiative in attempting to ensure greater coordination of activities. Such an approach should result in greater coordination of geographical spread of activities. One of the major findings of the Compass Project’s mapping activities is that there is seldom any logical correlation between need and activities. The aversion that not-for-profit organisations have to be coordinated by government agencies, ensuring better coordination amongst themselves should appeal to the not-for-profit sector. However, it is believed that government, by contracting this sector for service delivery, can influence where and what these organisations are involved in.

- The public sector should seriously look at the ability of the private sector to increase service delivery to the uninsured. The PEPFAR case study and the section on PPPs clearly demonstrate the ability of this sector to absorb substantial amounts of money, in a responsible manner, and the ability of this sector to reach large numbers of the uninsured population. Drawing on this expertise could dramatically increase service delivery and go a long way in creating a truly unified health care system. The former Secretary General of the United Nations, Kofi Annan, summarised this potential perfectly when he said: “The UN once dealt only with Governments, by now we know that peace and prosperity cannot be achieved without partnerships involving government, international organisations, the business community and civil society. In today’s world we depend on each other”.17

- The public sector needs to look at creating a forum at the health district level to engage private sector players to create an integrated health care system.

- The human resources issues highlighted need to be looked at, as a matter of urgency. Efforts to attract and retain health care professionals in the public sector have to move away from purely attempts to improve salaries, or coerce young professionals into public service. It is believed, that paying attention to how management treats health care professionals could have dramatic positive effects. In the final analysis, we are living in a world where competition for scarce resources, such as skilled people, is fierce and currently we are losing this competition.
The production of skilled health care professionals should be increased as set out in the Human Resources for Health Policy of 2006. However, it is time to explore how to engage the private higher education sector in these efforts. The fears expressed by some policy makers that if the private sector was allowed to establish, for example medical schools, that this will undermine the attempts of government to improve racial and gender representation in these professions, are valid given that the private sector cannot be instructed to apply targets to intakes of students. However, the inclusion of the private sector in the government higher education subsidy schemes would address these concerns, as those subsidies are linked to race and gender targets.

In a country with a desperate shortage of skilled human resources, ways need to be found to tap into the enormous potential of volunteerism. Creating company volunteer programmes is a positive beginning, but consideration should be given to establishing volunteer service organisations, that can act as brokers between those with skills and those in need of these skills.
References


29 Foundation for Professional Development. FPD internal report (unpublished); 2007.


