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Masters in Public Health
DISSERTATION

A Stakeholder Analysis of the UCT Hospital

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Abstract

The UCT Hospital is a private, fully independent hospital within the buildings of the Groote Schuur Hospital. It has been operational for well over two years. Planning and development began a further four years before this. During the last two years the hospital has changed its name, shareholders and management structures. Since the start of the planning the various stakeholders will too have changed their respective structure and business foci.

These changes have added to poor knowledge of all the stakeholders' aims and desires for the hospital.

The aims and objectives of this study are to establish what the various stakeholders wish to gain from their relationship with the UCT Hospital. Furthermore, this study investigates the degree of public-private interaction with Groote Schuur Hospital and proposes various possibilities for their future existence and co-operation.

A stakeholder analysis indicated that the primary stakeholders wish to expand and grow the hospital. Opponent stakeholders are not satisfied with the structure of and their relations with the UCT Hospital.

Key problems in the relationship with Groote Schuur Hospital include tense relations, poor regulation of resource-sharing, and that the two hospitals are vying for comparable markets. These problems are inhibiting growth for both institutions.

Communication, improved regulations and specialised market sectors are key needs to help resolve the problems between the two institutions.

Various possibilities for future co-existence revolve around the degree of public-private interaction between the two institutions. The most viable option seems to be for the two hospitals to work closely together to form a public-private partnership, where the Groote Schuur Hospital Private Ward is outsourced to the UCT Hospital. This will involve UCT Hospital relinquishing some autonomy and freedom, but result in them having less competition and a greater market base. GSH will have to abandon their own private ward, but can increase risk-sharing, gain in efficiency and effectiveness in the private ward, and get involved in a co-management structure.

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Glossary

Coherence	A co-ordinated and unified healthcare system, standardising provision and financing of care for all patients, irrespective of private or public sectors.
Community Hospital Group	A private hospital owner and operator
Descriptive study design	The process of mapping out a situation or a set of events to describe the situation or series of events and repercussions.
DHFE	Department of Health Finance and Economics under the MDoH.
Efficiency	*Technical efficiency:* maximising output at least possible costs, without compromising quality of care. *Allocative efficiency:* Fair distribution of available resources to all services, to maximise health outcomes
Elsenberg	The name given to the meetings (one and two) held between PAWC treasury and both, UCT and Stellenbosch universities, to plan the possibilities of creating specific private teaching hospitals/wards for the universities.
Equity	All sectors of the population have access to a basic package of affordable healthcare, irrespective of ability to pay.
FFS	Fee-for-service: A form of medical service billing where the service provider bills for each procedure completed.
GSH	Groote Schuur Hospital: A major tertiary institution in Cape Town.
Medi-Clinic	Private hospital group in South Africa.
Memorandum of Understanding	An agreement signed by both UCT Hospital and GSH to have a mutual understanding regarding resource-sharing, better communication and civil relationships.
NDoH	National Department of Health
PAWC	Provincial Administration of the Western Cape

PPI	Public-private interaction: A relatively loose association or interaction between the public and private sectors to work together with the effect to cut costs or share resources and expertise on the same project.
PPM	Public-private mix: A relatively loose association or interaction between the public and private sectors to work together with the effect to cut costs or share resources and expertise on the same project.
PPP	A well regulated, contractual arrangement between the public and private sectors. The private sector performs a function or utilises state property to perform a specific function, with specific outcomes for commercial gain.
Primary stakeholder	Stakeholders vital to the existence and functioning of the organisation or corporation.
Purposive sampling	Rational identification of sample group, by identifying the noticeable participants.
Quality of care	Scientifically sound care, which is acceptable to consumers and society.
Rhön-Klinikum	A German hospital owner and operator, that invested in Cape Town in a drive to expand its business internationally.
RWOPS	Remunerative Work outside of the Public Service: Time allowed for civil servants to garnish financial and work experience within the private sector.
SAHR	*South African Health Review*: Annual publication reviewing the health sector, policies and processes implemented and planned.
Secondary stakeholder	Stakeholders with whom the organisation or corporation interacts, but who are not vital for its existence.
Snowballing	A process of sampling where further participants are identified and included following interactions with original sample group or single participants.
Stakeholder analysis	Tool or set of tools for generating knowledge about actors.

Stakeholders	Persons or groups that have, or claim, ownership rights or interests in a corporation and its activities, past, present or future
UCT	University of Cape Town
UCTH	University of Cape Town Hospital: General term used referring to the private hospital established by UCT and other shareholders within the building of Groote Schuur Hospital.
UCT Medical Centre	The original name of the UCT Hospital, when RK was still the main shareholder.
UCT Private Academic Hospital	The current name of the UCT Hospital, amended after RK pulled out of the project.
Westcare Hospitals	A hospital shareholder and management company.

1 Introduction

This introduction places the thesis topic in its health system perspective and gives a brief background to the reasons for this study. Furthermore, the aims and objectives are established, the methodology is outlined and the structure of the dissertation is presented.

1.1 Motivation

Issues of Public-Private Interaction (PPI) are currently very topical. PPI topics are being tackled in both developed and developing countries across the world, and are being utilised in many sectors – including the health-care sector. PPI refers to relatively loose, but goal-orientated, relationships between the public and private sectors to co-operate towards joint or individual goals. PPP (public-private partnerships) refer to close co-operation between the public and private sectors – a formalised, contractual arrangement where the private sector performs a service, or rents resources, for commercial gain in return for specific benefits to the public sector (Chetty, 2001 and Du Toit, 2002).

PPIs are central to many health-reform processes in Africa, the East, Latin America and South Asia (Arias and Yepes, 2003; erc, 2001; Shepard, 2001; Birungi et al.; 2001). There are reportedly many potential advantages in terms of cost savings, administrative efficiencies and attaining equity through PPI (*The Globe and Mail*, 2002; Bennett, McPake and Mills, 1997, Newbrander and Parker, 1992). Furthermore, PPI can go a long way to resolve some problems in the human-resources sector of health-care structures by providing extra incentives for health professionals to stay in the public sector (Frenk, 1993).

The South African government is committed to the utilisation of PPI in health reforms for this country. The national- and provincial-government structures have specific PPI units within Treasury and Health Departments. Furthermore the National Health Bill, White Paper on Health System Transformation (1997) and the Health Sector Strategic Framework 1999 – 2004 (1999) all have specific references to PPI for the reform of the South African health sector.

This thesis explores interactions, aspirations and relationships of public and private actors, in a case study of a private hospital located on the site of a public hospital. The study examines the degree of PPIs currently utilised, and explores possible future scenarios.

1.2 Background

> *This section presents information regarding the history, organisation and business processes of the UCT Hospital and is taken predominantly from interviews conducted with UCT, Westcare Hospitals, Rhön-Klinikum, PAWC and several publications.*

In February 2002 the University of Cape Town Hospital (UCTH) was opened, after four years of planning and organising.

At that stage it was a partnership between UCT (University of Cape Town) and the Rhön-Klinikum (RK), a German hospital group which specialises in administration, systems and structures of private hospitals. It was called the UCT Medical Centre.

UCT had been looking for an independent site for a private teaching hospital and RK had wanted to expand its business interests internationally. UCT was specifically aiming to provide high-quality private work for its academics/clinicians – to attract and retain staff numbers. Furthermore the new establishment was to offer better training and research facilities, which were becoming progressively reduced with continued financial restraints at Groote Schuur Hospital (GSH) and other public facilities. RK also had a specific aim of running a financially profitable institute.

After several months RK realised they were not going to reach their expected targets (financially and occupancy rates), and terminated their involvement in the hospital. Westcare Hospitals and a group of practitioners from UCT/GSH stepped in to become shareholders alongside UCT, and ensured that the hospital continued to operate. This change brought about changes in shareholders, management and a new name: UCT Private Academic Hospital.

This change also brought about several structural and operational changes – some billing processes changed, re-introduction of fee-for-service (FFS) billing, a more relaxed management system, a change in relations with GSH, and some PPI interactions with GSH.

The change in shareholders (Westcare Hospitals was not involved at all prior to the changes), management structures and the planning period, all contribute to the fact that initial goals and ambitions for the hospital have changed. These changes have led to a lack of "focus" or direction for the stakeholders and management (as discussed by one of the main shareholders). The various stakeholders and management now need to know what all the actors require from their relationship with the hospital, now and in the future.

1.3 Problem statement

The UCT Hospital has gone through some important changes, including name, shareholders and management persons/structures. Original aims and requirements can easily be forgotten or overlooked through these changes, and the needs of stakeholders can change considerably over time.

The various stakeholders of this hospital need to understand what all the various parties want or need from the involvement in the hospital, and how this affects their future ideas and planning. Furthermore, any ideas of constructive public-private interaction need to be reviewed – to see whether the UCT Hospital can benefit the public sector while also meeting commercial interests.

1.4 Aims and objectives

1.4.1 Aims

The purpose of this study is to establish what the different stakeholders want or need from the UCT Hospital and to what extent these views converge on its benefits and disadvantages.

Furthermore, the study will establish to what degree the different stakeholders (public and private sectors) are interacting with each other; relating these findings both to the original intentions/ambitions of the various shareholders and to the current interface between the stakeholders of the hospital.

A further aim is to evaluate potential avenues of mutual participation.

1.4.2 Objectives

A: To establish
- the aims of the various stakeholders in the UCTH
- their position on the hospital's current stance and structure
- the stakeholders' future desires for the UCTH

B: To determine how the various stakeholders can best work together to further the aims of public-private interactions in terms of performance criteria such as equity, efficiency, coherence and quality of care

1.5 Abbreviated methodology

The comprehensive methodology is presented in chapter 4.

A stakeholder analysis was conducted to analyse all the ideas, needs and desires of those parties with a vested interest in the hospital. There is minimal literature

available on the hospital itself and no literature available on needs of the various interested parties.

Qualitative research (descriptive study design) is the most appropriate approach to compile adequate data about all the parties involved. It enables the parties' feelings, intentions and ideas to be collected and reviewed (Rosnow and Rosenthal, 1996).

Purposive sampling was used to identify and include the relevant stakeholders. Nine stakeholders were identified originally, and three more were included through snowballing.

Semi-structured interviews were utilised to give the interviewees relative freedom to express their ideas and input. This research approach is useful to gather large amounts of information for qualitative research, and reduces bias that may occur if interviewers prompt with too many guided questions which may lead to preconceived points.

The majority of the interviews were recorded and analysed at a later stage to ensure that the interviews were completed in a relaxed, uninterrupted manner.

1.6 Dissertation structure

The structure of this study is as follows:

Chapter Two
The *Literature Review* covers material on stakeholder analyses, regulations covering PPI and a general South African health-sector evaluation. This is followed by a slightly closer examination of the public and private sectors within South Africa. Finally, some examples of South African public-private interactions are examined.

Chapter Three
The *Context* chapter examines the history and set-up of the UCT Hospital. It includes the reasoning behind the development of this project and the various changes that have occurred in name, management, structures and shareholding.

Chapter Four
The *Methodology* expands on the design, sampling, implementation and data collection. Further content includes a detailed scrutiny of the data processing and results analysis.

Chapter Five
The *Results and Discussions* chapter includes the results, analysis and discussion of these results. The results are analysed according to the aims of the hospital, the current degree of PPI and potential future participations.

Chapter Six
Finally, the *Conclusion* chapter sums up the interests of the various stakeholders and evaluates potential avenues of greater or lesser PPI.

2 Literature review

This chapter reviews the literature available on the various topics relevant to this research. Firstly, there is a brief section on stakeholder analyses and a review of the regulations governing PPI in South Africa as well as examples from abroad. Following this is an analysis of the South African health sector, where the public and private sectors are reviewed. Finally, examples of South African public-private interactions are reviewed.

2.1 Stakeholders and analysis

Several definitions are available for stakeholders and stakeholder analyses, differing mainly with regards to semantics and the context in which they are being used. There are a variety of "specific" stakeholder classifications, and some literature is available on the importance of assessing the various stakeholders' impact or influence, with respect to specific contexts such as management structures, policy implementation or project developments.

2.1.1 Stakeholders

Clarkson (1995, in: Brugha and Varvasovszky, 2000) defines stakeholders:

> Persons or groups that have, or claim, ownership, rights, or interests in a corporation and its activities, past, present, or future. (p. 239)

Qualman (1997) adds that these groups, persons or institutions include those that will, or may, influence the project's outcome; basically stakeholders are those entities that have significant influence or importance to the project. Furthermore, stakeholders include winners *and* losers, as well as those parties involved and excluded from any decision-making process (Public Health WWW Networking Project, 2002).

Brugha and Varvasovszky (2000) review the literature on a variety of classifications for stakeholders. Clarkson (1995, in: Brugha and Varvasovszky, 2000) classifies them as

- *Primary stakeholders*
  Stakeholders vital to the existence and functioning of the organisation
- *Secondary stakeholders*
  Stakeholders with whom the organisation interacts, but which are not vital for its existence

This definition seems a bit too "black and white", with little possibilities for some stakeholders having influence, yet not being directly involved. Not all stakeholders will perfectly fit into either classification.

Fottler and Blair (1989 and 1990, in: Brugha and Varvasovszky; 2000) further classify stakeholders as

- *Internal stakeholders*
  Stakeholders function solely within the organisation
- *Interface stakeholders*
  Stakeholders interface with other organisations
- *External stakeholders*
  Stakeholders compete or collaborate with the primary stakeholders

Again, these classifications are not always appropriate, as some stakeholders may have several characteristics credible to more than one of the classifications. In reality, stakeholders may have some strong influences without direct association with any specific stakeholder, or have a variety of opinions on different aspects of a policy, organisation or process.

Fottler and Blair (in: Brugha and Varvasovszky, 2000) do give another form of classifying – considering the various stakeholders in "adversarial terms". In this situation one needs to assess the stakeholders and make some calculated deductions, and classify them with regard to being a *threat* or acting in *alliance* with the primary stakeholder/s. This idea can be expanded to grade stakeholders in terms of their perceived degree of threat or support. Some stakeholders may be associated with closely, others totally excluded and some used cautiously or only to a limited extent.

This study will make use of primary- and secondary-stakeholder classification; it is felt that the more basic classification is more user-friendly and applicable to the stakeholder groups identified in this study. A further classification has been included to describe stakeholders that are not involved in the day-to-day activities and functioning of the organisation, yet exceed the realm of a mere secondary stakeholder. These stakeholders are vital to the existence and regulation of the primary stakeholders, but do not interact with them on a regular basis. These will be classified as Additional Stakeholders.

2.1.2 Stakeholder analysis

Varvasovszky and Brugha (2000) define a stakeholder analysis as a "tool or set of tools for generating knowledge about actors"; this knowledge is used to understand their "behaviour, intentions, inter-relations, interests and influence and resources" brought into their relationships.

> Stakeholder analysis helps the team to assess the likely impact of the current and foreseeable environment, so that strategies can be put in place to minimise barriers to success, and to maximise opportunities. (Public Health WWW Networking Project – Planning, 2002)

This knowledge can be used in many ways: to develop policies, analyse policy development, implement projects, develop strategies and manage specific stakeholders.

Brugha and Varvasovszky (2000) present a four-point process of analysing stakeholders:

i. Identify Stakeholders
ii. Mapping Stakeholders
iii. Diagnosis
iv. Strategy Formulation

The first step, *identifying stakeholders*, seems quite straight forward, but in some circumstances it is not always immediately possible to identify all the stakeholders. A further problem may be in identifying the key, or most important stakeholders, if there are quite a few actors. Brugha and Varvasovszky suggest structured surveys to both identify stakeholders and to rate or to "score the level of power of a stakeholder" (p. 242).

The next step is to *map stakeholders* with respect to each other. This is often done schematically – to give a visual idea of how they relate to one another. A Forcefield Matrix, tabulation or schematic representation (maps) is useful. This can give a clearer, visual presentation of how the various stakeholders relate to each other, and how they may move or change with respect to each other through changes in relations with these stakeholders.

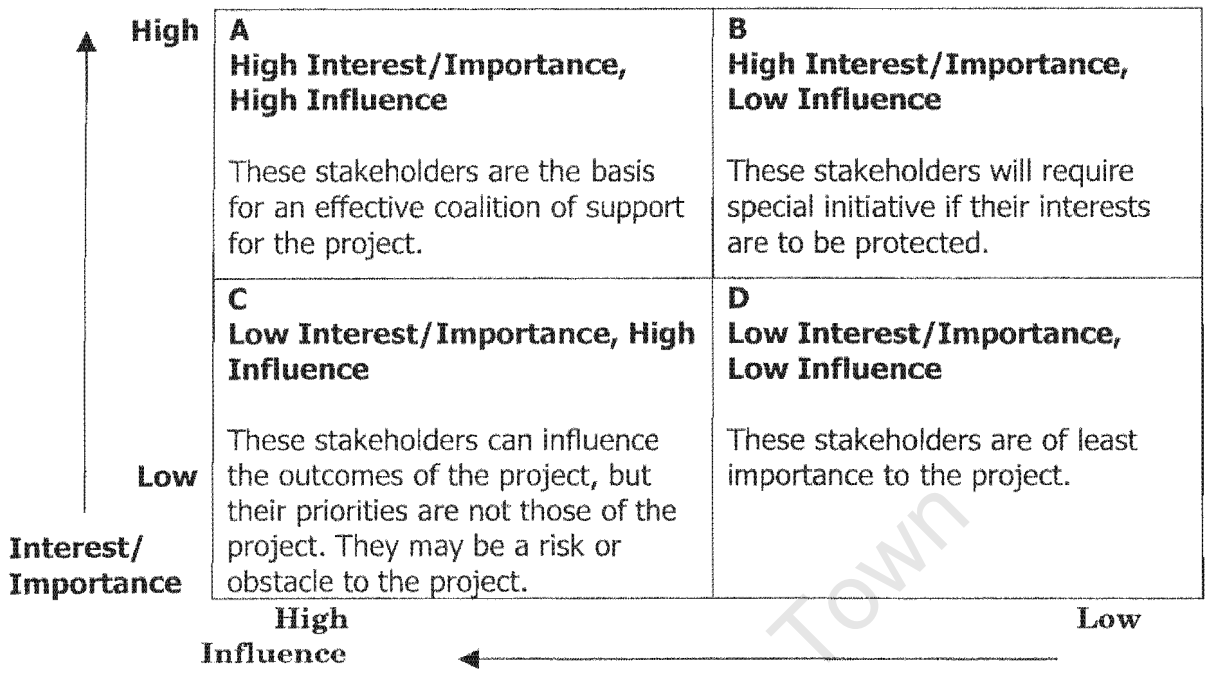
The *diagnosis* of stakeholders is the process of classifying stakeholders as threats or collaboration potential. Here one needs to clearly decide if one wishes, and to what degree, to work with the varying stakeholders.

Lastly the *strategy formulation* involves the process of fitting the ideal strategy or relationship to each stakeholder, with the aim of appeasing or excluding them, to achieve one's original goals.

Qualman (1997) presents a stakeholder matrix, which can be used to both categorise stakeholders and tabulate potential or necessary shifts of stakeholders between categories.

This matrix can help to get an overview of the various stakeholders according to their influence or interest. Furthermore, if one wishes to "mobilise" stakeholders into different categories, one can use this as a basis to develop strategies to increase or decrease interests or powers of various stakeholders.

DIAGRAM 2.1: Stakeholder Matrix (Qualman, 1997)



2.2 Public-private interaction

2.2.1 General

In literature reviewed there are several different terms used for the interaction between the public and private sectors. These are generally applied quite loosely and interchangeably. Included among these are: Public-Private Interaction (PPI), Public-Private Participation (PPP) and Public-Private Mix (PPM).[1]

It is generally understood that PPI and PPM are used for general relationships, where the public and private sectors work closely together on the same or similar goals. Dachs (in: "Report of the 'Public-Private Interactions Lekgotla'", 2002) and Chetty (2001) both explain the significance and specific, close co-operation between the public and private sectors, which signifies PPP.

> Treasury defines PPPs as: "A contractual arrangement between the public sector and a private entity where the private sector performs a departmental function OR uses state property for own commercial gain in accordance with output specifications for a significant period of time, in return for a benefit." Dachs (in: "Report of the 'Public-Private Interactions Lekgotla'"; 2002, p. 3)

Several sources consider the importance of a "risk-transfer" to the private sector in the definition of a PPP or PPI. Although this is not within the National Treasury's definition, Dachs does indicate core criteria needed over and above the definition, for those who wish to apply for PPP projects. These three criteria include

[1] For general reference to public-private co-operation in this article, the term "public-private interaction" will be used. For recognised structured policy-orientated participation, PPP will be used.

affordability, value for money and an appropriate risk transfer to the private sector.

Widdus (2003) gives further input in explaining that PPI should not be purely for profit-making reasons or to capture income from new enterprises. It should be a relationship where different skills, expertise and other resources are combined to achieve common goals that are unattainable independently.

Chetty (2001) lists five guiding principles[2] to consider when deciding on the implementation or approval of PPI in a formal (health-sector) setting:

1 The overall sustainability of the entire national health system
2 Promoting equity of access to primary care
3 Promoting equity of access to affordable hospital care and strengthened public-hospital care
4 Promoting equity in financing of health services
5 Promoting financial sustainability in the public sector

Most importantly, she adds, is the insurance that the implementation will at no time make any existing inequities or financing, within the health sector, worse – even in the short-term.

Before further analysis of PPI, it is important to note that the use of PPI is only one component available to the government to improve the provision, equity, efficiency and effectiveness of the public sector. Moorman (2001) emphasises this point and indicates that PPI are not preferred options, but are one possibility within the states "arsenal" to improve the health sector.

Besides being one of many possibilities to improve health services, PPIs can also take on a variety of different forms. These forms can involve the two sectors in different ways – either as financiers, providers, management or offering resources such as infrastructures or hardware. Goudge (1999) lists three broad categories where the two sectors can co-operate:

1 Public financing for private provision of care for public-sector patients
2 Private financing of private-sector care for private patients using public facilities
3 Private financing of public provision of care for public-sector patients

To sum up the information above, the main points to consider with respect to PPI are:

- Mutual agreement and co-operation between the public and private sectors
- Contribution to overall well-being of the state
- Contributing to equity, coherence, quality of care, efficiency and cost-effectiveness
- Contractual arrangement
- Output specifications

[2] These principles reflect a public-health-sector perspective in contrast to those of National Treasury.

- Benefit both parties
- Risk transfer (to the private sector)
- Affordability, value for money
- Each sector contributing some specific resources
- Not affecting any aspect of services or equity negatively – at any given stage

There is no literature readily available covering a comprehensive definition of the private health sector. It is important to remember that the private sector includes many different individuals and institutions. Some of these groups are specifically for profit, whereas others have more societal aims, and are less dependent on profit margins for their existence. The private sector is operational in both formal and informal market sectors. Furthermore, private-sector individuals or institutions operate in various market sectors such as health-care provision, financing, management and/or regulation. The feasibility and interest to implement PPIs will differ between the different sectors and groups within the private sector.

2.2.2 PPI – International

There are many examples of PPI internationally, in both developing and developed countries around the world.

Both in Europe and North America there are trends towards PPI and successful implementation of PPI. In the USA and Canada we find Medicare and Medicaid which are current examples of PPIs – these are private-hospital structures with public funding. In Germany the previously dominant Social Health Insurance is steadily becoming more privately funded and delivered.

Many developing countries in Africa, Asia and South America are also successfully implementing various PPI projects (Arias and Yepes, 2003). Several documented examples include:

- Thailand – contracting with the private sector for maintenance of medical technology and several non-clinical services (Tangcharoensathien et al., 1997)
- India – the public sector increasingly contracts-out hospital services – such as nutritional and cleaning services (Bennett et al., 1997).
- Tanzania, Uganda, Zimbabwe – contract-out non-clinical hospital services (McPake and Banda, 1994).
- Lebanon – has examples of public patients being seen in private hospitals (Smith et al., 2001).
- Bangladesh – has two successful PPI projects associated with their Diabetic Association and International Centre for Diarrhoeal Disease Research of Bangladesh (Shepard, 2001).

According to Shepard (2001) the public-health sector in India is in notably poor shape, short on resources, medication and has a problem with management constraints as well as shortages of staff. The private sector, on the other hand, is well equipped, has adequate capacity and offers high-quality care. But it is expensive, often inaccessible and utilised predominantly by the economic elite.

India is using many examples of PPI to expand quality care to the public-sector clients and make care available to those previously deprived of those services.

Birungi et al. (2001) have done a thorough investigation into the changes and effects of policies regarding PPI within Uganda. Uganda is an example where PPIs have been included into an array of health services over the last few years. Uganda also has a great deal of private health-sector expansion, which needs to be channelled or addressed to ensure fair distribution to all sectors of the population. These issues of private-sector regulation are paralleled in South Africa.

Some key points that come out of their analysis are:

- Institutional and legal issues need to be addressed adequately for the sustainability of PPI
- It is important to avoid duplication and wastage of services and resources through structured PPI policies
- It is important to involve all stakeholders at all levels of discussions and negotiations
- A conclusive process of negotiating and feedback is required to avoid continued delays in implementation of policies
- Correct semantics are important for the mutual understanding of all policies and intentions from the outset of negotiations
- Appropriate regulatory control and authority needs to be in place to prevent continued debates on who is in control
- Clear procedures and outcomes need to exist for the implementation of PPIs, and not merely an understanding to promote the collaboration of the sectors

Another very successful PPI project is the PROSALUD[3] project from Bolivia. PROSALUD is a PPI that was implemented in Bolivia in the mid-1980s (Shepard; 2001 and erc). It is a non-governmental, non-profit organisation establishing and running primary health-care services. The severe economic downturn and political structures in the early 1980s resulted in very poor health-care services in Bolivia. With the change of government – towards a more democratic government with new economic policies – there was an ideal chance to implement projects of this nature.

Some key policies of the PROSALUD system include

- decentralised clinics
- financial incentives for clinicians
- emphasis on quality of services
- stringent human-resources management including staff supervision, monitoring and evaluation
- solid financial structures with emphasis on cost recovery
- efficient management structures

[3] www.erc.msh.org

The project is still very successful after over fifteen years, and the World Bank has used the PROSALUD system as a basis for its own developments and consulting projects Shepard, 2001).

There is no doubt that there is a lot of progress locally and internationally with regard to the implementation of PPI. The key points that seem to surface regularly are needs for *clear procedures and outcomes* and the questions of *who owns whom* (who is in charge, and who regulates the sector). The successful implementation of PPI will only be possible through mutual agreement between the public and private sectors, clear outcome-based criteria – with specific goals and benefits for both parties – and with thorough, comprehensive discussions between all stakeholders.

2.3 The South African health sector

South Africa's current health policies, structures and distribution are directly related to the history of South Africa itself. The distribution and access to health-care still reflect the legacy of apartheid-era structures or policies (Thomas and Gilson, 2003). Although many changes have taken place since 1994, many of these structures still fall short of the government's policies on equity, efficiency, coherence and quality. These are evident in inter-provincial inequalities in urban and rural health services (Blecher and Thomas, 2003).

The private sector is known to have financial inefficiencies, over-supply of resources, over-utilisation of services and continually staggering costs (Doherty et al., 2002). Furthermore, there are questions about the incentives that drive output within segments of the private sector. It is possible that profit-driven health care may compromise quality and efficiency of care required (Palmer et al., 2003).

The public sector has a disproportionate distribution of clinical staff (skilled *vs* unskilled), which leads to increasingly adverse labour costs (Doherty et al., 2002). Doherty further highlights outdated/poor facilities, a lack of resources and management transformation in the public sector.

Chetty (2001) explains four key health-policy goals. She states that these policies are fundamental to the fair distribution of healthcare and should furthermore form the foundations of PPI evaluations.

- **Equity**
  All sectors of the population have access to a basic package of affordable healthcare, irrespective of ability to pay.

- **Coherence**
  A co-ordinated and unified health-care system, standardising provision and financing of care for all patients, irrespective of private or public sectors.

- **Quality of care**
  Scientifically sound care, which is acceptable to consumers and society.

- **Efficiency/cost-effectiveness**
  Technical efficiency: Maximising output at least possible costs, without compromising quality of care.
  Allocative efficiency: Fair distribution of available resources to all services, to maximise health outcomes

The government has some clear policies for the development, growth and restructuring of our health system. The core of this policy is available in the government's policy outline "Health Sector Strategic Framework 2000–2004: Accelerating quality health service delivery", the "National Health Bill" and the "White Paper for the Transformation of the Health System in South Africa".

The "Health Sector Framework"'s (NDoH, 1999) key aims include stabilising the hospital sector and revitalising hospital services. This refers to the accessibility, efficiency and quality of care available. The condition of state facilities, as described by the framework, is so poor that nearly one third of all facilities need complete replacement.

Key factors and policies that will address this state of affairs include hospital decentralisation, uniform patient fee-billing systems, improved capacity to manage and administer hospitals, and improved distribution of resources needed to increase and retain revenue generated (van den Heever, 2002; "Health Sector Framework", 1999 and the "White Paper"). The framework highlights the fact that partnerships with the private sector are crucial for these policies to be realised.

2.4 The public sector

The state's role, according to van den Heever (2002), is to provide and regulate the health sector and to finance care for the truly indigent. Its role is to ensure that all persons receive equitable, accessible and quality care (van den Heever, 2002). Currently the public sector provides care for all sectors of the public, indigent and more able clients. The state is unable to successfully identify and charge able-to-pay clients, due to capacity and infrastructural inadequacies (van den Heever, 2002).

The state's role to *regulate* the health-care sector is vital with respect to ensuring equity, coherence, quality and efficiency. There are many reservations about the private sector's ability to achieve these core aims. There are grave concerns whether a for-profit sector can ensure or will have an interest in providing equity, coherence and efficiency.

The regulation of the health sector will remain the role of the state. This includes regulation of health professionals, training of health professionals and training institutions, private-sector facilities and the health-financing markets.

Furthermore, the state has a duty to finance services, and ensure provision and management structures within the public sector and public-sector structures (Chetty; 2001).

The state of the public sector unfortunately requires a fair amount of financial and resource investments to make it truly accessible and equitable. The public sector has recognised shortages within management and administrative capacity, clinical-staff availability, noticeable centralisation and poor infrastructure, outdated facilities, a legacy of poor distribution of services throughout the country and recognised budgetary shortages (van den Heever, 2002; "Health Sector Framework", 1999 and Goudge, 1999).

The government is aware of these problems and is committed to alleviating the problems and improving their role in the health-care sector. The Department of Health's mission statement highlights the fact that they are committed to improving access for all and reducing inequities. They are working with all stakeholders to improve quality of care for all, especially in promotive and preventive health (Strategic Framework, 1999).

Chetty (2001) adds that it is the Health Minister's duty to prioritise health services the state can provide, considering the resources available and the needs of the health sector. Furthermore it is the duty of the minister to develop relationships between the public and private sector for the provision of health services for all. This highlights the role the public sector has to utilise all possibilities to ensure equitable, accessible care for all.

The "White Paper" highlights the fact that public hospitals generally have severe problems of inequity, inefficiency and poor quality services. In its endeavour to address the problems experienced within the public sector, the state has committed itself to specific restructuring plans ("White Paper on Health System Transformation", "Health Sector Strategic Framework", 1999-2004). These key restructuring plans envisaged by the state include upgrading hospitals, improving capital-investment plans, improving licensing procedures, staff issues and developing guidelines, and strengthening the resources available to specialised services. A further strategy is to decentralise hospitals and hospital-management structures. These management teams will be more focused on each hospital's needs. Furthermore, they will carry a responsibility to ensure quality care and efficiency. Basically, they will be held accountable for the performance of the hospital. The hospitals will function on a given budget, with the possibility to generate own income to decrease any budgetary shortfalls.

The funding available to many state hospitals has also been restructured over the last few years. The director general's "Keynote Speech" (NDoH, 2002) highlighted the discrepancies in financial support across provinces and urban-rural settings in the health sector. Due to the acute over-financing of tertiary health services in South Africa[4] there was an amendment in the "National Tertiary Services Grant"

[4] Especially Cape Town; where both Groote Schuur Hospital and Tygerberg Hospital provide tertiary services, in such close proximity.

(April 2002). This was implemented to ultimately "iron-out" major inequalities in the financing of health services. This resulted in many hospitals and services getting an improved budget, but also resulted in many larger, urban, previously advantaged hospitals (i.e. GSH) getting less money allocated to them.

Certain provinces (Gauteng and Western Cape) have invested in developing a private sector within their own facilities to compete financially with the private sector. Larger facilities, such as GSH, have full private wards, which are solely available to private patients. This was created both to generate increased income for hospitals and through national-level contracting with certain medical schemes to provide some low-cost options. The state's private rates are nationally controlled *uniform patient-fee schedules*. Although they are not ideal, nor reflect the true costing of all procedures, they attempt to undercut the general private-sector costs to encourage increased utilisation of private-sector services in the public sector (van den Heever, 2002, and "National Health Bill").

This section highlights two important aspects of the health sector in South Africa. Firstly, the state is the regulator of health services, teaching and financing sectors across the board. It has a responsibility to provide health services, predominantly to the indigent. Secondly, the state is responsible and committed to a drastic and ongoing restructuring of public services. This restructuring basically empowers local-service managers, but also holds them accountable for the quality, cost effectiveness and efficiency of services. Furthermore, the restructuring has brought financial constraints and changes in management structures to most services/hospitals. These hospitals now compete on a larger scale with the private sector, in trying to generate their own income, quality standards and efficiency.

The restructuring, accessibility and efficiency needs provide opportunities for the state to interact with the private sector. Public-private interactions are not new in South Africa (Goudge, 1999 and Wadee et al., 2003), but have received more attention with new policies and restructuring processes during the last ten years (Chetty, 2001; du Toit, 2002; Goudge, 1999). These interactions help tackle some of the key shortfalls facing the government; financial investments, capacity training, equity in accessibility, efficiency and quality of care.

2.5 The private sector

In the couple of decades prior to the 1990s the private sector in South Africa developed into a relatively unregulated service sector. It was seen, and still is by many, as a mutually exclusive health provider for the rich (Goudge, 1999). The private sector is predominantly urban-based, for profit, technically inefficient, expensive and not aligned with the state's aims of equity and coherence (Goudge, 1999, and van den Heever, 2002). The private sector serves less than 20 per cent of the population, yet utilises more than 60 per cent of the nation's health expenditure to finance these services (Goudge, 1999 and Wadee et al., 2003.)

Although the private sector, and health-care costs in general, are very high, there are still roughly 30 per cent of non-medical-scheme clients utilising the private sector (Palmer et al., 2003). Palmer et al. highlight several points contributing to this situation; public-sector facilities are often inaccessible in urban areas and private-sector care in urban areas is often perceived to be of greater quality and efficiency with regard to privacy, speed, diagnosis and counselling.

Before transition Broomberg (1993) dealt with several issues around national policies with regard to private hospitals. He noted a lack in uniformity of standards, licensing, quality control and quality itself. He noted then already that there were noticeable problems with fee-for-service (FFS) billing and incentives to over-treat. There have also been regular changes over the years, in policies/intentions to allow private patients into public hospitals.

One very important notion expressed by Broomberg as well as current literature reviewed (Palmer, 2003, and van den Heever, 2002) is the question of (technical) efficiency and quality of care within the private sector. When institutions and practitioners operate for-profit there is always a concern that profit margins may supersede quality and efficiency. Furthermore, Goudge (1999) questions if private-sector care can truly operate effectively with respect to public-health goals and health prevention.

Broomberg (1993) made a number of recommendations, several of which have been implemented or are still being changed into specific policies. He recognised the private sector's management and economic efficiency. Issues regarding licensing and quality control of private hospitals need to be centralised. He suggested that there should be a constructive plan to eliminate FFS, and notions were put forward about government owning, eradicating or integrating the private sector into the public-sector structures.

Even when Broomberg suggested the eradication or integration of the private sector, it was evident that this was not viable. Goudge (1999), van den Heever (2002), the "National Health Bill" and the "White Paper" all confirm that the private sector is here to stay. This ultimately leaves the state, as the regulator, with the duty to organise the private and public sectors in such a way that they both fulfil their role to provide equitable and coherent health-care to the overall health system in South Africa.

Goudge (1999) reviews this issue, but notes that the private sector should not be over-restricted through conservative regulations. There should rather be an establishment of constructive public-private partnerships, and incentives for the private sector to work with and alongside the public sector for the benefit of all health-care segments.

Although there is a long history of PPI in South Africa (Goudge, 1999, and Wadee et al., 2003), the health sector's inefficiency and lack of coherence leaves South Africa trailing in health-status ranks, when compared to countries spending equal or less percentage of GDP on healthcare (Wadee et al., 2003). This should compel the state to improve regulations and coherence with the aim to improve efficiency

within the health-care system. Wadee et al. (2003) believe that legislative developments, clear PPI objectives and capacity building are required to facilitate successful public and private interactions. These interactions are vital to integrate the private sector's resource availability with the state's large client base.

2.6 PPI – South Africa

South Africa's health sector has several features that offer itself for the implementation of PPIs. The private sector is known for readily available resources such as staff, facilities, services, capacity and financial investments. Although some sectors challenge the notion of superior efficiency and quality within the private sector, the general public still regards and utilises the private sector because they believe it to be superior (Goudge, 1999; Palmer et al., 2003; van den Heever, 2002; Wadee et al., 2003).

The last few years have seen a drastic reduction in the number of private hospital licenses that have been issued (PAWC interviewee). Furthermore, the growth of insured members within the private health sector has stagnated over the last few years (van den Heever, 2002). Considering that there is a lack of new private facilities as well as limited growth in numbers of new private patients, the private-sector providers and managers need to find new avenues for expansion.

The public sector serves roughly 80 per cent of the population, and struggles to fulfil this service with the equivalent of 40 per cent of the total health expenditure (Doherty et al, 2002). This indicates that the state has the larger *client base*, yet struggles to provide adequate services due to budgetary constraints, insufficient resources and poor infrastructure (Goudge, 1999; van den Heever, 2002). Considering that the private sector requires new avenues for expansion, and has well-established resources, there may be potential for mutual interaction to meet both their needs.

Goudge (1999) and Wadee et al. (2003) highlight that PPIs are nothing new in South Africa. There is a history of contracting with both, private for-profit and private not-for-profit institutions, where the state covers operating shortfalls or even full public-patient costs:

- disease-specific services (i.e. delivery for tuberculosis)
- church-aligned health services
- contracting with mining hospitals to provide local public care
- private hospitals making services or wards available to the public
- hybrid hospital partnerships – privately funded and managed hospitals for public-sector patients, hospitals remunerated at patient-day or bed-day tariffs

This commitment to pursue PPPs is visible in national and provincial governments' departmental developments. Nationally the Department of Health Financing and Economics (DHFE) is responsible for furthering interest and regulations on PPPs.

At provincial level, the PAWC has the Business Management Unit, which is responsible for the advancement of PPPs.

The NDoH interviewee from the DHFE explained that, in his view, the most common and successful form of PPP is co-location (same facilities being used for both sectors). Two successful examples are the Albert Luthuli Hospital (Free State) and Humansdorp (Eastern Cape). Other PPP strategies used include sharing resources – such as computers or clinical equipment. Limpopo Province is an example where there is successful privatisation of linen/laundry services, some management services and paramedic services. The interviewee also stated that there were no examples of staff sharing, via RWOPS[5] or other agreements, in any of the official PPP projects.

This interviewee (DHFE) stated that there were currently only roughly twenty official regulated PPPs represented in five provinces of South Africa. Other interactions were unofficial loose alignments between the public and private sectors (PPI).

Several examples of current PPPs are:

- private finance initiative to equip the Albert Luthuli Hospital
- co-location between the University of the Free State and Pelonomi Hospital, Bloemfontein
- co-location and resource sharing between the Hermanus private and provincial hospitals
- co-location of private and provincial hospitals of Swellendam
- contracting of non-clinical services to the private sector (Eersterivier Medical Centre)
  (Du Toit, 2002; Wadee et al., 2003; interview with representative of Community Health Group; interview with representative of the DHFE.)

The reviewers of the cases above stated that these examples showed PPPs did work, and that they were crucial to prevent unnecessary duplication of services, which ultimately led to cost savings for both parties. Du Toit (2002) emphasised that the projects showed that the private sector was willing and able to work with and alongside the public sector. Furthermore, an important observation was to start with small projects and expand with experience.

Another form of PPP which is currently being expanded within the public sector, is the provision of private wards or beds in public hospitals. These facilities will be public-sector facilities and services to treat private patients with private funding. The results of this venture are not yet thoroughly assessed, but concerns are basically around the state's capacity to bill and collect revenues, perceived quality of care and the state's capacity to market and expand such services. Furthermore, there are concerns that the *uniform patient-fee schedule* is not comprehensive

[5] Remunerative work outside of the public service (RWOPS) is time allowed for clinicians, within the government structures, to garnish financial and work experience within the private sector.

and truly reflective of the costs curtailed in the services performed (Goudge, 1999; van den Heever, 2002; "Health Sector Strategic Framework", 1999).

From the examples above one can see that there are numerous projects and processes currently utilising PPP and PPI. The results of all of these are not clear, but there are enough examples from recent and long-term projects that highlight the potential of these projects. Du Toit (2002) reminds us that these projects take time, thorough negotiations, consultation with all stakeholders, and the use of experience from current and other projects will aid to potential success.

2.7 Lessons from the literature review

There are several different classifications of stakeholders available in the literature. Many classifications are too "black and white", and fail to classify some stakeholders that overlap different categorisation. This case study utilises three classifications:

Stakeholder type	Definition
Primary	Stakeholders vital to the existence and functioning of the organisation.
Secondary	Stakeholders with whom the organisation interacts (or one that has a vested interest in the organisation) but who are not vital for its existence.
Additional	These stakeholders are not primarily involved in the day-to-day activities and functioning of the organisation. Their role, though, extends past the mere realm of a secondary stakeholder. They do have some interactions and are vital for the organisation's existence.

The analysis of the stakeholders is important to understand how the various parties within and around the organisation interact and contribute to its success or failure. An analysis collects information on all the parties' behaviours, intentions, interests, interactions and influence (Varvasovszky and Brugha, 2000).

This case study analyses the interactions between the stakeholders associated with the UCT Hospital. These stakeholders are primarily split into the private-sector institutions aligned with the UCT Hospital and the public-sector stakeholders connected to Groote Schuur Hospital.

The relationship between the two institutions is tantamount to a PPI. This PPI is basically a loosely aligned relationship where the two parties are working together, to limited effect, to cut costs or share resources. A more complex relationship, of greater co-operation and participation, would include PPP. A PPP is a contractual arrangement between the public and private sectors, where the private sector utilises public resources for commercial outcomes, at specified outcome criteria. Further specifications for PPP include risk sharing between the parties and an amalgamation of each sector's specialities for mutual attainment of similar goals (Chetty, 2003).

PPIs are widespread in developed and developing countries around the world. Some important points to incorporate into establishing PPIs include:

- Comprehensive communication between stakeholders
- Incorporation of all stakeholders
- Clear procedures and outcome-based planning
- Avoid duplication of services and planning procedures

South Africa's current health sector presents itself positively for the implementation of PPI. The government has committed itself to the restructuring and improvement of the health sector as a whole. The government, being the regulators of teaching, financing and provision of health services, can initiate and channel changes in this regard.

The public-health sector is noticeably under-funded, lacks resources and has visible capacity constraints. Compounding these constraints, the public sector provides services to the vast majority of the health-sector clients in South Africa.

The private sector on the other hand is oversupplied with resources, has well established management structures, has a better public image and needs to find areas of expansion.

Considering these needs and opportunities for both sectors there should be scope to work alongside each other. The public sector can supply clients for health services, and the private sector has ample resources and capacity to cover the necessary expansion.

Gouge (1999) clearly states that the government should aim to work in partnership with the private sector, as opposed to over-restricting and regulating the private sector.

3 Context – University of Cape Town Hospital

This chapter gives a detailed synopsis of the history and functioning of the UCT Hospital. It first discusses the hospital itself, then the history of how and why it came about. Furthermore, this chapter outlines the hospital's changes and the functioning of the hospital itself.

The information for this chapter is drawn from various interviews completed for this research, and information assembled from the various press releases around the opening of the hospital.

3.1 University of Cape Town Hospital

The University of Cape Town Hospital (UCTH)[6] opened its doors as the UCT Medical Centre on 15 February 2002 – following four years of planning (Caelers; 2002).

The UCTH is a privately-run hospital, situated within the building of Groote Schuur Hospital (GSH) – a major state-run, tertiary facility. The basic lease agreement is merely one of rental, with no other specified supplies or resource-sharing taking place between the two institutions. UCTH is situated literally across the road from the UCT Medical School.

Medical staff at UCTH are medical staff working for GSH/UCT, who do their allotted RWOPS at the UCTH. Some GSH nursing and para-medical staff also have RWOPS arrangements to do private-sector work at the UCTH. Management, cleaning staff and other support staff are all individually employed by the UCTH.

UCTH is a 124-bed hospital, including medical and surgical departments. It has a day clinic, high-care and intensive-care units, outpatients department, therapy departments and four operating theatres ("UCT Media Update"; 2002).

The UCTH was established for several reasons. There was a strong need for alternative or extra teaching and research facilities at UCT. GSH was also feeling the pinch of substantial budgetary cuts, and could no longer provide the human and material resources needed for sophisticated medical training. Furthermore, medical practitioners and specialists at GSH were looking for some private-sector experience and extra financial rewards (Caelers, 2002; "UCT Media Update", 2002; interviews). Finally, the shareholders also aimed to run a financially profitable institution.

[6] The hospital was originally called *University of Cape Town Medical Centre*. After Rhön-Klinikum pulled out, it changed its name to *University of Cape Town Private Academic Hospital*, and is still currently called such. Several publications and persons refer to the hospital merely as the *UCT Hospital*. For convenience and uniformity in this thesis it has been decided to generally refer to the hospital as UCT Hospital or UCTH.

There were also feelings that the "super-specialists" and academics, employed by the public sector at GSH, could offer a beneficial private-sector service, to offer a unique market among other private hospitals. Lastly, UCTH further intended to strive for superior financial cost-effectiveness, through contracting, efficiency and non-fee-for-service billing.

3.2 History of the UCTH

The earliest roots of the hospital stem from two sides (see Diagram 3.1). Firstly, Rhön-Klinikum (RK)[7] was looking to expand, and experiment with, its business interests overseas. Secondly, there were local developments where Stellenbosch University and UCT were both looking at the feasibility of developing their own teaching hospitals.

RK was interested in expanding their hospital group internationally. Due to RK's specialisation in cardiology in their German hospitals, they already had some connections to UCT and GSH. UCT was a strategic choice as business partner to help develop and guide their business interests in South Africa.

RK stated that they needed a local partner, who would help guide them through the business and local processes of establishing a hospital. In return UCT received a 19 per cent shareholding in the new hospital – without any specific capital investment in the project.

The available space within GSH, the established infrastructure and the location of the venue with respect to the UCT Medical School, made RK's plans all the more appealing. They at first wanted to establish a completely new hospital, but this did not make financial sense and was not deemed feasible by the provincial government.

RK's aim was to establish a completely independent hospital, with no connections to the public sector, GSH or other facilities. No PPIs were envisaged. There was merely a rental agreement with the Public Works Department, and UCT/GSH staff were to complete allotted private-sector work in the new premises. RK's prime objective was to run an independent profitable institution.

UCT's core objectives for the hospital were to recruit and retain more clinical staff, by making part-time private work available to this staff. Further objectives were to improve training and research facilities, especially in the light of continued cost cutting on the government's/GSH's side.

For UCT the connection with RK could not have come at a better time. Several years ago, both Stellenbosch University and UCT had envisaged possibilities of establishing their own teaching hospitals. Both hospitals were keen to extend the basic clinical work and teaching facilities available to the academic institutions.

[7] Rhön Klinikum is a German hospital group. They have vast experience in hospital management, systems and administration sectors.

Both universities had joint meetings (Elsenberg One and Two) with PAWC to thrash out possibilities in this field. The universities were given the go-ahead to establish independent teaching hospitals within Tygerberg Hospital and GSH – both were licensed and space was made available to both at highly reduced rates.

Stellenbosch University partnered up with Medi-Clinic, and after careful analysis found the development of an independent hospital to be unprofitable and not feasible. They did not take this project any further at the time. UCT pursued the idea and eventually partnered up with RK to establish the UCTH.

UCT's original aim was to establish a large (650 bed) independent private hospital, in a free-standing location, with no public-private interactions. It was soon realised that a hospital of this size was unfeasible and the province did not wish to license a facility of this nature.

3.3 UCT Hospital under Rhön-Klinikum

Unfortunately, the growth of the hospital did not correspond with RK's projected targets. Re-evaluations of targets and further calculations indicated that the project was not financially viable. Therefore RK withdrew from the project several months after opening their doors in February 2002. *The Monday Paper* (vol. 21, no. 23, 19–26 August 2002) reports that "RK left South Africa for strategic reasons, in terms of their global planning".

3.4 UCT Hospital post-Rhön-Klinikum

Westcare Hospitals[8] stepped in after the departure of RK. UCT increased its own shareholding to a level giving it more of a strategic influence. A group of the practitioners from UCT/GSH made up the remaining group of stakeholders.

New shareholders	
Westcare Hospitals	50%
UCT	26%
Group of practitioners	24%

UCTH has been functioning under this set-up for a while. The current management/CEO remains at the helm till mid-2004, when effective structures, systems and goals/objectives have been processed and realised. Then a new person will take charge and lead the hospital.

Some more recent changes have taken place in the shareholding of UCTH – bringing in more experience and vested interests in the success of the UCTH. Community Hospital Group (CHG)[9], in which Netcare and Malesela own shares,

[8] Westcare Hospital is a local hospital-management company.
[9] CHG is a local company that is an owner/operator/shareholder of several hospitals in South Africa

has taken over the majority shareholding of Westcare Hospitals. This has changed the shareholding of UCT Hospital slightly:

Individuals	07%
Westcare Hospitals	16%
Netcare	20%
Malesela	20%
UCT	26%
Practitioners	11%

3.5 Functioning of the UCT Hospital

UCT is a fully independent hospital. The clinicians at the UCTH are GSH clinicians, fulfilling their allotted RWOPS hours. At UCTH the infrastructure, patients and billing systems are established and provided to the clinicians. The clinicians do not function as a separate for-profit business, searching extensively for increased number of patients. The clinicians consult in the hospital setting and some outpatient services, and the hospital bills the clients. The clinicians are primarily academics and consultants at GSH and UCT, and use these premises for some extra income and experience. Although FFS is extensively used, there is a fair amount of contracting and developments (with medical schemes) taking place to cut costs and offer packages such as capitation for certain conditions or sectors.

UCT Hospital's goals are to offer the best specialists to the private sector and to be very cost-effective – aiming at 22 per cent below the average of other private hospitals.

Besides the sharing of staff by GSH and UCTH there are few true links between the two facilities. A few resources are being shared, and there is a "Memorandum of Understanding" set up by GSH to maintain an amicable and business-like relationship between the two parties. The memorandum also highlights the importance of sharing/exchanging and mutual consulting prior to the purchase of expensive resources – all with the aim to prevent duplication of unnecessary services/costs within both the facilities.

Although the two hospitals currently do work together to a limited degree (to cut costs and prevent duplication of some services), it is important to realise that the UCT Hospital was originally developed as a totally independent hospital. This means that all services of an established hospital are present and functional within this hospital. The UCT Hospital was and is an autonomous hospital running parallel to GSH (G4)[10]. Both hospitals offer a complete array of services and compete directly for much the same clientele. UCT Hospital is marketing itself and contracting with medical schemes, to offer inexpensive, efficient services to low-cost medical schemes. Furthermore, both GSH (G4) and UCT Hospital market themselves as superior private-sector institutions offering the very best in academic, "super-specialist" practitioners.

[10] G4 refers to the private ward of Groote Schuur Hospital.

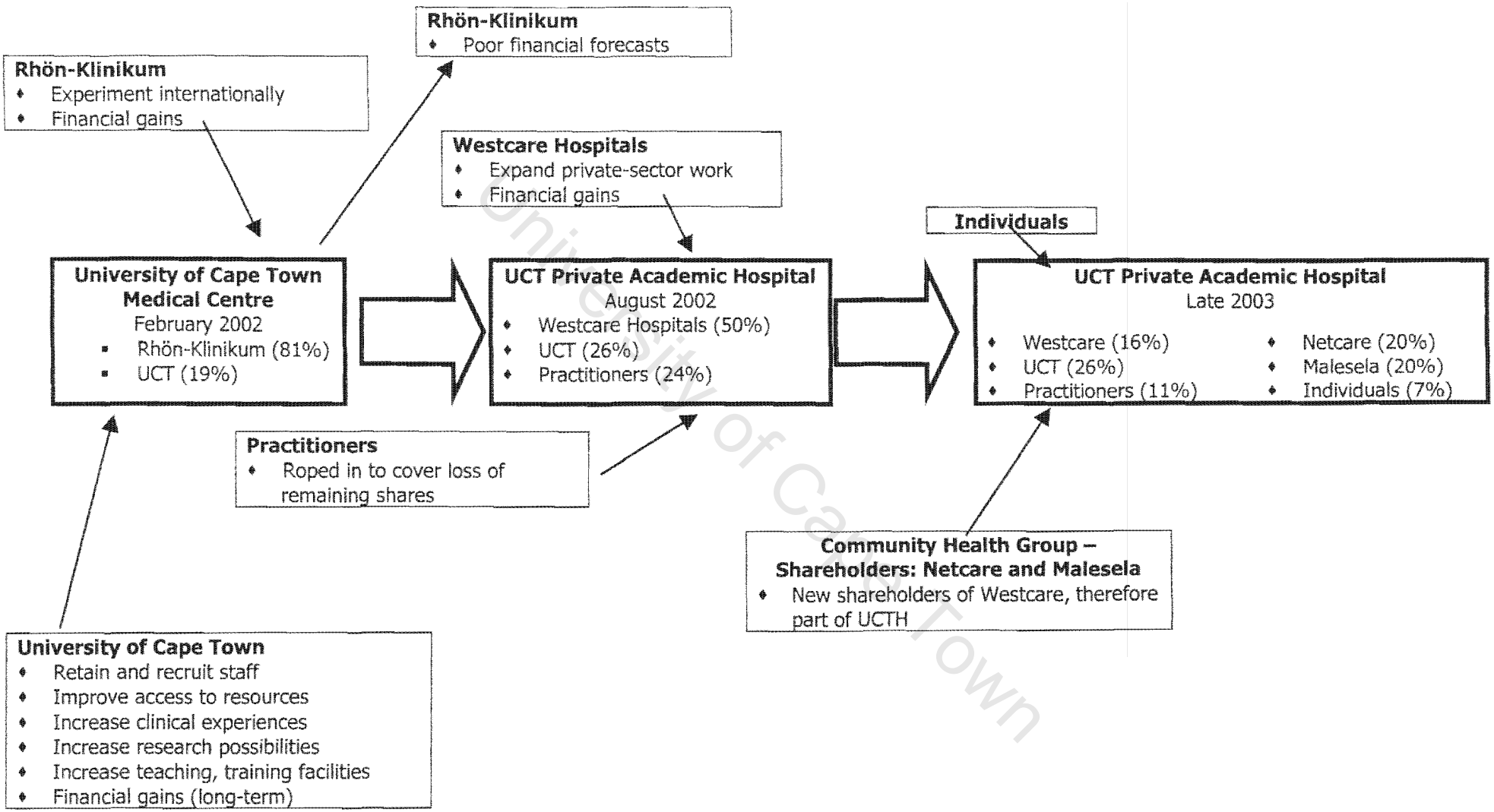


DIAGRAM 3.1: Schematic representation of changes of stakeholders over the last few years

4 Methodology

> *This chapter discusses the detailed methodology utilised to select, assemble and analyse data.*

4.1 Research design

This research is a stakeholder analysis – a qualitative study, using a descriptive study design as opposed to a relational or experimental design (Bowling, 1998).

> In descriptive research the goal of the investigation tends to be the careful mapping out of a situation or a set of events. (Rosnow and Rosenthal, 1996, p. 15)

Tellis (1997) states that case studies are appropriate study designs to do descriptive studies. Case studies offer "multi-perspectival analysis" to give a voice to all the actors, as well as associated groups and their various interactions (Tellis, 1997).

Yin (1994) highlights that single case studies are ideal to present unique ideas or situations. He furthermore refutes any notions that these single case studies cannot be generalised to other similar scenarios, and therefore believes case studies to be ideal for describing specific situations or state of affairs.

This case study analyses the relationship of the various stakeholders and describes their relationships towards the UCT Hospital. Further descriptions map out their commitment and intentions towards the degree of PPI utilised.

4.2 Subjects

Population
The population for this study includes all parties/organisations with a vested interest in the UCT Hospital itself.[11]

Sample
It is impossible to sample every individual with a vested interest in the hospital. Purposive sampling was therefore employed to sample the necessary organisations/groups. The primary stakeholders, those directly involved as shareholders or in the working relationship of the hospital, are all known.

Nevertheless, the technique of snowballing was also employed to increase the number of contacts in one sub-group of the sample. Snowballing refers to the process of subsequently including additional, relevant sample members when they are identified, during the research process (Bowling, 1998).

[11] Refer to description of *stakeholders* in the literature review.

The only group that was not included in the sample is the general public. It was deemed relatively impossible to garnish any relevant information from this group for two reasons:

1 Hardly anyone in the general public had knowledge of the existence of the hospital.
2 The percentage of the general public that has any true understanding of the intricacies of the relevant relationships between the different parties is minimal.

Tellis (1997) states that case study research is not actually a sampling research. The important notion is to include maximal and appropriate data sources to provide the necessary data during the time available for the study.

Sample size
The original intention was to use one representative from each stakeholder – which would have made it a sample size of nine.

Ultimately the number of practitioners interviewed went up to three, thus the overall sample size was eleven subjects. Three practitioners were chosen to get a diversity of views from this large group of representatives.

4.3 Instrumentation and recording

Instrumentation included a semi-structured interview with some key questions to the various stakeholders (Appendix A).

A semi-structured interview, with open-ended questions, was used to encourage the interviewee to discuss and expand on all ideas as freely as possible. The interviewees were allowed to speak freely about any points they deemed relevant to the topic.

Questions were posed along the way to ensure that specific detail required for the aims and objectives were covered. These relevant (guideline) questions were predetermined to ensure that all interviews covered comparable information and were asked the same questions.

Open-ended questions were included to help reduce the possibility of guiding the interview towards any pre-concluded assumptions.

Recording was relatively straightforward. A dictaphone was used to record the interviews. Paper and pens were required to make further points, and to scribe the interviews that were not recorded.

Other instruments merely included a computer for information storage and to write letters of intent and informed consent, and the telephone and internet for contacts with interviewees.

4.4 Implementation

Implementation was relatively straightforward. Only one contact person had to be replaced by another individual from the same stakeholder group.

Faxes and e-mails were sent out to previously identified representatives of the various stakeholders, explaining the aim of the study and requesting an interview. Six representatives were relatively easy to track down, and were readily willing to comply with an interview.

The seventh representative was eventually organised, after several delays. There was no avoidance to comply in this situation, merely a failure for the interviewer and interviewee to organise appointments around their schedules.

The original stakeholder representative at NDoH was unsure whether he was the true representative. He was willing to complete the interview if we wished to use him. But eventually it was near to impossible to get hold of that person. Finally, a representative from the same department was taken – this representative was easily contacted and freely willing to comply with an interview.

The original practitioner interviewee requested that further interviews be made from the group of practitioners to give more anonymity to their answers.

The existence of a new additional shareholder (in the UCT Hospital) was made known during the first shareholder interview. An interview with the new shareholder was arranged and followed the same procedure as the original interviews.

Three interviews were completed by telephone, eight in person. One personal interview was not recorded, on request of the interviewee. This interview as well as the telephonic interviews were recorded by note-taking.

One interviewee requested total anonymity, the others were not worried about this, and some requested their personal opinions were to be well documented for all to hear.

The personal interviewees signed an informed consent form (Appendix B), the telephonic interviewees were explained their rights to withhold answers or to withdraw from the interview if they so wished.

4.5 Data collection

Semi-structured interviews were used to collect the data required. Certain specific, structured data was required, and further information was solicited through unstructured, open-ended questioning to gain as much information as possible.

Yin (1994) and Tellis (1997) both emphasise the need to complete "careful investigations", especially in single case studies, to avoid misrepresentation of actors or information. At the same time Yin (1994) warns of the prospect of collecting too much data, as is common with case-study research.

Questions (Appendix A) generally revolved around two distinct core ideas. Firstly, the stakeholders' relationship with the hospital in general was analysed. Secondly, the degree of PPI was discussed with respect to their own involvement and the general position of the UCT Hospital.

Those stakeholders more directly involved with the hospital (either as shareholders or closer working partners) had some specific questions posed relating to their current, past and potential future relation with the hospital:

- How long have they been involved?
- What do they need or want from the relationship?
- What benefits do they have/are lacking from their participation?
- Where do they see their position in the near and distant future?
- Do they feel they are partaking and benefiting at a maximum level?
- What can be done to improve the current relationship?

Further questions revolved more around the degree of PPI taking place between themselves, UCT Hospital and the public sector:

- Is there any resource sharing between UCT Hospital and GSH/the public sector?
- Is there any/further scope to improve on the amount of participation?
- Has the degree of participation changed over the last two years?

Those stakeholders not directly associated with the hospital on a day-to-day basis were asked to briefly relate their relationship to the hospital and their knowledge about the circumstances of the hospital's existence and business. The core of their interviews was around the same PPI issues presented above.

All interviews were proposed to be roughly twenty minutes in length. Four interviews were longer than thirty minutes. On average the interviews lasted approximately twenty minutes.

Scribed interviews were transcribed soon after the interviews on computers. The interview recordings were also written out and transcribed to computer soon after the interviews.

4.6 Data processing and analysis

The first step, post-transcribing, was to tabulate the responses of all the stakeholders according to the key points of the objectives of the study.

These objectives were to find the following information from the various stakeholders:

Firstly,
- original aims of the stakeholders with respect to the hospital,
- their current stance and ideas about the structure of the hospital,
- their future desires for the hospital and their relationship with it.

Secondly,
- the degree of PPI and future possibilities in this respect.

These two data segments were processed and analysed separately. The first point, regarding the aims and wants of the hospital, were analysed with respect to each stakeholder in addition to broader stakeholder groupings. The second point, regarding PPI, was dealt with in general to identify what participation there is and what further possibilities there are.

4.7 Validity and reliability

Semi-structured interviews with open-ended questions were utilised to limit biases associated with acquiescence (yes-saying) and bias of assumption (Bowling, 1998).

The "reliability" refers to the reproducibility and consistency of the interview structure and questions (Bowling, 1998). There were no real inconsistencies in responses/data gathered from various interviewees. The recurrent accuracy or internal consistency was quite positive. Several responses from various interviewees varied in scale or emphasis; yet, no contradictions of data were observed.

The few inconsistencies can be attributed to:

1. some differences pertaining to semantics of answers
2. different stakeholders having independent views about the hospital
3. different stakeholders seeing issues differently
4. different stakeholders having different understanding or knowledge of pertinent issues

Validity in qualitative research refers to the insight of the data, the believability and credibility of the information established from the interviews (Brink, 1991). The validity of the research appeared good as will be seen in Chapter 5.

There was no non-response bias, as all subjects freely agreed to interviews. Furthermore, there was no bias of evaluation apprehension, publication bias or selection bias as the respondents were openly and freely responding with respect to their own knowledge and feelings, the study is not dependent on any specific publication and the sample group is relevant to the actual stakeholders.

There may have been some reporting bias or recall bias, if respondents failed to recall pertinent information or construed some information. Due to a lack of inconsistency between results, these biases are deemed to be minimal or not evident.

4.8 Ethical considerations

All normal ethical considerations have been taken in this study.

Primarily, no individuals or groups have been hurt or vindicated in any form. Secondly, all interviewees were given, and explained, an informed-consent form. Anonymity, where desired, was ensured, and the participation was purely voluntary.

Several individuals felt very strongly about what they had to say, and asked to have their points clearly stated and referred to. Although stakeholder groups/classifications are referred to in general, no individual representative will be identified at any stage.

Data collected is securely stored on computers, and script form is kept in the office of the researcher – with no circulation beyond the author working on the research.

5 Results and discussion

This chapter presents the results and discussion of the research. Firstly, the stakeholders are classified and analysed. Following this, the stakeholders' original aims, current ideas and future desires for the hospital are examined and tabulated. Lastly, the degree of PPI is discussed and future possibilities of PPP are deliberated.

5.1 Stakeholder classification and analysis

The basis of a stakeholder analysis is to classify the stakeholders, map their influences and then diagnose their ambitions and needs – prior to engaging them to any greater or lesser degree. The four-point structure of Brugha and Varvasovszky (2000) is used to analyse the stakeholders, map their influences and then plan their involvement:

1 Identifying stakeholders
2 Mapping stakeholders
3 Diagnosis
4 Strategy formulation

TABLE 5.1: Definitions of types of stakeholders

Stakeholder type	Definition
Primary	Stakeholders vital to the existence and functioning of the organisation.
Secondary	Stakeholders with whom the organisation interacts (or one that has a vested interest in the organisation) but who are not vital for its existence.
Additional	These stakeholders are not primarily involved in the day-to-day activities and functioning of the organisation. Their role, though, extends past the mere realm of a secondary stakeholder. They do have some interactions and are vital for the organisation's existence.

Identifying stakeholders

TABLE 5.2: Summary of stakeholders and involvement in the UCT Hospital

Stakeholder	Type of stakeholder	Role of shareholder	Involved during RK times
Westcare Hospitals[12]	Primary	Shareholder and management	No
Practitioners	Primary	Shareholder and employees	Yes
University of Cape Town	Primary	Shareholder	Yes
Community Health Group	Primary	Shareholder	No
Groote Schuur Hospital – CEO[13]	Secondary	Rival	Present, not involved
Groote Schuur Hospital – private ward	Secondary	Rival	Present, not involved
Provincial Administration of the Western Cape – Treasury[14]	Additional[15]	Regulator[16]	Yes
National Department of Health – Directorate for Health Finance and Economics[17]	Additional	Regulator[18]	Yes
Rhön-Klinikum	Secondary	Original shareholder/ developer	n/a

Eleven stakeholders were interviewed in total. Of these eleven, six were primary stakeholders, as classified by Brugha and Varvasovszky (see Tables 5.1 and 5.2). Three of the stakeholders interviewed were doctors who simultaneously work at the hospital and are shareholders of the hospital. These doctors represent practitioners in the hospital and are treated as one stakeholder grouping in Table 5.2. It was thought advisable to interview more than one practitioner because of their potentially differing views.

These primary stakeholders all perform and interact within the core of the hospital to provide services, management and various structures of the establishment. These stakeholders include the practitioners that work at UCT Hospital, Westcare

[12] Westcare Hospitals is a shareholder and has a representative as CEO of the UCT Hospital.
[13] The CEO of GSH is employed by the Provincial Department of Health. It is presumed that this representative will reflect this department's view.
[14] Referred to as PAWC.
[15] Additional Stakeholder: These stakeholders are not primarily involved in the day-to-day activities and success of the hospital, yet due to their role as regulators they have more of a role to play than mere secondary stakeholders.
[16] PAWC is involved in licensing and regulating private hospitals, but less involvement in day-to-day structures and regulation of the hospital itself.
[17] Referred to as NDoH.
[18] NDoH is the overall regulator of health systems and the operation of the private sector, yet has little involvement in actual hospital structure and function..

Hospitals, a shareholder of Westcare Hospitals and the University of Cape Town (UCT).

Westcare Hospitals is a hospital-management group. The shareholder of Westcare Hospitals interviewed is Community Health Group (CHG), an owner/operator of several hospitals in South Africa.

There are three secondary stakeholders with whom the hospital has some basic relations, but does not rely upon for ongoing success or integral business structures. These include the founding organisation (of the hospital), Rhön-Klinikum, and the two stakeholders representing the management of GSH and the private ward of GSH respectively.

Two further stakeholders (provincial and national governments) were not specifically classified as primary or secondary – but rather as additional stakeholders. The provincial and national governments are not really primary stakeholders, as they do not act specifically within the core of the hospital structure to ensure specific outcomes, yet they are more than merely secondary stakeholders, because their duty to regulate, license and enforce policies are crucial to the hospital's existence.

Rhön-Klinikum is a secondary stakeholder, as they may have interests in the ongoing success of the hospital since they are the original creators. Yet, they have no core influence on the continued activities within the hospital, nor do they reap any benefits from the success or failure of the hospital.

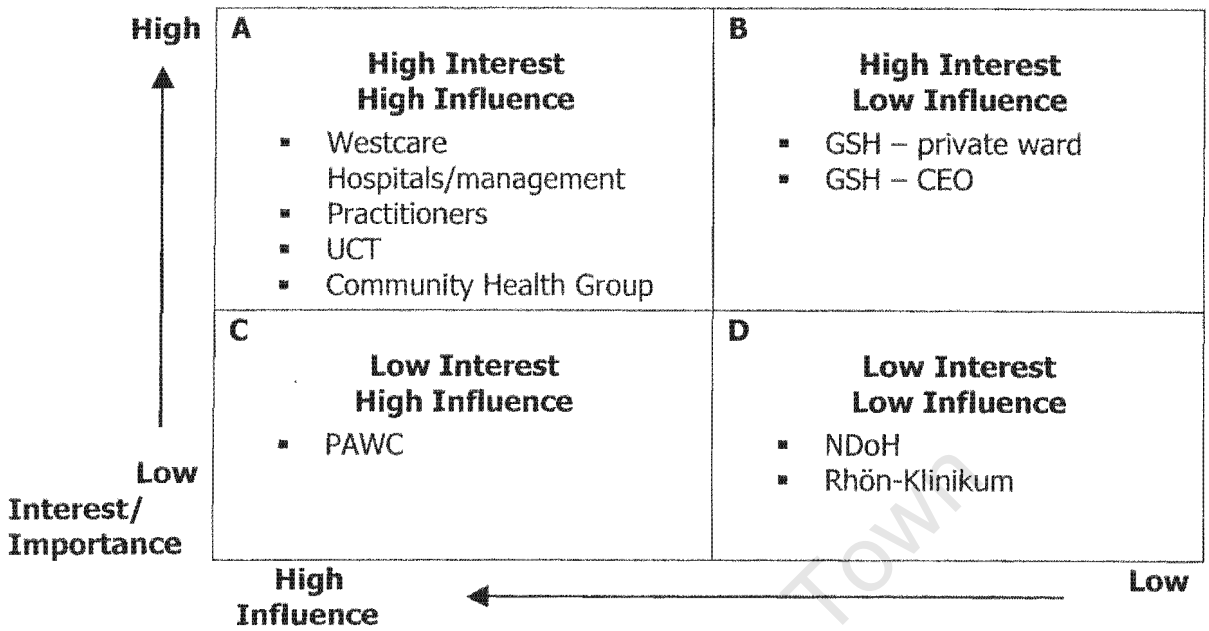
Mapping stakeholders

Table 5.3 (adapted from Qualman, 1997; see p. 42) sums up the influence and interest the various stakeholders have in the current structure and activities of the UCT Hospital.

Quadrant A includes the primary stakeholders. These stakeholders all have high interest and influence in the success of the hospital. They include Westcare Hospitals, UCT and CHG. The practitioners are included in this quadrant. They are understood to be representative of a group of stakeholders and employees, and when acting together have enough influence to be considered in this quadrant.

Quadrant D includes Rhön-Klinikum and the NDoH. RK no longer has any influence, and although they may have a slight interest in the progress of their original project, they have no real interest in the hospital. The NDoH representative had no knowledge of the hospital, or any possible related PPPs at present. They do not have any direct interest in its success, nor do they have any specific influence or power over the structures and processes of the hospital, besides the health regulations governing hospitals, private-sector activities, etc.

TABLE 5.3: UCT Hospital stakeholder matrix – current interest/influence



PAWC has been included in quadrant C. Although having licensed and helped develop the project to a degree, they currently have little interest in any changes or ongoing operations. PAWC, however, does have a fair amount of influence, through their regulatory powers and close proximity of their prime tertiary institution (GSH) and thus needs to be regarded as a high influence stakeholder. The PAWC interviewee stated some disappointments regarding the various shareholders' lack of commitment to increase greater co-operation with the province or GSH.

> "It [UCTH] is currently there, and UCT is supposed to be our partner, but this has been strained at times due to a competition for resources." PAWC

Furthermore, he stated that the current situation/relationship is not that bad, yet feels that there should ultimately have been more benefits for the public sector.

> "On paper (in rands and cents) it is at a disadvantage to us. But in a bigger picture I don't think it is that bad." PAWC

The two original aims PAWC had for this project, were to create an amicable working environment to encourage staff retention, and they were hoping that the new hospital (UCTH) would improve the general image of GSH. Under the current situation PAWC feels that they are happy to let this state of affairs continue for the time being and, therefore, they are included in quadrant C.

> "[Aim] The 'so-called' retention of scarce skilled staff ... to have a happy workforce, it is good to create a good work environment." PAWC

> "[Aim] The image of the public sector. Now that you have this place of excellence there, it might improve the image of the whole hospital." PAWC

The GSH private ward and the CEO of GSH (also representing the views of the Provincial Department of Health) both have high interests in the future of the UCT Hospital. Currently they have little to no direct influence on the ongoing processes of the UCT Hospital – after all the UCT Hospital is a fully-functioning, independent entity. They therefore get placed into quadrant B.

Depending on the route UCT Hospital chooses for the future, they will need to incorporate some of the stakeholders from quadrant B and C. Increased co-operation with GSH will give GSH more influence, and PAWC will increase its interest if there are discussions to align themselves for business or financial reasons, or for more recognised PPPs.

Currently GSH is very disappointed with the activities, structure and proximity of the UCT Hospital.

> "If they remain as a competitor, then they must be off my premises. They must be as far away of the premises as possible." GSH CEO

From the knowledge of the stakeholders and their interviews, the stakeholders have been tabulated according to their position of support, neutrality or acting as opponents. Table 5.4 tabulates the stakeholders under current situations. Under these current situations GSH, management and the private ward, is opposed to the existence and interactions of the UCTH. RK and the NDoH are both neutral, with PAWC leaning slightly towards supporting the existence of the hospital as it benefits the retention of staff and potentially gives GSH's image a boost for the better. The primary stakeholders are all very supportive of the current situation.

TABLE 5.4: Stakeholder support of current UCTH structures

UCT Practitioners Westcare Hospitals CHG	PAWC NDoH RK	GSH (CEO) GSH (G4)	**HIGH** ↑ ↑ ↑ **Influence** ↓ ↓ ↓ **LOW**
Strong Support of UCTH	**Neutral**	**Opponents of UCTH**	

Level of stakeholder support for the UCT Hospital

5.2 Aims, current ideas and future desires of stakeholders (diagnosing stakeholders)

The principal viewpoints (aims, current ideas and future desires) of the various stakeholders have been tabulated in table 5.5 (primary stakeholders) and 5.6 (secondary and additional stakeholders).

The data of the different stakeholders' aims, current and future ideas has been analysed according to the primary stakeholders, secondary stakeholders and then the additional stakeholders.

5.2.1 Primary stakeholders

The aims and objectives of the primary stakeholders are that they want to grow and develop the hospital, have adequate training/teaching facilities and offer the staff good private or extra work and experience. These issues were generally discussed as the original reasons to develop this hospital in 2002.

The shareholders also wish to have some returns on their investments. One of the later investors identified their need (reason to buy in) to expand in any possible private-sector project available, as there are limited private-hospital projects being licensed in the current South African health-sector environment. Furthermore, this shareholder saw this as an ideal opportunity to foster increased public-sector relations – clearly envisaging increased PPI in the future.

Two practitioners indicated that they were not in this for any extra income and merely wanted to get work/private experience. They stated that they did not even complete the full, allotted hours allowed for external RWOPS at the UCTH. The third practitioner was quite direct in stating their interest as a financial gain, to complement their public-sector income. This practitioner furthermore wanted the UCTH to be a "super-specialist" facility, placing itself upmarket and not focusing on low-end medical-scheme markets.

The stakeholders' opinions about the current structure and environment of the hospital are relatively unanimous. There is very limited exchange of resources with GSH. Proclaimed training possibilities have not been attained. Furthermore, the UCTH is performing at a very low occupancy rate and needs to improve in this respect.

Two points identified by specific practitioners, and not representative of the group as a whole, include the following: Firstly, some practitioners felt that the practitioners' responsibilities do not lie within the role of management and, secondly, there are no real, consistent cost savings at UCTH. One practitioner stated that management tried to consult with the practitioners on management duties – which they felt was not their responsibility. Another practitioner stated that there were no real cost-savings in the pricing structures of this hospital. The UCTH bills this doctor has reviewed are comparable to bills they furnish for equivalent conditions in other private facilities.

Lastly, there was a common problem identified by the primary stakeholders, which was also identified by the majority of all the stakeholders. It is the issue of GSH private-ward patients being poached by practitioners to relocate them to the UCT Hospital (see Box 1).

Box 1

The issue of "poaching" patients

Some GSH patients are being, or perceived to be, transferred to the UCT Hospital for no real, legitimate reason. Accusations abound that some patients get admitted to GSH private ward and are subsequently transferred by the consulting practitioners to the UCT Hospital. This problem is exacerbated by the fact that these practitioners, who complete their private RWOPS at both facilities, get remunerated for work/clients at the UCT Hospital and are shareholders at the UCT Hospital. This raises the question whether the patients are being transferred to UCT Hospital for financial gains, or for other more legitimate reasons.

There is a lack of regulations governing these transfers, which is a major contributing factor to the tensions between the two facilities. Some pertinent questions that arise are whether the patients get admitted to a specific facility or to a specific practitioner, whether there are any specific advantages for the patients by being at either of the two facilities, and whether there may be a specific resource shortage at GSH which may be contributing to the necessity of moving the patients to the UCT Hospital.

Regarding the future desires of the primary stakeholders, there are two predominant ideas that are identified. First, there is a strong desire for the hospital to grow and expand. It is currently running at about 30 per cent occupancy. This needs to increase to improve utilisation of services and space, make it a viable training facility and to improve financial returns. Second, they all agree that there is extensive scope and a need to expand PPIs with GSH. Increased PPI will keep costs of new resources and services down and can increase the total resources available to both institutions.

Several of the primary stakeholders also stated that they still wish to see the hospital grow into a viable training and research facility. Some independent comments that were aired include the need for some management/billing improvements (these were not efficient enough), the regulation of patient transfers needs to be enhanced, and the need was identified for both UCTH and GSH to identify and develop their own unique markets.

Finally, there was a bit of a discrepancy aired by some of the stakeholders regarding the future market sector of the hospital. The management of the hospital stated three key aims:

i. to establish a cost-effective, financially competitive hospital
ii. to contract successfully with medical schemes to attract low-end schemes and capitation structures
iii. to create a "super-specialist" facility

The idea to form a "super-specialist" unit, and at the same time provide services to the lower-end market of medical schemes does seem to be a contradiction. The management of the UCT Hospital highlighted both these aims.

One practitioner, who also claimed that the hospital was currently not noticeably more cost-effective than other private facilities, would like to see the UCT Hospital targeting a very upmarket clientele. With all the academic and specialist staff, the hospital should market itself internationally and locally as a superior, top-quality institute. Contracting for low-cost medical schemes will leave the hospital with financial problems if these clients' medical schemes expire or run out.

> "Let's say we get a Golden Arrow employee in, of which we see quite a few; they can't pay their bills. It is a total disaster if the medical aid does not cover. We should be aiming for an entirely different section of the market. ... Market the hospital by saying: 'Look we have these professors etc. working for us, hence it is better to come here, because we are the best.'" (Practitioner)

5.2.2 Secondary stakeholders

Secondary stakeholders include GSH, the management and private ward, and Rhön-Klinikum. Rhön-Klinikum has no current or future interests in the hospital. They merely started the UCT Hospital – to test the international market and to make money.

The wants, current ideas and future desires of the two GSH stakeholders are very similar to each other. The main difference is that the management of GSH is noticeably more adverse towards the UCT Hospital. The management believes the whole project is wrong, and that they have been left to deal with it. Their accusations go as far as insinuating that certain persons were bribed and coerced into accepting this project. The PAWC interviewee strongly believes that there were no such activities to get this project off the ground.

> "This entire arrangement is not of our making. It was a political decision, made by the MEC at the time, who was more favourably disposed after a visit to Germany. I'm having to deal with something that is de facto, I've got to make the best out of a bad situation." (GSH CEO)

> "Personally I don't believe persons were bribed or influenced illegitimately." (PAWC)

TABLE 5.5: Primary stakeholders – Summary of points highlighted by interviewees regarding UCT Hospital

Stakeholder	Original aims	Current ideas	Future desires for UCTH
Westcare Hospitals	▪ Grow, develop hospital ▪ Financial gains ▪ Create vision/direction for future	▪ Some sharing and mutual planning with GSH ▪ Some research and training taking place (informal) ▪ Hand over to new management in 2004	▪ Grow hospital ▪ Function as "super-specialist" facility ▪ Improve cost-effectiveness ▪ Effective medical scheme contracting ▪ Possible PPP
Practitioners	▪ Experience and time in private practice ▪ Supplement state income ▪ Incorporate public and private sectors ▪ Increase teaching, training and research facilities ▪ Doctors were asked/forced, to be stakeholders	▪ Doctors' duty not in management ▪ Issues of patient-"poaching" problematic ▪ Memorandum unilaterally from GSH ▪ Management structures much better since RK left ▪ No true cost-savings at UCTH ▪ Post-RK changed to "normal" private structures with regard to billing ▪ Still no real training/teaching facility	▪ Closer relations between hospitals ▪ Better contracting/regulating ▪ Grow hospital occupancy ▪ Each hospital concentrates on own specialities ▪ Regulate patient transfers between hospitals ▪ Establish recognised specialist departments within UCTH ▪ Change target market – up-market as opposed to low-end medical schemes ▪ Improve billing programme ▪ Financial rewards on investments ▪ Expand as training, research venue ▪ "Super-specialist" facility
University of Cape Town	▪ Retain and recruit clinical staff ▪ Increase training, research facilities	▪ Originally no PPI encouraged, now definite possibilities ▪ Do not want to loose money through UCTH ▪ Possibly extend facility to allied health professionals	▪ Increase patient volumes at UCTH ▪ Recruit further clinical staff to UCTH ▪ Incorporate UCT's *captive employee composition* into this health-care institution
Community Health Group	▪ Expansion in private-sector health-care ▪ Closer relations with public sector/GSH	▪ Need to increase PPP	▪ Financial gains ▪ Improve PPI – with GSH ▪ Contribute in management structures

TABLE 5.6: Secondary and additional stakeholders: Summary of points highlighted by interviewees regarding UCT Hospital

Stakeholder	Original aims	Current ideas	Future desires for UCTH
Groote Schuur Hospital – CEO	▪ Not interested in having competitor on doorstep	▪ UCTH is a direct competitor ▪ Staff sharing not ideal for GSH ▪ No training, education currently at UCTH ▪ Minimal sharing of resources ▪ No benefits for GSH from UCTH	▪ No "poaching" of patients ▪ Structured PPP, with risk-sharing ▪ Closer business associations with UCTH ▪ Much improved regulation of the relationship with UCTH ▪ If no changes, then UCTH must disappear
Groote Schuur Hospital – Private Ward	▪ Not interested in having competitor on doorstep	▪ Originally no contact between RK and G4 ▪ Currently amicable relations through memorandum ▪ Problem of "poaching" patients ▪ Minimal resource-sharing	▪ Increase revenue of G4 ▪ Create cost-effective, accurate costing for G4 ▪ Closer co-operation with UCTH ▪ Structured, regulated relations ▪ No "poaching" of patients
PAWC	▪ Stable working environment and retention of public-sector staff ▪ Wanted improved image for GSH as a whole	▪ Currently no real benefits for PAWC, financially probably a loss ▪ Happy to continue as is, for now	▪ Closer relations with GSH ▪ Resource-sharing, less competition ▪ Improved contracting, regulating ▪ Each focus on specific target markets
NDoH	▪ No specific UCTH aims	▪ Not specifically aware of this programme ▪ Encourages PPP in general	▪ Nothing specified
Rhön-Klinikum	▪ Financial gain	▪ No longer involved	▪ No longer involved

The wants or needs of the private ward are to grow occupancy and to eliminate obstacles for the success of this ward. Both stakeholders strongly feel that there is a huge problem with the UCT Hospital poaching patients. GSH management quite bluntly state that they wish the UCT Hospital would disappear, unless they join forces with GSH with respect to profits and risk sharing.

GSH management sees the UCT Hospital as a direct competitor. Both hospitals are vying for the same clientele. There is currently no additional or new training, or education of staff at UCTH. GSH management is also quite vociferous about the loss they experience through the sharing of staff with UCT Hospital. They believe that the staff complete more than their allotted RWOPS hours at the UCT Hospital. Furthermore they feel that these are hours they could be dedicating to GSH, and believe GSH should be compensated for this.

Moreover, GSH management believes that the practitioners are sole intellectual property of GSH, and ask how these persons could be allowed to trade their knowledge elsewhere.

> "I own the intellectual property of all the staff here – we pay their salaries, their housing subsidies, all their benefits. Like Old Mutual: They own the intellectual property of their CEO etc.; they would not want their people to work for Sanlam." (GSH CEO)

Basically both the private ward and management believe that with the UCT Hospital on their doorstep there are no real benefits for GSH. Both parties admit there is some resource-sharing, but this is minimal and not being administered properly.

Both the private ward and the management of GSH have relatively positive or hopeful desires for the future of their relationship with the UCT Hospital. They believe there is a lot of scope to improve and expand on the relationship including prospects of PPIs.

The private ward contact explained how there were no relations with the UCT Hospital during the times of Rhön-Klinikum. This changed once RK pulled out of the project. According to the private ward, GSH has now taken it upon itself to encourage or lead a structured relationship with the UCT Hospital, by drawing up a "Memorandum of Understanding". The management of GSH states that the memorandum is a bilateral agreement, based on mutual agreements reached through regular management meetings between the two hospitals. Either way it indicates that there are processes under way to establish a respectable working environment between the two parties.

Other future desires of the secondary stakeholders include tighter contracting and regulations to administer any resource-sharing, and the issue of poaching of patients needs to be sorted out urgently.

Box 2

"Memorandum of Understanding"

The "Memorandum of Understanding" was drawn up to foster a better relationship between the two institutions and to "emphasise the goal of mutual strengthening" ("Memorandum of Understanding", May 2003). It was signed by the CEOs of both the UCT Hospital and GSH in May 2003.

The memorandum sets out vital principles to foster a better relationship between the two institutions. The basic points include an understanding that there is a degree of interdependence between the two institutions, and that close co-operation, communication and sound business principles should be adhered to. Furthermore, antagonism and destructive competition is strongly discouraged, and the institutions should work together to achieve cost saving and co-operation for improved healthcare for all.

The memorandum also touches briefly on simple resource-sharing points. It suggests prevention of unnecessary duplication of equipment and encourages sharing of facilities, equipment and consumables – at agreed costs and through formalised agreements.

The GSH CEO expanded on his ideas to encourage a formalised PPP with the UCT Hospital. This would result in a decrease in competition between the two parties, profit-sharing, risk-transfer and generally closer business relations with the UCT Hospital.

5.2.3 Additional stakeholders

The two additional stakeholders include the NDoH and PAWC.

The national government was not directly aware of the UCT Hospital, nor did they have any knowledge of any PPI existing with GSH. The NDoH, though, strongly encourages PPIs and PPPs with specific goal-orientated regulations. They would naturally encourage any potential relations with GSH that are mutually beneficial to the hospitals and the South African health-care sector as a whole.

PAWC was originally encouraged by the prospect to improve the working environment for the public-sector practitioners at GSH and to provide additional incentives to retain staff. There was also hope that the UCT Hospital would improve the overall image of GSH.

According to PAWC the degree of resource-sharing is virtually nil, and there are no real benefits for GSH in the current set-up. PAWC believes that the province is probably slightly worse off financially in the current situation. On the whole, considering that the doctors are kept satisfied with some private work and the image of GSH, it is better with the UCTH alongside – the bigger picture is not too bad.

PAWC also has rather positive expectations for the future. They envisage definite closer relations with the UCTH, which will have to be fairly structured and regulated. But there is large potential for further interaction and co-operation.

Finally, they do recommend that the closer relations will only be possible if the two parties do not compete with each other. Basically, both parties need to focus on specific, individual markets and expand their areas without competing for the same patients.

5.3 Degree of public-private interaction

5.3.1 Original aims and current ideas

Table 5.7 presents the key points highlighted by the interviewees on the questions of PPI.

At the beginning, when the hospital opened in 2002, RK and UCT had no intentions of any PPI with GSH or any other public-sector institution. At this stage there was purely an agreement for the UCT Hospital to pay some rent, and for staff from GSH to complete their allocated RWOPS at the UCT Hospital.

When Westcare Hospitals and the group of practitioners came on board as investors they all envisaged a degree of interaction with GSH. At this stage GSH was included for some specific resource-sharing – to ensure cost savings and better relations for both parties.

Respondents, regarding the current degree of interaction between the two hospitals, gave very similar responses. These interactions are classified as minimal, little, some or very little. The interviewees are all in agreement that there is some sharing. Only PAWC and the NDoH were not aware of the degree or actual interactions taking place.

The generally agreed upon interactions are:

- staff-sharing exists (as allocated RWOPS)
- "some equipment-sharing"
- EEG, MRI, EMG (diagnostic equipment)
- ICU facilities (UCT Hospital gets used if GSH is fully occupied)
- pathology services are centralised, used for both institutions

From the interviews, and the aims of the "Memorandum of Understanding", it is clear that there is a very modest degree of interaction between the two institutions.

Although the memorandum aims to make the degree of interaction more significant, it remains a very loose arrangement and does not meet any of the formally recognised criteria required for accepted PPP. The primary stakeholders are ardent to highlight that there is a fair degree of resource-sharing, whereas the secondary stakeholders noticeably play down this interaction.

In essence there are several points impeding constructive expansion of closer relations. One stakeholder spelt it out clearly, and others made it relatively evident, that tense relations between the two hospitals are inhibiting further (successful) interactions. They furthermore noted that there is a definite need for efficient contracting and regulating to ensure fair and effective sharing of resources.

UCT expanded on this notion of contracting and regulation by stating that the two hospitals (and all stakeholders) need to have a common understanding of their aims and objectives. They both wish to grow and expand their respective private-sector businesses. In addition, there needs to be a common understanding between the hospitals about the potential outcomes from the interactions before successful co-operation can be implemented. It is pointless to continually encourage co-operation if neither party formulates what end-points they envisage.

PAWC and several of the primary stakeholders highlighted the points necessary for true formalised PPPs. They mentioned that effective, regulated interactions (similar to formalised PPPs) would require risk-sharing, co-management, no competition and formal contracting.

As discussed previously, the management of GSH feels that the issue of staff-sharing is not good, and that it is actually a liability for GSH.

5.3.2 Future expectations

All stakeholders unanimously agreed that there are many more possibilities available to increase the participation and resource-sharing between the two hospitals. They also all stated that this should be expanded and worked on in the future.

It is also unanimously agreed that the only way to make these interactions successful would be through specific contracting and regulations.

TABLE 5.7: Degree of PPI and future expectations

Stakeholder	Original aims	Current ideas	Future desires for PPP
Westcare Hospitals	▪ Staff-sharing ▪ Some equipment-sharing ▪ UCTH to "carry" GSH's excess ICU patients	▪ Memorandum of Understanding sets guidelines of sharing and co-operation	▪ Needs to expand ▪ Potential to expand to recognised[19] PPP
Practitioners	▪ Staff-sharing ▪ Some resources from ICU, radiology and pathology shared	▪ Contracting important to regulate interactions ▪ Some equipment at UCTH state of the art, which could be used at GSH ▪ Unsure of how, or how much, improvement possible	▪ Lots of scope for expansion
University of Cape Town	▪ Rental of premises ▪ Staff-sharing	▪ Need common understanding to expand	▪ It is vital that it expands ▪ Lots of scope for expansion
Community Health Group	▪ Some resource-sharing ▪ Staff-sharing	▪ True PPP requires co-management and risk-sharing	▪ Lots of scope for expansion ▪ Possibility of formalised PPP
Groote Schuur Hospital – CEO	▪ Some resource-sharing ▪ Staff-sharing	▪ True PPP needs risk-sharing ▪ Can not be competing with PPP ▪ Staff-sharing a liability to GSH	▪ Does support notion of PPI ▪ There is scope to expand ▪ Must involve risk-sharing
Groote Schuur Hospital – Private Ward	▪ Some sharing of equipment ▪ ICU, EEG, MRI, EMG	▪ Tense relations inhibit ideal co-operation ▪ "Memorandum of Understanding" sets guidelines	▪ There is scope to expand
PAWC	▪ Not aware of degree of interaction ▪ No formal application or PPP process	▪ Requires adequate contracting ▪ Less competition between the hospitals is required for success	▪ Definite possibilities
NDoH	▪ Not aware of any interaction ▪ No formal application or PPP process	▪ Risk-sharing important criteria ▪ Important to be mutually beneficial	▪ No knowledge
Rhön Klinikum	▪ No sharing of resources	▪ N/a	▪ N/a

[19] With respect to provincial and national regulations governing true PPP.

Westcare Hospitals/UCTH management stated specifically that a formalised PPP was a definite possibility; these thoughts were also discussed briefly by GSH, CHG, and PAWC.

> "We are in discussion with PAWC about making this a PPP, we are not sure yet how or what benefits it will bring – but we are exploring this route." (UCT Hospital)

Although they all agree that there should be expansion and developments to the degree of interaction, no stakeholder could give more concrete examples or outcomes to this dilemma. Everyone wants the problem regulated, they all want to benefit wherever they can. The secondary stakeholders also require risk-sharing, profit-sharing, co-management and closer business associations if there is to be any greater degree of PPI.

5.4 Possible future scenarios

The two hospitals currently find themselves in a situation where they exist on each other's doorsteps, and both are fully operational and independent of each other. It is very unlikely that either institution is going to close down or move elsewhere.

Both institutions have clear aims and goals. They both need to evaluate what outcomes they require, or wish to pursue, with regard to their existence alongside the other institution.

From the analysis above we can formulate some core aims and future desires of the stakeholders.

1. Both hospitals wish to grow and expand with regard to occupancy rates.
2. Both hospitals are dependent upon this growth (of their private sectors) to become financially viable.
3. All stakeholders are relatively positive regarding the potential for improved mutual co-operation and resource-sharing.
4. There is a need for contracting and regulations to make the co-operation functional.
5. It is mutually agreed that there is a problem of patients being "poached".
6. GSH and PAWC strongly believe that further co-operation is not in their interest if there is no progress towards risk-sharing, co-management and less competition.

There are three outcomes that can be earmarked as potential routes for the UCT Hospital to endeavour:

1 **No change**
Continue to follow current aims and business structures, with minimal co-operation with GSH.

2 **PPI**
Continue to follow current aims, yet constructively aim to achieve greater interaction with GSH.

3 **PPP**
Aim to formalise a structured relationship with GSH to encourage a recognised public-private partnership.

5.4.1 No change

The UCT Hospital could continue operating as it has done for the last while. This would result in continued poor relations with GSH. A *status quo* would inhibit both hospitals' growth and expansion possibilities, especially due to them both vying for the same markets.

Continued allegations with respect to RWOPS, patient "poaching" and poor administration of resource-sharing would abound.

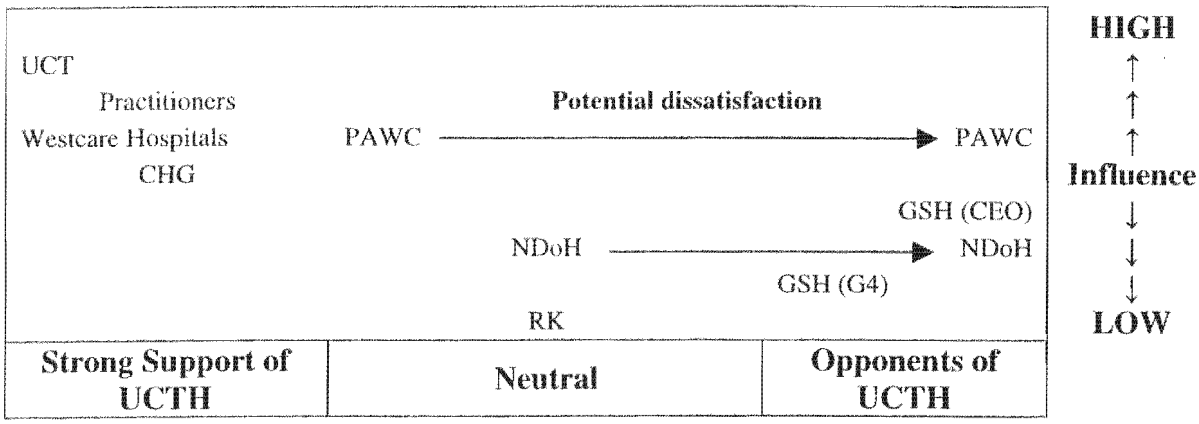
Ultimately the staff will suffer with respect to the allegations above. In addition, investors would not reap the benefits of investments, and the potential to utilise the UCT Hospital for teaching and research would be inhibited if there were no reasonable growth and expansion.

In the *No Change* example (Table 5.8) there would be no change in the support of any of the stakeholders, when compared to the current stakeholder-support structures (Table 5.4).

A potential problem, though, is the prospect of either regulator (national or provincial) becoming less co-operative and moving right on the table. In this case they would be less supportive of the current structures, and potentially enforce changes that would reduce any sacrifices regarding the relationship of the UCT Hospital with GSH and the public sector.

The PAWC interviewee highlighted a further point inhibiting the growth and expansion of the UCT Hospital and its client base: There is no marketing and lobbying done by the practitioners themselves. In conventional private hospitals the private practitioners are dependent upon their work and patient services for income, and they will therefore market, seek clients and concentrate on growing their practice. At the UCT Hospital the practitioners have their guaranteed income and job security at GSH, regular academic trips to conferences, etc. and are not dependent on the growth of the UCT Hospital.

TABLE 5.8: Stakeholder support of "no change" UCTH structures



Level of stakeholder support for the UCT Hospital

Potential dissatisfaction of PAWC and/or NDoH will result in their shift towards the right.

5.4.2 PPI

One possibility is to aim for greater public-private interaction, yet not attempting to alter major aims and business structures to accommodate a true, formalised structure of public-private partnerships.

To make greater interaction possible would require some changes to the current state of affairs. First and foremost the interactions would need to be adequately regulated and formalised. Secondly, GSH and PAWC have indicated that they are not too happy with the current relationship. Therefore, the secondary stakeholders would require some appeasement on their demands for closer relations before they would interact with the UCT Hospital. These include

i. less/lack of competition
ii. risk-sharing
iii. co-management
iv. each focus on independent market sectors
v. co-operation need to be mutually beneficial

Although it is possible, it will be a notable organisational task to define and enforce specific regulations on resource-sharing. Furthermore, it remains difficult to envisage success in this category if both parties continue to compete for the same market sector. It is rather difficult to openly share limited resources, while competing for the same market.

This relation will therefore probably only be possible if UCT Hospital and GSH each focus on unique or slightly different target markets. This situation should have been envisaged from the start of the UCTH, especially with the knowledge that PAWC was already reluctant to license any new private hospital due to the over-supply of private-sector hospital beds and services.

> "I personally don't believe there is space for additional private hospitals. It is firstly a totally over-traded environment – the private health-care industry in Cape Town." (PAWC)

The UCTH therefore needs to find a specific market niche to expand. Some examples highlighted by stakeholders are as follows:

- One practitioner and the UCT Hospital management envisage UCTH as a "super-specialist" facility where the best-of-the-best academics, professors and specialists are the main draw card for local and international private patients.

- The UCTH management envisages increased medical-scheme contracting and capitation possibilities. To further encourage this they aim to be extremely cost-effective, to attract ample contracting and co-operation with medical schemes.

- UCT adds that they have a captive market of 2 200 medical-scheme members within their employ. This could be expanded to tap into a portion of the 15 000 students active at UCT. There should be possibilities to expand this even further to attract additional tertiary institutions within Cape Town.

- Without expanding on any possibilities or what it includes, PAWC suggested future sectors such as the social-health-insurance (SHI)[20] market and other emerging markets as potential sectors.

Although these different possibilities do exist, they will be pursued by both hospitals. The idea of "super-specialist hospital" is also envisaged by GSH – after all, the practitioners and academics are primarily in their employ. UCT Hospital also admits that they are coming across more and more lower-end medical schemes also contracting with GSH. Although PAWC mentioned the possibilities of emerging markets and SHI as possibility for UCTH, they did state that they were also following these options actively.

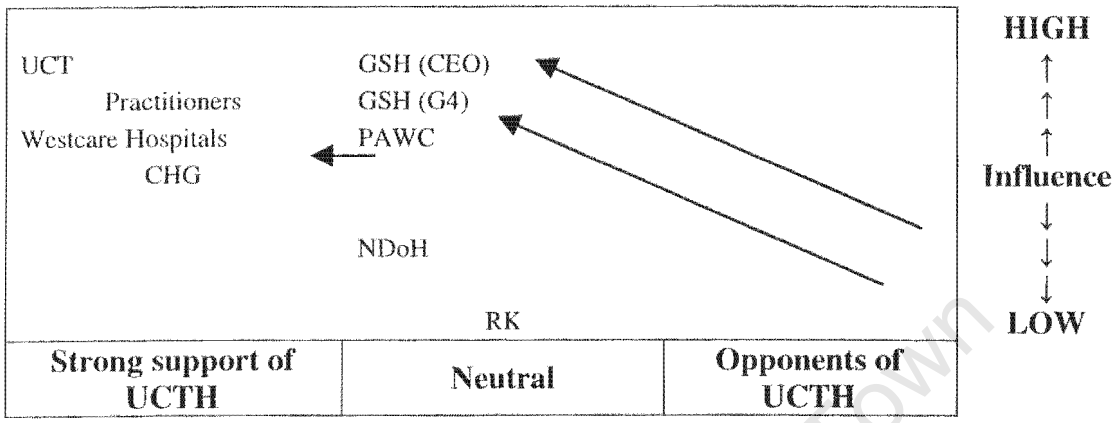
Even though increased co-operation and interaction (PPI) is a definite possibility and is, in general, supported by all stakeholders, it will require some adjustments from the current structures of the hospital. Primarily it will require tighter regulations governing these interactions. Secondly, GSH and PAWC will demand more benefits from their relationship with the UCT Hospital. Lastly, it would probably require vast efforts by either or both hospitals to find their own specific niche in the private-sector market.

Table 5.9 shows the change in influence and support the stakeholders would have if a PPI project were attempted or implemented successfully. GSH, management and the private ward, would both be more amicable towards the hospital. Furthermore, their influence would increase substantially, as they could dictate some degree of interaction or mutual benefits. PAWC would be more supportive,

[20] "Compulsory health-insurance contribution by formal-sector employees and their employers." (McIntyre, 1997) These funds either go to a centralised health fund or to smaller funds (centrally co-ordinated). Hospitals and providers can contract to provide health services for the smaller funds.

yet probably not more influential. NDoH would probably still be fairly neutral, yet more encouraged or supportive considering that there is a formalisation of PPI.

TABLE 5.9: Stakeholder support of PPI structures for the UCTH



Level of stakeholder support for the UCT Hospital

5.4.3 PPP

Formalising a structured public-private partnership is a definite possibility. It will ensure that both parties will benefit from the situation, and both parties can continue with their general aims and retain their core business structures.

Both parties would potentially gain from this participation, yet both parties would have to sacrifice some structures and current ideals. The UCT Hospital would sacrifice its autonomy and possibly some financial profits. On the other hand they would profit with regard to less competition, easier access to a wide variety of resources, greater potential to grow and expand, less confrontation with GSH and a larger target market. GSH would have to sacrifice its current management and private-ward structures (except for those structures that get incorporated into a new combined structure). But they would have less risk, less competition and probably gain better capacity, management, marketing and experience in their private ward. In addition, they would gain financially by having a well run, dedicated and goal-directed private ward.

An arrangement of this nature would potentially fulfil some of the co-aims of the health sector.

i. Quality of care could be improved.
ii. GSH could concentrate on their public-sector provisions and therefor insure appropriate care to both sectors (equity).
iii. Efficiency of the hospital and services would be improved with a well run private ward.

There are clear guidelines present for PPP projects, which would have to be adhered to. These regulations and conditions include:

- contractual arrangement
- mutual agreement and co-operation
- mutually beneficial
- contributing to equity, coherence, quality of care, efficiency and effectiveness
- specific output specifications
- risk-transfer
- affordability
- add to the sustainability of the national health system
- both sectors contributing resources to outcome

The primary questions are about what services the UCT Hospital has, that can benefit GSH. From what interaction would GSH benefit and in which project can each party contribute significantly? Lastly, one needs to consider what services or resources each institution has to contribute to the relationship.

The most probable possibility is the outsourcing of GSH's Private Ward. Several stakeholders touched on this possibility in the interviews.

> "At some stage – it has been aired totally unofficially – and not yet, we should be saying: 'Can we run G4 for you?'" (UCT)

> "National government will probably run it (GSH) as only a tertiary facility and will for financial reasons possibly consider contracting out G4." (UCT)

> "In the UCT Hospital and GSH case there is a possibility to address, and build on, the politics around G4." (CHG)

There is no doubt that the UCT Hospital is in the private-sector hospital industry; they make their money from this sector and are proficient in contracting, negotiating and developing this sector. The UCT Hospital is relatively pro-active in contracting and building relations to develop a successful hospital.

GSH's private ward is a very unique project and currently does not have the private-sector experience or capacity to develop this sector. A primary problem is the ineffectiveness of the NDoH's *uniform patient-fee schedule*. This curtails the G4 from costing, planning and administering their ward effectively.

> "GSH has one main problem in that they don't have a definite costing structure and don't know if they will be making money with G4." (UCT)

> "NDoH has set tariffs, which gives some ideas of cost recovery. But the problem lies with the inaccuracy of their costing structures, some procedures are calculated too low and some too high, and on average we may cover our costs." (GSH Private Ward)

Furthermore, the public sector's lack of experience in the private sector leads to a poor marketing drive and less pro-active contracting.

> "We have a hard-copy and electronic brochure available for medical schemes, but this drive is not very aggressive. We believe it needs to be done slowly to accommodate the ability of our service in the private ward." (GSH Private Ward)

> "We currently have no contracting with funds or medical aids. They first want to see how clients respond to our private ward within GSH." (GSH Private Ward)

The hospital's public-sector image is also a point that may effect its potential negatively.

> "GPs will more readily refer patients to 'respected' private hospitals, and less likely to G4, which is seen as GSH, and the general stigmas attached." (UCT)

> "Now that you have this place of excellence there, it might improve the image of the whole hospital." (PAWC)

When considering these points above it seems rather plausible to consider a possibility in this direction. This arrangement can be mutually beneficial, if the UCT Hospital can run a for-profit private hospital, remunerating GSH and not competing directly with GSH. GSH will relinquish some major risk, get remunerated, will be able to concentrate on its public-sector trade and potentially enter a co-management structure.

Although this would be a major contractual and regulatory task, it could be mutually beneficial, and specific outcomes could be developed and measured for both parties.

It is possible to gauge the support of the stakeholders for a PPP idea in general, yet not possible for the idea of specifically outsourcing G4 to UCTH. General PPP discussions and negotiations would be very welcome. The GSH and PAWC stakeholders will have increased influence and be quite supportive. If regulated successfully, and meeting the demands and wishes of GSH and PAWC, they would probably be able to control most of the decision-making according to current legislation (see Table 5.10).

TABLE 5.10: Stakeholder support for PPP structures of the UCTH

PAWC ← UCT	GSH (CEO)		**HIGH**
GSH ← Practitioners	GSH (G4)		↑
Westcare Hospitals	**PAWC**		↑
CHG			↑
			Influence
NDoH ←	NDoH		↓
			↓
	RK		↓
			LOW
Strong support of UCTH	**Neutral**	**Opponents of UCTH**	

Level of stakeholder support for the UCT Hospital

PAWC, NDoH and GSH in **bold** indicate potential influence and support, if well regulated and mutually acceptable PPP structures are implemented.

5.5 Summary

Of the three core possibilities available for the future of the combined existence of the two hospitals, the PPP approach seems to be most beneficial. It offers a possibility for close co-operation and resource-sharing, profit-sharing, risk-transfer, less competition and the continued existence of both hospitals. But it will also require the UCT Hospital to relinquish its total independence, and GSH will have to give up their current private-ward structures.

Both hospitals can benefit from this sort of arrangement. The UCT Hospital can continue with all of its original goals and aims, run a profit-making facility and hope to expand their business under less competitive circumstances. GSH can provide a well-run, pro-active, competitive, private ward with less stress, less risk and increased potential to experience health-care-management structures. Their wishes of co-management and profit-sharing should also be introduced into such a relationship.

The "no change" option seems inadvisable for both institutions, for now and in the long run. The continued competition and animosity with each other is not conducive for any successful business venture.

The option of aiming for better regulation and increased interactions (PPI) may go a long way to improve relations, and can help both institutions cut costs and perform more profitably. Yet it is hard to comprehend how this will work if both facilities are still competing for the same clientele and need all the available resources to achieve these goals.

The predominant barriers at this stage are probably the lack of communication between the two institutions, as well as the mutual pride in their respective services. Both parties will need to consider their potential sacrifices and weigh them up against the potential gains for themselves, the other institute as well as the potential benefits and problems for the consumer of these services.

6 Conclusions

> *The conclusion is divided into three sections – first the scope of PPIs are summarised, secondly the case study of the UCT' Hospital is dealt with, and finally the possible scope of regulators within the health sector are addressed.*

Public-Private Interactions

There are several factors that make the possibility of PPI encouraging within the South African health sector. Furthermore, the government can benefit with closer private-sector interactions to facilitate the proposed reforms for the general health sector.

The government has the substantially larger client base within the health sector, but lacks the capacity, funding and resources to efficiently expand and improve its health-care services.

The private sector, on the other hand, has well established management, capacity, resources and readily available funding. The private sector is also eager to find new avenues of expansion, as licensing of new private hospitals and clinics has virtually ceased over the last few years.

The future of the UCT Hospital

In general, even though there are some strong feelings regarding the actual existence of the UCT Hospital, most of the stakeholders seem to accept its existence and are willing to work with or alongside it.

The primary stakeholders are all meeting their main aims and objectives. There is a need to grow and expand, improve training and research facilities as well as improve the degree of PPI with GSH.

All stakeholders admit that there is a large amount of potential for structured co-operation between the two institutions. Both hospitals have resources to offer and each institute wishes to expand and grow its services.

Unfortunately, the current situation of poor relations, competition for comparable markets and lack of regulated sharing of equipment is obstructing both institutions' ability to expand and become truly profitable.

There is a need to improve the relations through mutual discussions and progressive planning. Improved control of resource-sharing and regulated co-operations will not benefit either party if the institutions continue to vie for comparable markets.

The public sector feels they are not benefiting from the current situation. Not only do they feel they are being short-changed financially, but they believe patients are being "poached", staff are representing themselves unfairly in a competitor hospital and their scope for growth in the private sector is restricted by the direct presence of the UCT Hospital.

UCT Hospital does not have a clear aim forward. They wish to be a "super-specialist" institution, as well as a contractor for low-end medical schemes – this seems to be a slight contradiction. Furthermore, the staff (practitioners) are not dependent upon the growth of the hospital for job security or basic income.

The alternative and possibly most viable solution is an outsourcing of the GSH Private Ward to the UCTH. The UCTH has the location, experience, staff contacts, combined resources, ambition and marketability to take on this responsibility. Furthermore, the GSH private ward can benefit from improved marketing, management, contracting, capacity and image.

If the two institutions do not wish to work that closely together, but still wish to co-exist and grow their businesses, UCT Hospital will have to research secure, viable, unique markets. Furthermore, the hospitals will need to regulate the resource-sharing to a greater degree, and the UCT Hospital will need to sacrifice more to meet the growing demands of financial and regulatory requirements by GSH and PAWC.

If they do want to work together, the institutions will need to thoroughly discuss their needs and aims. They will have to learn to work together and listen to each other's needs.

Health-sector regulations

Both the treasury and health departments have regulatory policies governing the implementation of PPP. The aim of these policies is to improve the overall health-care provision and to make the provision more financially viable. The government realises that the private sector has specific resources and abilities that need to be harnessed to help improve the overall health sector.

The government also notes that PPIs should neither be entered into for sheer financial gains, nor for mere health-care provision. Core goals for the existence of PPIs have been established, and include equity, coherence, quality of care and efficiency/cost-effectiveness.

As is evident from this case study, policies do exist for the regulation and implementation of PPIs. Unfortunately these regulations are not enforced or thoroughly encouraged. The PAWC (treasury) interviewee stated that they were accepting of the current working relation with the UCT Hospital – even though it probably proved to be a slight financial loss to GSH and/or the province. Furthermore, the interviewee from the NDoH stated that there were only roughly twenty regulated health-sector PPPs in the country. This figure seems very low,

and begs the question to what extent regulated – and therefore mutually beneficial – PPPs are being encouraged?

In conclusion, it is important to note that PPIs are possible, but do require close co-operation, mutual sacrifices, rigorous regulations and effective communication. National and provincial governments should probably play a greater part to encourage or impose formal PPIs, with effective outcome criteria and structured processes to facilitate communication and co-operation between the private- and public-sector organisations.

Appendix A

Questionnaires for the various interviews

The questionnaires have been split into three categories:

1 Shareholders: UCT, Westcare Hospitals/management, practitioners and CHG
2 Public-sector stakeholders: Groote Schuur Hospital, GSH Private Ward, national and provincial departments of health
3 Rhön-Klinikum

1 Shareholders

- What is your current involvement in the hospital?
- How long have you (institution) been involved?
- What are you getting out of, benefiting from your relationship with the hospital?
- What other benefits would you like to gain?
- Are there any specific problems in the relationships, and what could be done about them?
- Where would you like to see the hospital in the next year, in five years' time?
- Do you see yourself involved in a greater or lesser degree in the next couple of years?
- What interaction is there between yourself and the public sector through the hospital?
- Is there optimal PPP for the use of resources, research and training when regarding the relationship with GSH?
- Is there even greater scope for PPP?

2 Public-sector stakeholders

- What interactions do you have with the hospital?
- Has this relationship changed to any degree over the last two years?
- What are you getting out of, benefiting from your relationship with the hospital?
- What other benefits would you like to gain?
- What problems do you encounter in the relationship, and what would you like to do to tackle these?
- Where would you like to see the hospital in the next year, in five years' time?
- Do you see yourself involved in a greater or lesser degree in the next couple of years?
- Is there optimal PPP for the use of resources, research and training when regarding your relationship with the hospital?
- Is there even greater scope for PPP?

3 Rhön-Klinikum

- When did you originally get involved in the project?
- What were your aims/goals/ambitions in this venture?
- What were the reasons for your termination of your relationship with the hospital?
- Do you believe there is a place for an investor of your nature in the future, or in similar projects in South Africa/abroad?
- Would any specific changes to the previous relationship have changed your position on remaining in the relationship?
- What did you gain from your involvement in the project?
- Did you experience any PPP to any degree?
- Is there scope to improve on the PPP as you experienced it during your involvement?

Appendix B

Informed-consent form

Dear Sir/Madam,

could you kindly take a moment to read through this Informed-Consent Form, ensure that you understand the information and return the signed letter to myself prior to our arranged interview date (dd/mm/yyyy).

> **The interview aims to gather your organisation's views, interests and needs regarding the UCT Private Academic Hospital and potential Public-Private Partnership issues concerning the venture. This study aims to collect all of the hospital stakeholders', or interested parties', needs and wants for the success of the hospital. Aiming to analyse the various interests and needs to give all the stakeholders an accurate idea of where the hospital is going in the near- to mid-term future.**

- Your participation in this interview is completely voluntary. You may decline to answer any given question, or opt to withdraw/terminate the interview at any given moment.
- We do wish to analyse the data with respect to the specific stakeholders and therefore wish to identify who the stakeholders are and what their specific viewpoints are. Any information given "off the record", or in confidence, will be treated as such – without identifying the specific party interviewed.
- The researcher has the right to disseminate the results to all the relevant stakeholders of the UCT Private Academic Hospital, and to publish the findings appropriately.
- The researcher recognises his responsibility to report back (the findings) to all the interviewees/stakeholders, and to the Research Ethics Committee.

Many thanks for your time. Please sign below and return to the researcher, acknowledging that you understand and agree to the points set out above.

I, _____, voluntarily give my consent to participate in this project. I have been informed about, and feel that I understand, the basic nature of the project.
I understand that I may leave at any time and that some of the information, relating to the stakeholder, may be used in the discussion of the research – unless specifically identified as confidential.

_____ _____
Signature of Research Participant Date

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