Collapse of a Public-Private Partnership in Uitenhage: A case study

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Abstract

This paper examines the collapse of a public-private partnership (PPP) in the district of Uitenhage in 1999. Talks to revive the partnership are high on the agenda. It is therefore essential to examine the reasons for the collapse to avoid the pitfalls of the past and to ensure that a more sustainable and competent partnership is built for the future. The Eastern Cape is one of the most impoverished provinces of South Africa and can only benefit by better cooperation between the public and private sectors. *(SA Fam Pract 2003;45(8):14-16)*

BACKGROUND

Before 1996, private practices in the Uitenhage District were doing quite well. However, with the collapse of three medical aids, local doctors threatened to adopt a Health Maintenance Organisation (HMO). As a result, some of the doctors decided to form an Independent Practitioners' Association (IPA) to negotiate working relationships with local industries. During these negotiations, one of the trade-offs by the private doctors concerned the care of indigenous people through the formation of a PPP. The IPA's managed healthcare option was accepted by most of the Uitenhage companies as a means of providing care for their employees and as part of a social responsibility programme for the community. The local IPA was called UDIPA (Uitenhage and Despatch Independent Practitioners' Association). With the aim of ensuring viable practices for its members, the Association entered into a PPP with the Eastern Cape Government in 1996.

The objectives of the new PPP were:

1. To assist the Uitenhage Provincial Hospital in reducing its patient backlog by offering free services to inpatients.
2. To reduce the influx of patients to the hospital by placing doctors at the clinics to provide free primary health care services.
3. To use all under-utilised hospital facilities, including wards and theatres that were closed after the desegregation of services had led to the departure of some doctors and consequent staff shortages.
4. To open 24-hour emergency care centres in the communities that would be manned by private doctors for the benefit of both private and state patients.

These objectives eventually became the chosen goals of the local IPA and were pursued with an intensity that was characterised by the interdependence of its members, stable UDIPA membership and a sense of commitment by all those involved. Through its partnership with the Eastern Cape Government, UDIPA secured a previously closed ward in the Uitenhage Provincial Hospital for use by their medical aid patients. The ward was renovated by UDIPA to entice private patients. This dedicated ward was not always filled to capacity and, with bed occupancy sometimes less than 50 %, non-UDIPA patients used the available space. This improved the image of the hospital and attracted other specialists back to the hospital. UDIPA's Managed Health Care option paid the hospital a 30% premium over and above the gazetted hospital tariffs and this additional fee went into a development fund for the hospital. The fund was designated for the renovation of the hospital and the provision of other medical service to state patients. In addition, UDIPA doctors also provided three hours of service per week at satellite state clinics free of charge. After-hours emergency care centres were established in two major areas of Uitenhage.

QUANTIFIED RECURRENT BENEFITS

An independent survey by an EQUITY Project, MSH, in 1998 examined the impact of the Uitenhage PPP and identified the following benefits:

To the state:

- Outpatient and inpatient services by private doctors generated a total of R1 007 765.
- Doctors' sessions at the hospital's outpatient department and at a day hospital, estimated at 6396 hours and valued at R60.46 per hour for

normal hours and R50.00 for after hours, generated an estimated R327 959.
- Doctors' sessions at primary health care clinics, estimated at 2236 hours, were valued at R135 189.
- Doctors' sessions in the theatre, estimated at 204 hours for 1996/97, were valued at R60.46 per hour, giving a total of R12 334.
- Contributions to the Trust Fund amounted to R356 538, of which R81 819 was spent during 1996/97.
- The R81 819 mentioned above was spent on renovating Wards 2A, 2B, 3A and 3B, the bedside-calling system in Ward 2A, and dental theatre equipment.
- A further R280 000, not mentioned in the report of MSH, was used to buy equipment for a Neonatal Intensive Care Unit (NICU) and for the training of NICU nursing staff in 1999.

To the private sector:
- Private practitioners were allowed to use public sector facilities free of charge.
- The PPP contributed to the sustainability of the Managed Health Care option through the use of the dedicated wards in the public hospital at a cost far below private sector tariffs.
- Private patients with free choice medical aids were given the opportunity to prevent depletion of their medical benefits by utilising the state hospital at a cost far below private sector tariffs.
- Private doctors were given exposure to a wider spectrum of the community and were viewed as being part of the community with the interests of the community at heart.

PROBLEMS ENCOUNTERED

a. Clinics:

The following problems were encountered in clinics:
- The inability of some private practitioners to adjust to the lack of autonomy regarding prescriptions.
- The poor state of clinics, as well as a lack of equipment or faulty equipment.
- A shortage of drugs and a feeling of helplessness among doctors regarding the management of their patients.
- The realisation among the doctors that they were as powerless as the nurses to address these problems and that the only option left was to refer patients to hospitals, thus defeating the purpose of ensuring competent management within communities while reserving hospital care for patients needing tertiary care.
- A delegation from the IPA discussed these problems with hospital authorities, but these authorities were struggling with the same problems, namely difficulties in accessing drugs and a lack of functional equipment. Subsequently, most of the doctors lost their motivation to continue their voluntary clinic duties. This was the first step towards the collapse of the PPP.

b. The 24-hour emergency care service:

The following problems were encountered in this service:
- An unavailability of appropriate trauma drugs.
- Oxygen cylinders that ran dry, sometimes during critical stages in patient resuscitation. Hospital management blamed these problems on the head nurse and the chief professional nurse.
- Antiquated equipment that had been repaired many times. The IPA ended up buying new equipment.
- An emergency care centre in the township required the services of a security company to control drunk and unruly patients over weekends or at night. By October 1999, no funds were available for the company guarding the state facilities and the company withdrew its services.
- Most IPA doctors feared for their personal safety and for the safety of cars parked in a dimly-lit parking lot. The IPA negotiated with a community police forum to guard the state facilities at a nominal fee of R10 000 a month until the next hospital budget, due in April the following year. However, this budget made no provision to relieve the IPA of the monthly R10 000 burden. Mounting pressure from the IPA management, with threats of termination of the free after-hour service, led to the problem being resolved seven months later. By then, a total of R70 000 had been paid for security – R20000 more than the agreed amount. This created distrust in the partnership. Doctors started asking whether future relations with the government had to be based on threats to get results.

c. Hospital wards:

The following problems were encountered in the hospital wards:
- The ward set aside for Managed Health Care patients and other private patients was renovated to make it easily identifiable as a "private" ward. This ward had its own curtains, bedding, cutlery and decorations and was the pride of the IPA doctors. In terms of the IPA's agreement with the Union, no private staff were appointed, since this could be seen as furthering the aims of the privatisation of state assets. However, staff working in this ward received no additional payment that could serve as an incentive for providing the best possible patient care. Consequently, patients complained to their doctors about the attitude of the nursing staff.
- Poor security led to theft of luxuries, as well as items such as bedding.
- At one stage there was not enough food, water or medication for 'private' patients, leading to patients demanding transfers to private hospitals.
- Most patients refused to be hospitalised in the state hospital and opted to resign from the Managed Health Care option. A section 21 company called PUBPRI (PUB = Public; PRI = Private) was established jointly by the IPA and the other stakeholders in local government and hospital management. In an effort to save the situation, the company donated R220 000 to improve hospital services. Unfortunately, this happened too late, as the number of patients on the Managed Health Care option – the heart of the IPA – had

dwindled to the extent that some of the private practices could no longer survive. The practices of seven IPA doctors were closed. During a general meeting of members of UDIPA, it was decided to suspend the PPP pending a full investigation of its structure and *modus operandi*.

THE UITENHAGE HEALTH COMMISSION OF INQUIRY ON THE COLLAPSE OF THE PPP

Dr B. Goqwana, the MEC for Health in the Eastern Cape, established a commission to investigate the problems surrounding the PPP in Uitenhage. The commission consisted of members of Uitenhage's Ministers' Fraternal and the Transitional Local Council. The terms of reference were broadened to include issues relating to the general running of the hospital. All stakeholders, including political parties, were invited to make submissions to the commission. The issues that emerged that were pertinent to the PPP included:

- That UDIPA had failed to consult unions and political parties on a broad enough basis before embarking on a public-private partnership with the Eastern Cape Government.
- That, as a result of divisions in hospital management, it failed to make decisions on certain issues, such as the functioning of the PPP.
- That budget shortfalls in terms of annual costs led to destabilisation and impaired the effective operation of health services.
- That in-fights within the IPA, i.e. when one popular doctor broke away to form a rival Managed Health Care option competing for the same patient base, led to the opposing parties using the PPP as a weapon for survival.

The IPA was not pleased with this report and subsequently no efforts were made by any of the parties to re-establish the Public-Private Partnership.

CONCLUSION

Most IPA doctors believe that the government and the Health Commission of Inquiry lost sight of the fact that private doctors can only make a contribution to the community if they have a viable practice. The doctors in the IPA relied on the patronage of medical aid patients, but these patients were so frustrated by conditions in the public sector that they took their business elsewhere.

In this particular case, the public-private relationship was one-sided, with one partner being a 'donor' and the other a 'benefactor'. A significant finding by the Commission of Inquiry was that the terms and benefits of the partnership were not conveyed effectively to those who had to implement the plan. The perception of the IPA doctors was that the hospital staff regarded UDIPA and the dedicated private ward as a 'nuisance'. It appeared that the nursing staff had never understood the benefits of this ward, or the expectations of private patients to be treated differently. As part of the PPP, the IPA expected the leadership in the public sector to openly support the Managed Health Care option under UDIPA, rather than to adopt a neutral stance. Regular interaction between all stakeholders could have served to maintain and revive the objectives of the PPP, and a Quality Assurance project could have helped to refocus the goals of the partnership.

An important lesson to be learned from the failure of this partnership is that each partner should articulate its expectations of the relationship right from the start. In this case, it appears that one partner expected promotional advantage and long-term survival, while the other regarded it as a cost-saving measure in terms of free labour and donations.❐