MODULE 3.2: CONTRACTING-OUT IN THE PUBLIC HOSPITAL SYSTEM

1. INTRODUCTION

This report analyses and evaluates the current pattern of contracting out within the public hospital system in South Africa. It begins with a discussion of some theoretical aspects of contracting out, followed by an analysis of the extent and pattern of current contracting out including the type, nature and value of existing contracts, and by an evaluation of current contracting patterns against a set of objective criteria. This evaluation highlights critical areas and problems in current patterns of contracting out, and thus indicates potential efficiency gains from improvements in these areas. The report concludes with a number of strategic recommendations designed to improve the efficiency of contracting out by the public sector.

2. THE RATIONALE FOR CONTRACTING OUT

In theory, the public sector contracts out hospital services in order to improve the efficiency, the quality or the extent of services delivered, or some combination of these three objectives. It is argued by some observers that governments, by nature, are prone to some element of failure in delivery of services such as health care, resulting in inefficient, costly and often poor quality services. Contracting out is posed as a solution to this problem, on the basis that the public sector can benefit from private sector capabilities, while at the same time maintaining control over which services are provided to whom, and over the funding of services. More specifically, the private sector is argued to generate efficiency gains through cost reductions and improvements in the quality of services, derived from its advantages over the public sector in such areas as specialised and functional expertise, productivity of resources, flexibility, responsiveness and access to new technology and innovations. The various reasons for contracting out can therefore be summarised as follows:

- **The contractor may be able provide a similar or higher quality service at a lower cost than the government**

  The contractor may have a cost and/or quality advantage over the province due to some combination of economies of scale, and greater production efficiency due to competition, expertise or technology. In making a decision based on issues of comparative cost, it is essential to evaluate provincial costs as comprehensively as possible. This includes the full costs to the province of rendering the service itself, as well as the full costs of engaging a contractor, which includes not only the price of the contract, but also all transaction costs, such as those of negotiating and monitoring the contract.

- **The contractor may have skills, capacity or resources not available to the government**

  For highly specialised services, such as equipment maintenance, skilled contractors will almost always be more efficient than the equivalent provincial resources, and contracting out of these services will usually make economic sense. There are also other situations in which contractors can assist provinces to overcome temporary or permanent resource constraints. Some provinces currently face enormous difficulties in managing their existing hospitals efficiently, and the use of outside hospital managers to run specific hospitals for the next few
years may be a strategically wise decision. Similar comments would apply to the running of specialised hospitals, and to the provision of specialised services, such as laboratory or blood transfusion services. Some provinces may also face capital constraints in the face of large requirements, and in some of these situations, contractors may be willing to invest capital in return for a relatively long contract term.

- **The service to be contracted out may not be a core competency of the government**
  It might be argued that the provision of catering and laundry services, for example, is not the core function of a provincial health department, which should focus its energies on the delivery of high quality clinical services. On this argument, non-core services should be contracted out, since contractors are almost certain to be more efficient, for some or all of the reasons noted above.

- **The province may wish to contract out a service in order to focus its efforts on its specific priorities**
  Provincial and/or hospital management may wish to focus energies and efforts on specific hospitals or services, and might therefore justify the use of contractors to relieve some of the burden of service management.

### 3. THE FEASIBILITY OF CONTRACTING OUT

Even where a contract for a particular service is both justifiable and affordable, there may be a number of factors which make it difficult or even impossible to contract out, forcing the government to continue providing the service itself. Obstacles to effective contracting out include:

- **Poor government capacity to manage the contracting out process**
  This is perhaps the major obstacle to effective and efficient contracting out at the present time. In many cases, the provincial health administrations lack the data and the capacity to make appropriate decisions on whether to contract out a service, to negotiate fair and efficient contracts, and to monitor the performance of the contractor once the contract has been signed. In this situation, the risk of serious exploitation by contractors is significant. There are a number of options available to provincial health administrations to deal with this issue while local capacity is built up; one is for the Department of Health at national level to develop capacity to provide technical assistance in the contracting process. Another is for individual provincial administrations to engage outside technical assistance in the contracting out process. In the longer term, however, it will be essential for each provincial administration to develop strong in-house capacity to manage this vital function.

- **Lack of qualified contractors**
  While this problem is rare in South Africa, there may be a limited number of contractors for some services, due to the geographical location of the hospital/s concerned, or due to high barriers to entry for some services.
Limited competition between potential contractors

This is a relatively common problem in South Africa, particularly in respect of hospital management and other complex services. In many of these cases, historical patterns of contracting out have led to the dominance of a particular field by one contractor who holds a monopoly of the market. This situation may be problematic since the lack of alternative suppliers creates dependency by the government, and creates the opportunity for monopolistic suppliers to extract an unfair price, or unfairly favourable contracts. However, examination of the reality of the situation in South Africa at present indicates that, even where limited competition has existed historically, there is significant potential competition which could be introduced into the contracting process. In the case of hospital management services, for example, many of the companies who manage private hospitals are potential competitors for Lifecare. Similarly, there are numerous private pathology laboratories which could compete with the SAIMR for contracts to supply laboratory services. In general, therefore, the problem of limited competition is regarded as a minor one, which can be relatively easily overcome in most situations.

Political obstacles

The main source of political obstacles to both current and new contracts emerges from the negative attitudes of some trade unions and/or of individual workers at institutional level to the principle of contracting out or to the consequences of specific contracts. In many cases, contracting out is perceived as a threat to jobs, or as a mechanism by which the employer seeks to reduce wages over time. In order to forestall these problems, it is obviously essential for management at provincial and/or hospital level to engage in discussions with workers prior to the decision to contract out a service. This dialogue, which has been completely ignored in the past, would provide an opportunity for management to convince workers that contracting out is in the best interests of efficient service delivery, and is not merely a method of cutting jobs or wages. Conversely, this dialogue may alert management to the specific views and needs of workers, which could then be built into the contract, if feasible.

It is vital to note, however, that some of the contracting approaches used to appease unions or workers in the past may compromise the efficiency of the contract. For example, some contracts for catering or laundry services specify that the contractor must manage existing public sector staff working in the laundry or kitchen. This creates a situation in which these workers have dual loyalties, and seriously constrains the ability of the contract manager to achieve efficiency gains.

4. CONTRACTUAL EFFICIENCY

While an appropriate rationale for contracting out is an obvious and necessary condition to ensure efficient contracting, it is not sufficient. Efficient contracting out also requires appropriately designed contracts, which will ensure that there are sufficient bidders for the contract, that the contract is awarded at a fair price, and that once the contract is signed, the contractor will meet all of its contractual obligations, and will not exploit the purchaser.

The theory of contracts suggests a number of determinants of efficient contracts. One of the key factors is the distribution of risk in the contract between public sector and contractor. On the public sector side, the risk is that the contractor will exploit the contract, either by
charging a higher than fair price for its services, or by failing to deliver services of an appropriate level or quality. On the contractor side, the main risks are that it will not obtain a fair return on its investment, either because the price is too low, the contract too short, or the terms of the contract too difficult to fulfil. An ideal contract will therefore provide a fair balance of risk between the two parties, thus encouraging contractors to bid for the contract, while at the same time minimising the opportunities for exploitation by the contractor.

The distribution of risk and other elements of contractual efficiency are determined by several parameters. These include the method of awarding the contract, the price of the contract and the method of payment, the contract duration, monitoring provisions and sanctions for non-performance, and specific mechanisms for the adjustment of the contract during the contract term. Each of these contract parameters are discussed in detail below.

4.1 The method of awarding the contract

Contracts can be awarded through an open, competitive bidding process (such as occurs in the state tender system) or through direct negotiations. Each of these approaches has advantages and disadvantages. Open competitive bidding is required by law in most cases, and is generally perceived to be a fairer approach than direct negotiations. In economic terms, competitive bidding encourages new potential contractors to enter the market, and the resulting competition is argued to be the most efficient way of determining the best price for the contract. However, competitive tendering also has disadvantages; it may induce bidders to engage in predatory pricing, in which they bid at artificially low prices in order to secure the contract, after which prices rise rapidly. In order to secure the contract, bidders may also bid at such low prices that they are forced to reduce the quality of services they deliver in order to survive. An impersonal tendering system also makes it more difficult for the government to develop long term trusting relationships with contractors. Where trust is not present, the government may be concerned that the contractor will exploit the contract for profit, and this may require the government to incur higher monitoring costs than would be the case where levels of trust were higher. This situation can be partly solved through selective tendering, where experienced and known companies are pre-selected to bid. In this instance the price may be higher than in open competition, but the risk of failure and the monitoring costs are lower.

An alternative approach is direct negotiation of the contract with a pre-selected contractor. This usually occurs where an existing contract is extended, or where there is only one potential contractor. One obvious advantage of this approach is that the process is simpler and less costly. Direct negotiation also has specific advantages in situations where competition is limited and an open tendering system will not yield the price advantages usually achieved through bidding. Where competition is limited anyway (as with some specialised services), entering into long-term relationships with providers via direct negotiation may result in a fair price. In addition, the need for detailed contract specification and monitoring may be obviated because the relationship between the parties is based on trust. This approach however has some expected disadvantages. The two parties may not have balanced negotiating capacity, and if the contractor has superior negotiating skills, it is possible that an unfair price as well as an unfair contract may emerge. In addition, long term use of direct negotiation will reduce the number of potential suppliers of service, leading to a situation in which the government is dependent on a monopoly supplier.
Summary
Advantages of open competitive bidding:
- usually required by law
- generally perceived to be fairer
- often results in the best price for the contract

Disadvantages of open competitive bidding:
- may cause predatory pricing
- may cause bidders to bid too low, resulting in poor quality of services
- prevents emergence of trust in the contractual relationship
- incurs higher transactions costs than direct negotiation
- requires sufficient contractors to allow for competition

Direct negotiation has the converse advantages and disadvantages to those of competitive bidding. Some of the problems of competitive tendering can be resolved through the use of a selective tendering process.

4.2 The price of the contract and the method of payment

The price of the contract impacts directly on the balance of risk between the two parties. From the contractor’s side, the price must be sufficiently high to ensure that it can earn an adequate return on its investment, while on the government side, the price must be low enough to ensure that it is able to secure savings by contracting out rather than by providing the service itself. It is important to note, however, that the price which a contractor will find acceptable will also depend on the risk it faces in the contract. If risk is high, for example because the contract term is short, or because income cannot be accurately predicted, then the contractor is likely to demand a higher price. If however the perceived risk to the contractor is relatively low, then the contractor is likely to accept a lower price.

In addition to the contract price, the payment mechanism used in the contract may also be important, particularly in clinical contracts, since it again affects the balance of risk in the contract, and also creates incentives which may significantly influence the efficiency of the contractor. A number of payment mechanisms are used in hospital sector contracts:

- **Block contracts.** These are contracts in which a defined range of services are provided in return for a fixed annual fee. In this case, most of the risk lies with the contractor who must provide the service within the fixed block budget. The financial risk to the government is minimal since total costs are known in advance. However, because the contractor is operating within a fixed budget, there is an incentive to reduce quality of care in order to increase profits. This risk is especially important for clinical services, where quality of care is difficult to monitor on an ongoing basis.
- **Per diem contracts.** This refers to a contract in which a fixed fee is paid per day. In this case, most of the risk is borne by the government, since it is unable to predict total costs in advance. The contractor also bears some risk since the number of patients being treated may be below the occupancy rates required to break even. In some cases, the contractor may include a minimum occupancy clause in which the contractor is guaranteed a minimum payment, even if occupancy levels drop below the defined minimum level. Where this occurs, all risk is effectively borne by the government. A per diem contract also gives the contractor an incentive to increase length of stay so as to increase total contract revenues. Where it is difficult to monitor quality and clinical decision making, this approach poses significant risk for the government.

Similar comments apply to other contracts which are paid on a fee-for-service basis. Examples might include laboratory services, blood transfusion or catering. In all of these cases, total costs to the government are difficult to predict in advance. However, in some cases, the government rather than the contractor can determine the quantity of services required. In this instance, the risk to the government is somewhat lower than the situation in which the contractor controls the parameters.

- **Fee per case/episode contracts.** In these contracts, a unique price is attached to each episode of care, usually based on diagnostic categories. Again the government faces the risk of being unable to predict total costs in advance. However, the contractor also faces some risk, since it must treat each patient within the agreed cost per case. In this situation, the contractor has an incentive to reduce length of stay in order to reduce cost per case. As with block budgets, the approach may encourage the contractor to reduce quality of care, increasing the risk to the government.

- **Capitation contracts.** In these contracts, a fixed price is agreed for the provision of services to a defined population, irrespective of the number of services provided. For the government, this has the advantage of allowing prediction of costs in advance. The contractor therefore bears a significant element of the risk, since neither the number of cases, nor the cost per case can be predicted in advance. However, as with fee per case methods of payment, contractors in a capitation system face incentives to reduce quality of care.

In South Africa, all clinical contracts have been based on a per diem payment basis, while most non clinical contracts have been based on a fee-for-service approach. There is general consensus that these are not ideal methods, and that a shift to some combination of block budget, fee per case or capitation methods would results in efficiency gains. The actual choice of payment method will however be determined by several factors, including the information available, the attitudes of the contractor and the government to risk, and the nature of the actual services provided. Fee per case and capitation contracts, for example, require significant levels of information which is not routinely available in the public sector. In the absence of such information, the risks of these types of contracts can be extremely high for both parties.
Summary
- Price and risk in contracts influence each other directly. The higher the price, the lower the risk for the contractor. On the other hand, in a contract in which risk is higher due to other, non price factors, the contractor will usually demand a higher price.

- Block contracts pose minimal financial risk to the government, but do create the risk that the contractor will compromise quality of services
- Per diem contracts pose financial risk to the government, since it cannot predict total costs in advance. This is aggravated by the contractor’s incentive to prolong length of stay (in clinical contracts), or to increase the number of services (in fee-for-service contracts, such as for laboratory services)
- Fee per case contracts pose financial risk to both parties, and can balance risk. The government cannot predict total costs in advance, while the contractor must ensure that costs per case are lower than the contract price. This can lead to problems with quality of service in some cases.
- Capitation contracts pose minimal financial risk to the government, which can predict its costs in advance. However, they create significant risk for the contractor, and may lead to problems with quality of service.

4.3 The duration of the contract

The duration of the contract also influences the balance of risk in the contract. Short-term contracts present a lower risk for the government since it is will be easier for it to cancel a contract relatively quickly if the services provided are unsatisfactory, or if the contract no longer meets its needs. However, shorter contracts pose higher risks for contractors, who may be unwilling to invest their capital, or to enter into the contract at all, without a minimum guaranteed contract term. The balance of risk is obviously reversed in the case of long term contracts, and the lower risk profile of longer term contracts is likely to encourage more bidders for a contract. In addition, as noted above, long-term contracts have the advantage of encouraging collaboration and increasing trust between the two parties, resulting in lower transactions costs.

Summary
A long contract normally results in:
- increased risk to the government
- decreased risk to the contractor, often resulting in a lower contract price
- if a long contract allows trust to be established, this can bring benefits for both parties

A short contract, on the other hand results in:
- decreased risk to the government
- increased risk to the contractor. In return, the contractor may demand a higher price, and there may be fewer bidders for the contract
4.4 Specifications, monitoring and sanctions for non-performance

In order to minimise the risk that the contractor will exploit the contract, the government may specify most aspects of the contract in detail. Specifications might cover details of the quantity and quality of services, as well as mechanisms for monitoring performance and penalties for non-performance. While this strategy decreases the risk to the government, it creates high transaction costs for both sides. On the government side, these costs emerge from the need to develop the detailed contract, and more importantly, to engage in detailed monitoring. On the contractor side, complying with highly detailed specifications will increase delivery costs, leading to higher risk. If the risk is too high, there may be few or no bidders for the contract. On the other hand, a minimally specified contract, while simpler and cheaper for both sides, clearly increases the risk for the government that the contractor will exploit the contract. Efficient contracts will therefore find the appropriate level of detail of specification so as to share the risk fairly between the two parties.

In monitoring contracts, the nature of the relationship between the parties is important. Where the parties are assumed to have different interests, or where trust is low, sanctions may be required to ensure that the provider adheres to the contract. Where the parties are working towards the same end, or where trust is high, sanctions are a less important element of the contract.

Summary
An overspecified/highly detailed contract may result in:
- a more costly contract (contractors will bid a higher price than otherwise in order to offset their risk)
- an undermanaged contract (government may be unable to monitor the contract to its full level of detail)
- fewer bidders and therefore less competition

An underspecified contract may lead to lower contract costs, but also to lower levels of service from the contractor.

4.5 Specific mechanisms for the adjustment of the contract

Flexibility can be built into a contract in order to manage the risk on both sides. One example of this is a mechanism for adjusting the price on an annual basis in a multi-year contract. In some cases, price adjustments are based on the inflation rate, while in others prices are changed by agreement. Where an automatic price adjustment is included in the contract, the government bears the risk of higher inflation, while the contractor is protected from cost increases. This approach also provides the contractor with weak, or no incentives to contain costs. A more efficient approach may therefore be to negotiate price changes on an ad hoc basis. However, contractors may require a clearer sense that they will at least be protected against the effects of inflation.
5. REVIEW OF CURRENT PATTERNS OF CONTRACTING OUT IN THE PUBLIC HOSPITAL SYSTEM

5.1 General overview

In this section, the framework outlined above is used as the basis for evaluating existing contracting out within the public hospital sector. This evaluation begins with an overview of both clinical and non-clinical contracting, which shows the nature and value of contracts and their distribution by type and province. Thereafter, a number of the most important categories of contracts are individually analysed in some detail.

Table 1: Overview of Current Contracts

<table>
<thead>
<tr>
<th>Category</th>
<th>No. of Contracts</th>
<th>Total Value (R million)</th>
<th>% Total Hospital Budget</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital Management</td>
<td>106</td>
<td>502.3</td>
<td>4.1%</td>
</tr>
<tr>
<td>Laboratories</td>
<td>9+</td>
<td>236.4</td>
<td>1.9%</td>
</tr>
<tr>
<td>Blood Services</td>
<td>7</td>
<td>143.2</td>
<td>1.2%</td>
</tr>
<tr>
<td>Personnel</td>
<td>1</td>
<td>13.7</td>
<td>0.1%</td>
</tr>
<tr>
<td>Other</td>
<td>4+</td>
<td>16.3</td>
<td>0.1%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>127</strong></td>
<td><strong>911.9</strong></td>
<td><strong>7.6%</strong></td>
</tr>
<tr>
<td>Non-Clinical</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Waste Removal</td>
<td>9</td>
<td>7.2</td>
<td>0.06%</td>
</tr>
<tr>
<td>Clinical Maintenance</td>
<td>99</td>
<td>3.3</td>
<td>0.02%</td>
</tr>
<tr>
<td>Gardening</td>
<td>18</td>
<td>3.9</td>
<td>0.03%</td>
</tr>
<tr>
<td>Security</td>
<td>152</td>
<td>28.0</td>
<td>0.2%</td>
</tr>
<tr>
<td>Pharm. Distribution</td>
<td>2</td>
<td>68.2</td>
<td>0.5%</td>
</tr>
<tr>
<td>Patient Transport</td>
<td>2</td>
<td>7</td>
<td>0.05%</td>
</tr>
<tr>
<td>Laundry</td>
<td>5</td>
<td>1.8</td>
<td>0.01%</td>
</tr>
<tr>
<td>Catering</td>
<td>53</td>
<td>97.1</td>
<td>0.08%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>338</strong></td>
<td><strong>216.4</strong></td>
<td><strong>1.8%</strong></td>
</tr>
<tr>
<td><strong>Overall Total</strong></td>
<td><strong>467</strong></td>
<td><strong>1128 million</strong></td>
<td><strong>9.4%</strong></td>
</tr>
</tbody>
</table>

Note: This table does not include contracts for equipment maintenance which number in their thousands and account for substantial annual expenditure
Source: Hospital Strategy Project analysis

Table 1 indicates that in 1995, the departments of health at provincial and national level contracted out services to a total annual value of approximately R1.13 billion per year, equivalent to 9.4% of total hospital expenditure at that time. Note that these contracts are specifically for services rendered, and exclude all purchases of goods, supplies and equipment. The table also shows that 127 contracts for a range of clinical services, including hospital management services, laboratory services, blood transfusions etc. accounted for a total contract value of R912 million, or 80% of total contract spending. The remainder, equivalent to R216 million, was accounted for by 467 non-clinical contracts covering services such as catering, security, equipment maintenance and several others which are described in more detail below.
Table 2 provides further detail on current contracting out, with a specific focus on variations in these patterns between provinces. More detailed analyses of the numbers and values of contracts in each province are given in the Appendix. As the table indicates, most provinces spend between 7% and 11.5% of their annual hospital budgets on contracted out clinical services, the exceptions being the North West and the Northern Cape provinces, both of which spend substantially lower amounts. Gauteng and Kwazulu-Natal currently contract out clinical services to the highest value of all provinces, together accounting for over 50% of the total national value of clinical contracts. This pattern is maintained when per capita contract expenditure is examined. Again, the Northern Cape is an exception here, with a high per capita expenditure due to the low population of the province.

In the case of non-clinical contracts, the table again demonstrates substantial variation between provinces, with Kwazulu-Natal accounting for the highest total expenditure, followed by Gauteng and the Western Cape, and with the North West and Northern Cape provinces again contracting out to the smallest extent. This general pattern is maintained in the analyses of per capita expenditure and the percentage of total expenditures accounted for by contracted services.

Table 2: Provincial Variation in Contracting Out of Clinical and Non-Clinical Services

<table>
<thead>
<tr>
<th>Province</th>
<th>Contract Value (R million)</th>
<th>% Provincial Hospital Budget</th>
<th>Per Capita Expenditure (R)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Clinical Services</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>W.Cape</td>
<td>90.12</td>
<td>7.4%</td>
<td>24.9</td>
</tr>
<tr>
<td>N.Cape</td>
<td>26.95</td>
<td>1.7%</td>
<td>35.3</td>
</tr>
<tr>
<td>E.Cape</td>
<td>129.53</td>
<td>9.9%</td>
<td>20.6</td>
</tr>
<tr>
<td>Free State</td>
<td>42.42</td>
<td>8.3%</td>
<td>15.1</td>
</tr>
<tr>
<td>Kwazulu-Natal</td>
<td>241.10</td>
<td>11.0%</td>
<td>28.2</td>
</tr>
<tr>
<td>Gauteng</td>
<td>258.72</td>
<td>11.5%</td>
<td>37.8</td>
</tr>
<tr>
<td>Mpumalanga</td>
<td>41.41</td>
<td>9.3%</td>
<td>14.6</td>
</tr>
<tr>
<td>North West</td>
<td>22.84</td>
<td>3.1%</td>
<td>4.8</td>
</tr>
<tr>
<td>Northern Province</td>
<td>58.83</td>
<td>8.4%</td>
<td>11.5</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>911.9</strong></td>
<td><strong>7.6%</strong></td>
<td><strong>22.5</strong></td>
</tr>
<tr>
<td><strong>Non Clinical Services</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>W.Cape</td>
<td>27.28</td>
<td>2.2%</td>
<td>7.54</td>
</tr>
<tr>
<td>N.Cape</td>
<td>0.35</td>
<td>0.02%</td>
<td>0.46</td>
</tr>
<tr>
<td>E.Cape</td>
<td>5.81</td>
<td>0.4%</td>
<td>0.87</td>
</tr>
<tr>
<td>Free State</td>
<td>30.72</td>
<td>6.0%</td>
<td>10.94</td>
</tr>
<tr>
<td>Kwazulu-Natal</td>
<td>76.80</td>
<td>3.5%</td>
<td>8.98</td>
</tr>
<tr>
<td>Gauteng</td>
<td>34.91</td>
<td>1.6%</td>
<td>5.10</td>
</tr>
<tr>
<td>Mpumalanga</td>
<td>15.65</td>
<td>3.5%</td>
<td>5.51</td>
</tr>
<tr>
<td>North West</td>
<td>3.85</td>
<td>0.7%</td>
<td>1.10</td>
</tr>
<tr>
<td>Northern Province</td>
<td>21.09</td>
<td>2.2%</td>
<td>2.98</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>216.41</strong></td>
<td><strong>1.80%</strong></td>
<td><strong>5.37</strong></td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>1128.31</strong></td>
<td><strong>9.40%</strong></td>
<td><strong>27.87</strong></td>
</tr>
</tbody>
</table>

Source: Hospital Strategy Project analysis
There are a number of possible reasons for the significant disparities between provinces in the extent and nature of contracting out. These might include differing judgements by provincial administrators as to the relative advantages of contracting out vs. direct provision, variation in provincial priorities, and variations in contract prices. In the latter case, price variations might be explained by some combination of provincial negotiating capacity and market factors. Market factors, such as costs of labour and other inputs, competition and market size are more likely to influence price in the case of non-clinical contracts, since almost all of these contracts are let through the tendering process. By contrast, most clinical contracts are directly negotiated, and in these cases, price is more likely to be affected by the government’s bargaining capacity than by market forces.

While all of these reasons might play some part in explaining the variations noted here, it is more likely that they are due to the lack of a systematic approach, and a fairly high level of arbitrariness in decision making on the issue of contracting out. This analysis has demonstrated that none of the decisions to contract out were based on an explicit justification, and in no cases was there any evidence that the decision was taken after a systematic evaluation of the associated costs and benefits.

5.2 Clinical contracts

As noted in Table 1, clinical contracts are awarded for a number of different services of varying degrees of complexity. Three different providers, Lifecare, Province-Aided hospitals, and the South African National Tuberculosis Association (SANTA) provide hospital management services to the government. As demonstrated in Table 1 and Figure 1, these contracts together accounted for expenditure of R502.3 million in 1995, equivalent to 55% of total clinical contract spending, and 44% of total contract spending. As also shown in Figure 1, Lifecare is by far the most important provider of hospital management services, accounting for 55% of expenditure on this category, and dominating both clinical and total contracting, of which it accounts for 30% and 24% of expenditure respectively. Contracts for various laboratory investigations and provision of blood products, with the South African Institute for Medical Research, provincial laboratories and the various Blood Transfusion Services, are the next most important category of clinical contracts, together accounting for total expenditure of R378 million, equivalent to 41% of total clinical contracts. As Figure 1 shows, the SAIMR clearly dominates this group, accounting for 42% of total expenditure on laboratory investigations and blood products. Figure 1 also shows relatively small total expenditure on contracts for provision of nursing and other personnel, as well as on a range of smaller contracts, such as emergency transport services and home oxygen supplies.
5.2.1 Hospital Management Contracts

*Lifecare*

At the time of this study, Lifecare held 33 hospital management contracts, and operated in all provinces except the Northern Cape. The 33 contracts comprise a total of 15,239 beds, providing care to long term and acute psychiatric patients (10,251 beds in 15 hospitals), TB patients (3,061 beds in 8 hospitals), frail care patients (1,319 beds in 8 hospitals) and acute district hospital beds (608 beds in 3 hospitals). Within this total there is, however, a wide variation between provinces in the use of Lifecare as a contract hospital manager, as illustrated in Table 3.
### Table 3: Contracts with Lifecare Held by Provinces

<table>
<thead>
<tr>
<th>Province</th>
<th>Psychiatric Hosp</th>
<th>Psychiatric Beds</th>
<th>Psychiatric Value (Rm)</th>
<th>TB Hosp</th>
<th>TB Beds</th>
<th>TB Value (Rm)</th>
<th>Frail Care Hosp</th>
<th>Frail Care Bed</th>
<th>Frail Care Value (Rm)</th>
<th>Acute Hosp</th>
<th>Acute Bed</th>
<th>Acute Value (Rm)</th>
</tr>
</thead>
<tbody>
<tr>
<td>W.Cape</td>
<td></td>
<td></td>
<td></td>
<td>2</td>
<td>414</td>
<td>10.6</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>E.Cape</td>
<td>3</td>
<td>931</td>
<td>14</td>
<td>1</td>
<td>610</td>
<td>13.7</td>
<td>2</td>
<td>250</td>
<td>6.1</td>
<td>1</td>
<td>250</td>
<td>11.1</td>
</tr>
<tr>
<td>Free State</td>
<td>1</td>
<td>680</td>
<td>3.2</td>
<td>2</td>
<td>700</td>
<td>13.5</td>
<td>1</td>
<td>109</td>
<td>2.1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>KZN</td>
<td>1</td>
<td>1300</td>
<td>15</td>
<td>1</td>
<td>745</td>
<td>15.3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gauteng</td>
<td>8</td>
<td>5650</td>
<td>86.4</td>
<td>3</td>
<td>956</td>
<td>22.3</td>
<td>2</td>
<td>296</td>
<td>8.4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mpumalanga</td>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td>250</td>
<td>4.3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>North West</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td>92</td>
<td>6</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>North.P</td>
<td>2</td>
<td>1690</td>
<td>22.6</td>
<td>1</td>
<td>50</td>
<td>1.3</td>
<td></td>
<td></td>
<td></td>
<td>2</td>
<td>358</td>
<td>20.6</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>13</strong></td>
<td><strong>8561</strong></td>
<td><strong>141.3</strong></td>
<td><strong>8</strong></td>
<td><strong>3011</strong></td>
<td><strong>66.2</strong></td>
<td><strong>8</strong></td>
<td><strong>1319</strong></td>
<td><strong>31.7</strong></td>
<td><strong>4</strong></td>
<td><strong>700</strong></td>
<td><strong>37.7</strong></td>
</tr>
</tbody>
</table>

Source: Hospital Strategy Project analysis

- **Rationale for the contracts**

This analysis was not able to identify any written explanations or justifications for any of the current contracts with Lifecare. While this is not surprising, given that all contracts were inherited from previous administrations, it is arguable that these contracts should be now have been subjected to systematic review by the various provincial administrations which have taken them over. This has however not occurred, and there have to date been only limited evaluations of a very small number of existing contracts. As a result, there is extremely limited data on which to evaluate the relative merits of contracted out and directly provided services.

A number of different factors appear to have influenced the decisions of the previous administrations to contract out the management of hospitals. In many cases, contracts have been so long-standing that the governments no longer have the capacity to provide certain services themselves and have thus become dependent on Lifecare for delivery of these services. In some cases, Lifecare was able to assist the administration in overcoming specific beauraucratic or budgetary constraints. For example, some homeland administrations were unable to raise the capital to develop hospital services, while others were unable to set up the appropriate staff establishment necessary to commission already existing hospitals. In many cases, however, it now appears as if the long duration of contracting has itself become a reason for its continuation, even where governments do have the capacity to provide such services themselves.
The method of awarding the contract

With one exception, all of the existing contracts with Lifecare have been directly negotiated, rather than let through a competitive tender. The only exception to this is the contract for Hewu hospital, a 250 bed district hospital in the Eastern Cape. In this case, when the initial 5 year (directly negotiated) contract between the Ciskei administration and Lifecare terminated in 1993, Lifecare won a further 3 year contract in an open competitive tender. One obvious reason for the reliance on direct negotiations rather than the use of competitive tenders has been the real and perceived lack of competitors for Lifecare in providing hospital management services. While this may well have been true in the past, it is less likely to be true at present. As noted above, direct negotiation has several theoretical advantages, including the development of trust in the relationship between the two parties, with a consequent lowering of transactions costs of monitoring the contract. These advantages appear not to have been realised however. Interviews conducted for this analysis demonstrate some mistrust of Lifecare by officials in some provincial administrations, and a perception (whether justified or not) that Lifecare is making significant profits at the expense of the provinces. These perceptions clearly need to be tested and addressed by both sides if rational decisions are to be made, and if productive, efficient contractual relationships are to be established.

The price of the contract and the method of payment

Existing contracts reveal extremely wide variation in pricing, even for ostensibly similar ranges of services, as illustrated in Table 4. There may be several reasons for such price variation. One of these may relate to variations in underlying production costs incurred by the contractor in different hospitals. For example, labour or other costs may vary significantly between regions, justifying different prices. Where Lifecare incurred a capital cost in entering the contract (e.g. at Matikwana and Shiluvana hospitals, where Lifecare funded the capital costs of erecting the hospitals), the higher price is due to amortisation of the capital cost into the contract price. In other cases, however, price variations are more likely to be due to the poor negotiating capacity of the government, and to its lack of information on its own, or the contractors’ cost of producing hospital services. In this situation, it is relatively easy for a contractor to obtain a favourable price. Another important influence on contract price is the impact of apartheid policies - most of the very low cost contracts are those for historically black hospitals, for which the previous government was prepared to accept a lower quality of service, and hence was only willing to pay a lower price. It is obvious that these discrepancies should be eliminated as soon as feasible.
<table>
<thead>
<tr>
<th>Hospital</th>
<th>Service Contracted</th>
<th>Price per Patient Day (1995)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Randfontein (Gauteng)</td>
<td>Psychiatric</td>
<td>R39.13</td>
</tr>
<tr>
<td>Evuxakeni (Northern P)</td>
<td>Psychiatric</td>
<td>R64.75</td>
</tr>
<tr>
<td>Lifemed (Gauteng)</td>
<td>TB</td>
<td>R75.28</td>
</tr>
<tr>
<td>Allanridge Chest (FS)</td>
<td>TB</td>
<td>R61.45</td>
</tr>
<tr>
<td>Khanya Residensia (Mpumalanga)</td>
<td>Frail Care</td>
<td>R52.24</td>
</tr>
<tr>
<td>Lorraine Residensia (E.Cape)</td>
<td>Frail Care</td>
<td>R100.06</td>
</tr>
<tr>
<td>Matikwana (Northern P)</td>
<td>Acute Care</td>
<td>R209.40</td>
</tr>
<tr>
<td>Shiluvana (Northern P)</td>
<td>Acute Care</td>
<td>R143.62</td>
</tr>
</tbody>
</table>

Source: Hospital Strategy Project analysis

All existing contracts use the *per diem* payment method, requiring the government to reimburse Lifecare retroactively for the number of annual patient days delivered, and there has been no experimentation with alternate pricing structures, such as cost per case or global budget approaches. There is some suspicion, on the part of provincial officials, that the *per diem* payment method provides Lifecare with an incentive to prolong length of stay in its hospitals, or at least not to make efforts to reduce length of stay, as efficiency requirements would dictate. This is argued to be a particular problem in the long term psychiatric hospitals, in which the provinces would prefer a policy of shifting those patients who are well enough out of the long term institutions, while current practices are to retain patients within the institutions. Several points should be noted in relation to this observation; firstly, there is extremely limited data to prove the assertion that the *per diem* payment method does result in longer average length of stay in Lifecare hospitals; secondly, in many cases, Lifecare does not employ the medical staff, who presumably have the strongest influence over the decision to discharge a patient. Where Lifecare does employ the medical staff, the incentive effects of these contracts are more of a concern, and should clearly be investigated by the relevant provinces. It is also worth noting that in many cases, Lifecare has come to employ the medical staff because of a failure of the government to honour its contractual obligations to provide medical staff. This occurs, for example, in several of the psychiatric hospitals in Gauteng.

Despite these points, there are strong arguments for a reconsideration of the payment method used in the Lifecare contracts. Contracting theory does suggest that the *per diem* payment method shifts the burden of risk to the government, since it cannot predict its total costs in advance. This problem is aggravated by the use of minimum occupancy clauses, as occurs in two of the contracts (Matikwana and Shiluvana). In these cases, the contractor is guaranteed a minimum payment, even where occupancy drops below a defined minimum. There is also extensive international evidence that the *per diem* payment method results in longer average length of stay.

- **Contract Duration**

In 16 of the 33 hospitals managed by Lifecare, contract terms vary between 3 and 10 years. In the remaining 17, however, the contracts are open-ended, with no specified contract term. This means that contracts do not come up for renewal, are not reviewed on a periodic basis, and can, in theory, only be terminated in the case of breach of contract. Open ended
contracts of this kind are highly questionable from a contractual efficiency perspective. While they are clearly beneficial to the contractor, whose risk is significantly lowered by an indefinite contract term, they clearly increase the risk borne by the government. Where government’s capacity to inspect and monitor the performance of the contractor is relatively weak, shorter contract terms provides a means of forcing provinces to examine their contracts and to ensure that the contractor is meeting its obligations.

Having stated this, however, it is recognised that certain Lifecare contracts are open-ended because the contractual risk was perceived, at the time of contracting, to lie with Lifecare. An open-ended contract minimised their risk because they were thereby guaranteed to recover their initial capital investments. Many open-ended contracts though, especially those present in psychiatric hospitals, have been operating for over 15 years. In these contracts, contractual risk could well have passed to the government, and this should consequently be reviewed.

- Specifications, monitoring and sanctions for non-performance

All of the existing contracts reviewed specify the obligations of the contractor in only the vaguest of terms. In most cases, the contract simply specifies that the contractor will provide hospital services of an acceptable quality, with no further detail provided. In most of the older contracts, there is no mention at all of monitoring of the quality of care, nor of any other aspects of the contractor’s obligations. However, more recent contracts do make specific provision for the government to monitor services, but in all cases, the relevant clauses are extremely vague. As noted above, this situation again favours the contractor, since it is much easier, and less costly, to fulfil minimally specified contractual obligations. On the other hand, this situation creates a significant risk for the government that the quality of care, and other aspects of service provision will fall below acceptable standards without this being detected. Interviews and discussions with provincial officials reveals that monitoring and inspection of the Lifecare hospitals are not undertaken systematically in most provinces, further increasing these risks. More efficient contracts would therefore spell out the contractor’s obligations, the mechanisms and metrics for monitoring/measuring these, and the sanctions for non-compliance, in much more detail than is the case in the current contracts.

- Specific mechanisms for the adjustment of the contract

Most of the current contracts provide for an annual price adjustment to take account of inflation. In addition, many of the contracts make provision for the contractor to seek a further adjustment (increase) in the price should circumstances require this. Lifecare has exercised this clause in the past to request price increases when it has been forced to increase wages in response to increases in public sector wages. Once again this combination of an inflationary and an additional price adjustment mechanism clearly favours the contractor, since it is protected against almost all risk of increased costs. While stronger government negotiation might have been able to prevent the contractor from taking advantage of this situation, the evidence suggests that Lifecare was able to secure the increases it requested in almost all cases.
Conclusions

This analysis has demonstrated a number of trends in the current pattern of contracting with Lifecare. The extent of contractual obligation is very large, but has not been systematically justified nor evaluated. It is thus not possible, at this stage, to determine whether this form of contracting out is increasing or decreasing the efficiency of hospital delivery. In several cases, it is clear that Lifecare is filling a critical, strategic gap in the delivery of a range of hospital services, and that without these contracts, the provincial governments would not be able to meet their obligations. It is also the case that the role played by Lifecare allows the provincial health departments to focus their limited resources and efforts on improving the efficiency of their own services. This analysis has also demonstrated some disturbing common trends. Government negotiating capacity appears to have been uniformly weak, leading to the agreement of contracts which favour the contractor in most respects. Similarly, the heavy reliance on direct negotiation rather than competitive tender favours the incumbent contractor and prevents the emergence of an element of competition which may well enhance efficiency. Even in the absence of detailed analysis, it is obvious that efficiency gains would result from a revision of the contracts to more fairly share the risk between the government and Lifecare.

It is also vital that more of the current contracts be adequately evaluated. This evaluation should examine the extent to which the contract still meets the governments’ requirements, the details of the contract, and the relative performance and cost of contracted out versus directly provided services. This evaluation may well conclude that contracting out of hospital management, whether to Lifecare or to another contractor, can provide substantial benefits in particular circumstances. However, it is also likely to demonstrate areas of significant inefficiency within current contracts, and most importantly, it will allow existing contracts to be modified so as to improve their efficiency.

SANTA

SANTA, which is a not-for-profit non governmental organisation, owns and manages 22 institutions, and provides care to publicly funded patients with tuberculosis (TB) in the provinces of Western Cape, Eastern Cape, Free State, Kwazulu-Natal, Gauteng and Mpumalanga. Table 5 demonstrates that the total amount paid by these governments to SANTA amounted to R73 million in 1995. This relationship dates back to a verbal agreement, reached in the 1950s, between the then Department of Health and SANTA. The current SANTA “contract” remains in the form of a “gentleman’s understanding” between the two parties. Under the terms of this agreement, SANTA provides two services to the government. Its primary service is the provision of hospital care to TB patients, but since 1978, a Health Education Fund has also been in operation in the form of a partnership with the Department of Health and the SA Christmas Stamp Fund. A Memorandum of Agreement, reached in 1993, directs the functions and activities of SANTA’s volunteers and staff towards the development of community initiatives in the national Tuberculosis Control Programme.
Table 5: Details of Services Provided By SANTA

<table>
<thead>
<tr>
<th>Province</th>
<th>No. of Hospitals</th>
<th>Beds</th>
<th>Value (R million)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Western Cape</td>
<td>2</td>
<td>440</td>
<td>6.5</td>
</tr>
<tr>
<td>Eastern Cape</td>
<td>7</td>
<td>1325</td>
<td>18.4</td>
</tr>
<tr>
<td>Free State</td>
<td>1</td>
<td>150</td>
<td>2.4</td>
</tr>
<tr>
<td>KZN</td>
<td>6</td>
<td>1443</td>
<td>21.6</td>
</tr>
<tr>
<td>Gauteng</td>
<td>5</td>
<td>1340</td>
<td>20.1</td>
</tr>
<tr>
<td>Mpumalanga</td>
<td>1</td>
<td>240</td>
<td>3.8</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>22</strong></td>
<td><strong>1938</strong></td>
<td><strong>72.8</strong></td>
</tr>
</tbody>
</table>

Source: Hospital Strategy Project analysis

As with the Lifecare contracts, it is difficult to identify any explicit rationale for the existence or nature of the SANTA “contract” at this point, and this situation is only now receiving explicit and systematic attention. Some of the new provincial health administrations have expressed concern and dissatisfaction with several aspects of the current situation. These concerns have focussed on quality of care in the SANTA institutions, as well as on the clinical approaches used, and on the relationship between these hospitals and the rest of the public hospital system. This latter concern seems to emerge from a perception that the current “contract” is based on an outdated model of TB care, in which patients were hospitalised for lengthy periods. Current approaches focus more on supervised outpatient treatment close to the patient’s home, thus reducing the need for large scale in-patient capacity, which is often sited at long distances from where patients live.

It is also important to note that SANTA itself is experiencing some difficulties in its current contractual relationships with the new provincial health administrations. These appear to be related to the shift from a single relationship with the former Department of National Health and Population Development, to a situation in which the organisation has to relate to, and be paid by, nine provincial health administrations. For example, major difficulties in obtaining payment have been experienced in some provinces. All of these observations suggest the need for some formalisation of the current situation, and the development of an explicit contract. This process is currently underway, and a model contract, developed by the Hospital Strategy Project, has been submitted to the provinces for their views and for discussion with SANTA.

- The method of awarding the contract

Direct negotiations rather than a competitive tendering process will be used in the shift from an informal to a formal contract between the provincial health administrations and SANTA. The relative merits of these two approaches do not appear to have been seriously considered thus far, and it is worthwhile outlining them here. There are two main reasons for a directly negotiated contract: firstly, SANTA owns the hospitals in which it provides services, so that termination of the arrangement might require that new premises be found (although these could probably be purchased from SANTA at low cost); secondly, SANTA is a not-for-profit NGO, and is totally dependent on the “contract” for its survival. The awarding of some of the contracts to competitor organisations might therefore threaten its survival, and while this should not force provincial administrations into inefficient decisions, this risk should at least be made explicit. More importantly, however, the dependence of SANTA suggests that a strong negotiating position by the government is very likely to secure a highly favourable
contract, thus eliminating the benefits of a competitive tendering process. In favour of a competitive tender, it could be argued that actual or potential competition might force SANTA to improve its efficiency, and also that some competitor organisations might well be more efficient. Competitors might include other not-for-profit providers, such as NGOs who currently provide health services, or from for-profit providers, such as Lifecare, which also currently manages TB hospitals on state contracts.

- The price of the contract and the method of payment

Historically, prices have been determined for each hospital on an individual basis. SANTA is reimbursed on the basis of an agreed tariff per patient day, which varies between different hospitals. As with the Lifecare contracts, there is no obvious reason for the discrepancies between prices at the different hospitals.

Under the current arrangement, SANTA does not incur any losses, nor make any profits, and any deficits are funded by the government. This situation clearly places the burden of risk on the government side, and creates extremely poor incentives for efficiency on the part of SANTA. This situation has given rise to a breakdown of trust between SANTA and several of the provinces. In the Eastern Cape, a task team comprising SANTA, the Province and Nehawu are presently investigating all aspects of the TB Centres in order to resolve a funding dispute. SANTA claim that a 1994 deficit of R4.4 million has yet to be funded, which does not bode well for a projected 1995 deficit of R4.5 million. In Mpumalanga a deficit of R1.6 million has arisen because there was no tariff increase in 1995. Nationally SANTA project a R15.3 million potential deficit, which is a threat to their solvency. Clearly the issues of pricing and funding needs to be resolved. Most importantly, the funding arrangements should include a binding budget constraint, under which it is clear that the government will not meet any operating deficits.

The current cost per patient day, averaged across all the SANTA hospitals, is approximately R40.00, with approximately 1.8 million patient days of care provided in 1995, generating the total cost to the government of R73 million. Of this total, 7.5% (or R3 per patient day) goes towards a SANTA administrative fee, providing for the improvement of the SANTA centres, partial funding of the Health Education Programme, and a contribution to the financial, legal and technical services provided by a National Secretariat. It is important to note that the price charged by SANTA covers only “hotel fees”, since drugs, other medical necessities and transport are separately funded by the government.

As with the Lifecare contracts, there is almost no cost or other data on which to judge the appropriateness of the current prices charged by SANTA. This lack of data applies both to SANTA hospitals and to the government’s own costs of treating TB patients. As a result, SANTA’s claim that its services are rendered on a cost effective basis relative to other providers remains unproved. The Free State has recently initiated a detailed evaluation of one SANTA hospital contract, and this should provide invaluable information on which to base future negotiations.

The Health Education programme operates in all nine provinces, and cost R4 million in 1995. Initially, the Department of Health government provided seven eighths and SANTA one eighth of expenditure for this programme, but this was modified to a 50% split in funding as
of 1992. In 1995, the Department therefore provided R1.9 million towards this programme, with the balance provided by SANTA.

- **Contract duration**

Under the current arrangements, there is no formal contract term, so that the existing ‘implicit’ contract can be considered to be open ended. This should be modified when a new contract is negotiated. Although a shorter contract term will encourage regular review, it is less essential than in the case of a for-profit provider. Relatively short contracts, of say 2-3 years, may however be beneficial to both sides, providing stability and security to the hospital, while also allowing the provincial administration to review and rewrite the contract at regular intervals should circumstances require this.

- **Monitoring provisions and sanctions for non-performance, and specific mechanisms for the adjustment of objectives, services, prices and equipment**

These elements are absent from the current implicit contract, and must be included in a new formal contract.

- **Conclusions**

There is an urgent and obvious need to establish a formal, contractual relationship between the relevant provincial health administrations and SANTA, and as noted above, this process is already underway. In reaching these agreements, however, it will be essential to resolve a number of outstanding policy issues. These include the role of SANTA within the provincial health services network, appropriate prices, payment methods, approaches to funding, and the benefits and costs of opening up the SANTA contracts to competition.

*Province-aided Hospitals*

Province-aided hospitals are privately owned, not-for-profit hospitals, which operate on an autonomous basis under the governance of independent hospital boards. They receive a government subsidy which covers 90% of their recurrent costs, in return for which they are expected to provide hospital services to publicly funded patients. Table 6 demonstrates that in 1995, there were 50 such hospitals, accounting for 3193 beds in total, and these hospitals are distributed between four of the provinces. The table also shows that total government expenditure on these hospitals amounted to R152 million in 1995, of which hospitals in Kwazulu-Natal accounted for almost 50% (R83 million). The wide variation in numbers and expenditure on these hospitals reflects historical development of mission and other charitable hospitals, since most province-aided hospitals were founded by these organisations.
Table 6: Contracts with Province-Aided Hospitals

<table>
<thead>
<tr>
<th>Province</th>
<th>No. of Hospitals</th>
<th>Beds</th>
<th>Value (R million)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Western Cape</td>
<td>15</td>
<td>703</td>
<td>20.2</td>
</tr>
<tr>
<td>Northern Cape</td>
<td>8</td>
<td>237</td>
<td>18.7</td>
</tr>
<tr>
<td>Eastern Cape</td>
<td>19</td>
<td>899</td>
<td>29.2</td>
</tr>
<tr>
<td>KZN</td>
<td>8</td>
<td>1354</td>
<td>83.8</td>
</tr>
<tr>
<td>Total</td>
<td>50</td>
<td>3193</td>
<td>151.9</td>
</tr>
</tbody>
</table>

Source: Hospital Strategy Project analysis

In Kwazulu-Natal, arrangements with the province-aided hospitals are based on verbal agreements, most of which date back many years. The province currently perceives this lack of a formal contractual agreement as a problem, since it prevents clear definitions of the role and functions of these hospitals, and of standards of care etc. In the three provinces which were formerly part of the Cape Province, there are formal letters of agreement between the provincial health administrations and the province aided hospitals. These agreements provide for provincial representation on the hospital board, require that hospital management report to the provincial administration, but also allow hospital management significant autonomy and discretion in the expenditure of funds.

- **The method of awarding the contract**

While there is clearly a need to shift to a formalised contractual arrangement between all province-aided hospitals and the relevant provincial administrations, these are all likely to be developed on the basis of direct negotiation rather than competitive tender. In the long term, however, it will be important for the provinces to investigate the cost-effectiveness of service delivery in these hospitals, and to investigate potentially more efficient alternatives. In this situation, competitive tendering may emerge as an appropriate mechanism.

- **The price of the contract and the method of payment**

The value of the annual subsidy to each province-aided hospital, and hence the effective price paid by the province, varies significantly, and is based on a budget submitted annually to the provincial health administration. As a result, average costs per patient day vary significantly between these hospitals, and are determined on an arbitrary, historical basis, rather than on the basis of provincial cost norms. At a minimum therefore, provinces funding province-aided hospitals should begin to shift to a situation in which unit costs at these hospitals are brought into line either with average unit costs at comparable government hospitals (assuming that the latter are lower), or with provincial cost norms. This may require adjustments to the production patterns and quantity of services delivered by some of the hospitals, but this is an acceptable price to pay for a more rational allocation of resources.

As noted above, there is almost no cost or other data on which to judge the appropriateness of the current effective prices charged by the province-aided hospitals. Obtaining these data is therefore an urgent priority in the process of investigating the role of these hospitals in the wider health care system.
The use of an annual budget as the method of payment has the strong advantage of encouraging efficient use of resources, and should be retained when formal contracts are renegotiated or established for the first time. However, the efficacy of this budget approach is undermined in several cases by the fact that the provinces tend to fund any deficits faced by the province-aided hospitals. In this situation, hospital management faces no incentive to contain costs or to use resources efficiently. If a global budget system is to be used, it should therefore be combined with a binding budget constraint.

- Contract duration

Similar comments to those noted for SANTA apply in this case. Where contracts are relatively long term, it will be important to build into the contract mechanisms that allow for regular and rigorous review of the contractual arrangements. On the other hand, relatively shorter contracts, of say 2-3 years, may be beneficial to both sides.

- Monitoring provisions and sanctions for non-performance, and specific mechanisms for the adjustment of objectives, services, prices and equipment

As with the Lifecare and SANTA contracts, these elements are clearly absent from the current implicit contract, and must be included in a new formal contract.

- Conclusions

As with the SANTA hospitals, there is an urgent need to establish formal, contractual relationships between the relevant provincial health administrations and those province-aided hospitals in which there are no contracts. Where contracts do exist, all of them can be improved in several of the ways suggested above. Perhaps most importantly, it is essential that provinces begin a process or reviewing the role of each of the province-aided hospitals within their wider health care systems. This should ensure that these hospitals are both necessary and cost effective, and where this is found not to be the case, provincial planning norms and other measures should be used to improve the situation. As with the SANTA hospitals, the fact that the province-aided hospitals are not-for-profit means that there is substantially less risk of exploitation of the contract. This in turn implies that contract terms may be a little longer, and that contracts can be somewhat less detailed and rigorous.

5.2.2 Pathology services

The SAIMR is the major provider of pathology services to the public hospital system, servicing most public hospitals in the country. Exceptions to this pattern occur in KwaZulu-Natal, which has its own provincial laboratory service, in some academic hospital centres, which are serviced by the university, and in more limited cases, by specific contracts between provinces or hospitals and private pathology laboratories. The SAIMR is a non-profit organisation, owned jointly by the government and the Chamber of Mines.
Payments by provincial health administrations to the SAIMR amounted to a total of R159 million in 1995, equivalent to 17% of total expenditure on clinical contracts, and 14% of total expenditure on all contracted services. Table 7 shows that usage of these services varies widely between provinces, both in absolute and per capita terms, with Gauteng, for example, spending over four times as much per capita as the Northern Province. These differences are attributable to a number of factors. Some provinces use in-house or other laboratories (Kwazulu-Natal and the Free State); in addition, the higher per capita expenditure in Gauteng and the Western Cape reflects the higher numbers of tertiary/academic centres in these provinces, as well as higher per capita utilisation of laboratory pathology services.

### Table 7: Contracts with SAIMR for Laboratory Services

<table>
<thead>
<tr>
<th>Province</th>
<th>Total Value of Contract (R million)</th>
<th>Per Capita Expenditure (R)</th>
</tr>
</thead>
<tbody>
<tr>
<td>W.Cape</td>
<td>19.0</td>
<td>5.2</td>
</tr>
<tr>
<td>N.Cape</td>
<td>5.7</td>
<td>7.5</td>
</tr>
<tr>
<td>E.Cape</td>
<td>28.0</td>
<td>4.2</td>
</tr>
<tr>
<td>Free State</td>
<td>10.7</td>
<td>3.8</td>
</tr>
<tr>
<td>Gauteng</td>
<td>64.5</td>
<td>9.4</td>
</tr>
<tr>
<td>Mpumalanga</td>
<td>10.4</td>
<td>3.6</td>
</tr>
<tr>
<td>NW</td>
<td>9.5</td>
<td>2.7</td>
</tr>
<tr>
<td>Northern</td>
<td>11.4</td>
<td>2.2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>158.9</strong></td>
<td><strong>3.9</strong></td>
</tr>
</tbody>
</table>

Source: Hospital Strategy Project analysis

Those provinces which use the SAIMR do so on the basis of formal agreements, although there is currently a fair amount of confusion with regard to the status and future of these contracts. In the Western Cape, for example, the agreement reached between the SAIMR and the former Cape Province expired in mid 1995, and was extended to December 1995, at which point the Province expected guidelines from a policy committee at national level, regarding the future of public sector laboratory services. These guidelines are as yet not available, and the province is now investigating the alternatives of continuing its relationship with the SAIMR, or of putting these services out to competitive tender. Recent information indicates that the Northern Province has already issued a tender for the provision of laboratory services. The remaining provinces appear to have extended their SAIMR contracts, either formally or informally, while clarity on national policy guidelines is obtained, and while decisions are taken on whether to go to competitive tender.

- **The method of awarding the contract**

All existing agreements were directly negotiated. As noted above, however, there is now some expectation that some provinces may go out to competitive tender for some or all of their hospital laboratory services. This situation clearly illustrates the relative advantages and disadvantages of alternative approaches to contracting. The present, non-competitive arrangement has several advantages; it has given rise to a long term relationship in which the contractor is highly dependent on the provincial governments for its survival. This, together with the non-profit status of the SAIMR, provides some assurance to the government that it
will not be exploited, and its transactions costs are at this point virtually zero. However, the lack of competition has also created concern among some of the government purchasers that lower prices could be obtained through a competitive tender, and that the lack of competition has encouraged some inefficiency in the SAIMR. It is disturbing to note that, despite the substantial expenditures on laboratory services, there has thus far never been a systematic evaluation of the cost-effectiveness of these contractual relationships, or of possible alternatives. As a result, there is no hard evidence that competitive contracting will necessarily increase efficiency, and the none of the provincial health administrations have any data on the costs of laboratory services provided by different suppliers.

A competitive tender may therefore have the advantage of securing lower prices, although there may be several hidden costs and disadvantages to this approach. One important risk is that private laboratories will engage in predatory pricing, offering very low prices in order to secure the contract in the first instance. If this occurs, it is possible that SAIMR capacity will be lost, creating a dependence on the private sector. In the next round of bidding, private sector prices may then increase significantly, and the government will have no choice but to pay these prices. In addition, entering into a number of contracts with several new, private, for-profit suppliers will lead to much higher transactions costs, including the establishment of the tender process itself, and the negotiation and monitoring of a number of contracts. In this situation, it might therefore make more sense for the government to negotiate more firmly with the SAIMR, in order to secure lower contract prices, as well as any other changes to the contract which the government may require. The government has extremely strong bargaining power with respect to SAIMR, and may thus be able to secure highly favourable contracts.

It is also important to note the difficulties that may occur in assessing a competitive contract based on price. The SAIMR ‘price’ is unique for each investigation, and is based on the cost of each investigation in units, multiplied by the unit price, which is agreed annually. Comparing the relative contract prices will therefore require a complex assessment of the total cost of a defined basket of investigations, rather than assessment of individual unit prices.

- The price of the contract and the method of payment

The SAIMR charges public hospitals a fee per investigation, based on an annually agreed unit price, and on a calculated number of units per investigation. The total price of the contract therefore cannot be determined in advance, since it depends on the utilisation of services during the contract period. This places the government at some financial risk, since it cannot predict its total costs in advance. However, as the government does have some indirect control over the number of investigations ordered, it should be able to influence total contract price.

While contractors may resist capitation or block payments, it is certainly worthwhile for the government to investigate alternative payment methods in any new contract. It is very likely, for example, that the fixed costs for each batch of tests are fairly high, since a kit is required, no matter whether the minimum or maximum number of tests are done. If this is the case, the marginal costs of additional tests over and above the minimum required should be low. In this case, it might be possible to obtain lower average prices per test than is currently the case. At
a minimum, the governments should develop a better understanding of the production economics of laboratory investigations, so as to put it in a strong bargaining position. If direct negotiations with SAIMR were pursued, it might well be possible to obtain such information, but this will probably be more difficult in the case of the private laboratories.

- **Contract duration**

Similar comments to those noted above apply here. If longer term contracts are continued, it will be important to build into the contract mechanisms that allow for regular and rigorous review of the contractual arrangements. On the other hand, it is arguable that relatively shorter contracts, of say one year at a time, would be more efficient in this case, particularly if contracts with new suppliers are initiated. These would allow the provincial administration to review and rewrite the contract at regular intervals should circumstances require this.

- **Monitoring provisions and sanctions for non-performance, and specific mechanisms for the adjustment of objectives, services, prices and equipment**

As with the Lifecare and SANTA contracts, these elements are clearly absent from the current implicit contract, and should be included in a new formal contract.

- **Conclusions**

Although contracts for laboratory services have been shown to account for substantial expenditures, there has been no systematic evaluation of the cost effectiveness of current provision arrangements. In addition, there is now significant uncertainty surrounding the future role of the SAIMR, based on untested perceptions that the private for-profit laboratories can provide a more efficient service. There is therefore an urgent need to decide on the future provision of laboratory services, since the current uncertainty is negatively affecting both the provincial health administrations and the SAIMR. In making these decisions, it will be vital to obtain hard data on the relative cost effectiveness of the SAIMR and private providers, since inappropriate decisions to contract services to the private sector instead of the SAIMR will have very serious consequences for the SAIMR itself, and may well create dependence on private for-profit providers.

Once decisions are reached, contract design and pricing should be based on a sound understanding of production economics, and if possible, capitation or global budget payment methods, rather than fee-for-service contracts should be negotiated. As with the other contracts, these contracts should be specified in some detail, and should have explicit monitoring mechanisms and sanctions for non-performance written into them.
5.2.3 Supply of Blood Products

Public hospitals obtain blood products from 6 independent Blood Transfusion Service organisations, which cover different geographical regions, as shown in Table 8. The Blood Transfusion Services are Section 21 companies, and each maintains an independent relationship with the province/s which it supplies. The table also shows that a total of R143.2 million was spent on blood products in 1995, and indicates the distribution of this total between the provinces. None of the current relationships have been formalised on a contractual basis. The Blood Transfusion Services also provide ante-natal testing services on the basis of a national contract with the Department of Health.

Table 8: Contracts with Blood Transfusion Organisations

<table>
<thead>
<tr>
<th>Province</th>
<th>Total Value of Contract (Rand millions)</th>
<th>Per Capita Expenditure (R)</th>
</tr>
</thead>
<tbody>
<tr>
<td>W. Province BTS</td>
<td>33.7</td>
<td>9.3</td>
</tr>
<tr>
<td>Border BTS</td>
<td>3.8</td>
<td>3.3</td>
</tr>
<tr>
<td>E.Province BTS</td>
<td>7.6</td>
<td>1.1</td>
</tr>
<tr>
<td>Natal BTS</td>
<td>28.3</td>
<td>3.3</td>
</tr>
<tr>
<td>SA BTS (Gauteng, Mpumalanga, NW, FS)</td>
<td>67.1</td>
<td>4.27</td>
</tr>
<tr>
<td>Northern BTS</td>
<td>2.7</td>
<td>0.5</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>143.2</strong></td>
<td><strong>3.5</strong></td>
</tr>
</tbody>
</table>

Source: Hospital Strategy Project analysis

- Method of awarding the contract

All relationships between provincial health administrations and the various Blood Transfusion Services have historically been conducted on an informal basis. The only exception to this occurred in 1995, when the KwaZulu-Natal provincial administration put the supply of blood products out to tender. One private for-profit company bid against the Natal Blood Transfusion Service, but lost the tender since its range of products was narrower and its prices higher than those offered by the Natal Blood Transfusion Service.

Discussions with the various Blood Transfusion Services indicates that they expect significant increases in the demand for blood products and testing services over the next few years, suggesting that expenditures in this area may increase significantly. In this context, and for the reasons outlined in the previous sections, consideration should now be given to the development of formal contractual relationships between the provincial health administrations and the Blood Transfusion Services. The likelihood is that these organisations, which supply the private sector as well, will remain the monopoly suppliers of blood products for the foreseeable future, implying directly negotiated rather than competitive contracts. It will therefore be increasingly important for government to obtain full information on the underlying production economics of these services, in order to negotiate efficient and fair contracts.
The price of the contract and the method of payment

Under the current arrangements, each Blood Transfusion Service revises its unit prices annually, usually in line with inflation, and then informs the relevant health administration of the price increase. As far as could be determined, there is no negotiation around these prices. Discussion with some of the Blood Transfusion Services indicates that they set prices as low as possible, while still ensuring their viability. There appears to be a general understanding that their unit prices are determined on the basis of cost plus a 5-10% mark-up to cover administrative overheads. Delivery and after hours charges are also added to the cost of each unit. As with the supply of laboratory services, the total price of the contract is therefore determined by the total delivered price of different products, and by the total consumption of these products.

These arrangements thus imply a fee-for-service payment method, the risk of which is that the province cannot predict total expenditure in advance. The province can however control its usage of blood products to some extent.

Given the particular nature of the product delivered here, it is unlikely that other payment mechanisms would be acceptable or workable. However, the government could most probably improve on pricing if it had more information on the basis of which it could negotiate.

Contract duration

Similar comments to those noted for SAIMR above apply here.

Monitoring provisions and sanctions for non-performance, and specific mechanisms for the adjustment of objectives, services, prices and equipment

As with the Lifecare and SANTA and SAIMR contracts, these elements are absent from the current implicit contract, and should be included in a new formal contract.

Conclusions

As with several of the other contracted services, the ‘implicit’ contracts that currently exist for blood products and related testing services account for substantial expenditures, and should be placed on a formal, negotiated basis at the earliest opportunity. One aim of the negotiations should be to secure a fair price, which will require detailed data on the underlying costs of these products. Such data is not currently available, and should be collected. The contracts should require negotiation of annual price revisions, rather than requiring the province to simply accept the revised price, as occurs at present. These contracts should also specify appropriate contract terms, and should include a sufficient level of detail on services to be delivered, monitoring mechanisms and sanctions for non-performance.

Unlike many of the other service contracts discussed here, the supply of blood products is almost certain to be monopolised by the not-for-profit Blood Transfusion Services. This
allows the provincial health administrations some room for manoeuvre, since contracts do not have to be based on the assumption of potential exploitation. On the other hand, the lack of competition can create inefficiency on the part of the supplier, and the nature of the contractual relationship should aim to encourage efficiency as far as possible. This might be assisted by the province developing a better understanding of the production economics of blood products. This could then be used in price negotiation, which is likely to be the most effective way to encourage efficiency on the part of monopoly suppliers.

5.2.4 Emergency Patient Transport

Contracts for the supply of emergency medical services are conservatively estimated to value approximately R16 million. These contracts are between individual hospitals and service providers, and in some cases between the province and providers, with some variation in these patterns between provinces. In Mpumalanga, for example, the province has contracted the supply of ambulance services to local authorities for a three year term; at Baragwanath hospital in Gauteng, on the other hand, the hospital has an informal relationship with a supplier to provide service on an ad hoc basis as required.

- Method of awarding the contract

There is some variation here, with some contracts let on a competitive basis, using a formal tender, while others are directly negotiated on a less formal basis.

- The price of the contract and the method of payment

Current practice is for suppliers to quote prices to hospitals based on the expected utilisation of the services. Thus the higher the expected utilisation, the better the rate. These contracts operate in a very similar manner to those for the supply of Blood Transfusion Services -- total contract price is determined by the total number of services rendered and the quoted price for those services. There appears to be little negotiation around the prices; but the process favours larger hospitals since these have higher utilisation, and thus obtain preferential rates. These arrangements imply a fee-for-service method of payment, the risk of which is that the hospitals cannot predict total expenditure in advance.

- Contract duration

Similar comments to those noted for SAIMR and Blood Transfusion Services apply here.

- Monitoring provisions and sanctions for non-performance, and specific mechanisms for the adjustment of objectives, services, prices and equipment

These elements are absent from the contracts, since service is provided on an ad hoc basis, although quality of service is specified in some contracts.
• Conclusion

Current contracting arrangements have both advantages and disadvantages. The main advantage is the flexibility which hospitals have to change service providers should existing ones not perform; the disadvantage of this approach, however, is the lack of competition for some of the contracts. In this situation, it is not clear that the best price is obtained. For the various reasons outlined above, it is therefore recommended that these contracts be formalised, and let on a competitive basis wherever possible.

5.2.5 Supply of nursing personnel

Gauteng is the only province to retain the services of an outside nursing agency to supply nursing personnel when required. This contract is limited to the Johannesburg Hospital, and was signed in October 1994, with a duration of 2 years. The total value of this contract during 1995 was R13.7 million. The contract was awarded through a competitive tender process, and specifies requirements for nurse conduct, appearance, levels of training etc.

5.3. Non-clinical Contracts

Table 1 shows the data on use of non-clinical contractors by the provincial and national departments of health, and indicates that the major expenditures in this category are on catering, pharmaceutical distribution, and security services, which account for 48%, 31% and 13% of total non-clinical contract spending respectively. The table also shows that the remainder of the total R216 million spent on non-clinical contracts is accounted for by smaller expenditures on a range of other services, including waste removal and cleaning, equipment maintenance, gardening services, transport and laundry services. In comparison with the clinical contracts analysed above, the general pattern here is of a large volume of contracts, each of which is of relatively small value. This analysis was able to identify 338 such contracts currently in force within the public hospital system, most of which have values below R100,000 per annum.

It should be noted that the contracts analysed here exclude the many hundreds of individual equipment maintenance agreements entered into by provinces and hospitals each year. The annual value of this group of contracts is difficult to ascertain, since most do not have a fixed value, but are instead linked to the usage of maintenance services by the hospital in question.

Detailed analysis of the individual contracts in these various categories demonstrates a number of consistent patterns. All of the contracts analysed were awarded on the basis of a formal, competitive tender process which followed tender board regulations. In general, and unlike several of the clinical contracts described above, most of these contracts do not appear to prejudice the interests of the provinces, a fact which can be attributed to the rigorous stipulations of the tender process. This is illustrated in the complex and comprehensive tender documents used in most cases, which are often highly specific in detailing the service and quality obligations of the contractor. In all cases, the winner of the tender is informed by letter of their award, and this letter, together with the original tender submission, is taken to
constitute a binding agreement. It is thus essential to note that the tender document determines the full extent of the specifications of the subsequent contract, and that careful attention should therefore be paid to the writing of these documents.

The rights of the provinces are also protected to an extent by the relatively short duration of these contracts, very few of which are awarded for longer than 3 years at a time. In addition, and unlike some of the clinical contracts, those non-clinical contracts which are multi-year very seldom have automatic price escalation clauses built in. As a result, contractors have to negotiate price increases on an annual basis, ensuring that the province can contain price increases. None of the contracts allow for termination by either party through a notice period, although most do allow for termination of the contract should the contractor be in breach of the tender specifications. None of the contracts studied however made explicit provision for monitoring of contractor performance. As a result, it is likely that there would have to be gross breaches of contract before termination would be considered as an option. It is therefore recommended that future tender documents allow for monitoring of contractor performance, as well as for termination by either party with a fixed notice period.

In addition to these general comments on the contents of the tender documents, some of the trends in the process of awarding these contracts are also worthy of comment. When tenders are awarded for services to a number of hospitals, as occurs in some waste-removal, security and laundry contracts, a common practice appears to be one of splitting the contract between a number of contractors, each of whom is selected to serve a designated sub-group of all hospitals served by the tender. While no explicit justification for this practice was identified, this approach appears to be based on the need to avoid complete dependence on one contractor. While this approach increases the transactions costs of monitoring the contract, it does have the effect of preventing the emergence of monopoly contractors, thus ensuring that the province has the option of terminating contracts with one or more providers and switching to alternative providers.

There is also evidence that some tenders are often evaluated superficially, with judgements based solely on the bid price, and excluding issues such as the credentials and experience of the contractor, and other factors relevant to its ability to meet the tender specifications. In some of the cases studied, the provincial tender board overrode the recommendations of the provincial health administration, instead selecting a contractor solely on the basis of price. In at least one case, this has subsequently led to the appointment of a contractor who is not fully qualified to undertake its obligations under the contract. It is thus recommended that a more formal approach to tender evaluation be undertaken, with the use of specific non-price criteria of relevance to the health sector included in the decision making process. It may be useful, in this context, for the provincial health department to suggest such criteria to the provincial tender board in respect of each tender. Alternatively, the provincial health department could apply such criteria in its pre-selection of bidders to be submitted to the provincial tender board.

It is important to note that no formal evaluations of any of these contracts has been undertaken to date. Despite this, there are strong beliefs among many provincial officials that contracting out of these non-clinical services has the potential to generate efficiency gains. This is perceived to be the case particularly where problems with productivity, control and discipline of public sector employees hampers efficient in-house delivery. This is especially the case for security services, which are discussed in more detail below. While staff
productivity and discipline issues constitute the major justification for contracting out of non-clinical services, staff resistance and the consequent labour relations issues constitute one of the major stumbling blocks faced by provincial managers in the decision to contract out. In many cases, trade unions and unorganised workers have resisted decisions to contract out, usually on the basis of the fear that contractor will reduce the number of jobs, wages or both. While provincial managers have often been able to overcome this resistance, they have sometimes done so through compromises which undermine the capacity of the contractor to realise efficiency gains. One example of this, seen in many catering and laundry contracts, is for the province to insist that the contractor manage provincial employees working in the relevant section of the hospital. This leads to the predictable complications of managers employed by the contractor attempting to manage workers employed by the province. The dual accountability structures inherent in this situation severely undermine the authority of the contractors, leading to significant problems. While such compromises may at times be unavoidable, they should be avoided if at all possible.

**Table 9: Provincial patterns in contracting out of non-clinical services**

<table>
<thead>
<tr>
<th>Province</th>
<th>Waste Removal</th>
<th>Clinical Mainten ance</th>
<th>Garden ing</th>
<th>Security</th>
<th>Pharm. Distrib.</th>
<th>Patient Transport</th>
<th>Laundry</th>
<th>Catering</th>
<th>Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>W.Cape</td>
<td>1.2</td>
<td>2</td>
<td>1</td>
<td>8.7</td>
<td>2</td>
<td>12.2</td>
<td>27.3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>N.Cape</td>
<td>0.1</td>
<td>0.25</td>
<td></td>
<td></td>
<td>Included in W.C</td>
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<td>0.4</td>
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<tr>
<td>E.Cape</td>
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<td>1</td>
<td>0.5</td>
<td>4.3</td>
<td></td>
<td>5.8</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Free State</td>
<td>2.6</td>
<td></td>
<td>5.6</td>
<td>5</td>
<td></td>
<td>17.5</td>
<td>30.7</td>
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</tr>
<tr>
<td>Kwazulu-Natal</td>
<td>2.6</td>
<td>1.3</td>
<td>3.4</td>
<td>11.1</td>
<td>0.8</td>
<td>57.6</td>
<td>76.8</td>
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<td>Gauteng</td>
<td>3.3</td>
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<td>9.2</td>
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<td>34.9</td>
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<td>Mpumalanga</td>
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<td>7</td>
<td>4.7</td>
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<td>3.9</td>
<td>15.6</td>
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</tr>
<tr>
<td>North West</td>
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<td></td>
<td></td>
<td></td>
<td>3.8</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Northern Province</td>
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<td></td>
<td>5.8</td>
<td>10.5</td>
<td></td>
<td>4.7</td>
<td>21.1</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td><strong>7.2</strong></td>
<td><strong>3.3</strong></td>
<td><strong>3.9</strong></td>
<td><strong>27.9</strong></td>
<td><strong>68.2</strong></td>
<td><strong>7</strong></td>
<td><strong>97.1</strong></td>
<td><strong>216.4</strong></td>
<td></td>
</tr>
</tbody>
</table>

Source: Hospital Strategy Project analysis

**5.3.1 Contracts for distribution of pharmaceutical supplies**

Distribution of pharmaceutical supplies are currently contracted out to two different organisations: Intersolve, a subsidiary of DENEL, has a contract (worth a total of R58.2 million in 1995) with Gauteng, Kwazulu-Natal, Eastern Northern and Western Cape, and the Free State; and Stratmed, which is partially owned by Thebe Investments, has contracts with Mpumalanga and the Northern Province (worth approximately R15.2 million in 1995). In total, these contracts therefore accounted for expenditure of R68.2 million in 1995.
The Intersolve contracts

A single, trilateral contract between the Department of Health, the provinces and the contractor was agreed in 1987, and was revised in 1994, at which time separate contracts between Intersolve and the abovementioned provinces were agreed. These contracts specify that the contractor has to maintain the MEDSAS system, and there are detailed specifications concerning support, training, maintenance and database functions to be carried out by the contractor.

There has thus far been no formal evaluation of the cost-effectiveness of this long and expensive contract, either in its own right, or in comparison with other approaches to handling pharmaceutical distribution. Some informal evaluations have been undertaken at provincial and national level, although these have not been able to provide hard data on the effectiveness or ineffectiveness of the current system. This lack of a systematic evaluation is particularly worrying in the light of the high value of pharmaceuticals handled every year, and the well known problem of extremely high levels of shrinkage from government depots.

- Method of awarding the contract

The 1987 contract was awarded through a competitive tendering process, and the 1994 contract was directly negotiated as an extension to the existing contract. The province level contracts now appear to be annually renegotiated during January of each year, without a formal tender process.

- The price of the contract and the method of payment

The price of the contract is based on a percentage of the total value of all supplies handled by Intersolve, and currently stands at 7.6%. The total value of the contract in 1995 is estimated at R51 million, based on a total value of pharmaceuticals handled of R672 million. It is important to note that none of the provincial agreements mention price, which implies that a single price is negotiated nationally. During the most recent renegotiation, the Department of Health sought and was granted a 30% price reduction, indicating the power of a single purchaser in this form of contractual arrangement.

Pricing based on a percentage of value handled has both advantages and disadvantages from the perspective of the provincial health administrations. In its favour, this method allows the province to predict and to some extent, to control the total cost of the contract, since it makes decisions on the purchase and distribution of pharmaceutical supplies. However, there are also important disadvantages to this method of pricing. The first is that the price bears very little relation to the actual amount of work undertaken by the contractor. For example, a large volume of low cost drugs will result in more work and lower fees than a smaller volume of high cost drugs. A more accurate pricing system would thus be based on the actual work done (e.g. number of containers or volume of weight of supplies distributed) rather than on the value of the supplies being handled. Secondly, this method of pricing gives the contractor no incentive to improve the efficiency of drug storage and distribution. If the price included a penalty for shrinkage, for example, the contractor would face strong incentives to improve
this element of its service, an area which is well recognised as a major problem at the present time.

It is also possible that an entirely different pricing structure could be developed, for example, a total fee, based on known or predicted work loads, could be negotiated, thus separating payment from work volumes.

- Contract duration

The contracts are renegotiated on an annual basis.

- Monitoring provisions and sanctions for non-performance, and specific mechanisms for the adjustment of objectives, services, prices and equipment

The contracts with Intersolve note that the Department of Health will monitor the various processes involved in the MEDSAS system, but does not specify the methods or frequency of this monitoring. In the most recent negotiations, it was agreed that Intersolve would submit a three monthly report, but have thus far failed to do so, leaving the Department of Health with very limited information with which to monitor contractor performance.

The operation of this contract demonstrates one important danger with large and complex contracts. All computer and other information systems used for tracking the volumes and values of drugs handled under the contract are operated by the contractor itself. This makes it extremely difficult for the provincial health administrations to verify the accuracy of reports and of billings to them by the contractor, without allocating dedicated audit staff to such a task. This situation clearly need to change - either the provinces should allocated audit staff to tracking key elements of the contracts and to verifying billing, or a method must be found through which the province can keep a closer watch on the actual volumes and values of drugs handled. In either case, the costs of this form of monitoring will contribute significantly to the transactions costs of the contract, and should be taken into account when the cost-effectiveness of this approach is evaluated.

The Stratmed Contracts

These contracts cover the procurement, warehousing and distribution of pharmaceutical supplies, as well as the provision of relevant pharmaceutical management information to hospital and provinces, and the provision of training to provincial staff. Stratmed had contracts with two of the former homelands now incorporated into the Northern Province - Gazankulu, and Venda, in which it had been operating for 6.5 and 4 years respectively. There is some evidence that the Gazankulu contract resulted in significant efficiency gains, with savings in terms of improved stock control estimated at approximately 15.9% of total value of pharmaceuticals in the first two years of that contract.

- Method of awarding the contract
The Mpumalanga government awarded a 5 year contract for coverage of 25 of its hospitals, after a formal tender process, conducted in 1995. The Northern Province similarly awarded a 5 year contract in 1995, again after a formal tender. This contract is to cover all 44 of the hospital in the province.

- The price of the contract and the method of payment

As with the Intersolve contract, the price of the contract is based on a percentage of the total value of all supplies handled by Stratmed, and in this case, the percentage was fixed at a level of 10.25%. The discrepancy in the percentage of total value charged by Stratmed and Intersolve is worthy of note, and should be investigated. While it is possible that Stratmed were the lowest bidders for the contract at the time, the lower percentage charged by Intersolve suggests that there is significant room for manoeuvre in negotiating annual revisions to the price. In this context, it should be borne in mind that these contractors are totally dependent on the provincial health administrations for their survival, giving the provinces substantial bargaining power in negotiating contract prices.

In addition to this concern about the level of pricing, the comments on structure of pricing noted above also apply here. Specifically, prices should be renegotiated on the basis of volumes, and not of the values of supplies handled, and the price should also include penalties for shrinkage.

- Monitoring provisions and sanctions for non-performance, and specific mechanisms for the adjustment of objectives, services, prices and equipment

The Stratmed contracts spell out the responsibilities of the contractor in some detail, including the provision of detailed management information, as well as training to provincial staff to prevent long term dependence on the contractor. In addition, the contractor is required to insure all stock under its control, computerise all information systems and insure and maintain the building and equipment. Notwithstanding the advantages of this well specified contract, the problems of monitoring noted above apply equally in this case. As with the Intersolve contracts, it would be extremely difficult for the provinces in these contracts to properly verify the accuracy of accounts submitted to them, and this problem merits urgent attention.

- Conclusions

Unlike the situation with several other clinical contracts, the contracts for distribution of pharmaceutical services are explicit, and have generally been awarded on a competitive basis. However, there remain some important actual or potential problems with these contracts, and these should be attended to as a matter of some urgency. Firstly, with the exception of limited data from the former Gazankulu, there has as yet been no systematic evaluation of the relative cost-effectiveness of contracted versus directly provided distribution services. Secondly, there are important problems with the pricing structure used in the contracts, and these should be amended so as to create incentives for improved security of supplies. Thirdly, the actual volume and value of work undertaken by the contractors is not transparent to the purchaser,
creating opportunities for potential exploitation by the contractors. While there is no evidence that such exploitation has occurred, the intention of this analysis is simply to point out the potential danger of such exploitation.

5.3.2 Security services

Security services represents the major growth area in contracted out services, and accounted for expenditure of approximately R28 million in 1995. As shown in Table 9, 7 provinces contract out security services to some extent, with total provincial expenditures ranging from R9.2 million in Gauteng to R500,000 in the Eastern Cape.

Formal surveys conducted by provinces have lent weight to the general perception that substantial increases in efficiency can be obtained by contracting out these services, primarily through reductions in theft of equipment and supplies from hospital grounds. The main arguments in favour of this approach are the same as those noted in the general discussion on non-clinical contracting - namely that under current public service regulations and management systems, it is very difficult for hospital management to hold in-house staff accountable for theft or loss, nor to enforce discipline when staff are caught stealing. Outside contractors, on the other hand, can be explicitly held accountable for losses, and are much easier for hospital managers to control. These issues were recognised in a cabinet decision, taken in 1989, to approve in principle the contracting out to the private sector of security services in public institutions including hospitals. Despite this level of official approval, many hospitals and provinces continue to encounter difficulty in contracting out these services due to the difficulties associated with replacing in-house labour. This has led hospitals in some provinces to liaise with each other in attempts to transfer in-house security staff to places where they may be needed, allowing hospitals to contract out their security services.

- Method of awarding the contract

As noted in the general introduction, all contracts for security services are awarded on a competitive basis, through the formal tender system, and contracts covering several hospitals are often awarded to more than one company, with each contractor serving designated hospitals. This affords the province some measure of protection against the risk that the contractor will not perform. Should a contract with one contractor be cancelled due to non-performance, tender regulations allow provinces to appoint one of the other winners of the tender to take over that portion of the contract without a second formal tender process.

- Price of the contract and method of payment

These contracts are usually based on a fixed global price, based on the number and size of the institutions to be protected, and the level of security (and hence personnel) required.

- Contract duration
These contracts are generally of short duration, often lasting 1 or 2 years, with a maximum duration of 3 years. This approach appears to be based on the need to avoid dependence on any one contractor, and on the concern that many security contractors are ‘fly-by-night’ operators, who may not perform to contract requirements. Short contracts therefore protect the provinces against unscrupulous contractors, and allow it to identify and use more reputable and stable companies over time. Interestingly, the Mpumalanga province has found that shorter contracts are inefficient, since they do not allow adequate time for development of constructive working relationships between the contractor and the province. As a result, all security contracts in that province are awarded for 3 years at a time.

- Monitoring provisions and sanctions for non-performance

Unlike virtually all other contracts analysed in this survey, monitoring of contractor performance is taken very seriously by most provincial governments. In some provinces (Gauteng, Northern Province, Kwazulu-Natal and Mpumalanga), a dedicated sub-directorate of security administration is charged with the tasks of entering into and monitoring these contracts. In most provinces, dedicated provincial personnel monitor contractor performance on a weekly basis to ensure that the contractor has sufficient staff on duty and that these staff are adequately trained and are performing adequately. In addition, some contracts make explicit provision for regular meetings between contractors and the province in order to ensure smooth operation of the services. Discussions with officials in several provinces highlighted the importance attached to monitoring of performance, and the fact that numerous contracts have been cancelled on the basis of non-performance.

- Conclusions

It is interesting to note the differences in perceptions of provincial officials of the efficiency effects of contracting out of security as opposed to other domestic or administrative services. As noted here, there is clear perception that outside contractors will be more efficient than in-house security, mainly due to the difficulty of ensuring adequate performance by in-house staff. There is no hard data to prove this belief, although some hospitals have conducted studies to demonstrate that the value of losses due to theft outweigh the incremental costs of hiring outside security contractors. On the other hand, there are much less consistent views on the efficiency effects of contracting out of other services, such as catering or laundry.

The strong efforts devoted to contract specification and monitoring of performance in security contracts are also noteworthy, particularly in contrast with the poor specifications and monitoring of virtually all other contracts. There are two possible reasons for these differences; the first is that provincial officials understand the potential for non-compliance with the contract, given the prevalence of unscrupulous operators, and the relative ease with which such operators could deceive the province by providing too few or untrained personnel. The second reason is that these contracts may be simpler to specify and monitor, due to the ease of identifying performance parameters such as number of staff on duty etc. To the extent that these observations are true, they highlight the urgency of alerting provincial officials to the fact that these observations apply to all contracts, not only to those issued for security services. As has been made clear throughout this analysis, virtually all contracts are open to
some degree of exploitation by the contractor, and in many cases, performance parameters and indicators are relatively easy to identify and monitor.

5.3.3 Catering services

As Table 9 demonstrates, 6 provinces spent R97 million on catering services in 1995, with Kwazulu-Natal accounting for the highest expenditure (R57.6 million), and Gauteng the lowest (R1 million). These differences are attributable to variations in the nature and number of contracts. In Kwazulu-Natal, for example, contracts cover the provision of meals for patients, whereas most other contracts are for more limited services, such as the staff canteen or meals in the nurses residence. All catering contracts are awarded by competitive tender, and have an average duration of 3 years. Most contracts are fairly detailed, with appendices outlining the quality of food to be delivered.

Most of these contracts use a model in which the contractor supplies management staff and systems, but makes use of hospital staff in hospital kitchens to provide the services. This approach creates inefficiencies for the reasons outlined above, but has the strong advantage of lowering resistance to this form of contracting out by trade unions and hospital staff. This problem is addressed in some contracts through specific provision for management teams, composed of hospital administration staff and contract managers, which meet regularly to project requirements, and to resolve problems.

5.3.4 Laundry services

As demonstrated in Table 9, only Gauteng and Kwazulu-Natal contract out laundry services, and in both cases, total expenditure on these services is relatively limited. In the case of Gauteng, for example, total expenditure amounted to R1 million, and was on contracts for laundry services at specialised psychiatric hospitals. Port Shepstone hospital, in Kwazulu-Natal has contracted out laundry services because it is located too far away from any of the provincial laundries.

Discussions with provincial officials indicate that most hospitals continue to rely on regional provincial laundries rather than on contractors, mainly because few private contractors have the capacity to handle the required volumes, and because of the risk of theft of linen. There is also significant resistance to contracting out by hospital workers, since unlike catering services, the use of outside laundries would clearly led to job losses within the hospitals. In the Western Cape, for example, attempts by the province to contract out some laundry services failed due to trade union resistance. Despite these problems, many provincial officials believe that substantial efficiency gains could be achieved through contracting out of some of the laundry requirements of hospitals. These views are again based on perceptions of poor labour productivity within hospitals. In the case of laundry in particular, provincial officials noted that costs are especially high as a result of large overtime payments, which would be eliminated by contracting out. Some provincial officials also argued that in-house laundries could be made more efficient if they were forced to compete with private contractors.
5.3.5 Waste removal services

Most contracts for waste-removal are relatively new, and remain fairly limited, with the majority of hospitals continuing to incinerate their own waste and/or to rely on municipal waste-removal services. As a result, total expenditure remains limited, and amounted to R7.3 million in 1995. There is currently one large, national waste-removal contractor, Wastetech, which holds contracts with some provinces. There are also a number of smaller contractors who operate in specific areas only. When a contract is signed by a province, all hospitals within the province are in theory covered by the contract, which includes removal of both general and medical waste. However, individual hospitals retain the right to choose whether to use the contractor or to use alternative services. In most cases, contract pricing is based on a price per container removed. Average contract duration is 5 years. Some provincial officials voice concerns at the market power exerted by Wastetech which is perceived to result in non-competitive prices in some cases.

5.3.6 Other non-clinical services

A large number of other services are contracted out by individual hospitals or by provinces on behalf of hospitals. These include gardening services, contracted by the Free State and Kwazulu-Natal, with a total value of R3.9 million in 1995; patient transport (Western Cape and Free State, with a total value of R7 million); specific clinical equipment maintenance (Western, Northern and Eastern Cape, total value R3.2 million), collection of user fees (Northern Province; price based on 5% of collections), and pauper burials.

6. GUIDELINES FOR IMPROVING THE EFFICIENCY OF CONTRACTING OUT IN THE PUBLIC HOSPITAL SECTOR

The situation analysis described above has highlighted the substantial expenditures, as well as the strategic importance of improving the efficiency of contracting out by the public hospital sector. It has also, however, demonstrated that this area is complex, remains largely unevaluated, and appears to have achieved mix results. This section attempts to address these problems by providing recommendations and guidelines to assist managers at provincial and hospital levels in dealing with these issues. Specifically, the guidelines are focussed on assisting decision makers to evaluate and, if necessary, improve the efficiency of current contracts, to make sound decisions on the need for new contracts, and to negotiate fair and efficient contracts.

6.1 Recommendations

- Provincial health administrations should urgently undertake a systematic evaluation of all existing contracts.

This should begin with a process of prioritisation of current contracts, in terms of their monetary value and in terms of their strategic importance. The most important contracts (i.e. those of highest annual value, and those playing the most important strategic role in hospital service delivery) should be examined first.
Where an existing contract is found to be inappropriate for current service needs, or where it is judged that the service could be better delivered by the province or by another contractor, steps should be taken to terminate the contract at the earliest opportunity permitted by the law.

Even if damages or penalty clauses have to be paid as the price for early termination, this may well be justified by the efficiency gains realised through termination of the contract.

Where an existing contract is found to be inefficient, and could potentially be improved through re-negotiation of some of the contract terms, the province should make every effort to renegotiate the contract as soon as possible.

Most of the major contractors to the provincial health departments are highly dependent on the province as their major purchasers. For this reason, they are very unlikely to raise legal or other obstacles to re-negotiation of the contract. In fact, interviews undertaken for the situation analysis indicate that many of the major contractors would welcome the opportunity to put their contracts on a sound, mutually acceptable and stable footing.

Evaluation of existing contracts, and of decisions to engage in new contracts should be undertaken systematically, along the lines suggested by the guidelines laid out in section 6.2 below.

Provincial health administrations should consider engaging outside professional assistance in the design, negotiation and monitoring of large and strategically important contracts.

As demonstrated throughout this report, contracting for clinical and other services can be highly complex, and it is not clear that all provincial administrations have the required technical skills to ensure that this is done efficiently. When contract values are large, the small incremental cost of engaging outside assistance in developing and monitoring the contract will be insignificant in relation to the potential efficiency gains achieved. Such outside assistance might come from the Department of Health at national level, or from agencies outside of the government.

6.2 Guidelines for the evaluation of current and potential contracts

This section provides a series of questions which can be used by managers in the evaluation of both current and potential future contracts.

Is the contract required, justifiable and affordable in terms of the strategic objectives and resource position of the province?

- can the contractor provide a similar or higher quality service at a lower cost than the province?
  - does the province know its own production costs and quality levels?
  - have full costs been taken into account in the comparison; i.e. do government’s own production costs include the services provided by other departments (works, transport); and in assessing the costs of the contract, have both price and transactions costs been included?

- does the contractor fill a gap faced by the government in skills, capacity or resources?
- is the gap due to deficits in skills or capacity, or due to lack of capital resources?
- is the gap regarded as temporary or permanent?
- if temporary, are there plans to ensure that the province will develop the skills or capacities in the long term, avoiding a situation in which contracting out will entrench the gap faced by the province?
- does the contract include mechanisms to ensure skills transfer from the contractor to the province?

- is the service to be contracted out regarded as peripheral to the core competencies and objectives of the government?
- will contracting out allow the government to focus on its core activities?

- will contracting out allow the province to focus its efforts and energies on more urgent priorities
  - is this strategy a permanent or temporary measure?

- is the contract consistent with the current strategic objectives of the province?

- is the contract affordable over the full duration of the contract?
  - have the total costs of the contract been factored into this calculation?
  - to what extent will the contract reduce provincial flexibility to reallocate resources should this be required?

In cases where a government is deciding to terminate a contract and take over provision itself, the following issues should be examined:

- does the province have the capacity to provide the service, and if not, can this capacity be developed?

- what are the total costs of bringing the service back ‘in-house’?
  - capital costs
  - recurrent costs
  - penalties payable to the contractor

- **Is contracting out feasible?**

  - does the government have the capacity to design, negotiate and monitor the contract?
    - if government capacity is inadequate, can the assistance be obtained from the Department of Health or from outside technical advisors?

  - are there qualified contractors capable of fulfilling the contract specifications?

  - are there sufficient contractors to allow for competition between contractors?
    - if there is limited competition, can the government still ensure a good price, and avoid long term dependency on the contractor?

  - is contracting out politically feasible?
- what is the attitude of workers at institutional level and of the trade unions to the contract?
- what is the attitude of the local community to the contract?

- Is the contract fair and efficient?

- What is the overall distribution of risk between the government and the contractor, and what impact will this have on contract price, contractor performance and overall contractual efficiency?

- will the contract be let through competitive bidding, selective tendering or through direct negotiation?
  - have the relative advantages and disadvantages of the two approaches been thoroughly evaluated?
  - what will be the impact of the method used on contract price, and transactions costs?
  - if direct negotiation is being used, is this due to:
    - lack of competitors, or
    - advantages of a long term relationship with high levels of trust, or
    - current contractor has extensive experience

- Is the agreed contract price fair?

  - is it advantageous for the government?
    - is it lower than the government's own production costs, when other contract costs are taken into account?)?

  - is it acceptable to the contractor?
    - what is the likely return that the contractor will earn; is this sufficient?

  - what is the relationship between the price and other determinants of contract risk?
    - is the price relatively high due to high risk being taken by the contractor?
    - is the price relatively low due to low risk being taken by the contractor?

- what type of payment mechanism is being used?
  block payment
  per diem payment
  fee per case or per episode
  fee for service
  capitation

- what is the impact of the payment mechanism on risk and on efficiency of the contract?
  how does the payment mechanism affect the financial risk of the two parties?
  how does the payment mechanism affect the risk of receiving poor service from the contractor?

- how long is the contract, and how does this duration impact on the risk of the two parties?
  if the contract is unusually long, what are the reasons for this?
    high risk taken by contractor, or
government prefers long contract due to long term relationship and lower transaction costs

- to what level of detail is the contract specified, and how does this impact on risk of the two parties?

- does the contract specify mechanisms for monitoring the contract, and what is the impact of this on risk for the two parties?
  
  does the government have the capacity to ensure monitoring in accordance with the contract?

- does the contract specify sanctions for non-compliance with the contract?
  
  are these sanctions enforceable?

- are there mechanisms for adjustment of the contract terms during the contract period?
  
  does this affect price or other parameters?
  
  how does this impact on risk for the two parties?