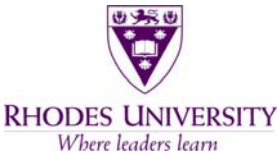
Commercialisation of health and capital flows in east and southern Africa: Issues and implications

Greg Ruiters and Brett Scott



Institute of Social and Economic Research, Rhodes University; with York University; Training and Research Support Centre; Southern and Eastern African Trade Information and Negotiation Institute
In the Regional Network for Equity in Health in east and southern Africa (EQUINET)

EQUINET DISCUSSION PAPER 77

August 2009

With the support of Southern African Trust

Table of contents

Cite as: Ruiters G, Scott B (2009) Commercialisation of health and capital flows in east and southern Africa: Issues and implications, *EQUINET Discussion Paper Series 77.* Rhodes University Institute of Social and Economic Research, York University, Training and Research Support Centre, SEATINI, EQUINET: Harare.

Executive summary

While there is much promotion of private capital flows into the health sector in Southern Africa in reality these flows have been minimal. Private health is the fifth most promoted sector in African after tourism, hotels and restaurants, energy, and computer services (UNCTAD, 2005). Like globalisation, which is part ideology and part substance, the myth of large commercial flows and FDI for Africa creates and sustains false expectations, and further debilitates public sector initiatives and policy.

To understand flows of private capital behind the growth of the for-profit health care sector in SADC, the Regional Network for Equity in Health in east and southern Africa (EQUINET) working through Rhodes University Institute of Social and Economic Research (ISER), Training and Research Support Centre (TARSC), Southern and Eastern African Trade Information and Negotiations Institute (SEATINI) and York University are examining health sector capital flows in ESA, and commissioned this overview study.

Despite the minor movements of capital in the ESA health sector, Mauritius, South Africa, Botswana and Namibia appear as the growth points for big capital, with the rest of the region relegated to the margins in terms of large investments. Investment is uneven, as a consultative group of the WHO (2006b: 8) points out, and 'there are indications of *both* the relative growth and decline in differing countries'.

Many African countries are seen as among the *least* attractive business environments in the world, with the DRC, Angola, Zimbabwe and Madagascar designated as highly unsupportive towards private enterprise. Investment potential exists in the pharmaceutical, hospital and hospital services sectors, but much of it is tied to expectations of economic growth — unlikely to happen given the global recession that began in 2008. Most of new FDI in health is in the pharmaceutical sector often for the production of ARVs to absorb large donor funds. The pharmaceutical sector has also had the most significant amounts of overt privatisation of all health-related sectors, either through selling fixed assets or transfer of equity.

The sheer dominance of the South African private health sector in Africa suggests not only that South Africa is likely to be the biggest destination for investment in health care, but also is likely to be the major regional source of whatever FDI flows there are to other ESA countries. However, South Africa with its large private health sector has not expanded significantly in the health sector in the rest of Africa, except for pharmaceuticals and drug retail.

Our regional study found that the use of term 'private sector' in Africa is misleading since for the most part it consisted of informal shops and non-profit organisations; nearly 40% of the 'private provision' is just shops selling drugs of unknown quality. If the shops are removed from the data, then the share of services in the private sector falls dramatically, especially for poor people. Data across fifteen sub-Saharan African countries shows that only 3% of the poorest fifth of the population who sought care saw a private doctor (Oxfam, 2009). Usage intensity estimates in Sub-Saharan Africa as a measure of the relative sizes of private and public sector shows two in ten persons use private, another three in ten use public facilities and *five in ten are not able to access health care at all*.

However the size alone of the formal for-profit private is not a good indicator of its influence and role in the health system. Despite low FDI, governments continue a policy bias to encourage FDI in health systems. Even if the FDI dries up, internal shifts in the health sector within countries, even those not regarded as good investment options, are very significant as Zimbabwe and Tanzania show. One of the key challenges faced by governments arises from the increased (or anticipated) private sector participation in health services as well as cross-border trade in health services.

1. Introduction

Since 1945 in many advanced democracies health care became part of redistributive social policies associated with Keynesian economics. Functioning health systems ensured healthier citizens, basic social security, eliminated or limited the impact of epidemics and sought to contain the overall costs of health care to the individual while indirectly boosting the productivity of capital and economic sectors of a country as a whole (Koivusalo and MacKintosh, 2004). Health care was also later embedded politically in notions of rights and social citizenship and equity. Many came to hold the view that it is not ethically acceptable that access to care when sick should depend on ability to pay. The exception has been the USA. In the late 1960s and 1970s, many developing countries and post-independence sub-Saharan African countries governments successfully reduced morbidity by focusing on primary health care. Tanzania was held up a particularly successful model of public services (Sanders and Carver, 1985).

While countries in the Southern Africa Development Community (SADC) have identified priorities of combating poverty — through building up the capital assets of the poor, reducing inequalities, and promoting knowledge and health in poor areas — the last two decades have been a marked by shift away from state-provision towards encouraging the private sector. Most SADC governments have embraced the idea that governments should regulate service provision, not directly provide and many encourage privatisation and outsourcing. User charges at the point of use, prepaid care and corporatisation have also found their way into policies. Only four out of fourteen countries in SADC increased health budgets between 1997 and 2001; by 2004 only one met the New Economic Program for African Development (NEPAD) goal stated in the Abuja Declaration of 15% of government spending for health care (Equinet 2007: 9).

This paper draws on existing literature to look at the growth in for-profits health sector in Southern Africa in the last decade and attempts to map cross-border and intra-country capital flows in the commercial (private-for-profit) health sector in the east and southern Africa (ESA) (Angola, Botswana, The Democratic Republic of Congo (DRC), Lesotho, Madagascar, Malawi, Mauritius, Mozambique, Namibia, South Africa, Swaziland, The United Republic of Tanzania, Zambia and Zimbabwe, Kenya and Uganda). We consider the debates on privatisation and trade in health services. In order to map capital flows, we looked at the composition of the health sector in ESA, the composition of the private-for-profit sector, the main sources and types of private capital flow, and the legal framework (including the international framework) in which these flows take place.

Capital flows are examined in the context of the ESA health profile, which shows a high prevalence of diseases caused by poverty. The health status of ESA populations is among the worst in the world. The profile of health problems in the region indicates common problems arising from social and economic poverty and inequality: food insecurity; lack of access the safe water, sanitation, energy, transport and shelter. There are also high prevalence levels of HIV/AIDS, TB, Malaria and other communicable and non-communicable diseases, while in Namibia, Malawi, Zambia and Zimbabwe maternal and infant mortality rose in the 1990s (EQUINET, 2007: 6).

These problems are unequally distributed across urban and rural areas, across high and low income communities, across gender, race and social class groupings. The different experiences of ill health reflect inequalities in access to incomes, infrastructure and in ownership of wealth. While access to health care has expanded, there are continuing problems for the lowest income groups having less access to health care.

Allowing the unfettered growth of the private health sector has been proposed as a solution to the region's health problems. For over two decades, the World Bank advocated a solution

based on investment and growth of the private health-care sector (Oxfam, 2009). Proponents of private-for-profit sector expansion in health care have argued that the private sector is cost effective, provides quality care, is able to complement government in expanding coverage while relieving pressure on public funding. 'The idea is that those who can afford it should buy their own health care in the private sector and governments should contract private providers to serve those who can't. The approach is promoted as a matter of "common sense"' (ibid). As a result of pressure from private-for-profit providers and from organisations such as the World Bank and International Monetary Fund (IMF) — who promoted structural adjustment programmes (SAPs) from 1981 onward — the region has experienced reductions in financing for public services and a growth in commercialised services — in the informal sector primary care level services through to specialised private hospitals.

However, this paper shows that as many governments have moved away from public sector delivery under SAPS, health indicators have worsened in the region. And while the private sector is often touted as the best possible solution to health problems in ESA, this paper shows that capital flows in the health sector in the region are relatively small, the private-for-profit health sector — where it exists — caters for a small portion of the population (typically in urban areas), and there is little evidence that the private-for-profit health sector has an interest in expanding into areas where access to health care is poor. In the absence of large private-for-profit capital flows into the health sector, and in the environment of decreased government spending on health, a huge gap exists between the services needed and the services provided, especially in poor rural areas. Private capital has not jumped in to fill the gap.

Many frameworks have been developed for understanding the composition and dynamics of the health system and of health sector financing flows. For the purposes of this study, we focussed on the structure of the health system in ESA, as well as private-for-profit health financing flows for in region, focusing on the provision or delivery of health products and services.

2. Methodology

We conducted a desk review of published and grey literature on capital flows in the health sector in ESA between 1995 and 2007, focussing on:

- the current composition of the health sector, particularly the public-private mix and the nature of the for-profit sector;
- the current private capital flows situation and trends since 1995;
- key entry points for capital, including within the public sector and geographical distribution;
- the impact of these flows on the health sector;
- arguments in support of private flows; and
- issues related to data availability and bias, and methods of analysis.

The overarching issues of equity, efficiency, effectiveness and quality of the health system and their contributions to health outcomes were also considered, within the limits of what information was available.

We conducted a document search on websites for using search terms such as: east Africa, southern Africa, health care services, health care delivery, health care financing, access to health care, out-of-pocket payment, medical insurance, medical schemes, private hospitals, private health care, pharmaceutical, pharmacies, retail pharmacies, private health services and customer satisfaction. We also searched the scientific literature through

Pubmed/Medline, EBCOhost and Google Scholar search engines with a document search strategy using terms such as South Africa. The search was further broadened through the obtained documents which were used to snowball the search by looking at the references therein for primary sources of information.

The study was limited in that in some cases there were no reliable sources of data, with for example, out-of-pocket expenditures often being based on estimates in most countries in ESA. In many cases the information was obtained using different parameters/ denominators, so it was sometimes difficult to establish trends for the period under review, especially where different groups looked at the same problem in different years. Much of the data on the private sector was based on self-reporting of earnings by private providers, which may not be a true reflection of the situation. While there is a wide perception that many people turn to traditional healers when facing health problems, data on the size of this sector (as a proportion of the health sector, or in terms of monetary value) is not readily available.

Definitional issues also blurred the picture, since the distinction between private and public is usually based on the institutional or administrative identity of the health care provider. The term 'private' broadly applies to health care delivered by individuals, corporations and institutions (faith-based organisations (FBOs), non-governmental organisations (NGOs), etc.) not falling under state/public administration. Since 'existing health care systems are not generally segmented into a "private" sector (only) funded privately only and a "public" sector funded only by the government, and even public bodies charge cost recovery fees, there is, no straightforward way to create an index of health care commercialisation even by bringing together indicators of commercialisation of expenditure and of ownership of provision' (Koivusalo and MacKintosh, 2004). The picture is further muddied by private and international donor money that flows into government, NGOs and for-profit firms. Public spending often makes possible and supports the private sector through tax systems that reward those with private health insurance.

And, there are many non-profit health organisations, partly subsidised by the state whose purposes have no commercial intent but which are classified as 'private'. Within the category of the private-for-profit sector the divide between informal, unregulated suppliers and formal multinational corporations is also often not clearly delineated in the literature. To address these definitional issues, we first looked at the broad structure and composition of the health sector in the region, then looked at the formal private-for-profit health sector, where data was available.

3. Findings

3.1 The regional health picture

As the World Bank (2000b) argues, there is 'substantial variation among African countries in their health experiences. For example, public sector health spending was $4 per capita or less (with the median nearly $6 per capita) in the lowest quartile of countries, while the top quartile of countries spent about $21 or more per capita. However, conditions with regard to other indicators, such as access to safe water and the proportion of supervised deliveries varied much less'.

Mozambique, DRC, Zambia, Malawi, Angola and Tanzania have low human development indices; Uganda, Zimbabwe, Kenya, Madagascar, Swaziland, Lesotho, Namibia, Botswana and South Africa have medium human development, and Mauritius as having high human development (World Bank, 2003).

.

However, there are 'significant differences in health *within* and across countries of the region … A child born in Mozambique has a projected life 16 years shorter than one born in neighbouring South Africa' (EQUINET, 2007). In six of the sixteen countries in the region, life expectancy is below 40 years, and below 50 years in fourteen of sixteen countries (ibid). AIDS has had the greatest impact on mortality in most countries of the region. SADC countries, with 194 million people, have adult HIV infection rates of over 20% with some fourteen million infected adults and children, about 51% of all of Africa's HIV infection. By 2003, ten million had already died of AIDS related disease; 120 million of people are directly or indirectly affected by HIV-Aids. AIDS patients fill 40% of beds in some hospitals (EQUINET SC 2004).

3.2 Regional policy developments

A regional policy forum, the SADC was established in 1992 out of the South African Development Coordination Conference. Various SADC members have been tasked with leading different economic sectors. South Africa leads the coordination of the finance, investment and health sectors (Lee et al, 2003: 51). An SADC treaty calls for the broadening of cooperation among member states in 20 sectors, including transport, health, tourism, mining, and water.

In 1999, the SADC Health protocol committed member states to regional strategies to support health systems. In 2004 at a Summit in Mauritius members signed protocols (related to Doha and Trips exemptions) enabling governments to regulate prices, excessive profiteering, promote local production of essential drugs, and curb monopolies of pharmaceuticals and health services (EQUINET, 2007: 26).

In 2000, 53 Sub-Saharan African heads of state pledged to allocate 15% of their national budgets to health care. This pledge was reaffirmed in the *Gaborone Declaration* during the October 2005 session of the Conference of African Ministers of Health in Botswana (AU, 2005). However, according to the latest available figures for 2003, only one country (Liberia) has reached this level of expenditure, while 33 countries have not even reached 10% (IFC, 2008).

Recently, the South African government said, 'we must continue to insist, particularly at this time of global economic crisis, on the right to regulate in the public interest, and not to have this right undermined by unfair demands for access to service sector markets' (Davies, 2008).

Various civil society groups have called for 'the building of national people's health systems, equitable public funding and trade justice' (Health Civil Society Network, 2005), to 'address the scale of public health challenge we need to build on the positive examples of state-civil society, professional and parliamentary alliances and strengthen the collective alliance of public interests, nationally and regionally'. They argue for policies:

- 'with an orientation towards prevention;
- for the removal of cost barriers to accessing primary health;
- with fairer distribution of resources between private and public sectors'; and
- for safe water access to one fifth of the population in the region lacking supply.

3.3 Capital and Health: Measuring and tracking capital flows in the health sector

Tracking capital growth and flows is complex because:

- capital flows exist in the formal and informal sectors;

- the ‘mix’ of private and public as measured in total health expenditure (THE) is a blunt indicator of commercialisation; and
- the numbers of facilities (e.g. hospitals) in private hands is a problematic indicator, because of the very different sizes of hospitals, types and levels of service provided.

Several National Health Accounts reports noted the lack of capacity to formally monitor the private health sector and the poor quality of data in this regard. The lack of comprehensive data and measures of health resources flows is notable (see Global Health Resource Tracking Working Group, 2007; WHO/World Bank/USAID, 2003; Poullier et al, 2002; WHO, 2000b; Koivosalo and Mackintosh, 2004).

Private-for-profit capital flows in a number of different sectors in the ESA economy, including: pharmaceutical manufacture, pharmacy retail, private hospitals and diagnostic services, private practices (GPs and specialists), private medical insurance schemes, community-based health insurance schemes, public-private partnerships, private finance initiatives, franchises, health worker training, and the informal sector.

The organisations that specialise in tracking and packaging this information are privately run investment consultancies and business intelligence agencies. Examples include Business Monitor and Global Insight, management consultancies (for example, McKinsey & Company), accounting firms (for example, KPMG and PriceWaterhouseCoopers), ratings agencies (for example, Moody’s and Standard & Poor’s), banks and other institutional investors. WHO (2006b) provides a list of online sources for academic material on private health services while watchdog groups collect anecdotal accounts of corporate misconduct. Anecdotal evidence from local citizens, may offer understandings of local health systems and insights into the real meaning and effects of private services.

How might a business invest in the public sector in health services?
- hospitals or clinics as a whole might be sold to the private sector;
- certain functions of health service provision;
- *private capital may finance health*, e.g. private health insurance, medical aid, prepayment schemes and health management schemes; and
- public services may take of features of private companies through market-related user fees. The commercialisation of the public sector from within and under pressure from the private sector has become an important trend in the marketisation of health).

Some kinds of investment are more difficult to track and do not easily show up on a ‘monitoring radar’, such as:
- small investments under US$1m;
- donor investments (e.g. to NGOs, FBOs, etc.);
- reinvestments (to catch these, tip-offs from investors are needed); and
- contracts that include consultancies, i.e. services — which is a big growth area of cross-border investment.

We list the various proxy indicators for the size of the private sector below.

Usage

A helpful indicator of the size of the private sector might be derived from usage patterns. In primary care for example, we can look at the proportion of children who, when ill with acute respiratory infection or with diarrhoea were taken to a private facility.

For example Marek et al (2005) (using 26 the National Health Accounts of sub-Saharan African countries) shows that an average family with a child who had diarrhoea or respiratory infections:

- 52% did not seek *any* medical help (using home remedies);
- 26% went to a public facility; and
- 22% went to a private sector facility (broadly defined i.e., either for-profit or FBO/NGO facility or traditional healer).

Commercialisation can only really be assessed comparatively by data on usage (Koivusalo and MacKintosh, 2004). Private ownership varies by national or international ownership, degree of monopolisation, sector of activity and history of the company or organisation - all these characteristics affect the kind of private sector that emerges over time; policy can also influence the kind and scale of the private sector.

Number of beds

Another way of looking at the private sector in health is through the number hospitals, but simply saying there are *x* private hospitals is not helpful. Beds data provide a better indicator than the number of privately owned facilities. However, the division between private and public as measured by beds is partially obscured by the trend to establish private wings inside public hospitals (Marek et al, 2005).

Total Health Expenditure

THE — 'the sum of general government expenditure on health plus private expenditure on health in a given year (in international dollars)' (WHO, 2009) — is one of the most common measures used, but it can be misleading. For example, activities such as food and hygiene control and health research and development are considered health-related, but are not included in total health expenditure.

Proportion of FDI on health

The size of flows of capital in health can also be crudely measured as the proportion of foreign direct investment (FDI) going to health care in a country or region. Disinvestment, liquidations, and the 'statement of intent' (which could later be followed up to see if FDI actually happened), are useful indications of the ebbs and flows of FDI. The phasing, the actual final delivery compared to the projected investment, and abandonment of investment are as important as actual investments, for revealing where investor's interests lie, and why and when investments are made, or not.

Trade in health services

What about trade in health services? In recent years — thanks to electronic technology, flexible rules and rapid transport — health services have become more mobile across national borders. The growth of private health care largely reflects a context and a consensus that the private sector and competition rather than the state and public monopoly should be the main drivers of economic growth and capital expansion (Newbrander, 1997: 12). The growth in cross-border delivery of health services, through movement of personnel and consumers (by electronic telemedicine and health tourism), and through an increasing number of joint ventures and collaborative arrangements between public and private sectors has also been notable aspects of private sector growth.

The General Agreement on Trade in Services (GATS) (2001) marks out four modes of trade which might imply potential capital flows.

- **Cross-border delivery of trade (mode 1)** includes shipment of laboratory samples, diagnosis, and clinical consultation via traditional mail channels, as well as electronic delivery of health services, such as diagnosis, second opinions, and consultations. Countries use a variety of telehealth services, including telepathology, teleradiology and telepsychiatry. Many cross-border telemedicine initiatives have also emerged (Chanda, 2002).

- **Consumption of health services abroad (mode 2)**: affluent patients seek specialised high-quality treatment in hospitals abroad or in neighbouring developing countries with superior health care standards; or patients from industrialised countries seek affordable, high-quality treatment or alternative medicines and treatments in developing countries. For example, Grootte Schuur in South Africa has a scheme to treat British patients who need heart operations, 'the scheme, which is a move to cut the hefty hospital waiting lists in Britain, could see between 500 and 1,000 British patients sent to Grootte Schuur annually for cardiac bypasses alone'. The operations would be performed in Grootte Schuur's private wards with a 50/50 split of profit between the hospital and the private sector (Cleary and Thomas, 2003).
- **Commercial presence (mode 3)** involves the establishment of hospitals, clinics, diagnostic and treatment centres, and nursing homes. Health care companies increasingly engage in joint ventures and alliances, resulting in several regional health care networks and chains.
- **Movement of health personnel (mode 4):** China and Cuba send health personnel abroad on short-term remunerated contracts to countries in Africa, under government supervision. Permanent migration occurs mainly from developing to industrialised countries, with he most prominent source countries for health personnel are India, the Philippines, and South Africa, whose nurses, physicians and technicians emigrate to Australia, the Eastern Mediterranean, the United Kingdom, and the USA.

3.4 The composition of the health sector in ESA

Generalisations about African countries hide some important differences: for example, Botswana, between 2000 and 2006 public health expenditure as a percentage of Total Health Expenditure (THE) increased from 49% to 63%, well above the sub-Saharan African average of 42%. Usage of public facilities varies dramatically by country (see *Table 1*), but in South Africa, Mozambique, Tanzania, Zambia and Namibia, the very poor who do seek health care, clearly have relied heavily on the state.

Table 1: Use of private and public facilities by the poorest 20% when a child is sick

Country and year of Demographic Health Survey (DHS)	Private sector (%)	Public sector (%)	Other (%)	Seeking care outside the home (%)
Kenya (1998)	47	47	6	63.9
Malawi (1998)	46	53	0	58.8
Malawi (2000)	74	24	7	52.7
Mozambique (1997)	32	63	5	36.6
Namibia (1992)	7	90	3	67.2
South Africa (1998)	14	84	2	64.5
Tanzania	29	68	3	58.1
Uganda (1995)	69	29	3	73.6
Uganda (2001)	68	27	5	77.7
Zambia (1996)	24	68	8	64.0

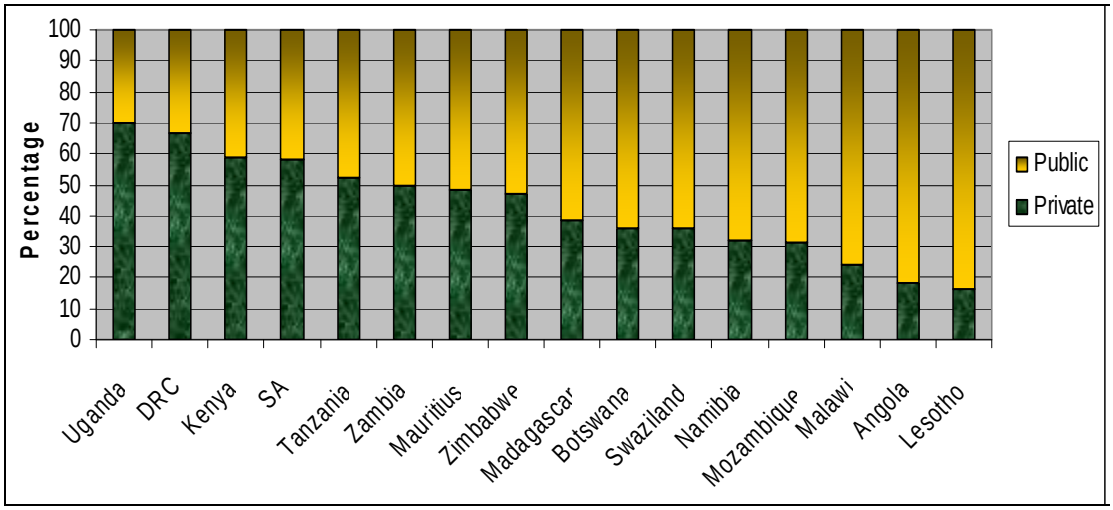
Source: Marek et al, 2005: 10

Malawi presents an interesting case, where 'use of the public sector diminished by about half between 1992 and 2000 (going from 53 to 24%). At the same time, the use of the private sector went from 27% to 39% for the poorest quintile and from 31% to 49% for the richest quintile [which] might indicate a dynamism of the private sector and a problem in the public sector" (Marek et al, 2005). However the 'private sector' in Malawi mostly consists of Christian Health Association of Malawi (CHAM) institutions and other private-for-profit providers (WHO, 2006c). Similarly, for other countries in the region, 'private' medical service

provision is often not private-for-profit provision. Therefore, measuring the sizes of public and private health service provision in ESA is complicated.

In terms of THE in eleven ESA countries in 2005, the public sector was dominant. In nine of fifteen ESA countries (see *Figure 1*) the public sector spent more than the private sector (broadly defined since private includes NGOs, charities and donors). Uganda, followed by DRC, Kenya and South Africa have a small public sector and a large private sector as proportions of its total health expenditure, but the NGO and FBO sector dominates the private sector in most of these countries. In sub-Saharan Africa the private-for-profit sector accounts for 25–30% of total health expenditure (THE).

Figure 1: Total Health Expenditure: public/private percentages, 2005



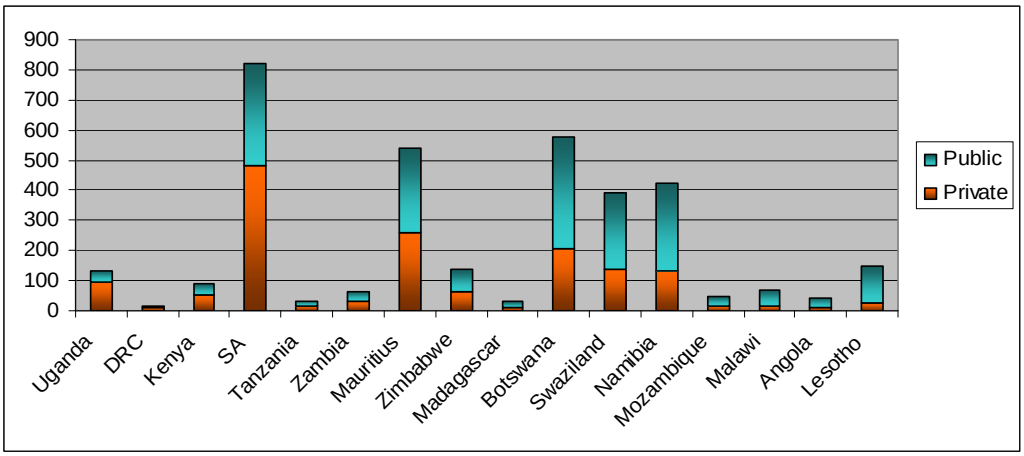
Source: WHO NHA Data, 2005

Figure 1 shows that the relative importance of private finance sources in health differs widely between countries in the ESA; for example South Africa and the DRC have similar public-private expenditure ratios but the DRC health expenditure is very low in monetary terms. The South Africa private sector takes up 60% of THE, but only serves 15% of the population.

When we consider annual per capita private health expenditure in absolute terms, South Africa, Mauritius, Botswana, Swaziland and Namibia have had the greatest absolute private expenditures per capita (WHO NHA data, 2005) (see *Figure 2*). South African per capita expenditure stands at $810, compared to DRC, Mozambique and Tanzania which spend under $50 per capita. South Africa Angola, Malawi and Zimbabwe have experienced absolute decreases in private expenditure per capita since 1996.

In the early 1990s, NGO/FBOs provided 30–40% of health services in Kenya, Malawi, Swaziland, Uganda, Zambia and Zimbabwe, with even higher levels in Tanzania and Lesotho (Turshen, 1999). NGOs sometimes provide the *only* health services, for example, in parts of the DRC, Angola, Uganda and Mozambique during conflict periods (Toth, 2007; Carlson, 2004). FBO health services seem to be particularly well-established in East Africa (Marek et al, 2005; Malawi MoH&P, 2001; Tanzania MoH, 2001).

Figure 2: THE per capita by sector in ESA (US$), 2005



Source: WHO NHA Data, 2005

Drechsler and Zimmerman (2006) note that along with global funds and foundations, NGOs have also become increasingly important in the field of development finance for health. There is a close relationship between the public sector and the non-profit sector in several ESA countries. Public funds, or donor funds channelled through the public sector, are passed to NGO/FBOs. In Mozambique for example, the public sector is highly reliant on donor contributions and the public sector works extensively with NGOs (Yates and Zorzi, 1999; Fustukian, 2004). This may be because these groups have expertise in working within poor and rural areas. The emphasis to date in ESA has been placed on partnerships between governments and NGO/FBOs, rather than with for-profit providers (Turshen, 1999). The World Bank (2003) argues NGOs are effective because they have an 'intrinsic motivation' to serve poorer people and thus have the potential to be contracted to provide high quality services at a comparatively low cost. A study by Reinikka and Svensson (2003) suggests that religious NGOs in Uganda provided cheaper services than both the public and private for-profit health sector and obtain higher levels of quality than the public sector.

3.5 Who is behind the push for private health service delivery in ESA?

The apocalyptic neoliberal vision (Osewe, 2006: 16) is that within the next twenty years in Africa 'there is likely to be a transition from a Ministry of Health charged with managing hospitals and health centres, and staffed primarily by clinicians, nurses, [and] pharmacists to one charged with overseeing the broader health system' and that 'ministries of health are gradually starting to separate service provision from their responsibilities for policy making, planning, financing, monitoring, regulating and informing the public on health matters'. In other words, he envisages that public health ministries will increasingly not provide services and become 'stewards' over a much larger private system of health.

The IFC (2008), using projections of economic and population growth rates, predicts that 'the health care expenditure in sub-Saharan Africa is expected to grow from $16.7 billion in 2005 to $35 billion in 2016 (see Annex 6 for details), an annual growth rate of 7.1% per annum. This report also estimates that around US$25–US$30 billion in incremental investment will be required for the physical assets (hospitals, clinics, distribution warehouses, etc.) needed to meet this increased demand over the next ten years. The private sector it hopes will contribute about $11 billion. 'For health care companies looking for markets in which to expand, and for investors looking to invest in health care businesses, this $11–$20 billion in private health care expansion represents a significant opportunity' (IFC, 2008:15).

It is conspicuous that the ten-member technical advisory board to the IFC (2007) report includes three senior executives from major South African companies (Netcare, Discovery Health and Aspen Pharmacare), with the two other African members being involved in banking. The sheer dominance of the South African private health sector suggests not only that South Africa is likely to be the biggest destination for investment in health care but also that it is likely to be the major regional source of whatever FDI flows there are to other ESA countries. The reality, as a recent World Bank book argues is that 'countries most in need of additional capital and resources, may be least likely to receive it' (Blouin et al, 2006: 194). If this is so, then less developed countries might have to look inward as well as to South-South forms of cooperation for development.

The IFC have vigorously marketed Africa as a major opportunity for the private sector. They argue that pent-up demand for pharmaceutical, medical supply facilities distribution and retail systems is in excess of $11 billion:

> *For health care companies looking for markets in which to expand, and for investors looking to invest in health care businesses, this $11–$20 billion in private health care expansion represents a significant opportunity* […] *Medical insurance and medical training will also present investment opportunities.*

While the World Bank Group is at the forefront of promoting privatisation, the World Health Organisation (WHO) in it's *World Health Report* (2000a) also added their voice to the chorus of support for a market-based solutions, although these sentiments have more voice in certain WHO departments (for example, MAKER and CHOICE) than in others.

USAID props up private sector involvement through its *PSP-One* initiative and Global Development Alliances. DFID encourages public-private partnerships (PPPs) through the *Initiative on Public-Private Partnerships for Health* (IPPPH), which in turn is linked to the World Bank, the Gates Foundation and the Rockefeller Foundation.

The Gates Foundation and the Global Fund have risen to prominence in health financing and have more influence than WHO in the direction of global health funding (Yamey, 2002). The World Bank (2007) notes that in addition to the Gates Foundation and the Global Fund, global PPPs like the *Global Alliance for Vaccines and Immunisation* (GAVI) and *Global Alliance for Improved Nutrition* (GAIN) are now globally prominent in financing. Such global PPPs incorporate international pharmaceutical companies.

The Dutch government campaigns for private health insurance in Africa (Global Insight, 2006b). Similarly, the United Kingdom's *Commission for Africa* has sponsored stronger PPPs as a solution to social problems (WHO, 2006b), and the *Bamako Initiative Management Unit* of UNICEF promoted user fees and other cost-recovery schemes in the public sector in the 1980s (Turshen, 1999; Singh, 2003).

In 2005 in sub-Saharan Africa $16.7 billion was spent on health of which 60% was out-of-pocket (OOP) expenditure by individuals. Marek et al (2005: 3) conclude that the high OOP figure for sub-Saharan Africa shows there is 'more money in the health sector than is usually thought'.

The International Finance Corporation (IFC, 2008) study (funded by the Gates Foundation and the World Bank) found that the private sector (broadly defined) accounts for about half of the region's $16.7 billion spending on health care. They also claim that poor people are just as likely as the better-off to use private providers, but these findings are based on a broad and definition of the private health sector that includes traditional healers, NGOs and FBOs. They maintain that the business environment in Africa is improving and that higher incomes stemming from recent growth will impel demand for private services. Huge amounts

of capital, they argue, will flow into infrastructural development required to expand private sector health care provision capacity.

Moreover, the IFC (2008) claims that of the total investment needed to meet African health demand in the next decade, about half is expected to come from the private sector, although most of these near-term investments, they predict, will be in the small and medium enterprise (SME) sector, with comparatively few large-scale investments. The IFC envisages unique roles for financially-driven investors (for-profit enterprises), 'angel' investors (social enterprises and start-ups), development institutions and donors in this process. The IFC ends up being 'very upbeat' about the potential of private sector investment.

Remarkably, a recent Merrill Lynch report ranks the investment prospects of the African health sector as more attractive than African infrastructure or telecoms (The Economist, December 2007). However, McKinsey & Company, at a recent IFC conference, put Africa last on the list with the most lucrative potential in China, India, Asia in general, Latin America, the Middle East, Europe and the US (Kocher, 2007). More cautious, however, Frost and Sullivan (2008), for example, advise private investors that several governments are tightening up regulations, and while there is considerable opportunity, there are huge risks associated with regulatory uncertainty. According to Frost and Sullivan (2008) companies will need to understand regulatory changes and anticipate developments in order to penetrate markets and be aware of problems such as counterfeit drugs (with estimates that the sub-Saharan African pharmaceutical market is made of 45% counterfeit drugs). Moreover, they advise that much will depend on Africa's overall economic growth prospects in the coming period.

In any event, the IFC's Africa plan is to build a US$500 million equity investment fund to invest in the private health sector and also build a debt vehicle to promote bank lending to this sector. But, doubts about the IFC's ability to set up such resources has already begun to emerge (Harding, 2007; Oxfam, 2009). The IFC and the World Bank organised five Health Conferences in Africa Forums (from 14 April to 5 May 2008 in Yaoundé (Cameroon), Dakar (Senegal), Lagos (Nigeria), Johannesburg (South Africa), Dar es Salaam (Tanzania)) to discuss how they can better support the health sector in sub-Saharan Africa

Where, does the IFC say, capital should flow? In terms of host-countries for investments, the IFC's *Doing Business Database* (2008b) and Preker (2006) listed Mauritius, South Africa, then, Namibia, Botswana and Kenya as the best corporate business environments in ESA.

Mauritius is setting itself up as a regional medical services centre catering exclusively for the wealthy and those seeking comfortable retirement or a comfortable setting for recovery from illness, while the Kenyan health sector is seen as a significant investment opportunity due to its skills base (UNCTAD, 2005b).

3.6 Private-for-profit capital flows in health sectors in the ESA

In general as the African Labour Research Network (2003) points out that 'investment flows to Africa have declined steadily in the 1990s. In 1992, Africa accounted for 5.2% of FDI to developing countries compared to 25% in the 1970s. According to the UNCTAD (2001) FDI inflows to Africa declined from $10.5 billion in 1999 to $9.1 billion in 2000. African share of FDI in the world fell below 1% in 2000'.

Although South African mining firms and South African-based multinationals have been active in region for more than a century, investment flows since the end of apartheid and transition to majority rule in 1994 reflects a number of critically new features. Service sectors (banking, retail, food and beverage, and tourism) are increasingly significant and there has

been growing South African investment in regional public infrastructure including in the energy, telecoms, railways, airlines, and ports and shipping sectors (Daniel et al, 2003).

South Africa dominates the SADC region accounting for 71% of regional GDP (compared to Tanzania's 4%, Zimbabwe's 3.8%, Namibia 1.9% and Zambia's 1.9% (Lee et al, 2003: 63). The region has been seen as the hinterland of South Africa, with foreign investors seeing South Africa as a conduit into the region (Lee et al, 2003: 49–50). South Africa has taken the lead role as a source of foreign direct investment in Africa, displacing Germany, the US and Japan. In SADC in the early 2000s, South Africa accounted for more than 40% of new investments, moving it into first place as a source of investment, ahead of the US and UK. China in the 1990s did not show up so much as leading trader, but that has changed, and China now a key trade competitor against South Africa.

South Africa's regional dominance may be measured in medical supplies, equipment and drugs which comprised almost 10% of high technology exports to SADC region in 2008 (DTI, 2008). It was the fourth largest category of high technology exports with Tanzania, Zimbabwe and Mozambique as major recipients.

It seems that recent South African investment has been driven by a powerful push-pull combination of:

- saturation and stagnant profit levels in the 'home' domestic market;
- production economies of scale for South African companies (Daniel et al, 2003);
- relatively high levels of profit in regional markets and the relative disinterest of other large multinationals in the non-South African SADC consumer markets (Rissik et al, 2001)
- favourable 'liberalised' conditions for the repatriation or externalisation of regional earnings by South African countries, which have effectively enabled the conversion of Rand-financed production into foreign currency earnings (Daniel et al, 2003; Carmody, 2002); and
- stronger regulation in South Africa pushing capital over the border (Carmody, 2002).

South African financial services/ banks often followed 'anchor investments into a country, to help service home country investors in cross-border situations. To some extent, there has been an agglomeration of services (telecoms, financial, services, tourism/ travel) that emerged around new FDI. Retailing and transport infrastructure investment has strengthened conduits for other forms of capital penetration, e.g. for 'South African-produced food, clothes, durable goods, medicines. FDI has helped consolidate South African power, but elements of resistance to some FDI by communities, local business and governments, once the impact of dispossession and displacement of some FDI became clearer have emerged (Miller et al, 2008).

Transfer pricing — pricing of intra-firm transactions which does not reflect the true value of products entering and leaving the country — could lead to a drain of national resources. Countries may lose tax revenue from corporations, as they are able to avoid their tax liabilities. Transnational corporations (TNCs) use their economic power to influence government policies in directions that usually do not favour development. They are able to extract sizable economic and political concessions from competing governments tax rebates, investment allowances and the cheap provisions of factory sites and services. Research conducted by UNCTAD (2000) for the *World Investment Report* revealed that, for the host country, the benefits of mergers and acquisition are low and the risks high.

From a FDI viewpoint, UNCTAD (2005a) reports that private health and social services is the fifth most promoted sector in the African sample after tourism, hotels and restaurants, energy, and computer services; of nineteen surveyed African national investment promotion

agencies (IPAs), nine (or half) actively promote FDI in health and social services, which is a higher percentage than for IPAs from other regions. Yet, in most ESA countries, domestic investment is greater than FDI, even in relatively wealthy countries like South Africa.

In the early 1990s privatisation of public services was promoted across the ESA, and became reality in terms of various kinds of privatisation contracts with different time frames, for example:

- **service contracts** whereby private enterprises undertake specific functions are annual contracts;
- **management contracts** whereby private enterprises manage publicly-owned health facilities and services last from two to five years;
- **lease contracts** whereby private enterprises rent and upgrade existing public health facilities or spaces;
- **concession contracts** whereby substantial new capital investment occurs public establishments and the private sector uses the new facility for a specified time (ten years or more).

Each of these forms involves different commitments and levels of risk/ protections for capital. But public money often assumes the risk while private firms make profits (Harvey, 1989). The source of funds supporting such ventures varies from banks to public sources like government guaranteed loans, overseas development aid (ODA) and international financial institution (IFI) funds from the World Bank. The World Bank African Privatisation Database indexes comparatively few health-related privatisations since the mid-1990s, except for complete or partial privatisations of various state-owned pharmaceutical manufacturers. Marek et al (2005) note that, other than in the pharmaceutical sector, there has been no substantive divestiture in the African public health sector.

A notable shift since the initial health sector liberalisation policies of the early 1990s has been the move to promote public private partnerships (PPPs) in national health strategies. PPPs avoid unpopular sell offs and are seen as 'privatisation through the back door' (*The Economist*, 2007; Hall et al, 2005).

In this section we look at several sub-sectors within health, including: pharmaceutical manufacturers, pharmaceutical outlets, private hospitals and diagnostic services, private practices, private health insurance (PHI), community based health insurance (CBHI), PPPs, private financing initiative (PFIs), franchises health worker training and the informal sector.

3.6.1 Pharmaceutical manufacturers

The predominant form of recent trade/globalisation in health is on the input side, in medical technology and pharmaceuticals, where multinational corporations operate increasingly in integrated markets, actively seek scope for further integration, and are having considerable success. Most of new FDI in health is in chemicals and pharmaceutical sector. The pharmaceutical sector has also had the most significant amounts of overt privatisation out of all health-related sectors, either through the selling off of fixed assets or through the transfer of equity.

During the 1970s and 1980s, local pharmaceutical production capacity in the third world was encouraged by governments and to some extent by international organisations. The aim was to grow countries' self-sufficiency in medicines supply, to reduce imports and loss of foreign exchange, to gain foreign exchange earnings and to create employment. In the late 1980s, international organisations and donors stopped promoting domestic production. Yet, there have been notable success stories from outside the region, such as Brazil, Thailand, Bangladesh or Cuba (Losse et al, 2007). Compliance with international standards is a crucial

pre-requisite for local firms to access the national, regional and international market and stay in the market.

In the last ten years big-pharmaceutical companies became more powerful; they:

- command twice the combined GDP of sub-Saharan Africa
- influence rules of trade and patent rules
- function as global monopolies (Global Health Watch, 2005).

Profit and market-driven prescribing of medicines means companies profit for over-prescribing and inefficient prescribing (e.g. using expensive drugs when cheap ones are as good). The fortunes of private pharmaceutical production and retail are closely tied to the dynamics of public sector pharmaceutical procurement and distribution systems as well as donor-driven demand for drugs. Uganda and Kenya, for example, have the most developed markets for antiretrovirals (ARVs) in East Africa, but much of this market is driven by public procurement, such that opportunities for private retail are limited (Losse et al, 2007)

There are four types of pharmaceutical companies in developing countries (Seiters, 2005):

i. **Subsidiary companies** of large multinational companies producing branded products for the local and regional market.
ii. **Generic manufacturers, operating globally** (for example Cipla, Ranbaxy, Sandoz, Teva). These companies work increasingly with a globally integrated manufacturing strategy. Key parameters influencing investment decisions are access to main markets, costs, infrastructure, and skilled labour. Their core business is focused on developed markets in the US, Europe, and large middle income markets such as India and China. Some have manufacturing operations in smaller developing countries or joint ventures with local companies. They offer a large portfolio of generic drugs, are capable of meeting global standards for quality (a prerequisite for their presence in the developed markets) and a few of these companies have made significant investments in Research and Development.
iii. **Generic companies with predominantly national operations** with the main market being the country of residence, sometimes exporting to nearby countries. The product range of these companies is typically based on off-patent drugs.
iv. **Small local companies**, which produce a small scale of generic products for the national market and hardly meet good manufacturing practice (GMP) standards, often focussing on the informal sector and traditional medicine.

Some companies cut across all four categories (Losse et al, 2007). The IFC (2007: Annex 3) reports that local manufacturers (type iii and iv) produced 25-30% of the total 2006 value of pharmaceuticals in sub-Saharan African markets, and less than 10% of the medical equipment. These pharmaceutical industries often specialise in processing and repackaging imported active ingredients and, apart from South Africa, do not have a significant local research and development (R&D) capacity supporting the development of new or improved drugs.

According to the WHO (2005) monitoring 46 countries in Africa, there are 38 countries with local pharmaceutical industries, and eight who have none. UNCTAD (2005b) record FDI in the Kenyan pharmaceutical sector and in Botswana's health care sector (UNCTAD, 2003), as well as South African, Mauritian, Malaysian, Chinese and Indian investment in Tanzania's SME pharmaceutical sector (UNCTAD, 2002). Guimier et al (2004) provide lists of local pharmaceutical manufacturers in ESA and relevant references.

Different procurement standards are applied by different agents. International donors will not accept local drug companies who do not meet tough international quality standards; US American Food and Drug Administration (FDA) standards or European Pharmaceutical

Inspection Co-operation Scheme (PIC-S) standards have to be applied. Given that much of the demand for drugs comes from donors, the market for local pharmaceutical companies tends to be government tenders.

Foreign firms are significant in certain cases, particularly in South Africa and Kenya. Kenya has the most developed pharmaceutical production capacity in East Africa, with a significant number of both local and foreign players and playing an important part in the Kenyan industrial sector (EPZA, 2005; UNCTAD, 2005b; WHO and HAI, 2003; Lewis-Lettington and Munyi, 2004). Production of generic drugs is a central part of the industry, having attracted US$40 million worth of investment by the three most active local manufacturers (Lewis-Lettington and Munyi, 2004). Kenya is an important pharmaceutical exporter in the region, especially to the DRC, Ethiopia, Rwanda, Sudan, Tanzania, Uganda and Zambia, and is the source of about 8% of those countries pharmaceutical imports (UNCTAD, 2005b). However, since the mid-1990s Kenya has lost market share within these countries to South Africa, India and China.

Within Kenya, private hospitals tend to source their drug supply through the local marketers and distributors of the major international pharmaceutical companies and Indian and Chinese generic manufacturers, rather than sourcing from Kenyan manufacturers (Lewis-Lettington and Munyi, 2004). Indeed, there is considerable tension between local manufacturers and international subsidiaries, as they fight over the local market and the Ugandan and Tanzanian export markets (Euromonitor International, 2006a). GlaxoSmithKline in particular manages to maintain its historical dominance in East Africa (Euromonitor International, 2006a). The institutional environment in Kenya is not conducive to stemming unfair and unscrupulous business practices, and Kenya is noted to be at the centre of the counterfeit and expired drugs trade (Euromonitor International, 2006a).

South Africa has over 64 pharmaceutical manufacturers. South Africa has by far the largest manufacturing and R&D capacity in the sub-Saharan African pharmaceutical sector, including a large presence of foreign pharmaceutical firms (Dummett, 2002; IFC, 2007). South African producers now account for about 16% of the pharmaceutical imports of the East African countries, over double the corresponding 1994 level (UNCTAD, 2005b); and South Africa and Kenya still account for larger shares of the pharmaceutical imports within the region than India and China (UNCTAD, 2005b).

There was a huge expansion in the South African pharmaceutical manufacturing sector in the early 1990s, and the development of a significant pharmaceutical export output (Dummett, 2002). Key local firms include Aspen Pharmacare (the biggest firm in Africa) and Adcock Ingram (the second biggest). These firms, along with large foreign multinational firms, dominate the domestic market for pharmaceuticals (Dummett, 2002). 50% of sales are channelled through retail pharmacies, although it has only been in the last ten years that corporate ownership of retail pharmacies has been allowed (Dummett, 2002). There are signs of increased concentration in the drug retail sector as small pharmacies have been disproportionately hit by recent government price controls, thus losing ground to large chain pharmacies (Euromonitor International, 2006b; IFC 2007: Annex 3). At the same time, according to Kahn (2008) the largest private medical insurance scheme in the region, Discovery Health, ‘has used its market dominance to persuade drug firms to lower their prices, and prices in the medical device industry. Discovery Health also works closely with private hospital groups to try to persuade manufacturers of medical devices and consumables to lower their prices, and limit price hikes to once a year. Unlike medicines, which are tightly regulated, the thousands of new medical devices and consumables launched each year do not have to be registered, nor are they bound by price regulations’.

Aspen clinches 60% acquisition of Shelys

Pharmaceutical titan Aspen Phamacare Holdings has acquired 60% of over-the-counter medicine maker Shelys Africa for an undisclosed sum from private equity firm Aueros Capital and other shareholders.

Shelys, set up in 1984, sells its products in east and central Africa and is part of the Sumaria Group, one of the largest private sector groups in east Africa headquartered in Tanzania. The deal comes nearly a year after Aureos introduced Shelys to Aspen — Africa's largest pharmaceutical firm — to explore opportunities to work together. This culminated in them agreeing there were strong synergies that could be exploited.

Aureos on Friday said Aspen saw in Shelys a group with good manufacturing capabilities and a strong brand presence in its core markets. “To Shelys, Aspen offers access to a broader distribution network and wider product range," it said.

Shelys group chairman Jayesh Shah said the acquisition would create a formidable group in the pharmaceutical sector in the region, while Aspen Group CEO Stephen Saad said the deal would help bring affordable medicine to Africa: “We are delighted to have formed this partnership which is instrumental to achieving our goal of providing quality, affordable medication throughout Africa,” he said.

Aspen’s offshore subsidiary recently acquired for R2,7bn the intellectual property rights to four branded pharmaceutical products — Eltroxin, Imuran, Lanoxin and Zyloric — from GlaxoSmithKline.

Source: Kamhunga, 2008

In Tanzania, eight manufacturers produce mostly penicillin, infusions and injectibles, and one manufacturer, Tanzania Pharma Industries (TPI), producing ARVs. The other major player, Shelys, which has about 50% market share, may follow soon (Losse et al, 2007: 10–11). They cover 400 Pharmacies, 4,000 dukala dawas, and 10,000 kiosks, all government regional hospitals, referral hospitals, private hospitals. Shelys is working in a Public Private Partnership with the BEGECA, a Private Limited Company for Procurement for Church-related, Charitable and Social Institutions, supported by the German Government. Shelys Pharma is noted as a significant Tanzanian TNC by UNCTAD (2006d). The market size for drugs in Tanzania itself is large when it comes to the donor market. This ‘parallel’ market is considered a ‘real’ and very profitable market in the medium term (Losse et al, 2007).

Keko Pharmaceuticals, a former parastatal organization established in 1972 under the Ministry of Health was privatised in 1997, with government retaining 40% of shares and the rest were purchased by Diocare Ltd. Currently, Keko Pharmaceuticals is engaged in the production of pharmaceuticals including tablets and infusions.

Tanzania’s pharmaceutical industry has received investment from South Africa, Mauritius, Malaysia, China and India, mostly in the SME sector — small-scale pharmaceutical enterprises that are comparatively labour intensive and that rely on local personnel (UNCTAD, 2002). The government has made attempts to encourage Indian investment in the pharmaceutical sector (ibid).

Uganda also has a small pharmaceutical sector, with five large-scale pharmaceutical manufacturers and five small-scale pharmaceutical manufacturers (WHO and Uganda MoH, 2002). Malawi has very limited manufacturing capacity in pharmaceuticals, with only four companies that target the local market (Lewis-Lettington and Banda, 2004). In 2008 Swiss drugmaker Roche expanded its *Technology Transfer Initiative* for the production of generic versions of the company's patented second line antiretroviral Invirase (saquinavir) to four local manufacturers in Africa and Asia. The deal will allow saquinavir to be produced by Regal Pharmaceuticals in Kenya, CAPS Holdings in Zimbabwe, Shely's Pharmaceuticals in

Tanzania and Bexmico Pharmaceuticals in Bangladesh. Already included in the initiative are South Africa's Aspen and Cosmos (Business Monitor, 2008). Zambia also has limited capacity (Dlamini et al, 2004) and is encouraging private investments in pharmaceutical production and medical equipment (UNCTAD, 2006b).

3.6.2 Pharmaceutical outlets

Local pharmacies in sub-Saharan Africa are largely single-outlet businesses rather than chain pharmacies, the key exception being South Africa (IFC, 2007: Annex 4), Zimbabwe and Namibia. The level of home-care is considerable and the pharmaceutical retail sector, either formal or informal, may be the closest many people come to the health care system (Marek et al, 2005). This is why pharmaceutical retail is the most profitable health industry in sub-Saharan Africa (IFC, 2007: Annex 4). The private sector benefits in increased sales during public procurement delays and distribution snags (Global Insight, 2006a). Private distribution networks for public supplies may become more important in the future, with some already in use (IFC, 2007: Annex 4; Fine et al, 2001).

Local pharmacies also play an important part in facilitating the sales of foreign pharmaceutical firms; Global Insight (2006a) notes that in East Africa '[m]ost global pharma firms are established through local pharmacies and agents while Indian, South African and Latin American firms have adopted a direct approach of establishing marketing networks. The power and behaviour of large foreign pharmaceutical companies within ESA markets is always controversial (Global Health Watch, 2005). Cases of devious misconduct are recorded; such cases are also found among local manufacturers as well. There are many reports of donated shipments of drugs being sold illegally on open markets or in private clinics (Spooner, 2002).

Most private for-profit pharmacies are found in urban areas. There are, for example, hundreds of retail pharmacies in Luanda, many of them small family-owned enterprises (Connor et al, 2005) and in Uganda 80% of pharmacies and 90% of pharmacists are urban based (WHO and Uganda MoH, 2002; Jefferys, 2004). In Zimbabwe, the 184 pharmacies in the retail pharmacy sector are private for-profit, ranging from single pharmacists to huge pharmaceutical chain stores; CAPS Holdings Limited, controls 40% of a retail pharmacy market worth over US$5 million (Munyuki and Jasi, 2009). Clicks and Discom (South African owned companies) operate in a franchise arrangement with the Meikles Group as franchisees with Medix which owns a chain of fourteen pharmacies (Clicks, 2002). In South Africa, there are 174 private institutional pharmacies (at private hospitals and clinics, 20 virtual pharmacies (South African Pharmacy Council, 2003), but statistics on the number of retail pharmacies were not available, although they are known to be widespread, particularly in urban centres.

3.6.3 Private hospitals and diagnostic services

In the late 1990s Africa had the lowest number of private-for-profit beds per capita when compared to other developing regions such as Latin America and Asia (Berman et al, 1998). Therefore, by this measure the private sector is very small. Berman et al (1998) contend that the high investment costs of in-patient facilities means that hospital services in the developing world tend to be dominated by the public sector, whilst the ambulatory sector is dominated by private providers.

However, the South African private hospital sector witnessed a 34% expansion in the number of private hospitals during the period 1998–2006. It is dominated by Netcare, Medi-Clinic and Life Healthcare. South Africa has also experimented with lease and concession arrangements in public hospitals (Shuping and Kabane, 2007; Marek et al, 2005).

Cleary (2003) argues that while there is no ready data on foreign ownership of or investment in private hospitals in South Africa, it is clearly happening. For example the recently opened University of Cape Town (UCT) Medical Centre was developed through direct investment from Rhon-Klinikum, a German private hospital group.

This is also happening in the other direction, with South African-based companies investing abroad. Afrox health-care group has non-South African operations in Botswana, Namibia, Zambia, Mozambique and others; Medi-Clinic also owns private hospitals in Namibia (Medi-Clinic, 2008), and Life Healthcare operates private hospitals and clinics in Botswana (Life Healthcare, 2008).

According to a survey conducted by the Zimbabwe Guardian, hospital consultation fees in urban areas are ten times less at rural health centres operated by church missions (Pharmaceutical Insight, June 2008).

3.6.4 Private practices

Private practices run by general practitioners are well-established in ESA. Gilson and Mills (1995) report that, in the early 1990s, about 40% of doctors in Zimbabwe worked in the private-for-profit sector and Sekhri (2005) claims that 46% of doctors in Africa work in the private sector. A significant feature is the presence of public health workers simultaneously running private practices (Ferrinho et al, 2004). In Mozambique for example, the most private practitioners are also government staff, and in Uganda a very high percentage of public staff work in the private sector, even though this is illegal (Jefferys, 2004).

Private practices and private-for-profit clinics are focused on urban areas. Jefferys (2004) shows that over 95% of independent doctors in Malawi, Mozambique and Tanzania and 70% of doctors in Uganda operate in urban areas. The same situation can be found among nurses, with 80% and 70% of nurses working in urban areas in Malawi and Uganda respectively. A recent innovation seeking to combat the problem or rural health worker shortages is telemedicine, with pilot projects occurring in South Africa (IFC, 2007: Annex 1). Private sector midwives are also becoming more prevalent (White and Levin, 2006).

Governments are also experimenting with contracting out primary health services to the private sector, with examples being noted in South Africa and the DRC (Marek et al, 2005). Commercial companies have also moved into the area of primary health care, traditionally the preserve of private GPs and public clinics (Palmer et al, 2003; IFC, 2007: Annex 1). Although often not included in the normative concept of a private practitioner, indigenous healers are a very important source of primary care (IFC, 2007: Annex 1).

3.6.5 Private health insurance (PHI)

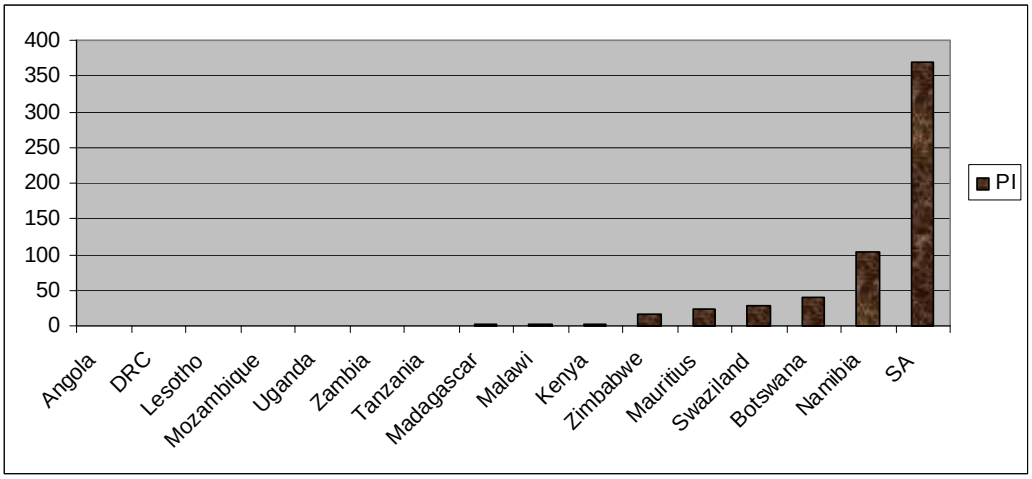
Only 1% of Africans have private health insurance (82% of whom are South Africans). Thus excluding South Africa 0.18% of Africans has private health insurance, limited to wealthy minorities (Drechsler and Jütting, 2005a). South Africa is an anomaly in the region – it has by far the largest PHI sector in Africa, displays the highest penetration rate of PHI in the world (Drechsler and Jütting, 2005b) and had the world's seventh largest absolute amount of health care spending funded through private insurance in 2007 (Swiss Re, 2007).

The Board of Healthcare Funders of Southern Africa (BHF) is a regional representative body for 95% of medical schemes in Southern Africa, which includes 108 medical schemes in South Africa, 20 in Zimbabwe, nine in Namibia, three in Botswana and one in Lesotho (BHF, 2006). Many of these however, are restricted medical schemes for the employees of specific large firms, and are not open to the general public. This applies in the case in Lesotho, whose sole BHF member is an employee benefit scheme. The BHF reports that since 2002

there has been an 11.6% increase in membership to open medical schemes and a 5.7% increase in restricted scheme membership, suggesting a relatively dynamic PHI industry in Southern Africa (BHF, 2006). South Africa's Discovery Health runs the largest of Southern Africa's medical schemes, which is four times as large as the second biggest scheme (ibid). Figures from the schemes sampled in the BHF survey indicate that 39.53% of money disbursed by PHI companies went to hospitals, 20.62% to medical specialists, 13.71% to medicines, 9.12% to allied and support health professionals, and 7% to general practitioners, showing an emphasis on higher order curative care.

Namibia and Zimbabwe also have comparatively high PHI membership, contributions and coverage scale and, along with South Africa, were among the six countries in the world to finance more than 20% of THE through PHI 2001 (Sekhri and Savedoff, 2005). Botswana is significant in absolute spending on PHI, although PHI institutions finance a relatively low proportion of THE. Country-specific National Health Accounts reports suggest that PHI sectors are fairly well established but small in Kenya, very small in Malawi, and more or less absent in Mozambique and Uganda. In Tanzania and Zambia the small PHI industry appears to be used exclusively by some formal sector private companies for their employees (Tanzania MoH, 2001; Phiri and Tien, 2004). There is no private insurance sector in Angola (Connor et al, 2005). PHI is clearly out of the question for most people in ESA, where even micro- and community-based insurance schemes have had trouble attracting followers (Basaza et al, 2007; Carrin et al, 2005).

Figure 4: Per capita expenditure channelled through private insurance institutions in 2005 (International Dollars)



Source: WHO, 2005

Swiss Re (2007) note that going global is a rare phenomenon in the health insurance industry. An increase in other types of FDI may be a spur to PHI however; Moss et al (2004) found that foreign firms in Uganda, Kenya and Tanzania provided significantly higher levels of health insurance to their employees than local firms did.

3.6.6 Community-based health insurance

The World Bank, IFC and OECD champion low-income community-based health insurance schemes as a means to stimulate demand for private sector health provision and also as a measure to reduce catastrophic household expenditures in the face of increasing health service commercialisation and low levels of public financing (Drechsler and Jütting, 2005a:20). Yet while CBHI schemes have grown during the last few years (ibid), CBHI schemes are local affairs and do not imply any major prospects for FDI, although 'it can be expected that PHI involvement [in Africa] will primarily occur on a non- or low-profit basis

organized by local communities, private associations, or national and international NGOs' (ibid). These schemes are more popular and well-established in West Africa than in ESA. Basaza et al (2007) point out that these schemes are likely to take off when some governments have abolished user fees, which removes some of the necessity to join risk-pooling arrangements. The DRC appears to be a key site for CBHI, as does Tanzania, Kenya and Uganda (Kirigia et al, 2006; Carrin et al, 2005; Jakab and Krishnan, 2001; Arhin-Tenkorang, 2001).

The IFC (2007: Annex 2), remains optimistic about the potential of certain risk-pooling arrangements and provides examples of what it believes to be promising business strategies in the field. The Dutch government recently set up a US$128 million fund to support the development of health insurance in Africa, including specific projects in Uganda and Namibia (Global Insight, 2006b).

3.6.7 Public-private partnerships

A PPP is a contractual agreement in which a private party delivers a service or performs a function for the public sector with the private sector assuming the risks associated with the delivery or function. However, PPP's often apportion risks to the public sector. The key issue for many is how they are structured, negotiated and managed (Bennett and Mills, 1998). PPPs are often compromised by problems of communication and trust between the sectors, a lack of wholehearted willingness to engage each other, and a lack of agreement on strategies (Osewe, 2006). In addition, there are questions about the actual capacity of the private sector, the lack of public sector familiarity with the dynamics of the private sector (ibid), and the capacity of government to successfully undertake and manage contracts (Bennett and Mills, 1998). Perrot (2004) suggests that contracting can promote opportunistic and corrupt behaviour that may counteract any potential positive benefits. Loevinsohn and Harding (2005) however, believe that despite the lack of documented evidence on its effects, contracting should be tried on a larger scale.

In addition, some donors like USAID, specify PPPs as a condition of their financial support in the health sector. All governments in ESA officially stated their willingness for increased co-operation with the private sector. Yet it appears that this has been a piece-meal commitment, with Marek et al (2005) noting the absence of large-scale PPPs in African health systems (also see existing case studies by Marek et al, 2005: Annex 2, 3, 4; Patouillard et al, 2007; Perrot, 2004; Bustreo et al, 2003). Increases in PPPs in Africa have been noted (WHO, 2006b; Dare and Buch, 2005), and National Health Accounts data shows that public funds are being directed to private agents in some cases, although often largely to NGOs and CBOS. Donors, along with governments, international agencies and pharmaceutical companies have also played a key role in the development of 'global PPPs' (Osewe, 2006). These are co-ordinated initiatives are often 'vertical programmes' to combat specific diseases. Within ESA, companies such as Merck and Pfizer work with funding bodies like the Global Fund and the Gates Foundation, using government and NGO personnel at ground level (Osewe, 2006).

PPPs exist in social marketing in Tanzania and Kenya, in the use of vouchers in Zambia, Tanzania and Kenya, pre-packaged treatments in Uganda, health franchises in Madagascar, Kenya and Zimbabwe, accreditation of pharmacies as a form of PPP in Tanzania and contracting-out of health provision in South Africa, Lesotho, Madagascar, Zambia, Uganda, Namibia, DRC and Zimbabwe (Mudyarabikwa, 2000; Mudyarabikwa and Madhina, 2000; Grace, 2004; Caines et al, 2004; IFPMA, 2007; PhRMA, 2003; Sekhri, 2005). The scope of global PPPs leaves them susceptible to corruption, and the Global Fund has recently suspended funding in Kenya, Zimbabwe, Namibia, Tanzania and Uganda for this reason (Wakabi, 2007).

South Africa formed a 'PPP Unit', designed to facilitate and monitor government interaction with the private sector in all fields (Dutz et al, 2006). The National Treasury has developed guidelines on PPPs (National Treasury, 2000) providing a framework for the development and implementation of PPPs by all national and provincial government departments.

South Africa is the only country to experiment with leasing and concession arrangements (Marek et al, 2005; Shuping and Kabane, 2007). Co-location means leasing spare capacity to the private sector (NDOH, 2001) or sharing under-used public or private resources, which is being explored in the Eastern Cape, Western Cape and the Free State. Private doctors, for instance, use public capacity to treat private patients in return for free sessions or even a facility upgrade. Private clothing industry clinics in the Western Cape use public facilities for X-rays and laboratory tests in return for payment of variable costs (Wadee et al, 2004). Also Netcare opened the Port Alfred Hospital, built through a PPP deal with Nalithemba Hospitals, an empowerment firm and the Eastern Cape government (Khanyile, 2009).
In South Africa, the Inkosi Albert Luthuli Hospital in Kwazulu-Natal was designed to provide the region (one of the fastest growing in the world) with state-of-the-art tertiary care. The winning consortium, which included Siemens medical systems and equipment and a leading Information Technology (IT) systems group, will provide full facility management, medical equipment provision and maintenance, and specified facility upgrades throughout the 15-year concession period. Government closed five aging hospitals in Durban neighbourhoods to concentrate its resources on Albert Luthuli. Siemens has designated the hospital as a paperless facility and works there in co-operation with South Africa's public medical staff to pioneer IT solutions for healthcare management. It is estimated that this concession will save government R370 million over the 15-year partnership. A similar model was used by Treasury to attract investors to refurbish the Pelonomi hospital in Bloemfontein. In this model, the Free State Government and South Africa's leading private healthcare provider, Netcare, entered an agreement for Netcare to refurbish and update the entire hospital facility. In addition to this capital investment, completed in 2004, Netcare will take over one wing of the hospital to provide services using their own staff and equipment to private pay patients. Netcare will also share access, under strict contractual agreement, to some of the operating and other facilities with the public medical staff.

In the Tanzanian pharmaceutical market, there are two major local firms: Shelys and TPI. Both have recognised and are aiming at the donor market. All producers can participate in tenders issued by the government. Local producers enjoy a 15% preferential treatment and have to comply with Tanzanian Good Manufacturing Practices (GMP) standards. However, as no local producer complies with international standards yet, they are not eligible for international donor financed tenders, which are more profitable.

Shelys is part of a PPP Initiative aiming at achieving international quality standards. The area of quality standards poses one of the three most significant challenges of local production and competitiveness of the pharmaceutical sector. German Development Cooperation (GTZ) can contribute to the improvement of quality standards, in particular through its PPP facility, but also through the facilitation of knowledge transfer or advisory services to the Tanzanian Food and Drug Regulatory Authority (TFDA).

Case study: Shelys

Shelys is a large market player in the entire region and has been manufacturing a number of drugs. The ongoing manufacturing forms the economic basis for the investment in the manufacturing of the 'essential' drugs (mainly ARVs), to be purchased by government and donors. The management is convinced that local production – regardless of TRIPs – related opportunities – is worthwhile due to the sheer market size for Malaria drugs, ARVs, TB drugs and medicines for other basic diseases affecting public health. This indicates that the company is geared towards the donor market, which will be in demand of drugs for these diseases in particular, as stated in MDG 5. Shelys' staff comprises mainly of Indian and British expatriates. Tanzanian staff is still the minority and it was mentioned by

the CEO that this is a major problem. Shelys would prefer to employ Tanzanian staff, but the competency needed for pharmaceutical production is simply not available in the country. In total the company employs 800 people in Tanzania. Out of these, the majority are from India and the UK. The Tanzanian employees are nskilled and work in the packaging area, whereas the Indian and British staff is skilled.

BEGACA's main objective in East Africa is to deliver emergency aid to the crisis-affected areas in the Democratic Republic of Congo (DRC) and Sudan, but the local procurement of pharmaceutical products in this region is particularly difficult. Despite the existence of a number of pharmaceutical manufacturers in the region, there is a constant lack of drugs that BEGECA can procure within the region. The core of the problem is the low quality and the absence of international standards of locally manufactured drugs. If the top companies in the region could improve their quality standards up to the level of PIC-S standards, the sustainable and swift delivery of drugs in the region could be improved substantially. But without international expertise, private companies will not be able to introduce and sustain such high standards.
This is the starting point of the BEGECA and GTZ public private partnership (PPP). The project supports seven selected pharmaceutical companies from Kenya and Tanzania, such as Shelys, in introducing and maintaining PIC-S standards in order to get access to international pharmaceutical markets. Shelys benefit through the Public Private Partnership project through regular inspections and trainings. After each inspection, the international inspectors who audit the production plant in Dar es Salaam once a year, using a regular GMP checklist, hand over a list of issues that need to be improved in order to fulfil the standards. This list includes issues like required staff training or other investments. Only companies who fulfil international standards are eligible to participate in international, donor-financed tenders, compliance is an important opportunity. Therefore, the perspective of compliance in itself is an incentive for a local firm like Shelys to participate in the project and finance the necessary improvements and investments in its company. For BEGECA, who finances the inspections, the benefit is that in the future they will be able to procure drugs in the region and thus avoid transport costs and delays. Finally, GTZ's PPP facility, which is partially financing the undertaking, has the objective to support the development of a sustainable pharmaceutical industry and improve the availability of essential quality drugs in the region.

Netcare has a partnership with the Lesotho government which is using as a model to convince other southern African states of the attractions in private-public partnerships. In 2008 Netcare was selected as the preferred bidder in a public-private partnership to build a hospital, refurbish two feeder clinics and run the clinical services by the Lesotho government. The project will cost more than R800 million.

Dutch electronics company, Philips, has completed the initial phase of a seven-year project to modernise Zambia's healthcare infrastructure. Involving medical hardware and the associated training, the €25 million (US$39.5 million) scheme is expected to further reduce infant mortality, improve surgical outcomes and extend life expectancy in one of the world's poorest countries (Pharmaceutical Insight, 2008).

3.6.8 Private Finance Initiatives (PFIs)

The Private Finance Initiative (PFI) refers to raising capital through private donations to build a public facility; it has become quite prominent in both national and provincial level discussions, and to a limited extent in local government. Being a different sphere of government, beyond the jurisdiction of National Treasury, local government is not compelled to follow Treasury's PPP guidelines when embarking on a PFI. The evidence is limited, but preliminary data suggests that local government perspectives of what PFI is, differs markedly from that espoused by Treasury. From the survey data the local government planning on embarking on a PFI is actually embarking on a project that involves no contract with a private agent over a lengthy time period (Wadee et al, 2004).

PFI involves raising capital on private money markets. Nkosi Albert Luthuli Hospital in KwaZulu Natal (KZN) has embarked on the first health-PFI in the country, and subsequently

the KZN health department is planning to embark on a few more (interview data). PFI has also been planned by the Gauteng Health Department to revitalise Chris Hani Baragwanath, and has featured in policymaker and management thinking at both provincial and facility level (interview data). PFI can essentially take on two dimensions:

i. It can be used to build new facilities or revitalise existing ones.
ii. It can also be used to equip facilities with the latest high-tech medical and non-medical technology.

In the case of the Nkosi Albert Luthuli PFI it is the latter, whereas the former has featured in thinking in both Gauteng and KZN to revitalise and rebuild facilities such as Chris Hani Baragwanath and King Edward respectively. The private construction industry benefits from public hospital construction, as in the case of the public hospital revitalisation project in South Africa (Van Wyk, 2007).

3.6.9 Franchises

For the World Bank Group and USAID, the establishment of private provider networks and franchises holds great promise for boosting the SME health sector in Africa. Their potential has been the focus of several studies (Montagu et al, 2002; WHO/USAID/PSP-One, 2007; Chandani et al, 2006; Ruster et al, 2003; Prata et al, 2005; Jefferys, 2004; Stephenson et al, 2004). Franchising is not widespread in ESA, but examples of private network forms can be found in South Africa, Kenya, Uganda, and Madagascar (Chandani et al, 2006; Ruster et al, 2003; Montagu et al, 2005). In South Africa, there are various franchises in the pharmaceutical retail sector, such as Link Pharmacies, Clicks, Discom, MediRite, Durbell Pharmacies. The New Clicks franchise has spread to Zimbabwe, as already discussed in *Section 3.5.2*, and Discom also has stores in Nambia and Swaziland (Discom, 2009).

The idea is that they will increase the appeal of the private health sector to consumers due to price decreases and quality gains afforded through economies of scale in procurement, training and advertising, and through entry requirements providers will have to fulfil in order to gain access to such benefits. Equally importantly, they are seen as the ideal structures to overcome the problem of poor government regulatory oversight in many regions, with the franchise requirements creating a type of self-regulating private sector.

3.6.10 Health worker training

Private involvement in health worker training has been limited in sub-Saharan Africa through government regulations, high capital costs for some aspects of training, and low spending power among students (Conway et al, 2007). The IFC (2007: Annex 5) discusses large private medical universities, distance learning programmes, and schools for nurses, midwives, and technicians; examples include African Medical and Research Foundation (AMREF) in Kenya and Hubert Kairuki University in Tanzania. Uganda is noted as encouraging private involvement in education (IFC, 2007: Annex 5). Parent et al (2004) mention that while there are both public and private medical schools in the DRC, the very low government subsidy means they are all effectively autonomous private units

3.6.11 The Informal sector

The informal sector (including unregistered vendors of pharmaceutical products, commercial herbalists, and traditional healers) form the overwhelming part of so-called 'private-for-profit' health care in most African countries. About 70–80% of people in Africa at some point in their lives use the traditional sector although not exclusively so (Osewe, 2006; JLI Africa Working Group, 2006). The IFC (2007) estimates that the traditional sector captures only 10% of expenditure directed towards the private sector in SSA, but in Zambia, for example, traditional healers account for 60% of private household health expenditure, (over 30% of THE) (Phiri and Tien, 2004).

The traditional and informal sectors have been perceived to be at odds with official national health objectives. Not only are they difficult to monitor for quality and ethics (Mudyarabikwa and Madhina, 2000) but traditional healers have been suppressed by nationalist governments that perceive them to be anti-modern. In Mozambique, for example, attempts were made to ban traditional practitioners in the 1970s and 1980s (Yates and Zorzi, 1999). Informal pharmaceutical markets may also be linked to corruption in the public sector (Transparency International, 2006; Mohamed, 2008).

However, the traditional health sector is considered important enough by the African Union to include it as an integral element of their 2007–2015 health strategy (AU, 2007). The traditional sector is of great strategic importance in national health goals because it is often the most accessible health sector for most people who live in rural areas and also has a strong cultural resonance within many communities (Osewe, 2006). The sector has become particularly important in the broader political and medical dynamics surrounding the response to the HIV/AIDS crisis (Osewe, 2006; Wreford, 2005; Kayombo et al, 2007).

4. Issues and implications

There is fierce debate but poor information and slippery definitions when we examine the size, nature and growth of the private-for profit health sector (Oxfam, 2009). The proponents of privatisation have exaggerated the size of profit sector in health and conflated for-profit and non-profit providers and formal and informal providers. The poor and rural populations in Africa rely more heavily on *informal private sector* providers, especially unregulated drug peddlers (Koivusalo and MacKintosh, 2004). Within the informal sector the quality of pharmaceuticals is known to be poor, with fake and counterfeit drugs a chronic problem.

Since the late 1990s, private-for-profit activity in the formal sector has increased in some countries but from a low base (Castro-Leal et al, 2000: 67). Investment is uneven, as a consultative group of the WHO (2006b: 8) points out, and "there are indications of both the relative growth and decline in differing countries". Small flows from donors and investors have been used to sustain pressures on governments to adopt market-friendly policies.

The myth of large commercial flows creates false expectations and further debilitates public sector initiatives.

However, commercialisation appears more as an 'affliction of the poor countries, not preferred by the rich' (Koivusalo and MacKintosh, 2004). In most wealthy countries, most citizens still enjoy free public health services. Rich countries (with the exception of the USA and Singapore) have universally established social insurance or government-based health financing systems. The role of the state *vis a vis* the market especially since the 2008 financial collapse and massive bailouts of banks has undercut the ideology of 'leaving it to the market' and created a new policy landscape.

Public systems ideally are based on quality care based on need, accessible facilities and security that people are getting good professional care from trusted providers (Global Health Watch, 2005: 66, 67, 101). Healthcare in effective public systems is a holistic, comprehensive activity; market-driven policies treat health as a commodity. As a commodity, health is broken down into discrete saleable units with the patient represented as 'a customer'. In the 1980s environment of structural adjustment, coinciding with economic crisis and a fiscal squeeze on public sector wages and supplies, African countries were forced to cut back on health spending, reversing social gains of the 1970s. Fees were introduced for public health, many public sector health workers also worked informally in the private sector; the public sector was steadily undermined (Gilson, 1997).

Another well-known issue of private-for-profit health care is the almost exclusive focus on curative services as opposed to preventative care, probably due to the comparatively low amounts of people who are prepared to pay for such care. The IFC (2007: Annex 1) notes that NGO/FBOs are the only private providers who devote significant resources to preventative services. There are indications however, that governments are experimenting with contracting out preventative services to private sector providers (Marek et al, 2005).

Many argue that the commercialisation of health has increased inequalities: for instance, 42% of global expenditure on medicines is spent on only 5% of the world's population. New and deepening North-South inequalities have emerged in health as health workers are lured to higher paying private sector jobs. As UNCTAD (1998) noted, 56% of all migrating physicians flow from developing countries to industrialised countries, while only 11% migrate in the opposite direction; the imbalance was even worse for nurses.

The private sector, however, has a mixed record in health systems,

- poor quality care
- over-prescribing
- limited reach beyond higher income groups
- barriers to access due to user charges and fragmentation of risk pools (Mills et al, 2002).

Prices in the private-for-profit sector are higher than those in the public or non-profit sectors, although the extent of the difference varies (WHO and Uganda MoH, 2002; WHO and Tanzania MoH, 2002; WHO and HAI, 2003; WHO and HAI, 2005). Spiralling costs and exclusion of populations from medical aid have become a major political issue in South Africa (Dambisya and Modipa, 2009). Higher prices are less easily absorbed by those with lower levels of discretionary income.

A key point emphasised by critics of the private sector is that the commercial drive and its measures of success structure its overall operations. It has very different operational criteria from the ideal public health services guided by a view of health as a public good to be provided to as many as possible as a right. The entire logic, design, accountability mechanisms are different in genuine public systems where health is seen as an 'inherently social and public responsibility, and an element of the public sphere' (Koivusalo and MacKintosh, 2004). Many commentators admit the limits of the private sector but then go on to suggest finding ways to make the two systems complement each other . This is a doubtful proposition as we have argued.

Comparisons between the efficiency of public and private services, are often misplaced because these two sectors operate in different 'markets' at different scales and within different segments of the population. The public sector usually has to deal with very sick. The public often picks up where the private sector excludes and they offer different kinds of services to different populations.

Vertical interventions harm the long-term integrity of broader national health strategies (Global Health Watch, 2005). The critiques of privatisation of services show that whatever failures there might be in state health systems, the private sector by definition has distortions and limitations given its all-consuming drive for profit.

The Globalisation Knowledge Network of the WHO Commission on the Social Determinants of Health (Labonte and Schreker, 2008) provides a good overview of the negative implications that globalisation may have for health systems. The report holds that while governments have every right to pragmatically experiment with commercialisation to achieve defined outcomes, these measures are very much still policy *experiments*. It is thus

inappropriate to include such measures within binding treaties that will 'lock in' their application within countries. Binding treaties should only occur for measures that are well-tested and generally agreed upon.

5. Conclusion

In the ESA, we find informalised, small-scale health services paid for on the spot, much of it unlicensed and uninspected, involving widespread sale of drugs off prescription as the norm. Commercialised health in ESA takes small scale forms very different from corporate capitalism in the advanced capitalist countries. With the exceptions of South Africa and Zimbabwe and Namibia, there is no significant private insurance sector, few forms of private risk pooling, and social insurance is restricted to sections of the formally employed and sometimes public sector workers.

Since the late 1990s, formal private-for-profit investment has been short-term, opportunistic and uneven. Evidence shows *both* its relative growth and decline in different countries. Mauritius, South Africa, Botswana and Namibia appear as the most attractive for big capital, with the rest relegated to the margins and with a few efforts to formalise to informal and unregulated sectors (Tanzania).

A rather different pattern of commercialisation can be seen in some middle-income countries like South Africa, where the development of private medicine, funded through private insurance for the well-off is well advanced. Yet, the small numbers of people served by the high-end private-for-profit sector at higher prices, commanding a much larger share of expenditure and resources worsens gross inequalities in health provision as South Africa shows. The system reflects remnants of apartheid with the mainly white well-off and black middle class, belonging to private 'medical aid' insurance schemes, and the rest left to a strained public health sector (often defrauded by big corporate e.g. Adcock-Ingram) (Dambisya et al, 2009). The private sector is subject to cost escalation and is itself financially fragile.

Like globalisation, which is part ideology and part substance, the myth of large commercial flows and FDI for Africa creates false expectations, a waiting game and further debilitates public sector initiatives and policy. These myths are part of the IFC and World Bank influence to make business environments in Africa more 'friendly'. The IFC's 2008 *Doing Business Database* still ranks many African countries among the *least* attractive business environments in the world, with the DRC, Angola, Zimbabwe and Madagascar being designated as highly unsupportive towards private enterprise. It notes that investment potential exists in the Tanzanian pharmaceutical, hospital and hospital services sectors – the CDC Group, for example, has expressed interest in increased investment in Tanzanian health care (UNCTAD, 2002). Still, such investment like G7 commitments is often on a smaller scale than might be expected. The IFC envisages a prominent role for the NGO and social enterprise sectors.

Nonetheless, complete or partial privatisations of various state-owned pharmaceutical manufacturers have been a significant aspect of corporate capital's movement into health. Tanzania's pharmaceutical sector offers an interesting case study of the flow of capital — largely donor money, but recently South African capital as well. South Africa provides a good example of how unregulated and rampant privatisation can go wrong (Dambisya et al, 2009). Zimbabwe provides a good example of how despite limited inflows of private capital, there has been a market-orientated reconfiguration of the health system led by private health insurers (Munyuki and Jasi, 2009).

A widespread but questionable view is that, if properly regulated, the for-profit sector can assist the public sector and that the two sectors need not be in competition. But aside from what we have already argued, the weakness of this argument is that it appeals to the same weak state that has failed to build a public health sector to become the regulator. This is a leap of faith in the ability of the state to regulate and the risk is on the side of the state not being able to regulate (Mills, 2000). Weakening the state leaves countries more vulnerable when dealing with epidemics which require that it has infrastructure and provides services both at the public and personal level (since the separation of personal health services from the 'public goods' concept of public health services and regulatory functions is to a large extent artificial). Controlling large-scale risks requires a cooperative unified relationship between service providers.

As Koivusalo and Mackintosh (2004) argue providing only "basic services" is not a solution. It portends the danger of the gradual 'return to the selective vertical programmes approach in the public sphere, in contrast to a more comprehensive primary health care'. This problem can be seen in the stress on three diseases and the establishment of Global Fund to fight against HVI/AIDS, tuberculosis and Malaria. It can thus be argued that the more selective and basic primary care services become, the more prone they are to become part of a vicious circle increasing commercialisation in health care. The danger is that poor state services drives users to the expensive private sector. The focus on providing only *basic* services in the public sector might be a mistake.

Finally, drawing from Koivusalo and Mackintosh (2004) we urge that ways must be found to extend public service access and to improve and reconfigure the informal sector. Pro-poor policies have to include the more affluent and healthy in a common system to build one that is healthy for all with cross-subsidisation and risk pooling. A critical problem for poverty policy is how to make the rich and healthy pay more than their share for the services, and to ensure that good quality of services for all are maintained.

References

1. African Labour Research Network (2003) *Social Observatory Pilot Project*. Naledi: Johannesburg, available at: http://www.alrn.org/images/upload/socialobs.pdf
2. African Union (2005) 'Gaborone declaration: On a roadmap towards universal access to prevention, treatment and care,' 2nd Ordinary Session of the Conference of African Ministers of Health (Camh2), Gaborone, Botswana, 10-14 October 2005. African Union: Gabarone, available at: http://www.aumission-ny.org/documents/GABORONE_DECLARATION.pdf
3. African Union (2007) 'African health strategy 2007–2015.' African Union: Addis Ababa, accessible at: http://www.africa-union.org/root/UA/Conferences/2007/avril/SA/9-13%20avr/doc/en/SA/AFRICA_HEALTH_STRATEGY.pdf
4. Arhin-Tenkorang D (2001) 'Health insurance for the informal sector in Africa: Design features, risk protection, and resource mobilization,' HNP discussion paper. World Bank: Washington DC, available at: http://siteresources.worldbank.org/HEALTHNUTRITIONANDPOPULATION/Resources/281627-1095698140167/Arhin-HealthInsurance-whole.pdf
5. Basaza R, Criel B and Van der Stuyft P (2007) 'Low enrolment in Ugandan community health insurance schemes: Underlying causes and policy implications,' *BMC Health Services Research* 7(105), available at: http://www.biomedcentral.com/1472-6963/7/105
6. Bennett S and Mills A (1998) 'Government capacity to contract: health sector experience and lessons', *Public Administration and Development* 18(4): 307–326.
7. Berman P, Nwuke K, Hanson K, Kariuki M, Mbugua K, Ngugi J, Omurwa T and Ong'ayo S (1995b) 'Kenya: Non-governmental health care provision.' Data for Decision Making Project, Harvard School of Public Health: Boston, available at: http://www.hsph.harvard.edu/ihsp/publications/pdf/No-20.PDF
8. Blouin C, Drager N and Smith R (2006) *International Trade in Health Services*. World Bank: Washington DC.
9. Board of Healthcare Funders of Southern Africa (BHF) (2006*) Key performance indicators from the 2006 survey of medical schemes in Southern Africa*. BHF: Johannesburg, available at: http://www.bhfglobal.com/files/KPI%20REPORT%202006.pdf
10. Bustreo F, Harding A and Axelsson H (2003) 'Can developing countries achieve adequate improvements in child health outcomes without engaging the private sector,' *Bulletin of the World Health Organisation* 81(12): 886–894, available at: www.scielosp.org/pdf/bwho/v81n12/v81n12a07.pdf
11. Caines K, Bataringaya J, Lush L, Murindwa G and N'jie H (2003) *Impact of public-private partnerships addressing access to pharmaceuticals in low and middle income countries: Uganda pilot study.* Initiative on Public-Private Partnerships for Health: Geneva.
12. Carlson C (2004) 'Review of health service delivery in Uganda – General country experience and northern Uganda,' *Case Study 6*. DFID Health Systems Resource Centre: London, available at: http://www.dfidhealthrc.org/publications/health_service_delivery/Uganda.pdf
13. Carmody P (2002) 'Between globalisation and (post) apartheid: The political economy of restructuring in South Africa,' *Journal of Southern African Studies* 28(2).
14. Carrin G, Waelkens M-P and Criel B (2005) 'Community-based health insurance in developing countries: a study of its contribution to the performance of health financing systems,' *Tropical Medicine and International Health* 10(8): 799–811, available at: http://www.blackwell-synergy.com/doi/pdf/10.1111/j.1365-3156.2005.01455.x?cookieSet=1
15. Castro-Leal F, Dayton J, Demery L and Mehra K (2000) 'Public spending on health care in Africa: Do the poor benefit?' *Bulletin of the World Health Organisation* 78(1): 66–74, available at: http://whqlibdoc.who.int/bulletin/2000/Vol78-No1/bulletin_2000_78(1)_66-74.pdf
16. Chanda R (2002) 'Trade in health services,' Bulletin of the World Health Organisation 80(2): 158–163.

17. Chandani T, Sulzbach S and Forzley M (2006) *Private provider networks: The role of viability in expanding the supply of reproductive health and family planning services*. PSP-One, Abt Associates Inc.: Bethesda, MD, available at: www.abtassociates.com/reports/private_provider_networks_0406.pdf

18. Cleary S and Thomas S (2003) *Mapping Health Services Trade in South Africa*. TIPS: Pretoria.

19. Connor C, Rajkotia Y, Lin YS and Figueiredo P (2005) 'Angola health system assessment.' The Partners for Health Reformplus Project, Abt Associates Inc.: Bethesda, MD, available at: http://www.sarpn.org.za/documents/d0001872/Angola_Health_Sept2005.pdf

20. Conway MD, Gupta S and Khajavi K (2007) 'Addressing Africa's health workforce crisis', *The McKinsey Quarterly*, available at: http://www.mckinseyquarterly.com/article_abstract_visitor.aspx?ar=2079&l2=12&l3=63&srid=141&gp=1

21. Dambisya YM, Modipa SI and Health Systems Research Group, Department of Pharmacy, University of Limpopo (2009) 'Capital flows in the health sector in South Africa: Implications for equity and access to health care,' *EQUINET Discussion Paper 76*. Rhodes University, York University, TARSC, SEATINI, EQUINET: Harare.

22. Daniel J, Naidoo V and Naidu S (2003) 'SA expansion into Africa: Can the leopard change its spots?' *South African Labour Bulletin* 27 (5):14–16.

23. Dare L and Buch E (2005) 'Editorial: The future of health care in Africa', *British Medical Journal* 331:1–2.

24. Davies R (2008) 'Deputy Minister Davies' address at the2008 Service Exporter Network Conference.' South Africa Department of Trade and Industry: Pretoria, available at: http://www.thedti.gov.za/article/articleview.asp?current=1&arttypeid=2&artid=1713

25. Discom (2009) 'About Discom.' Edcon: Johannesburg, available at: http://www.discom.co.za/Discom/About+Discom/

26. Dlamini QQ, Lush L, Auton M and Nkandu P (2004) 'Impact of public-private partnerships addressing access to pharmaceuticals in low and middle income countries: Zambia.' The Initiative on Public-Private Partnerships for Health: Geneva, available at http://www.dfid.gov.uk/pubs/files/ipph-accesspharmaceuticals-zambia.pdf

27. Drechsler D and Jütting J (2005a) 'Private health insurance in low and middle-income countries: Scope, limitations, and policy responses.' OECD Development Centre: Paris, available at: http://hc.wharton.upenn.edu/impactconference/drechsler_031005.pdf

28. Drechsler D and Jütting J (2005b) 'Policy insights 11: Private health insurance for the poor in developing countries?' OECD Development Centre: Paris, available at: http://www.oecd.org/dataoecd/25/14/35274754.pdf

29. Drechsler D and Zimmermann F (2006) 'New actors in health financing: Implications for a donor darling,' *Policy Brief 33*. OECD Development Centre: Massachussets, available at: www.oecd.org/dataoecd/27/6/37903846.pdf

30. Dummett H (2002) 'Pharmatech business briefing: An overview of supply and demand in South Africa's pharmaceutical industry: Opportunity or risk.' World Markets Research Centre: London, available at: http://www.touchbriefings.com/pdf/17/pt031_r_14_dummett.pdf

31. Dutz M, Harris C, Dhingra I and Shugart C (2006) 'Public-private partnership units: What are they, and what do they do?' *Public Policy for the Private Sector* 311, available at: http://www.ifc.org/ifcext/psa.nsf/AttachmentsByTitle/Viewpoint_PPPunits/$FILE/VP_PPP+Units.pdf

32. Export Processing Zones Authority (EPZA) (2005) 'Kenya's Pharmaceutical Industry', Government of Kenya: Nairobi, available at: www.epzakenya.com/UserFiles/File/Pharmaceutical.pdf

33. Economist, The (2007) 'Of markets and medicines: Big donors are betting on Africa's private sector to improve health,' *The Economist*, 19 December 2007, available at: http://www.economist.com/finance/displaystory.cfm?story_id=10339384

34. EQUINET SC (2004) 'Reclaiming the state: Advancing people's health, challenging injustice,' *EQUINET Policy paper 15*. EQUINET: Harare.

35. EQUINET (2007) *Reclaiming the Resources for Health: A regional analysis of equity in health in east and southern Africa*. Jacana, Fountain Publishers and Weaver Press: Harare, available at: http://www.equinetafrica.org/bibl/docs/EQUINET%20Reclaiming%20the%20Resources%20for%20Health%20in%20ESA.pdf

36. Euromonitor International (2006) 'OTC Healthcare in Kenya: Market insight: Executive summary.' Euromonitor International Plc.: London, accessed 21 January 2008 at: www.euromonitor.com/OTC_Healthcare_in_Kenya

37. Ferrinho P, Van Lerberghe W, Fronteira I, Hipólito F and Biscaia A (2004) 'Dual practice in the health sector: Review of the evidence', *Human Resources for Health* 2(14), available at: http://www.human-resources-health.com/content/2/1/14

38. Fine D, Hazlewood J, Hughes D and Sulcas A (2001) 'AIDS: A flicker of hope in Africa,' *The McKinsey Quarterly*, July 2001, available at: www.mckinseyquarterly.com/article_abstract_visitor.aspx?ar=1049&l2=33&l3=117&srid=6&gp=1

39. Frost and Sullivan Research Services (2008) 'The regulatory environment for Pharmaceutical Products and medical devices in key sub-Saharan Countries.' Frost and Sullivan, available at: http://www.biotech.frost.com/prod/servlet/report-document.pag?docid=M122-01-01-01-01

40. Fustukian S (2004) 'Review of health service delivery in Angola,' *Case Study 2*. DFID Health Systems Resource Centre: London, available at: www.dfidhealthrc.org/publications/health_service_delivery/Angola.pdf

41. Gilson L (1997) 'The lessons of user fee experience in Africa,' *Health Policy and Planning* 12(4): 273–285.

42. Gilson L and Mills A (1995) 'Health sector reforms in sub-Saharan Africa: Lessons of the last 10 years,' *Health Policy* 32: 215–243.

43. Global Health Resource Tracking Working Group (2007) *Following the money: Toward better tracking of global health resources*. Center for Global Development: Washington, available at: http://www.cgdev.org/files/13711_file_Resource_Tracking.pdf

44. Global Health Watch (2005) *Global Health Watch 2005-2006: An alternative world health report*. Zed Books: London, UNISA Books: Pretoria.

45. Global Insight (2006a) 'Progress report on ARV consumption names Uganda, Kenya as leaders in East Africa,' *Global Insight Same-day-analysis,* 20 September 2006. Global Insight: Massachusetts, available at: www.globalinsight.com/SDA/SDADetail6959.htm

46. Global Insight (2006b) 'Africa's health-insurance initiatives gain momentum,' *Global Insight Same-day-analysis,* 5 July 2006. Global Insight: Massachusetts, available at: http://www.globalinsight.com/SDA/SDADetail6281.htm

47. Grace C (2004) 'Leveraging the private sector for public health objectives,' *Briefing paper on technology transfer in the pharmaceuticals sector*. DFID Health Systems Resource Centre: London, available at: http://www.dfid.gov.uk/pubs/files/dfidtechtransfer.pdf

48. Guimier J-M, Lee E and Grupper M (2004) 'Processes and issues for improving access to medicines: The evidence base for domestic production and greater access to medicines.' DFID Health Systems Resource Centre: London, available at: http://www.dfidhealthrc.org/publications/Issues_papers/ATM/Guimier.pdf

49. Hall D, Lethbridge J, Lobina E and Public Services International Research Unit, University of Greenwich (2005) 'Public-public partnerships in health and essential services,' *EQUINET Discussion Paper 23*. EQUINET and Municipal Services Project: Harare, available at: http://www.equinetafrica.org/bibl/docs/DIS23pub.pdf

50. Harding A (2007) 'Harnessing the commercial health sector in Africa: The devil is in the details.' The Center for Global Development: Washington DC, available at: http://blogs.cgdev.org/globalhealth/2007/05/harnessing-the-commercial-heal.php

51. Health Civil Society (2005) 'Resolutions of the Health Civil Society in Southern and East Africa meeting, 13 October 2005,' *EQUINET Resolutions*. EQUINET: Harare, available at: http://www.equinetafrica.org/bibl/docs/RES102005gov.pdf

52. International Federation of Pharmaceutical Manufacturers and Associations (IFPMA) (2007) *Partnerships to build healthier societies in the developing world*. IFPMA: Geneva, available at: http://www.ifpma.org/pdf/IFPMA%20Building%20Healthier%20ENG%202007.pdf

53. International Finance Corporation (IFC) (2007) *The business of health in Africa: Partnering with the private sector to improve people's lives*. IFC: Washington DC, available at: http://www.ifc.org/ifcext/healthinafrica.nsf/AttachmentsByTitle/IFC_HealthinAfrica_Final/$FILE/IFC_HealthinAfrica_Final.pdf

54. IFC (2008) *Doing Business 2008*. World Bank: Washington DC.

55. IFC (2009) 'Health in Africa: IFCs strategy.' IFC: Washington DC, available at: http://www.ifc.org/ifcext/healthinafrica.nsf/Content/IFCStrategy

56. Jakab M and Krishnan C (2001) 'Community involvement in health care financing: A survey of the literature on the impacts, strengths, and weaknesses.' World Bank: Washington DC, available at: http://siteresources.worldbank.org/HEALTHNUTRITIONANDPOPULATION/Resources/281627-1095698140167/Jakab-CommunityInvolvement-whole.pdf

57. Jefferys E (2004) 'Evaluating the private sector potential for franchising TB and HIV/AIDS diagnosis and care in Sub-Saharan Africa.' Institute for Health Sector Development: London, available at: http://www.ihsd.org/doc/JeffrysFranchising04.pdf

58. Joint Learning Initiative on Human Resources for Health and Development: Africa Working Group (2006) *The health workforce in Africa: Challenges and prospects*. JLI Africa Working Group: Geneva, available at: http://www.hrhresourcecenter.org/node/1355

59. Kahn A (2008) 'Discovery pushes costs down further,' *Business Day*, 18 July 2008, available at: http://www.businessday.co.za/Articles/Content.aspx?id=50856

60. Kamhunga S (2008) 'Roche Offers More ARV Technology Transfer Deals,' *Business Day*, 11 August 2008, available at: http://www.pharmaceuticalsinsight.com/file/55741/roche-offers-more-arv-technology-transfer-deals.html

61. Kayombo EJ, Uiso FC, Mbwambo ZH, Mahunnah RL, Moshi MJ and Mgonda YH (2007) 'Experience of initiating collaboration of traditional healers in managing HIV and AIDS in Tanzania,' *Journal of Ethnobiology and Ethnomedicine* 3(6).

62. Khanyile S (2009) 'Netcare wants other states to adopt PPPs,' *Business Report*, 23 February 2009, available at: http://www.busrep.co.za/index.php?fSectionId=563&fArticleId=4856315

63. Kirigia JM, Preker A, Carrin G, Mwikisa C and Diarra-Nama AJ (2006) 'An overview of health financing patterns and the way forward in the WHO African Region', *East African Medical Journal* 83(9): S1–S28, available at: http://www.who.int/health_financing/documents/eamj-health_financing_africa.pdf

64. Kocher B (2007) 'Global provider trends,' *McKinsey & Company Presentation at IFC Conference for Private Health Care in Emerging Markets, April 2007*. IFC: Washington DC, available at: www.ifc.org/ifcext/che.nsf/AttachmentsByTitle/Healthpres_2007_BobKocher/$FILE/Healthpres_2007_Bob+Kocher.pdf

65. Koivusalo M and Mackintosh M (2004) 'Health systems and commercialisation: In search of good sense,' Paper prepared for the *UNRISD international conference on Commercialization of Health Care: Global and Local Dynamics and Policy Responses*. UNRISD: New York, available at: www.unrisd.org/unrisd/website/document.nsf/ab82a6805797760f80256b4f005da1ab/32a160c292f57bbec1256ed10049f965/$FILE/koivmack.pdf

66. Labonte R, Shrecker T (2008) 'Towards health-equitable globalisation: Rights, regulation and redistribution,' *Final Report to the Commission on Social Determinants of Health of the Globalisation Knowledge Network*. WHO: Geneva, available at: http://www.who.int/social_determinants/resources/gkn_final_report_042008.pdf

67. Lee M (2003) *The Political Economy of Regionalism in Southern Africa.* Lynne Rienner: Colorado

68. Lewis-Lettington R and Banda C (2004) 'A survey of policy and practice on the use of access to medicines-related TRIPs flexibilities in Malawi.' DFID Health Systems Resource Centre: London, available at: www.dfidhealthrc.org/publications/atm/Lettington.pdf

69. Lewis-Lettington R and Munyi P (2004) 'Willingness and ability to use TRIPs flexibilities: Kenya case study.' DFID Health Systems Resource Centre: London, available at: http://www.dfidhealthrc.org/publications/atm/Lettington2.pdf

70. Life Healthcare (2008) 'Hospitals". Life Healthcare, Johannesburg: available at: http://www.lifehealthcare.co.za/hospitals/

71. Loevinsohn B and Harding A (2005) 'Buying results? Contracting for health service delivery in developing countries,' *Lancet* 366: 676–81.

72. Losse K, Schneider E, Spennemann C (2007) *Analysis of Economic Aspects of Local Pharmaceutical Produc tion in Tanzania*. Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ): Eschborn, available at: http://www.gtz.de/de/dokumente/en-local-pharmaceutical-production-tanzania-2007.pdf

73. Malawi Ministry of Health and Population (2001) 'Malawi national health accounts: A broader perspective of the Malawian health sector.' Government of Malawi: Lilongwe.

74. Marek T, O'Farrell C, Yamamoto C and Zable I (2005) 'Trends and opportunities in public-private partnerships to improve health service delivery in Africa,' *Africa Region Human Development Working Paper Series*. World Bank/Sara Project: Washington, available at: http://siteresources.worldbank.org/INTAFRICA/Resources/wp93_health_service.pdf

75. MediClinic (2008) 'Our hospitals.' MediClinic: Cape Town, available at: http://www.mediclinic.co.za/framesets/fshospitals.htm

76. Mills A, Brugha R, Hanson K, McPake B (2002) 'What can be done about the private health sector in low-income countries? *Bulletin of the World Health Organization* 80(4): 325–330.

77. Miller D, Saunders R and Oloyede O (2008) South African Corporations and Post-apartheid Expansion in Africa. *African Sociological Review* 12(1):1–19.

78. Mohamed N (2008) 'Opinion: Support local producers by taxing imported drugs,' *New Vision*, 1 January 2008, available at: http://allafrica.com/stories/200801020101.html

79. Montagu D, Prata N, Campbell MM, Walsh J and Orero S (2005) 'Kenya: Reaching the poor through the private sector - A network model for expanding access to reproductive health services,' *HNP Discussion Paper 11*: Reaching the Poor Programme. World Bank: Washington DC, available at: http://info.worldbank.org/etools/docs/library/114527/RTPmaterials/Reaching%20the%20Poor/Session%206A-Pres/Campbell%20Kenya%20Feb%2019.ppt

80. Moss TJ, Ramachandran V and Shah MK (2004) 'Is Africa's skepticism of foreign capital justified? Evidence from East African firm survey data,' *Working paper 41*: Center for Global Development working paper series. Center for Global Development: Washington DC, available at: http://www.cgdev.org/files/2748_file_cgd_wp041rev.pdf

81. Mudyarabikwa O (2000) 'Public sector subsidies to the private health sector in Zimbabwe,' *EQUINET Policy paper 8*. EQUINET: Harare.

82. Mudyarabikwa O and Madhina D (2000) 'An assessment of incentive setting for participation of private for-profit health care providers in Zimbabwe,' *Small applied research 15*. Partnerships for Health Reform Project, Abt Associates Inc.: Bethesda, MD.

83. Munyuki E and Jasi S (2009) 'Capital flows in the health care sector in Zimbabwe: Implications for equity and access to health care,' *EQUINET Discussion Paper 70*. Rhodes University, York University, TARSC, SEATINI, EQUINET: Harare.

84. Newbrander W (1997) *Private Health Sector Growth in Asia: Issues and Implications*. John Wiley: New York.

85. Osewe MDP (2006) 'Strengthening the role of the private sector in expanding health coverage in Africa.' The Woodrow Wilson International Center for Scholars: Washington DC, available at: http://www.wilsoncenter.org/topics/docs/Osewe.pdf

86. Oxfam (2009) 'Blind Optimism Challenging the myths about private health care in poor countries,' *Briefing Paper 125*. Oxfam: Oxford.

87. Palmer N, Mills A, Wadee H, Gilson L and Schneider H (2003) 'A new face for private providers in developing countries: What implications for public health?' *Bulletin of the World Health Organization* 81(4): 292–97.

88. Parent F, Kahombo G, Bapitani J, Garant M, Coppieters Y, Levêque A and Piette D (2004) 'A model for analysis, systemic planning and strategic synthesis for health science teaching in the Democratic Republic of the Congo: A vision for action,' *Human Resources for Health* 2(16), available at: http://www.human-resources-health.com/content/2/1/16

89. Patouillard E, Goodman CA, Hanson KG and Mills AJ (2007) 'Can working with the private for-profit sector improve utilization of quality health services by the poor? A systematic review of the literature,' *International Journal for Equity in Health* 6(17), available at: www.equityhealthj.com/content/6/1/17

90. Perrot J (2004) 'The role of contracting in improving health systems performance,' *Discussion paper* 1: *Health System Financing, Expenditure and Resource Allocation Discussion Series.* World Health Organization: Geneva, available at: http://www.who.int/entity/contracting/the_role_of_contract_dp_e_04_1.pdf

91. Pharmaceutical Insight (2008) 'Rural Healthcare: The Least Worst Option?' *Pharmaceutical Insight*, June 2008. Business Monitor International: London, available at: http://www.pharmaceuticalsinsight.com/file/65979/rural-healthcare-the-least-worst-option.html

92. Pharmaceutical Research and Manufacturers of America (PhRMA) (2003) *Global partnerships: Humanitarian programmes of the pharmaceutical industry in developing nations*. PhRMA: Washington DC, available at: http://world.phrma.org/global.partnership.2003.pdf

93. Phiri F and Tien M (2004) 'Zambia national health accounts 2002: Main findings.' The Partners for Health Reformplus Project, Abt Associates Inc.: Bethesda, MD, available at: www.phrplus.org/Pubs/WP007_fin.pdf

94. Poullier JP, Hernandez P and Kawabata K (2002) 'National health accounts: Concepts, data sources and methodology,' *EIP Discussion Paper Series*. World Health Organisation: Geneva, available at: http://www.who.int/healthinfo/paper47.pdf

95. Prata N, Montagu D and Jefferys E (2005) 'Private sector, human resources, and health franchising in Africa,' *Bulletin of the World Health Organization*, 83(4): 274–279.

96. Preker A (2006) '2006 was a vintage year.' Health Investment and Finance: New York, accessed on 26 November 2007 at: http://healthequityfund.com/2007/01/01/Review.html

97. Reinikka R and Svensson J (2003) 'Working for God? Evaluating service delivery of religious not-for-profit health care providers in Uganda,' *Working paper* 3058. World Bank: Washington DC.

98. Rissik D, Cargill J and BusinessMap SA (2001) *Regional Investor Survey 2001*. BusinessMap: Johannesburg.

99. Ruster J, Yamamoto C and Rogo K (2003) 'Franchising in health', *Public Policy for the Private Sector* 263, available at: http://rru.worldbank.org/Documents/PublicPolicyJournal/263Ruste-063003.pdf

100. Sanders D and Carver R (1985) *The struggle for health: medicine and the politics of underdevelopment*. Macmillan: Hampshire.

101. Seiters A (2005) 'Access to Medicines and the Innovation Dilemma — Can Pharmaceutical Multinationals be Good Corporate Citizens?' *Business Ethics of Innovation* 31: 89–100.

102. Sekhri N (2005) 'From funding to action: Strengthening healthcare systems in sub-Saharan Africa', *World Economic Forum White Paper*. Centre for Public-Private Partnership, Global Health Initiative: Geneva, available at: http://www.weforum.org/pdf/whitepaper.pdf

103. Sekhri N and Savedoff W (2005) 'Private health insurance: Implications for developing countries,' *Bulletin of the World Health Organization* 83(2): 127–134.

104. Shuping S and Kabane S (2007) 'Public-private partnerships: A case study of the Pelonomi and Universitas Hospital co-location project,' in Harrison S, Bhana R and Ntuli A (eds) *South African Health Review 2006*. Health Systems Trust: Durban, available at: www.hst.org.za/uploads/files/chap10_07.pdf

105. Singh A (2003) 'Building on the user-fee experience: The African case,' *Discussion paper* 3: Health System Financing, Expenditure and Resource Allocation Discussion Series. World Health Organisation: Geneva, available at: www.who.int/entity/health_financing/documents/dp_e_03_3-building_on_userfee_africa.pdf

106. South African Pharmacy Council (2003) 'Stats on pharmacies.' South African Pharmacy Council: Johannesburg, available at: http://www.pharmcouncil.co.za/documents/Stats%20on%20Pharmacies%2016%20February%202005.PDF

107. Spooner MH (2002) 'Africa-bound AIDS drugs resold illegally,' *Canadian Medical Association Journal* 167(11): 128.

108. Stephenson R, Tsui AO, Sulzbach S, Bardsley P, Bekele G, Giday T, Ahmed R, Gopalkrishnan G and Feyesitan B (2004) 'Franchising reproductive health Services', *Health Services Research* 39(6) Part II: 2053–2080.

109. Swiss Re (2007) *Sigma 6: To your health: Diagnosing the state of healthcare and the global private medical insurance industry*. Swiss Re: Zurich, available at: http://www.swissre.com/resources/a467dd8047f012418f7daf233224b1e1-sigma6_2007_e.pdf

110. Tanzania Ministry of Health (2001) 'Tanzania: National health accounts.' Government of Tanzania: Dar es Salaam.

111. Toth C (2007) 'Voices from the village 1: Meeting needs for reproductive health services in post-conflict environments,' *CARE's family planning project in the Democratic Republic of the Congo*. CARE: Atlanta, available at: www.sarpn.org.za/documents/d0002687/RHP_DRC_Care_May2007.pdf

112. Transparency International (2005) *Global corruption report 2006*. TI: Berlin.

113. Turshen M (1999) *Privatizing health services in Africa*. Rutgers University Press: New Brunswick.

114. United Nations Conference on Trade and Development (UNCTAD) (1998) *The 1998 Trade and Development Report of the United Nations Conference on Trade and Development*. UNCTAD: New York.

115. UNCTAD (2000) *World Investment Report 2000: Cross-border Mergers and Acquisitions and Development employment, skills, local linkages and the like*. UNCTAD: New York, available at: http://www.unctad.org/en/docs/wir2000_en.pdf

116. UNCTAD (2001) *World Investment Report 2001: Promoting linkages*. UNCTAD: New York, available at: http://www.unctad.org/en/docs/wir2001overview_en.pdf

117. UNCTAD (2002) 'Investment policy review: The United Republic of Tanzania.' United Nations: New York.

118. UNCTAD (2003) 'Investment policy review: Botswana.' United Nations: New York.

119. UNCTAD (2005a) *World investment report 2005: Transnational corporations and the internationalization of R&D*. United Nations: New York and Geneva.

120. UNCTAD (2005b) 'Investment Policy Review: Kenya.' United Nations: New York.

121. UNCTAD (2006b) 'Investment Policy Review: Zambia.' UN: New York.

122. Van Wyk L (2007) 'Construction contractors and healthcare delivery in South Africa: Challenges and interventions.' South African Federation of Hospital Engineering (SAFHE): Cape Town, available at: http://researchspace.csir.co.za/dspace/bitstream/10204/1458/1/Van%20Wyk3-2007.pdf

123. Wadee H, Gilson L, Blaauw D, Erasmus E and Mills A (2004) *Public-Private Interactions in the South African Health Sector*. Health Systems Trust: Durban.

124. Wakabi W (2007) 'Global Fund pulls grants from mismanaging countries,' *Canadian Medical Associations Journal* 176(3): 311–312.

125. World Bank (2003) *World development report 2004: Making services work for poor people*. World Bank: Washington DC.

126. World Bank (2007) 'Healthy development: The World Bank strategy for health, nutrition, and population results.' World Bank: Washington DC, available at: http://siteresources.worldbank.org/HEALTHNUTRITIONANDPOPULATION/Resources/281627-1154048816360/HNPStrategyBackgroundNoteFinaltoCODEJune7.pdf

127. WHO (2000a) *World Health Report 2000: Health systems: Improving performance*. World Health Organisation: Geneva.

128. WHO (2000b) *National health accounts in eastern and southern Africa: A comparative analysis*. World Health Organisation: Geneva, available at: www.who.int/nha/docs/en/NHA_in_eastern_and_southern_africa.pdf

129. WHO (2006b) 'Working with the non-state sector to achieve public health goals,' *Consultation on priorities and actions: Background paper, Geneva 20–21 February 2006*. World Health Organisation: Geneva, available at: http://www.who.int/management/background.pdf

130. WHO (2006c) 'Country Health System Fact Sheet 2006: Malawi.' WHO: Geneva, available at: http://www.afro.who.int/home/countries/fact_sheets/malawi.pdf

131. WHO (2009) 'Health systems statistics.' WHO: Geneva, available at: http://www.who.int/healthinfo/statistics/indhealthexpenditure/en/index.html

132. WHO and Health Action International (HAI) (2003) 'Assessment of the pharmaceutical situation in Kenya: A baseline survey,' World Health Organisation: Addis Ababa, available at: http://www.haiafrica.org/downloads/Pharmaceutical_Baseline_Survey_Kenya.pdf

133. WHO and HAI (2005) 'Medicine prices in Tanzania.' WHO and Health Action International: Geneva.

134. WHO and Tanzanian Ministry of Health (2002) 'Baseline assessment of the pharmaceutical sector in Tanzania.' WHO: Geneva, and Tanzanian Ministry of Health: Dar es Salaam.

135. WHO and Ugandan Ministry of Health (2002) 'Uganda pharmaceutical sector baseline survey.' WHO: Geneva, and Ugandan Ministry of Health: Kampala.

136. WHO, World Bank and USAID (2003) Guide to producing national health accounts: With special applications for low-income and middle-income countries. World Health Organisation: Geneva, available at: http://www.who.int/entity/nha/docs/English_PG.pdf

137. WHO, USAID and PSP-One (2007) Public policy and franchising reproductive health: Current evidence and future directions: Guidance from a technical consultation meeting. World Health Organisation: Geneva, available at: http://www.who.int/reproductive-health/publications/publicpolicy_franchising/publicpolicy_franchising.pdf

138. World Trade Organisation (2001) *General Agreement on Trade in Services*. WTO: New York, available at: http://www.wto.org/english/docs_e/legal_e/legal_e.htm#services

139. Wreford J (2005) 'Missing each other: Problems and potential for collaborative efforts between biomedicine and traditional healers in South Africa in the time of AIDS,' *Social Dynamics* 31(2): 55–89.

140. Yamey G (2002) 'WHO in 2002: Why does the world still need WHO?' *British Medical Journal* 325: 1294–1298.

141. Yates R and Zorzi N (1999) 'Health expenditure review: Mozambique.' WHO: Geneva, available at: www.who.int/nha/docs/en/Mozambique_NHA_report_english.pdf

Acronyms

AIDS	acquired immunodeficiency syndrome
AMREF	African Medical and Research Foundation
ARV	anti-retroviral
BHF	Board of Healthcare Funders of Southern Africa
CBHI	community based health insurance
CHAM	Christian Health Association of Malawi
DRC	Democratic Republic of Congo
DTI	Department of Trade and Industry
EPZA	Export Processing Zones Authority of Kenya
EQUINET	Regional Network for Equity in Health in east and southern
ESA	east and southern Africa
FBO	faith-based organisations
FDA	Food and Drug Administration
FDI	Foreign Direct Investment
GAIN	Global Alliance for Improved Nutrition
GAVI	Global Allinance for Vaccines and Immunisation
GDP	Gross Domestic Product
GMP	Good Manufacturing Practices
GP	general practitioner
GTZ	German Development Co-operation
HAI	Health Action International
HIV	human immunodeficiency virus
IFC	International Finance Corporation
IFI	international financial institution
IMF	International Monetary Fund
IPA	Investment Promotion Agencies
IPPPH	Initiative on Public-Private Partnerships for Health
ISER	Institute of Social and Economic Research
IT	Information Technology
NEPAD	New Economic Program for African Development
NGO	non-governmental organisations
NHA	National Health Accounts
ODA	overseas development aid
OECD	Organisation for Economic Co-operation and Development
PIC-S	Pharmaceutical Inspection Co-operation Scheme
PFI	private finance initiative
PHI	private health insurance
PPP	public-private partnership
R&D	research and development
SADC	Southern African Development Community
SAPs	structural adjustment programmes
SEATINI	Southern and Eastern African Trade Information and Negotiations Institute
SME	small and medium enterprise
TB	tubercolosis
TFDA	Tanzanian Food and Drug Regulatory Authority
THE	total health expenditure
TNC	transnational corporation
TPI	Tanzania Pharma Industries
TRIPs	Trade Related Intellectual Property Rights
UCT	University of Cape Town

UK	United States
UNCTAD	
US	United States
WHO	World Health Organization
WTO	World Trade Organization

Acknowledgements

The authors acknowledge the financial support of the Southern African Trust and wish to thank EQUINET colleagues for support and advice. Thanks in particular to Richard Saunders, Rene Loewenson, Rebecca Pointer and to the external reviewers for valuable comments.

Equity in health implies addressing differences in health status that are unnecessary, avoidable and unfair. In southern Africa, these typically relate to disparities across racial groups, rural/urban status, socio-economic status, gender, age and geographical region. EQUINET is primarily concerned with equity motivated interventions that seek to allocate resources preferentially to those with the worst health status (vertical equity). EQUINET seeks to understand and influence the redistribution of social and economic resources for equity oriented interventions, EQUINET also seeks to understand and inform the power and ability people (and social groups) have to make choices over health inputs and their capacity to use these choices towards health.

EQUINET implements work in a number of areas identified as central to health equity in east and southern Africa

- Protecting health in economic and trade policy
- Building universal, primary health care oriented health systems
- Equitable, health systems strengthening responses to HIV and AIDS
- Fair Financing of health systems
- Valuing and retaining health workers
- Organising participatory, people centred health systems
- Social empowerment and action for health
- Monitoring progress through country and regional equity watches

For further information on EQUINET please contact the secretariat:
Training and Research Support Centre (TARSC)
Box CY2720, Causeway, Harare, Zimbabwe
Tel + 263 4 705108/708835 Fax + 737220
Email: admin@equinetafrica.org
Website: www.equinetafrica.org

Series Editor: Rene Loewenson
Issue Editor: Rebecca Pointer