UNIVERSITY OF GHANA

PUBLIC-PRIVATE PARTNERSHIP IN THE CONTEXT OF GHANA'S HEALTH SECTOR REFORM: A CASE STUDY OF PRIVATE NOT-FOR-PROFIT ORGANISATIONS IN THE VOLTA REGION OF GHANA

BY

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DECLARATION

I, the undersigned, hereby declare that apart from authors and institutions, whose works were duly acknowledged in this write-up, this dissertation is a product of my personal endeavour towards the award of a Doctor of Philosophy (PhD) degree in Public Administration carried out under supervision. This document has not been wholly or partly submitted to any higher institution of learning for the award of any degree whatsoever. Any weaknesses found therein solely remain my responsibility.

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CERTIFICATION

We, the undersigned, hereby certify that this dissertation was under our supervision and therefore consider it credible to enter the cannon of certified academic research through the award of a Doctor of Philosophy (PhD) degree in Public Administration.

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DEDICATION

This dissertation is dedicated to the members of my family, whose names are too many to be listed here. However, my father, Mr. Andrews Kofi Adzei, who insisted that he would like to see me decorated with doctoral colours before he goes back to his Maker deserves a special mention.

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LIST OF ACRONYMS

AAI	Accelerating Access Initiative
ATFR	Accounting, Treasury and Financial Reporting
BMC	Budget Management Centre
CHAG	Christian Health Association of Ghana
CHN	Community Health Nurse
DANIDA	Danish International Development Agency
DFID	Department for International Development
DHD	District Health Directorate
DHIMS	District Health Information Management System
DHMT	District Health Management Team
DPF	Donor Pool Fund
ECH	Ethics Committee for the Humanities
EPI	Expanded Programme on Immunisation
ERP	Economic Recovery Programme
EU	European Union
FIMR	Foetal Infant Mortality Review
GAVI	Global Alliance for Vaccines and Immunisation
GHP	Global Health Partnerships
GHS	Ghana Health Service
GOG	Government of Ghana
GPRS	Ghana Poverty Reduction Strategy
GRVD	German Rotary Volunteer Doctors
GSS	Ghana Statistical Service
HFA	Health For All
HHV	Help Helpen Vision
IGF	Internally Generated Funds
IMF	International Monetary Fund

LMIC	Low- and Middle- Income Countries
MAF	Millennium Accelerated Framework
MDG	Millennium Development Goals
MHD	Municipal Health Directorate
MMR	Maternal Mortality Ratio
MOH	Ministry of Health
MOU	Memorandum of Understanding
MSO	Management Service Organisations
MTHS	Medium Term Health Sector Strategy
NCHS	National Catholic Health Service
NDPC	National Development Planning Commission
NGO	Non-Governmental Organisations
NHIS	National Health Insurance Scheme
NID	National Immunisation Day
NIT	Neo-Institutional Theory
NPM	New Public management
PEPFAR	US President's Emergency Plan for AIDS Relief
PH	Public Health
PHC	Primary Health Care
POW	Programme of Work
PPC	Public-Private Collaboration
PPP	Public-Private Partnership
RBM	Roll Back Malaria
RHD	Regional Health Directorate
SAP	Structural Adjustment Programme
SSA	Sub-Saharan Africa
SWAp	Sector-Wide Approach
TB	Tuberculosis
TBA	Traditional Birth Attendants

UN	United Nations
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VRHD	Volta Regional Health Directorate
WHA	World Health Assembly
WHO	World Health Organisation
XSP	Cross Sector Partnerships

ABSTRACT

This study investigates public-private partnership for health delivery in the context of Ghana's health sector reform. It sets out to understand the nature of collaboration between the government and private not-for-profit health organisations in Ghana by uncovering the factors that necessitated the partnership, the mechanisms by which the partners engage each other, how the partnership arrangement fits within the governance architecture of the health sector reform and how the partnership has shaped the organisational performance of the institutions involved. Neo-institutionalism forms the theoretical anchor for the study alongside other theories that have shaped inter-organisational studies over the years. Qualitative research paradigm was used in this study with the interpretivist epistemological orientation in a case study design. Data were collected through in-depth interviews, archival records and personal observations. Analyses were done by thematic content analysis and theoretical sampling. Results of the study show formal and informal partnership between the public and private health sector actors in Ghana and identified the main drivers for the partnership. Furthermore, the partnership shows a positive relationship between the actors, and the major arrangements for collaboration were identified as properly positioned within the architecture of the health sector reform of the country by contributing immensely to realising the objectives of the reform. The partnership also impacts positively on the organisational performance of the actors involved in the study. Despite these contributions, the study also found some difficulties that militate against the partnership. The conclusion of this thesis is that the partnership arrangement between the government and mission health service providers is yielding positive results. However, the outcome of the partnership could be better if the deep-seated mistrust is minimised or eliminated. For that reason, the partnership can be successful on condition

that there is mutual trust and good behavioural leadership style in addition to all the instruments put in place for the joint action. The study makes a modest contribution to knowledge by extending the boundaries of theory, method and policy. The results of this study would help reform the national policy on PPP, which virtually ignores the non-profit service sector.

CHAPTER ONE

RATIONALE FOR THE STUDY

1.1 Introduction

This chapter presents the general introduction to this dissertation, which emphasises the necessity for carrying out the research. It gives a brief background to the study by providing the contextual basis for the research and brief historical trajectory that necessitated some changes that resulted in this research. It also presents the objectives set out for the study, the research problems that were addressed and the questions the study sought to answer, which collectively form the major conclusions of the study in chapter eight. The necessity for private and public sector health providers working in partnership has received considerable attention in research, theory and practice. This chapter also discusses the roles of government and the private sector as actors in the planning, packaging and delivery of health services. It concludes with the thesis outline, which specifies the morphological structure of this dissertation.

1.2 Background to the study

The health sector in Ghana has experienced varied transformations since independence. However, a major shift in policy was experienced in the 1980s in the form of administrative restructuring dubbed Ghana Health Sector Reform. Following economic recession in the mid-1980s, the country embarked on Structural Adjustment Programme (SAP) to address some socio-economic imbalances in the country's most important sectors, which are health, education, employment and agriculture. Consequently, a policy document was unveiled to propel Ghana into a middle income country bracket dubbed 'Ghana Vision 2020'. According to this document, the overall objective

of the country's health policy is to improve the health status of all Ghanaians and foreigners resident in Ghana. The Ministry of Health, following the thrust of Vision 2020 document, declared a health sector reform, which led to the development of a five-year medium term programme of work (POW) for the period, 1997 to 2001 (Ministry of Health, 1996). The document has five integral objectives, which are: increasing geographical and financial access to health services; improving quality of care in all health facilities; improving efficiency in the health sector; ensuring equitable and efficient distribution of health resources; and fostering closer collaboration and partnership between the health sector and communities, other sectors and private providers (Ministry of Health, 1996). As a result, the public health sector has gone into partnership with other sectors that are not under the direct control of government agencies to improve the health of the nation through some joint health activities. In spite of these efforts, there still exist some deficiencies in how this policy arrangement is translating into practice. Antwi-Boasiako (2010) noted that Ghana has undergone a steady, but often overlooked transformation in terms of policies toward improvement in health, education, transportation and economic growth but most of the infrastructural facilities do not receive proper maintenance due to lack of sense of ownership by the communities.

In 2002, another five-year programme of work was developed for the period, 2002 to 2006 with the theme: 'Partnership for health – Bridging the inequality gap' (Ministry of Health, 2002). The objectives were not too varied from those of the previous programme of work but an integral component includes increasing the use of non-government sector in health service provision, including curative healthcare and public health activities such as health promotion and education

programmes. Based on the thrust of the second programme of work, the ministry, through a collaborative process with its development partners, developed the Common Management Arrangements, which spells out the roles of the collaborating partners. The ministry is responsible for setting out the sector policy framework; issuing annual strategic planning guidelines for all agencies; ensuring budgeting and resource allocation to reflect national priorities; signing performance and service agreements with the service provider agencies; and producing the annual progress report (Ministry of Health, 2002).

Closely related to the first and second five-year programmes of work was the third, which was developed for the period 2007 to 2011 with the theme: 'Creating Wealth through Health'. It has, among other objectives, the promotion of governance, partnerships and sustainable financing (Ministry of Health, 2007b). Similarly, the national health policy of the country also has, among other priority areas of action, 'ensuring good governance and partnership' (Ministry of Health, 2007a: 34). Partnership here includes the involvement of the private sector, which include private-for-profit and private not-for-profit health service providers in the planning, development and provision of health services to ensure effectiveness, efficiency, equity and sustainability in the health sector. This arrangement, normatively, would largely support in strengthening the entire health system of the country. Specifically, the third POW seeks to achieve 'partnerships and coordination mechanisms including stakeholder participation in policy development and service delivery, harmonisation and alignment of support within the sector, the management of internal service agreements and of contracts with non-government agencies' (Ministry of Health, 2007b: 11).

It is important to note that policy reform was a top priority on the development agenda of many countries in the 1980s and 1990s (Thomas & Grindle, 1990). This period witnessed a growing interest in changing policies, practices and management systems within the health sector of many developing countries. These changes are collectively referred to as health sector reform. Before this period, there was the concern that reforms were going to reduce public spending with substantial effects on the health status of the population. It rather turned out that public health expenditure did not reduce after reform implementation in most developing countries. Moreover, many health indicators deteriorated after the implementation of the programme, which provides a paradoxical situation of some sort given the pattern of health expenditures (Berman, 1995; Sahn & Bernier, 1995). The health sector of many countries have experienced various forms and degrees of reforms. Developed and developing countries alike have not been spared the wave of health sector reforms. In principle, health sector policies in developing countries have underscored equity and focused on delivering services to the poor and the less-privileged, but in practice, the fundamental aims of Health For All (HFA), which was the bedrock for health reforms, have not been achieved in the years gone by (Lundberg & Wang, 2006). The experience of Ghana has seen varied results in different aspects of the reform, especially with regard to the involvement of the private sector. The next section discusses on the overview of the Ghanaian health sector.

1.3 Overview of the Ghanaian health sector

Ghana has a health sector profile typical of other developing countries in Sub-Saharan Africa (SSA). The country's population and housing census of 2010 yielded a population of 24.6 million, which represents an increase of 30.4 percent over the 2000 census population (Ghana Statistical

Service, 2012). On the average, the population is growing at the rate of 3.04% per year, which means that at this rate, the population will double in 30 years, placing unmaintainable pressures on Ghana's economy and environment. Not only is the country growing rapidly but Ghana has a young age structure, with children under 15 years comprising almost half of its current population. The average life expectancy is 64.6 for women and men and the rates of infant mortality and under-five mortality are 50 and 74 per 1000 live births respectively (United Nations Development Programme, 2013). These statistics represent a fairly good performance over the regional average life expectancy, which is 54.9 for Sub-Saharan Africa (SSA). Although the total fertility rate has declined from 6.9 births per woman in 1988 (Ghana Statistical Service, 1989), to 4.5 births in 1998 (Ghana Statistical Service, 1999) and marginally to 4.0 in 2008 (Ghana Statistical Service, 2009), women continue to have more children than they desire and suffer from many problems related to pregnancy and childbirth. Only 13% of Ghanaian women use modern family planning methods (Ministry of Health, 2012). A figure that delineates a rather slow rate of utilisation, given the amount of investment made by donor agencies and the government into this area of reproductive health. Overall, the country's human development index has shown marginal progress over the years, with the most current index of 0.558 at the rank of 135 worldwide (UNDP, 2013). Ultimately, the decision of how to structure the government's role in the health sector depends on a society's values, inherited structures, political processes (Harding, 2003) and to some extent, the demands of country's development partners.

The first GOG's Poverty Reduction Strategy (GPRS I) primarily focusses its attention on realising the poverty-related MDGs but it also emphasizes the critical importance of reducing population

growth, addressing the HIV/AIDS epidemic and combating malaria. A statement in the GPRS I reads: 'rapid natural increase, especially among the poor is a constraint on household incomes and access to basic services. Successful management of fertility in Ghana will require a more results-oriented approach to increasing literacy and incomes of women, improving service delivery and effectively providing access to information on choices' (NDPC, 2003, p. 5). The GOG objective, as stated in the GPRS I, was to reduce the total fertility rate to 4.2 by 2004 (NDPC, 2003). This represents a new emphasis by GOG on fertility reduction but this objective has not been realised until 2008, after the successful conduct of the Ghana Demographic and Health Survey (Ghana Statistical Service, 2009). Since this study is about PPP, the next section gives attention to the involvement of the private participants in the health sector.

1.4 The involvement of the private actors in the health sector

Notwithstanding the under-provision of health services in most part of SSA, there is relatively little involvement of the private sector (Bennet, McPake, & Mills, 1997; Hanson & Berman, 1998) on the whole. Even though most of the countries do not have any apparent private sector, few of them like Ghana, Kenya and Tanzania have reasonable representation of private participation in health (Leonard, 2002). There are several actors in the health sector of Ghana, which include the public sector, the private sector, other government departments and the traditional practitioners, all coordinated by the Ministry of Health (Ministry of Health, 2012). Private providers are made up of private-not-for profit organisations (also known as NGOs) that provide essentially public health services such as family planning services; the mission institutions that are essentially

curative service providers but also provide public health services, and the private-for-profit organisations that are predominantly curative based.

Christian Health Associations of Ghana (CHAG) is a network of private not-for profit health service organisations. The network is a semi-autonomous agency partly funded by the Ministry of Health and recognised as one of the corporate organisations by the ministry. CHAG is responsible for managing and operating an extensive network of mission health facilities across Ghana, including many facilities in rural and more marginalized areas. In Ghana's health sector, CHAG institutions account for 20% of all health facilities in the country. However, they provide for about 50% and 40% of all out-patient attendance and in-patient care respectively across the country (CHAG, 2012). This is the extent to which the private not-for-profit organisations are contributing to the delivery of health services in the country.

As stated earlier, the second five-year programme of work within the Medium-Term Health Strategy (MTHS) on the theme: 'Partnership for Health – Bridging the Equity Gap' captures the policy thrust of the GPRS policy to focus on the greater involvement of the private sector in the delivery of the health services. Among other things, the private health sector is an important and growing source of health services in Ghana, providing about 42 per cent of the healthcare services (MOH, 2002). The involvement of the non-public sector service providers of health services is reinforced by the Ministry of Health as follows:

> 'A major strategic thrust… will be to improve and establish formal commissioning arrangements with non-government service providers. These service providers

> would be integrated into the health system, recognized for their capabilities, coordinated, supported, and regulated through appropriate mechanisms to enhance the equity focus of the sector' (MOH, 2002, p. 34).

The private sector has been involved in different ways within the health sector of Ghana. For example, CHAG has been regarded by the Government of Ghana as a very important partner in the health sector over the years. They are involved in the formulation and planning of health programmes and activities, especially at the national level. However, the spirit and letter of this partnership appears unsatisfactory with CHAG, which is echoed in its 2011 annual report as 'At regional and district levels, the relationship between CHAG and GHS remains strained and does not lead to desired synergy in planning and management of health care delivery. The MOU is neither understood nor implemented at this level' (CHAG, 2012, p. 14).

1.5 Overview of Global Health Partnerships

Partnerships occur when two or more entities work together to achieve common goals and objectives by agreeing to share both efforts and benefits (Gómez-Jauregui, 2004), and there are different levels of partnerships in the health sector. Whiles some transcend international boundaries, others are intra-country. Since the onset of the present millennium, global health partnerships (GHPs) have been formed as a response to the many challenges that plague the developing world, especially in Africa. Most GHPs are collaborative arrangements among pharmaceutical companies in partnership with UN-based organisations, developing country governments and public and private sector foundations to ensure efficient product development,

healthcare delivery and technical support for the implementation of national programmes on diseases (Buse & Walt, 2000; Buse & Harmer, 2007; Ngoasong, 2009, 2010). These stakeholders, originally, have their respective interests and strategies of operation but the overall goal of these partnerships is to attend to the health needs of disadvantaged world populations at affordable costs. Some of such partnerships include Global Alliance for Vaccines and Immunisation (GAVI), Roll Back Malaria (RBM), Accelerating Access Initiative (AAI) for HIV/AIDS treatment and care (Ngoasong, 2009), the Global Fund for malaria, TB and HIV/AIDS, US President's Emergency Plan for AIDS Relief (PEPFAR) (Alexander, 2007), etc.

Ngoasong (2009: 952) identified the key components of GHPs as 'global', which signifies the worldwide nature of initiatives; 'health' implying the goal to deal with health problems principally those affecting the poor in developing countries; 'national health system' signifies procedures and processes for achieving national health targets; 'public–private partnership' signifies an inter-organisational relationships in which 'risks and benefits are shared in pursuit of a shared goal' (Buse & Walt, 2000). Ultimately, GHPs refer to relatively institutionalised initiatives that are established to address global health problems, in which public and for-profit private sector organisations play major roles in collective decision-making (Buse & Harmer, 2007). From the foregoing, the next section would discuss the research problems given the context that has be provided by the previous sections.

1.6 Statement of the research problem

Any enterprise that seeks to address complex social issues like poverty, education, health and economic development requires the involvement of more than just one entity because those problems warrant collaboration across several institutions, organisations and sectors. These inter-sector actions make up a unique form of social organisation (Koschmann, Kuhn, & Pfarrer, 2012) that requires different structures to be properly managed.

Health as a social commodity is an indispensable asset for any country, especially in the wake of global actions to attain optimal health status for the entire world. Many interventions have been put in place to ensure that the entire world attained health for all but challenges still persist. Many simple, affordable and effective disease control measures have had only limited impact on the burden of disease due to their inadequate distribution in poor and remote communities (Amazigo *et al.*, 2010). Although many health initiatives championed globally have improved the delivery of selected health interventions, many priority interventions, such as those directed at addressing issues with malaria and other infectious diseases, still have low coverage, especially in Africa and other developing countries (UNICEF, 2009; WHO, 2008).

It is against this background that many countries, especially developing ones like Ghana, embarked on a good number of policy reforms in the sector. The health sector in Ghana has experienced varied transformations since independence. However, a major shift in policy direction was experienced in the 1980s in the form of administrative restructuring dubbed Ghana Health Sector

Reform. Partnerships and collaboration constitute some important elements in health sector reforms.

In the last quarter of the twentieth century, policy reform was a topmost priority on development agenda of many countries (Thomas & Grindle, 1990). Before this period, there was the concern that reforms were going to reduce public spending with substantial effects on the health status of the population. It rather turned out that public health expenditure did not reduce after implementation of sector reforms. Moreover, many health indicators deteriorated after the implementation of the health sector reform programme, which gives somewhat of a paradox given the pattern of health expenditures (Sahn & Bernier, 1995; Berman, 1995). The foregoing arguments for reform have led to changes in the public sector ethos, which have rather been framed in the context of general pressures of public sector restructuring (Hebson, Grimshaw, & Marchington, 2003). This involves the rise of new public management concept, emphasising decentralisation, privatisation and reduction in public sector expenditure. These developments have called for the new model of governance, which is often referred to as public-private partnership (PPP) for service delivery. Similar to strategic alliances and mergers between business entities for maximisation of benefits, the public sector organisations also partner with private sector organisations to reinforce their respective successes and maximise returns from scarce resources. By combining resources, partnerships in general must result in performance benefits (Andrews & Entwistle, 2010) and promote effective results for all concerned agencies and the larger society (Jamali & Keshishian, 2009) by the theories of synergy and resource dependency. Health sector reform promised a period of new thinking and innovation in health systems that

would address the disparity in the health gains of countries at different stages of health transition. Ideas such as new public management or public-private partnerships heralded an exciting potential synthesis of public purpose and entrepreneurial creativity that could launch a new period of rapid health gains (Berman & Bossert, 2000). Improvements in health care financing and delivery were realised to be stimulating bureaucratically-run health care systems in developed nations so these similar interventions were perceived to, perhaps, bring the much-needed new energy and results to the developing countries' health care systems (ibid).

Despite the good intentions of any health sector reform, evidence from other parts of the world indicates that reform policies often run into problem of implementation. Many sector reports and health sector assessments consistently have demonstrated that health systems in numerous developing countries suffer from clearly ineffective and inequitable resource allocation, declining service quality and unmotivated work forces in the health sector (Berman & Bossert, 2000). It has been argued that such structural changes need to be activated in conjunction with changes in the organisational culture that require consolidation of institutional policy-dialogue that reinforces social linkages and collaborative spirit among all stakeholders in health at the local levels (WHO, 2009) because the relative roles of public and private sectors in health service delivery are often analysed according to the respective parts they play in financing health care or providing such services (Bennett, 1991).

The debate in the extant literature regarding the contribution of the private healthcare providers in the health system of developing countries is still ongoing. While some scholars argue that public-

private engagements play a positive role in enhancing the efficient use of scarce resources for health by improving access to quality health services and achieve equity is service distribution (Selsky & Parker, 2005; Gazley & Brudney, 2007; Jamali & Keshishian, 2009), others are of the view that not all government engagements with the private health sector are as good as the proponents of PPP want us to believe but rather results in a rip off on the citizenry (Arya & Lin, 2007; Andrews & Entwistle, 2010). Others also contend that whereas government officials working with private providers may record some benefits in respect of efficiency and reduced costs, sometimes it may be more costly to work with heterogeneous, disintegrated, unorganised private sector health providers (Taylor, 2003). Moreover, even when partners work together, the value created by their collective efforts is what should be the priority for assessment and not merely the fact that there are connecting fibres upon which their operations hinge (Koschmann *et al.,* 2012). This research seeks to resolve this debate by assessing the contribution of the joint action of the public and private sectors in the realisation of health sector objectives of Ghana in the context of health sector reform, using the Volta Region as a case study.

An extensive review of the literature on cross-sector partnerships resulted in some key propositions put forth by Bryson, Crosby, & Stone (2006). They argue that cross-sector collaborations are created in turbulent environments, especially where their formation and sustainability are challenged by competitive forces. This creates some initial challenges for the partners to navigate their pathways. Also, cross-sector collaborations are likely to emerge when public policy makers realise that separate efforts of different sectors to address a public problem 'have failed or are likely to fail, and the actual or potential failures cannot be fixed by the sectors acting alone' (ibid,

p. 46). On the success of any partnership, it is argued that this is likely, when one or more of the major interconnections are apparent at the formation stages (ibid). Regarding the outcomes of collaboration, the essential ingredients in the collaborative agreement as well as the processes of their choice are what determine them.

There are some schools of thought that posit that public-private partnerships do more harm than good to the masses whiles others argue that cross-sector partnerships between the private and the public sectors have provided greater good than harm to the larger society. Despite the diametrically opposed arguments for and against adoption of PPP in the delivery of public services, its continuous presence in the developing and developed worlds gives some credence to understanding the role of PPP in the planning, financing, packaging and delivery of health services in the context of Ghana's health reform programme. It would be appropriate to understand the role of PPP in health services outputs in the forms of effectiveness, efficiency and equity in the delivery of health services. This clarion call was aptly echoed by Frenk (1994) earlier in the latter part of the last century that the way global health actors deal with the issue of the 'public/private mix' will largely shape the architecture of health service delivery in the 21st century. Partnerships in the health sector have been very complex and Mills *et al.* (2002) cautioned that there is a very thin line between state and non-state actors in the health sector. Despite this difficulty with delineation, Palmer (2006) cited in Walker *et al.,* (2009) defines the non-state sector as:

> '…all providers who exist outside of the public sector, whether their aim is philanthropic or commercial, and whose aim is to treat illness or prevent disease. They include large and small commercial companies, groups of professionals such as doctors, national and

> international non-governmental organisations, and individual providers and shopkeepers. The services they provide include hospitals, nursing and maternity homes, clinics run by doctors, nurses, midwives and paramedical workers, diagnostic facilities e.g. laboratories and radiology units, and the sale of drugs from pharmacies and unqualified static and itinerant drug sellers, including general stores' (p. 4).

The above definition attempts to summarise all actors, presumably, in the non-state sector of health delivery despite their respective interests and foci. It also makes it copiously clear that the non-state sector is a very large subsector with expansive but difficult to define boundaries. But for the purposes of simplicity and convenience in this academic research enterprise, this amorphous group would be further classified as either private for-profit or private not-for-profit health services providers.

In the literature on PPP, many studies have focussed on the partnerships between the public and the private-for-profit sectors (Buse & Harmer, 2007; Campos, Norman, & Jadad, 2011; Naik, 2006; Ngoasong, 2009) whereas very little attention, comparatively, has been given to the private not-for-profit sector. Moreover, the country's national policy on PPP (Ministry of Finance and Economic Planning, 2011) gives virtually no attention to the private not-for-profit participants but

focuses solely on private for-profit organisations for infrastructural development and improved public service delivery[1].

The study examines the extent of collaboration and interrelationships between actors in the reform process on the health of Ghanaians, using the Volta Region of Ghana as a case study. Empirically, the study sought to verify the extent and dimensions of collaboration existing between the two actors, public sector and private sector agencies and whether such collaborations will translate into improved health status of the Ghanaian through improvements in their operations. The study adopts the Public-Private Partnerships (PPPs) as a conceptual framework and the neo-institutional theory among other theories as its analytical framework to explain the complex relations that can ensue between the actors on one hand and the complex nature of cross-sector partnerships on the other and the interface between the actors in implementing the partnership component of the health sector reform programme. In a nutshell, this study seeks to make further exposition on the collaborative practices in the health sector of Ghana by bringing to the fore PPP from the perspectives of non-profit organisations. In this study, the private sector is restricted exclusively to private not-for-profit health service organisations with specific emphasis on mission hospitals.

[1] Even though this document is titled private participation in infrastructure and services for better public service delivery, there is no mention of the non-profit private sector participants. Moreover, the health sector has not seen any attention in this document.

1.7 Objectives of the study

The main objective is to **assess the contribution of the partnership arrangement between government health sector actors and the private not-for-profit organisations towards achieving the objectives of Ghana's health reform.** Specifically, the following objectives directed the study.

- To find out the collaborative structure between GHS facilities and their counterpart CHAG institutions in Ghana.
- To examine the various factors that necessitated the partnership for health.
- To assess how the characteristics of the private sector organisations influence the realisation of the objectives of Ghana's health sector reform programme.
- To determine the effects, and challenges of the collaborative structure on the organisational performance of the partners.

1.8 The research questions

To achieve the above objectives, the study was guided by the question: **how has public-private partnership transformed the relationship between the public and private health service providers in achieving the objectives of Ghana's health sector reform?** Specifically, the following sub-questions offered the direction for the study.

- How is the collaboration between the government health agencies and non-profit health organisations structured?
- What factors, and by what dimensions did public-private partnership for health in Ghana come about?

- How do the activities of private sector partners in the health sector fit into the health sector reform of Ghana?
- To what extent has the partnership between the private and public sector organisations enhanced their organisational performance in the health sector of Ghana?

1.9 Thesis outline

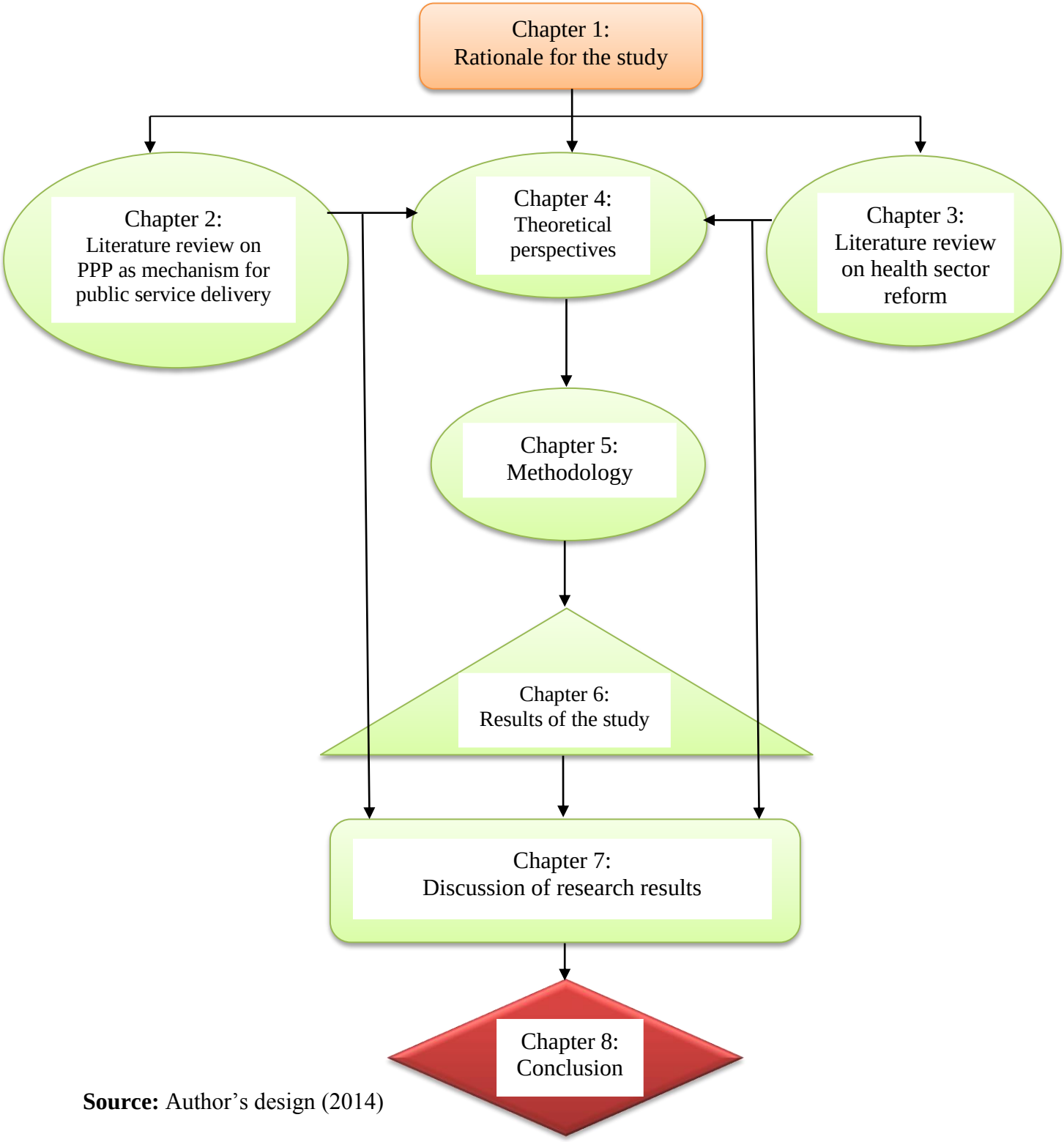
The thesis is divided into eight chapters. Chapter one gives a general background to the study by indicating what the key objectives and key research questions are. It also establishes the motivation for the study by discussing its scholastic rationale. This chapter also presents the Ghanaian contextual outlook vis-à-vis global health partnerships. The second chapter examines the relevant conceptual literature on public-private partnerships (PPPs) and their value for understanding the public-private sector interface. It provides discussions on literature on partnerships and collaboration as the governance model for the delivery of public services. Chapter three examines the empirical literature on health sector reform as the proper domain for improved service delivery since this study is about PPP in the context of health reform. Chapter four discusses the theoretical lenses of the study, which culminates in the construction of a conceptual framework that guided the analysis in the study. Chapter five is devoted to the methodology employed for the study. It provides the justification of the research paradigm chosen as well as the detailed description of the processes employed from the design of the study to the completion of the research report. Chapter six presents the results of the research with the key conceptual issues that are embedded in the framework of the study. The seventh chapter is devoted to the discussion of the research findings, which focusses on the theoretical framework by

juxtaposing the results of this study with previous findings in the extant literature. Chapter eight addresses the conclusion of the study, which also includes the study's contribution to knowledge, summary of key findings and direction for future research.

1.10 Summary

This chapter provides the general introduction to, and an outline of the research activities that culminated in the production of this dissertation over the last three years. The key objective is to provide a framework for the study by understanding the relationships that exist between local government health sector agencies and the private non-profit sector and how these relationships impact on the improvement of health status of Ghanaians, using the Volta Region as a case study. This chapter discussed the contextual situation of Ghana and the justification for the study. A brief overview of global partnerships have been provided with emphases made for the justification of the public-private mix in planning, packaging and delivery of health services. It also addressed the research problem that necessitated the study by posing the relevant research questions that followed from the objectives of the study. Finally, a brief outline of the entire dissertation has been summarised to guide readers of this report, which is delineated by the structure in figure 1.1.

Figure 1.1 Structure of the dissertation



Source: Author's design (2014)

CHAPTER TWO

PARTNERSHIPS AS MECHANISM FOR PUBLIC SERVICE DELIVERY

2.1 Introduction

The previous chapter introduced the entire research by providing the background and motivation for the study on partnerships for health delivery in the context of Ghana's health reform. This chapter discusses conceptual literature on the various forms of partnerships that exist in the public administration scholarship, with particular emphasis on health. It begins with the experiences that necessitated partnerships, continues with the various typologies of partnerships and makes the case for public-private partnerships with emphasis on the public-private not-for-profit partnerships for health. It also highlights the public-private partnership as an instrument for delivering public services with particular attention to health. It concludes with discussions on pre-requisites for successful partnerships.

2.2 The need for partnerships in public service delivery

Partnerships, also known as collaborative arrangements, have become a growing organisational imperative (Austin, 2000) and phenomenal in the delivery of services to the people in the last three or four decades in the governance structure of many countries (Naidoo & Wills, 2000). They have become more imperative because social problems are becoming more complex (Bryson *et al*., 2006; O'Leary & Vij, 2012). These collaborative engagements may take place on different platforms, which involve partnerships among businesses, government and the civil society. Selsky & Parker (2005, p. 849) identified these platforms as 'business-non-profit, business-government, government-non-profit, and trisector'. In the business-non-profit platform, the partnership

arrangement incorporates social issues that usually tend to include environmental issues and economic development initiatives. They also cover such other social causes as health, social justice, equity and education. Business-government platform deals essentially with an arrangement between the public sector and private-for-profit businesses that address social issues but with more emphasis on infrastructural development for the provision of essential social services such as water and energy, which have important social implications. The third arena epitomises partnerships between governments and not-for-profit organisations. It usually involves contracting out of public services to private not-for-profit organisations to develop social welfare matters. Research in this platform is inclined mainly towards job development and social welfare issues. The final platform symbolises partnerships that involve actors from all three sectors, the government, the private-for-profit and the private not-for-profit. This arena focuses on large-scale national or international multi-sector projects. However, subnational projects and programmes are also covered. Research relating to this platform is disposed to economic and community development, social services, environmental concerns and health services. This last arena is widespread across the developing countries for services delivery and Ghana is replete with this typology in the delivery of essential services. As stated earlier, the focus of this study is in line with the third arena, which discusses the partnership between government and private not-for-profit organisations. Specifically, the partnership between government health institutions and mission hospitals in the Volta Region form the focus of this research.

Arya & Lin (2007) also discussed the relationships between partners in a collaborative process. Their study makes an important contribution to the literature by showing how the ownership of

resources along with partners' resources and structural attributes in the not-for-profit collaboration network context may both contribute to, and impede, organisational competitive advantage. Normatively, partnerships are considered to be unavoidable, 'win-win' imperatives that must be applied in most of the social services sectors, especially in the low- and middle-income countries (LMIC) (Buse & Harmer, 2004). In this regard, it is considered as a desirable solution to the global health crises but any undesirable and unintended consequences of partnerships should be classified as regrettable but inevitable (ibid). The logic of partnership, therefore, is very straightforward in many instances because the strengths of all organisations are not sufficient to carry out everything they seek to achieve. This logic explains the resource dependency and transaction cost viewpoints of collaboration.

Partnerships have also been largely employed by governments to satisfy policy goals in the social services sector. Koontz, Buckley, & Ruderman (2004) found that partnerships with the involvement of key leaders and prominent health-related organisations and foundations as advocates to address health problems have largely helped in the reduction of infant mortality rate in the United States. This was achieved through the growth of Foetal Infant Mortality Review (FIMR) in all public health programmes. In a partnership arrangement between a large pharmaceutical company and a charity organisation responsible for healthy lifestyle among children in the United Kingdom, it was established that most teenagers have given up on smoking and other unhealthy lifestyles, which were social policy goals of the government at the time (Macdonald & Chrisp, 2005).

2.3 Determinants of successful collaborations

A review of the extant literature on collaboration and partnerships is replete with several dimensions of which collaboration can be said to be effective. While some authors classify them as cultural, social, human and organisational, others may explain them as just internal and external. Some scholarly works also identified formal and informal factors as contributing to the success or otherwise of collaborations (Ansell & Gash, 2007; Powell, 1998; Sullivan, Williams, & Jeffares, 2012). Whichever taxonomies or nomenclature authors assume, determinants of collaboration range from interactional factors, through organisational factors to systemic factors (San Martín-Rodríguez, Beaulieu, D'Amour, & Ferrada-Videla, 2005). Organisational factors include those conditions inherent in the partner organisations that facilitate the existence of the collaboration. Interactional factors encompass such interpersonal relationships between team members, and systemic factors cover such areas as conditions outside the organisations. The macro environment of the partnerships is the major driver of the collaboration process and it is made up of such constituents as social, cultural, educational and professional systems. Social system determine the bases of power differentials among the members of the partnerships (San Martín-Rodríguez *et al.*, 2005). When power equality is breached, collaboration cannot be very effective because balance of power is an essential determinant of collaborations and partnerships. The social order in organisational setups, which are vestiges of the socialisation processes in the communities, influence largely, the possibility of a smooth collaboration or otherwise among members of the team. The cultural system, which is so closely related to the social system comprises value systems of a community, can largely affect the collaboration process. For example, a cultural belief that promotes autonomy and independence is likely to run counter to collaborative spirits and rather

encourage individualism and independence of partners (Mariano, 1989; San Martín-Rodríguez *et al.*, 2005).

For inter-organisational cooperation to become a generally accepted policy among the partners, there needs to be full understanding of what promotes or hinders it inter-disciplinarily. Re-socialisation, training and new skills will be required of practitioners and administrators (Mariano, 1989) and this must be deliberately occasioned by the advocates. In this sense, champions of inter-sector action have the onerous responsibility of ensuring that those who would ensure the smooth running of the collaboration agenda are fully educated and become mentally prepared for the joint action. Guo & Acar (2005) also identified factors such as resource sufficiency, strength of network effects, institutional factors and other factors that fall outside the former three as the main environmental and contextual factors that predict the choice and success of any form of collaboration.

Common values, shared goals and interests are also crucial to the success of global partnerships for health. Especially for product development PPPs, a mismatch in these crucial variables could pose dangers for the partners (Campos *et al.*, 2011). Trust has also been acknowledged as a key determinant of successful partnerships. However, the place and time of trust has not been expatiated in the literature but it has been advanced by Blois (1999) that if people in partner organisations tend to trust by inclination rather than the organisations as artificial human beings trusting, there is the likelihood of success in the collaboration process. As an extension to the trust factor, Huxham & Vangen (2007) identify other factors as the ability of partners to successfully

manage their independent aims, power relations, language and culture as key determinants of effective collaboration and partnership.

2.4 The changing nature of public sector ethos

The public administration literature is replete with arguments on the changing nature of public sector ethos, which have rather been framed in the context of general pressures for public sector restructuring (Hebson *et al.*, 2003) and innovation. This involves the rise of new public management, emphasising decentralisation, privatisation, agencification, autonomisation (Sakyi, Awoonor-Williams, & Adzei, 2011) and reduction in public sector expenditure. The New Public Management (NPM) concept has received a wide acceptance in the last three to four decades because of the normative and idealistic benefits it espouses. It follows the reformers' era, which built on the works of the classical administrative theorists like F. W. Taylor's scientific management. This concept is rooted in the public choice theory and managerialism (Gruening, 2001). It makes the case for the transfer of market principles and business-management techniques from the private enterprises into the governance architecture of public sector organisations (Gruening, 2001; Heyer, 2011; Lane, 2008; Luke, Kearins, & Verreynne, 2011; Siltala, 2013). Whereas classical public administration underscores the rule-oriented nature of public sector decisions and that positions of politicians are legitimized as the 'owners' of public resources in deciding on public sector ends and means, strategic management in private firms presupposes that senior managers are not too detached from the shareholders. The managers exude considerable autonomy to engage in decision-making about organisational ends and means in the future (Lane, 2008). The ethos of NPM emphasizes business values, such as functional rationality, cost-

effectiveness and productivity, which are in loud opposition to the orthodox democratic ideals of public administration such as political democracy, public ethics, and security of life and property. As stated earlier, the underlying and essential thrust of NPM is the urge to transform the organisational identity of public organisations into a business. The justification for such a change is to increase efficiency and effectiveness (Skålén, 2004). The distinct characteristics of NPM include reduction in budgetary allocation for government departments, performance management, privatisation, agency autonomy and decentralisation[2]. The two major models of NPM are the Agency Model and the Neo-Weberian State Model (Pollitt, Thiel, & Homburg, 2007). Whiles the former emphasises the creation of executive agencies from traditional ministries, the latter focuses on more separation of policy and administration by the use of divisional structures of decentralisation. The summary of philosophical arguments enshrined in this new wave is that NPM is a brand that captures a range of reforms inspired by the impression that private sector management techniques and market mechanisms increase public sector efficiency at all levels of public administration (Pollitt, 1995; Samaratunge, Alam, & Teicher, 2008).

The process of these public management reforms, however, must be incremental to determine the smooth pathways for institutional and contextual factors (Horton, 2006). Institutional variables including the type of political leaders, party system, interest negotiation, administrative system, public sector work relations and legal system all combine to fashion the type of public management reform and the speed with which it should be introduced (Horton, 2006; Farnham, Hondeghem,

[2]For detailed discussions on the features of NPM, see Pollit (1995), Gruening (2001) and Pollitt, Thiel, & Homburg, (2007).

& Horton, 2005). Contextual factors, on the other hand, include the state of the economy, the influence of political elites, and the openness of the system to international managerial ideas disseminated through governance institutions have also been reflected in different ways across countries (Pollitt & Bouckaert, 2004).

Some latter advocates of NPM promote the delayering of the monolithic, centralised, bureaucratic structure of the public sector agencies (Sakyi, 2008) to make way for improved effectiveness and efficiency in services delivery. Many scholars have written about the necessity for paradigm shift in the belief systems of the public sector organisations (e.g. Clark, Denham-Vaughan, & Chidiac, 2014; Lane, 2008; Mukokoma & van Dijk, 2012). They discussed the pros and cons of reforms and promoted the need for reforms in the public services delivery. Reforms in the public sector have become more necessary for developing countries because unimpressive showings in their development indicators coupled with the demands by their development partners to meet specific targets require that business in the public sector encompasses some renewed sense of urgency in operations. This implies that existing service delivery approaches should merit some tweaking. Given the continuous rise in collaborative mechanisms, one of the concepts of societal sector platform (Selsky & Parker, 2005) for collaboration is the partnership logic, which is the springboard for the third way governance typology, private-public partnerships. This phenomenon has emerged in the last few decades as a response to address the individual inefficiencies of the private and public sectors. NPM thus proposed the formation of PPPs as the means for enhancing innovation in the public sector (Sorensen & Torfing, 2010).

Despite the uncritical praise-singing that heralded NPM as the panacea for public sector management inefficiencies, evidence-based research have proven otherwise. Pollitt & Bouckaert (2000) consider it as self-defeating, the blend of attempts at motivating staff and promoting cultural change with the synchronized tendency to weaken stability of tenure and downscale. To a very large extent, repeated downscaling in organisations destroy confidence and commitment and any public-service ethic among employees. These occurrences naturally give rise to a 'hollowed out' (p. 475) phenomenon and ultimately less-competent form of government (Siltala, 2013). Sorensen & Torfing (2010) further criticised NPM for its foundational weaknesses. They argue that the theory stands on a dogmatic assumption that innovative efficiency can be realised automatically in the public sector by mimicking what pertains in the private sector. Also, the concept leaves this drive for innovation solely in the hands of public sector managers. A phenomenon they describe as lacking critical inquiry. Meanwhile, reforms in the form of centrally-determined performance indicators have rather led to the growth of individualistic and competitive cultures at the expense of the much needed collaborative climate for improved organisational performance (Maddock & Morgan, 1998). The logicality and rationality of such reforms in the public service have been widely acclaimed by policy makers but their effects on critical sectors such as health and human services still remain to be adequately justified. On the basis of this premise, one needs to be mindful of the consequences of managerialism on workers and their ability to deliver responsive services to their clients.

2.5 What constitutes public-private partnerships?

The growing importance of PPPs has led to a large and increasing literature in public management. Partnerships between public and private sectors are usually referred to using various denominations, often as public–private partnerships (PPPs), public private mix (PPM) (Kaboru, 2012) or cross-sector partnerships (XSP) (Bryson *et al.*, 2006). While there are no universally agreed definition of this concept, a partnership, collaboration or a coalition can be taken to mean any joint action between two or more actors to achieve some agreed upon goals (Naidoo & Wills, 2000; Taylor, Braunack-Mayer, Cargo, Larkins, & Preston, 2012). The concept is further expanded to denote an arrangement of functions and relationships in which two or more public and private entities coordinate and/or combine complementary resources to realise their institutional objectives by jointly pursuing one or more mutual objectives (Lawther, 2002; National Highway Institute, 1999). PPPs, which have also been loosely defined as cooperative institutional arrangements between public and private sector actors, have gained wide interest around the world. But few people agree on what a PPP actually is. Some see it as a new governance tool that will replace the traditional method of contracting for public services through competitive tendering. Others see PPPs as a new expression in the language of public management, one intended to include older, established procedures of involvement of private organisations in the delivery of public services (Linder, 1999). Yet others view PPPs as a new way to handle infrastructure projects, such as building tunnels and renewing harbours (Savas, 2000). The definitions also extend to cover procurement of public services. In the view of Chung (2009), PPPs are public procurement policies, which involve the private sector providing services that are traditionally the responsibility of the government.

Apart from the definitions offered by scholars above, PPPs have also been viewed as alliances between a firm and a government agency (Rangan, Samii, & Van Wassenhove, 2006). Studies in this literature focus mostly on two issues: from the public policy side, which engenders the desirability of PPPs as instruments for the elaboration and implementation of public policies in resource poor settings, and from the public management side, which focuses on the practical considerations regarding how agencies should manage PPP arrangements (Williams, 2003) for the mutual benefits of both partners.

Other works contribute to the emerging literature on PPPs by introducing theories and insights originating in the extensive strategic alliances of business-to-business literature by highlighting the similarities and differences between both types of alliances. In doing so, this study is in line with the comparative approach advocated by the new public management perspective, which calls for the introduction of business-like practices in government agencies to improve their efficiency and guarantee effectiveness and equity (Berman & Bossert, 2000; Gazley & Brudney, 2007). As noted earlier, partnerships or collaborative arrangements have received varied conceptualisations in the literature but the common denominator for all definitions has to do with a joint action by two or more stakeholders to achieve some common goals. Table 2.1 provides a summary of some general definitions.

Table 2.1 Summarised general definitions of collaboration and partnerships

Author	Year	Definition
Waddock	1991	Partnerships are described as 'the voluntary collaborative efforts of actors from organisations in two or more economic sectors in a forum in which they cooperatively attempt to solve a problem or issue of mutual concern that is in some way identified with a public policy agenda item'. (Cited in Selsky and Parker, 2005, p. 850).
Roberts & Bradley	1991	Collaboration is 'a temporary social arrangement in which two or more social actors work together toward a single common end requiring the transmutation of materials, ideas, and/or social relations to achieve that end' (Roberts & Bradley, 1991, p. 212).
Sink	1998	Collaboration is the 'process by which organisations with a stake in a problem seek a mutually determined solution pursuing objectives they could not achieve working alone' (Sink, 1998, p. 1188).
Naidoo & Wills	2000	Partnership refers to 'joint action between partners' (2000, p. 157).
Sullivan & Skelcher	2002	Partnership involves negotiation between people from different agencies committed to working together over more than the short term and aims to secure the delivery of benefits or added value which could not have been provided by any single agency acting alone or through the employment of others. It also includes a formal articulation of a purpose and a plan to bind partners together (cited in Dickinson & Glasby, 2010, p. 815).
Selsky and Parker	2005	Collaboration is the cross-sector projects formed explicitly to address social issues and causes that actively engage the partners on an ongoing basis (Selsky and Parker, 2005, p. 850).
Bryson, Cosby & Stone	2006	Cross-sector collaboration is 'a partnerships involving government, business, non-profits and philanthropies, communities, and/or the public as a whole' (Bryson, Crosby & Stone, 2006, p. 44)
Taylor, Braunack-Mayer, Cargo, Larkins & Prestron	2012	Collaboration or partnership or coalition can be understood as 'joint action to achieve agreed upon goals' (Taylor *et al*, 2012, p. 507).

Source: Author's compilation from literature review (2014).

2.5.1 Conceptions, forms and typologies of public-private sector collaborations

There is a hot debate over the concept of public-private partnerships with respect to definitions. Whereas some schools think it should be defined, others consider it needless (Khanom, 2009) since such an effort would find it difficult to find a globally acceptable definition for the concept. However, some authors have attempted and defined it in various ways. While some scholars consider it as a combination of market forces and government agencies, others view PPP as a shift from public to private sector production (Klijn & Teisman, 2007). The term is usually used to refer to virtually any ongoing relationship or institutional arrangement between the public and private sectors (Harding, 2003; Hodge & Greve, 2007) to plan, package and deliver services to people or to construct infrastructural projects. Privatisation was actually introduced to PPP mainly in the 1980s, when discussions on rearrangement were largely focussed on financial viability of government programmes and projects. In the wake of such developments, a lot of public service provisions were privatised in some developed countries (Kickert, Klijn, & Koppenjan, 1997) and the developing world in order to streamline the operations of those organisations to guarantee continuity.

The phrase public-private partnership is an umbrella term that encompasses a range of financial and organisational relationships between the public and private sector actors in the delivery of services to people (Edwards, Shaoul, Stafford, & Arblaster, 2004). It involves 'a set of institutional relationships between the government and various actors in the private sector and civil society' (Mitchell-Weaver & Manning (1991) cited in Jutting, 1999, p. 5). These relationships between partners are often regulated by a concession contract, which enables a commercial organisation to

finance, build and operate an asset for a period agreed by both parties (Chung, 2009). However, most of these concession contracts get implemented sluggishly, thereby creating the necessity for real time risk minimisation approaches to guarantee value for money. In the wake of the competing and complementary connotations of PPP concept, Jutting (1999) attempted a summary definition as 'institutional relationships between the state and the private for-profit and/or the private not-for-profit sector, where the different public and private actors jointly participate in defining the objectives, the methods and the implementation of an agreement of cooperation' (pp. 5-6).

Collaboration may take different forms depending on the degree or levels of intensity of alliances (Arsenault, 1998). Murray further argued that collaboration can be defined as a continuum of interdependence of activities, where there is an exchange of something at one end and the other end signifies a full merger (Guo & Acar, 2005). Snavely & Tracy (2000) also describe collaboration as 'an overarching commitment to working closely with other organisations where their missions overlap and intersect and where the combining of resources leads to improved service effectiveness and efficiency' (p. 148). In relation to the health sector, Zajac & D'Aunno (1993) identified inter-organisational relations spanning a continuum of varying extents of autonomy and resource commitment. In a descending order, they made discussions on hospital associations, alliances, joint programmes, joint ventures, contract management, leases, mergers and acquisitions. Similarly, Khom, La Piana & Gowdy (2000) identified three ways in which non-profit organisations work together in decreasing autonomy and increasing formality. These are collaboration, alliances and integrations. Collaboration encompasses information sharing, programme coordination and joint planning. Alliances, however, span such activities as

administrative consolidation and joint programming. Finally, management service organisations (MSO), parent subsidiary, joint venture and mergers constitute the integration frontier. After closer analysis and further elaborations, one larger permanent and formalised category emerged by consolidation of alliances and integration into strategic restructuring.

Guo & Acar (2005) extend the frontiers of these classifications by denoting formal and informal collaborations as the two major forms of inter-organisational relationships. Formal arrangements include joint programmes, parent subsidiary, joint venture and merger. On the other hand, information sharing, referral of clients, sharing of office space and MSO complete the set for informal arrangements. The argument, therefore is that, in informal arrangements, the organisations do not make permanent commitment to partnership but the power for critical decision-making is still vested in the managers of individual organisations in the partnership. However, member organisations in the formal category make ongoing and sustainable commitment to the relationship through shared, combined or transferred resources or services (Kohm *et al*, 2000; Guo & Acar, 2005). PPPs are specialised forms of partnerships and has been typologised variously by actors and researchers alike. Some of these connotations are summarised in table 2.2.

Given the several classifications of PPP, it is important to contextualise any form of analysis involving partnerships. Johnston & Gudergan (2007) provide such contextual dimensions as technical rationality, sociality, and risk avoidance and protection. The technical rational context argues that PPPs involve contractual obligations on partners, which emphasise the focus on

realising specific objectives. The sociality context recognises the social relationships that exist between the members of partnering organisations. It is more necessary to be considered because it can help in building trust among partners and managing or avoiding conflicts. This dimension is usually evident in what some scholars call the personality of the contrived organisation (Weick, 2001). The context of risk combines the technical rationality and sociality in one dimension. For the technical rational aspect compels partners to take precautionary measures in the development of PPP contracts to avoid risks at all cost. Whereas these technical process pursue causes to avoid risks, the social element in the organisations drive members to be weary of the possibility of risks.

Harding (2003) outlines three distinct forms of partnership that are most pertinent for the health sector, which are global public-private partnerships; domestic public-private partnerships with commercial sector, which includes both production and distribution; and domestic public-private partnerships with health care providers. Global PPPs are in the ranges of such collaborations, where multi-national organisations interact to solve common global problems. Examples include the Global Health Partnership (Ngoasong, 2010) for making medicines accessible to poorer communities of the world, and the Global Fund, which is an alliance of international organisations to provide funding for the eradication of infectious diseases such as malaria, TB and HIV/AIDS. The second category implies any government arrangement with business organisations for their mutual benefits. It may involve service agreements or management contracts, coordination, networking or collaboration on specific projects. The last group is the exclusive partnership with government and health service providers, whether private for-profit or private not-for-profit providers. This study is formed within the framework of the latter classification.

Table 2.2 Summary of definitions of public-private partnerships

Author	Year	Definition
Chung	2009	PPPs are public procurement policies which involve the private sector providing services that are traditionally the responsibility of the government.
Harding	2003	PPP virtually involves any ongoing relationship between the public and the private sector
Lawther	2002	PPP is an arrangement of roles and relationships in which two or more public and private entities coordinate/combine complementary resources to achieve their separate objectives through joint pursuit of one or more common objectives.
Jutting	1999	PPPs are institutional relationships between the state and the private for-profit and/or the private not for-profit sector, where the different public and private actors jointly participate in defining the objectives, the methods and the implementation of an agreement of cooperation (pp. 5-6)
Peters	1998	PPP involves two or more actors, at least one of which is public, where each of the actors can bargain on its own behalf. It also involves a long-term, enduring relationship, where each actor makes contributions to the partnership, either material or symbolic and share responsibility for the outcomes. (Peters, 1998: 12-13).
Mitchell-Weaver & Mannig	1991	PPP is 'a set of institutional relationships between the government and various actors in the private sector and civil society' (cited in Jutting, 1999: 5).

Source: Author's compilation from literature (2014)

The growing literature on public-private partnerships (PPPs) in the health sector have accorded the concept another classification at the global level of partnerships – horizontal and vertical partnerships (Buse & Walt, 2000). Whereas vertical partnership describes a hierarchical, bureaucratic relationship between the individual government and its representation in the

international organisations that make up the UN, horizontal participation is more typical of the networks in which states and non-state organisations, including the UN and private for-profit organisations, form less hierarchical and less bureaucratic inter-organisational relationships. Most Global PPPs provide some form of horizontal participation. Meanwhile, vertical representation provides, at least in theory, both some form of participatory democracy and social accountability. Reich (2002) identified and made discussions on several types of partnerships that are associated with health. They include partnerships for disease control, commercialising traditional medicine, strengthening health services and for coordinating health programmes. Others include partnerships that focus on health services delivery, product donation and for coalition to provide health service or engage in public health actions (see table 2.3). The partnership models that are covered in this study reflect the numbers 3, 8 and 10 in the table. The private not-for-profit health providers partner the government in the provision of health services through mission hospitals in the study area. By so doing, they help by strengthening the health system through the delivery of critical health services, especially in the deprived communities of the country. Moreover, there is a network of mission hospitals called the Christian Health Association of Ghana (CHAG), which serves as a network of health organisations with a common interest. The areas covered by health facilities in this category are usually rural and deprived. Their presence is an indication of reducing the burden of healthcare access in those parts of the country. For the purposes of this research, PPP refers to an adaptation of Jutting's (1999) definition as:

> Institutional relationships between the state and the private not for-profit sector, where the actors jointly participate in defining the objectives, the methods and the implementation of an agreement of cooperation in the health sector.

Table 2.3: Categories of public-private partnerships for health

1. Partnerships for disease control—product development
2. Partnerships for disease control—product distribution
3. Partnerships for strengthening health services
4. Partnerships to commercialize traditional medicines
5. Partnerships for health program coordination
6. Other international health partnerships
7. Country level partnerships
8. Private sector coalitions for health
9. Partnerships for product donations
10. Partnerships for health service delivery

Source: Reich (2002)

2.6 Partnerships and collaborations as a voluntary process of negotiation

Partnerships, alliances or other forms of inter-sector collaboration involves a voluntary process of negotiation among the actors. In the case of health sector, it involves the freewill of interdependent professionals working towards the health needs of the people. Every collaboration is premised on a voluntary basis, which implies a process of negotiation. It demands that partners in the process discard any competitive tendencies and adopt approaches based on collaboration, both between health professionals and between health care institutions (San Martín-Rodríguez *et al.*, 2005).

Having mentioned the voluntary nature of partnerships, the power relations and the political nature of partnerships in the health sector cannot be overemphasized. The analysis in extant literature makes discourses along the lines of elitist and pluralist propositions. Buse & Harmer (2004) identified three broad lines of this discourse. They proposed elitism, pluralism and neo-pluralism points of view. The elitism theory contend that partnerships are euphemisms for imperialism and colonisation. It involves the system in which power is wielded by the few elites in society who do

not practice the true tenets of democracy (ibid). According to Richter (2003), corporate elites dominate partnerships and would ultimately subvert the public service of international organisations such as the WHO. However, the pluralists claim that partnerships are neutral arrangements between several stakeholders that do not champion the interest of any of the partners. In this vein, power is shared and no particular group wields the right of hegemony (Walt, 1994). It is therefore a riposte to the elitist theorists. A moderate school of thought in-between these two diametrically opposed opinions is the neo-pluralism. This theory posits that there are several interest groups that form the networks that govern society but most often, agenda setting seems more predisposed to some powerful individuals or groups (Buse & Harmer, 2004).

2.6 Levels of partnerships and collaborations

The scientific literature on PPP shows different levels at which such arrangements can take place since partnerships are expected to contain a wider range of stakeholders, and with particular attention on local communities (Ranade & Hudson, 2003). The first classification that holds promise for application in this study include the strategic, tactical and operational levels and the success of any PPP project depends largely on an effective integration of the goals of the strategic, the tactical and the operational levels of authority (Chung, 2009). At the strategic level, the political authority defines a set of overriding objectives to be followed by other authorities at lower ranks. These objectives claim to satisfy the needs of citizens. The next level of political authority is the tactical authority. At this level, respective regulators design systems for public service delivery, define policies and articulate the strategic goals into operational specifications. The last is the operational or ground face level where production and consumption of services occur.

Decisions made at this level should be in line with strategic goals and tactical planning. The final outcome is the achievement of strategic objectives within the defined tactical system (Chung, 2009).

Collaborative partnerships also operate at global levels, national levels and local or community levels. Global partnerships (Ngoasong, 2009) involve the cross-country arrangements to meet service needs of many people. It usually involves international statutory organisations like the WHO, multilateral donors and governments of countries. At the national levels, partnerships involve a collaborative arrangements between a government department at the ministerial level and a private organisation. For example, the partnership between MOH and the network of mission hospitals, CHAG, is a manifestation of national level partnerships. This is anchored by the Memoranda of Understanding that have been signed by the parties involved at different times to guide their operations. Similar to the ministerial level partnerships, the community level partnerships arise usually between local government authorities and private sector organisations. These also are often times guided by a form of an agreement. At all levels of partnership, it is important to underscore the different arrangements that can occur. They may take the form of co-determination, contracting, co-provision, delegation or devolution (Jutting, 1999).

2.7 Arguments in favour of public-private partnerships

Despite the reported cases of failure of alliances in health care, especially in North America (Zajac, D'Aunno, & Burns, 2011), there are still very strong arguments in the extant literature making the case for public-private partnerships. Particularly, the collaboration between government and the

non-profit sector has been well established (Stone & Sandfort, 2009). In the first place, it is necessary because the world is made up of many constituents that have various roles to play at given moments of time (Bryson *et al.,* 2006) and no individual sector can tackle the numerous challenges all by itself (Reich, 2002). Multi-member partnerships, which have become popular in recent years, 'reflect a recognition that some problems require many partners and complex organisational mechanisms to address all the different aspects' (p. 8). This trend has replaced the antagonistic and confrontational suspicion that has hitherto characterised workings between governmental agencies and private sector actors in health. Partnering with the private sector carries the potential for meaningful benefits to be gained for the public partner, the private partner and the health sector in general. Such benefits can include reduced government spending in the form of eliminating large initial investments of scarce public funds, greater efficiency, which usually characterises private partners' operations, or better healthcare management (for example, of hospital services and infrastructure). In addition, collaboration empowers the larger society to draw on the creative energies of human and financial resources of all sectors, bringing them together communal benefits (Bloomfield, 2006; Snavely & Tracy, 2000).

In their study to examine the strengths and weaknesses of government organisations partnering with the non-profit organisations, Gazley & Brudney (2007) identified such benefits as improving community access to services, promotion of mutual goals and objectives, improvement in community relations and joint action towards addressing common problems. These benefits of partnership have also been specifically amplified for the health sector.

> 'In the health sector, partnering can also be particularly valuable as a method of leveraging technical or management expertise (e.g. performance-based monitoring and incentives), and spurring technology transfer, all of which can lead to quality improvements' (Nikolic and Maikisch, 2006: 3).

Partnership approaches have received widespread support in the provision of social services of all kinds. It has gained much prominence particularly in the health sector for many reasons, especially the obvious fiscal and social constraints of governments to meet their needs through government's budgetary allocations. The notions of development strategy of PPP are covered by (Osborne, 2007) as he notes that PPP has also become a tool for providing public services and developing civil society in such post-communist regimes as well as a mechanism for combating social exclusion and enhancing community development under the European Union policy. PPP has traditionally been associated with urban renewal and economic development in the USA but has now received a global acceptance for the synergistic effects it provides (Macdonald & Chrisp, 2005), even in the social services sector. When partnerships work as planned, they become essential contributors to the development process of any society. Particularly, they help build the capacity of partnering organisations and their members, facilitate the transfer of skills and knowledge and encourage mutual dialogue (Hailey, 2007).

The various issues that are addressed by these partnership arrangements range from health (Harding, 2003) to education, environment, economics, etc. (Selsky & Parker, 2005). Selsky & Parker (2005) also described two logics that give credence to the engagement of two or more

sectors to deliver public services. These are the substitution logic and the partnership logic. Substitution logic posit that in as much as sectors have their natural roles to play, another sector may supplant the other, if it is evident that the former cannot sufficiently play those natural roles. This is the logic that underpins privatisation of government institutions. The partnership logic, however, engenders the active participation of two or more willing sectors, referred to as partners to deliver services to the people. This is usually characterised by an agreed contract between the partners, which usually spells out the rules of engagement clearly.

Some contributory factors such as expanded privatisation of state assets and the growing loss of public confidence have debilitated governmental structures at all levels, compelling them to rely more extensively on private sector businesses and civil society organisations to provide public goods and services (Googins & Rochlin, 2000). In specific circumstances such as delivery of health services, the challenges of providing top quality services coupled with efficiency and equity make it difficult for only the public sector to continue to single-handedly provide health service. This phenomenon adds impetus for many governments the world over to engage the private sector by partnering them with innovative solutions towards the advancement of human health (Ratzan, 2007).

One very important argument for cross-sector partnerships is that when actors from different sectors focus on the same social issue and seek to address it, they are likely to think about it differently by considering wider perspectives (Hailey, 2007), to be motivated by different goals, and to use different approaches in their endeavour (Selsky & Parker, 2005) to unlock their

comparative advantages (Gazley & Brudney, 2007). This proposition has been amplified by O'Leary & Vij (2012) that in most collaborative arrangements, managers find themselves not solely as unitary leaders of unitary organisations. Rather, they often find themselves smoothing and operating in multi-organisational arrangements to alleviate problems that cannot be solved, or solved easily, by single organisations (Bryson *et al.*, 2006). In this regard, organisational individualism does not stand as a proper antidote to the increasing demands on the limited resources of individual organisations. The degree to which a problem is to be solved must be addressed from many perspectives because greater knowledge persuades researchers to perceive problems as multi-faceted, which in turn make it possible for the establishment of different kinds of collaborative mechanisms (Hailey, 2007; Ranade & Hudson, 2003). Moreover, organisational individualism is also seen as less appropriate in delivering public sector goods and services.

Andrews & Entwistle (2010) also argue that in most cases, public sector partners may possess specific mandates or powers that make it possible for them to deal with what they describe as 'wicked issues' (p. 680) or 'wicked problems' (Sorensen & Torfing, 2010, p. 5; Torchia, Calabrò, & Morner, 2013, p. 2). These wicked issues encompass such matters that political authorities would normally shy away from tackling because of the political consequences but can be easier handled with the involvement of the private sector. Wicked problems are ill-defined, difficult to respond to, require attention from multiple stakeholders and command the potential for creating conflicts. Collaborative arrangements emerge largely to address problems that are sophisticated and in general, complex problems bring with them multiple issues and sub-issues. Multiple issues and sub-issues typically yield multiple challenges (O'Leary & Vij, 2012). On the other hand,

private sector partners may also be enjoying the ability to maximize value for money by delivering service outcomes at lower costs, thus signifying efficiency in production. This, in a nutshell, contributes to the synergy of unlocking the respective strengths of both sectors, which underscores the tenets of the transaction cost theory.

Other research findings also suggest that the involvement of the private sector in the delivery of services helps largely in avoiding and resolving disputes (Gray, 1985), which has the ripple effect of helping build stronger sense of communities and improve services largely (Snavely & Tracy, 2002; Snavely & Tracy, 2000). Given the social origins of the formation of private not-for-profit organisations in particular, their comparative advantage over business organisations largely includes their relatively less antagonistic relationships with government institutions. A PPP arrangement involving the non-profit sector could be perceived superficially as an extension of the public sector in the provision of social services. In many cases, this explanation is evident due to institutional isomorphic pressures that may warrant their loss of identity.

The foregoing discussion is presented only to illustrate that there are no technical grounds to rule out working with private providers or disallowing private provision of public services. It is to reinforce the continued existence of the private sector in providing and distributing social services, including health since cross-sector partnerships may enable public agencies to tackle social problems more effectively by unlocking the benefits of comparative advantage of respective service sector agencies. Table 2.4 provides a summary of many reasons why PPP still remains a popular and viable programme that should be pursued by governments in the delivery of public

services. The next section also provides arguments that run counter to those expressed in this section. Since this write-up is an academic endeavour, it is natural that those views are also discussed and properly digested.

Table 2.4. Summary of arguments for adoption of PPP in governance

Author(s)	Year	Justification for PPP
O'Leary & Vij	2012	Networks typically are formed to address complex problems that are not easily solved by one organisation
Andrew & Entwistle	2010	The higher possibility of solving wicked problems
Ratzan	2007	Public sector partnering with the private sector leads to innovative solutions towards the advancement of human health
Gazley & Brudney	2007	Effectiveness in addressing shared problems, efficiency in service delivery, organisational learning, improved quality services, access to new skills, competitive advantage, diffusion of risks
Selsky & Parker,	2005	Partners think about shared problems differently, apply different approaches to resolving them and are to be motivated by different goals
Snavely & Tracy	2000	Service improvement, building of stronger sense of community; enables society to draw on the creative energies and human and financial resources of all sectors, bringing them together to benefit communities and the nation
Gray	1985	Avoidance of, and peaceful resolution of disputes

Source: Author's compilation from literature (2014)

2.8 Arguments against the adoption of PPP

Despite the many arguments advanced for adopting PPP in the delivery of public services including health, many varied opinions have also posited its limitations. Some health campaigners

and researchers have criticized partnerships for diverting resources from public actions and distorting public agenda in ways that favour private companies (Reich, 2002). Sometimes, some cross-sector collaborations rather create more problems than to solve existing problems they have been made to help solve. This may be due to the interconnection of events and processes (Bryson *et al.*, 2006), where a change in one or more activities or processes would have ripple effects on others (Luke, 1998). Most often, how to respond collaboratively and effectively to social problems that are so interconnected and encompassing is a major challenge (Bryson *et al.*, 2006; Hodge & Greve, 2007; Word & Park, 2009) to policy makers at all levels. Among the challenges that hinder working through partnerships include unclear goals, cliques usurping power, resource costs, unequal power, differences in philosophy of partners, organisational problems and impact on other mainstream activities (McQuaid, 2007).

Collaboration may not always be a wise enterprise for partners because of differences in motives. Whiles some may collaborate to gain some added advantage that could not have been attained by organisations individually, others may also be involved in partnerships to play the 'free riders' role (O'Leary & Vij, 2012: 510). Whenever there is lack of common understanding of goals for any partnership arrangement, effective implementation of the partnership arrangement is most often faced with great challenges. Moreover, most partnerships are not equal in many respects. Whereas some are sophisticated and well-managed, others are haphazard and chequered in structure and their management is very poor. In the latter scenario, collaboration can be a rip off on both partners. Power differentials also create difficulties in realising the objectives of the partnerships (Buse & Harmer, 2007; De Pinho Campos *et al.*, 2011) because the inequality in of power relations

in the governance structure may restrict the potential benefits of the 'weaker' partner, while positioning the 'stronger' partner to take the lion's share of the gains.

Rigg and O'Mahony (2013) have identified several frustrations participants in collaborative networks sometimes have to endure. These, when prevalent, would certainly not engender the benefits of collaboration that have been widely espoused by scholars discussed earlier in this chapter. Lack of centralised coordination of activities, which is common in many inter-agency collaborations, has led to a consternation in service delivery in some critical areas. Another challenge identified include individual organisational agenda, which leads to unnecessary inter-organisational competition because of lack of trust for collaborating organisations. In addition, accountability issues shared between the centre of networks and the local organisation make it difficult for collaboration to be effective due to diffusion of attention by partner organisations. Finally, in formal collaboration setups (Guo & Acar, 2005), where boundaries are tightly defined, restrictions on individual initiatives by partner organisations can hamper the much-needed collaborative spirit. In a rather cautious fashion, Buse & Walt (2002) are concerned that in addition to their many potential benefits, partnerships also pose a variety of potential challenges and threats in relation to international cooperation in health. For instance, where they are horizontal at the global level, they 'further fragment international cooperation in health and undermine United Nation's aims for cooperation and equity among states' (Buse & Walt, 2002, p. 170).

2.9 PPP as a method for transforming public service delivery

There are many methods recorded in the public administration literature by which governments interact with the private sector. One of these strategies, which features very prominently in government-private sector engagements is contracting (Taylor, 2003; Nikolic & Maikisch, 2006). It is a strategy that involves more than just buying and selling of commodities to cover the procurement of employee training, health education, institutional cleaning, food services, and many other health-related services. Taylor (2003, p. 158) defines contracting as 'a purchasing mechanism used to acquire a specified service, of a defined quantity and quality, at an agreed-on price, from a specific provider, for a specified period. …it implies an ongoing exchange relationship, supported by a contractual agreement'. As governments look out for options to direct provision of health services and to implement agreed programmes that are exclusively through public facilities, contracting is emerging as a valuable instrument for connecting private providers in order to help realise national health sector goals.

Apart from contracting, other institutional arrangements of PPP surveyed in the literature include co-provision, delegation, co-financing, co-determination and devolution of power and authority (Jutting, 1999). The health sector in most developing countries share varied degrees of each of these institutional arrangements. However, it is the political authority, cultural context, managerial capacities of the institutions involved that largely influence the particular method that applies in any setting.

2.10 The relationship of PPP and health service delivery

Discussion of Public-Private Partnerships and Collaboration (PPPs and PPC) in the health sector is important and timely in light of the challenges the public sector is facing in healthcare financing, management and provision (Nikolic & Maikisch, 2006). Whereas it is highly argued that the state cannot continue its monopoly in the provision of health services and that private involvement is necessary, others contend that partnerships may not be very necessary for health delivery (Andrews & Entwistle, 2010). However, this debate does not seem to be getting to a close with more and more evidence in the extant literature to support both positions. The decision of how to structure the role of government in the health sector is largely dependent on the culture, values and inherent structures and political processes of that society (Harding, 2003). It is further argued that in some instances, the appropriate focus may be public service delivery strategy, especially in populations that are sparsely distributed (ibid).

The changing attitude of government officials towards age-old belief that the state must maintain its monopoly in delivering health services is gaining currency all over the world. Many leaders in the developing world are also engaging the private sector in the development and implementation of overall health sector policies and goals. However, these experiences in the developing world are rarely well documented, so policymakers and analysts are usually unable to learn from these initiatives. Rigorous evaluation of these efforts is rarer, making it difficult, even perilous, to write policy guidelines based on those experiences (Harding, 2003).

In many instances, it is the presence and capabilities of the private health sector providers that would necessitate governments engaging them whereas in some situations, their responsiveness to patients, flexibility, familiarity with local circumstances and their apolitical disposition may warrant government working with and through them (Filmer, Hammer & Pritchett, 1998; Harding, 2003).

The synergistic effects of the private sector actors and the public sector actors in health services delivery have been widely discussed in contemporary literature. Whereas public sector is generally all structures and institutions that are owned and directly controlled by the state, the private sector actors include individual or corporate healthcare providers, private logistical companies, insurance companies, private training institutions, etc. (Kaboru, 2012).

2.11 Fundamental prerequisites for engaging the private health sector

Several mechanisms for engaging the private sector have been advanced in the ongoing intellectual discourse. Broadly speaking, all such conditions for PPP in the health sector can be categorised into two – micro and macro issues (Jutting, 1999). The macro level issues involve those conditions that relate to the motivation derived from institutional factors for engaging in partnerships whiles the micro level issues centre on the organisational capacities to partner with the other sector. Some of the institutional factors include the overall political environment for partnership, economic and financial issues as well as conducive legal frameworks to facilitate partnership arrangements. On the organisation's competences, the financial viability, organisational structure, technical expertise and multi-actor interests are very important drivers of any collaborative effort.

Some other generic classification of attributes include knowledge about the private sector; ongoing dialogues between public and private sector actors; and institutional arrangements for interacting with the private sector. These have been found in health systems that are performing well with the mixed service delivery typology of health service provision (Harding, 2003). Knowledge about the private sector stakeholders involves a system of information that allows a collection of data about the activities of private healthcare providers. This involves their locations, their capacities, range of activities they are engaged in and so on. Whereas this may be well-established in most developed countries due to proper functioning of systems, it has been argued that this phenomenon is ineffective in many developing countries (Harding, 2003).

Policy dialogue includes the ongoing transparent communication between government officials involved in health policy development and the private sector stakeholders. This continuous interaction makes room for better policy designs that take into account the needs, expectations and aspirations of private healthcare providers since good regulation relies on continuous interface between the regulators and the regulated. Effective regulation can only take place in an arena where there is regular, continuous and consistent communication between the private sectors actors and their public sector counterparts (Hanks, 2006; Nikolic & Maikisch, 2006; Ratzan, 2007; Reich, 2002). However, Harding (2003) argued that this continuous interaction is not effective in many developing countries for several reasons that go beyond the focus of this dissertation[3]. Moreover, even in instances that they are present, they may be characterized by *ad hoc* arrangements and

[3] For more details on the reasons for these ineffective interactions, see Harding (2003).

political affiliations to the ruling elites instead of focusing on meritocracy and health priority areas of action.

The third dimensions of engaging the private sector has to do with institutionalized policy instruments. For these institutions to function effectively, they must be operated by competent government officials who must be conversant with and competent in using these instruments. These institutional arrangements include an effective and efficient health insurance system; a guideline for direct regulation of their activities; and providing the necessary support for self-regulation. One of the most critical instruments, however, is a universal provider-financing system that underwrites equity in health service provision and health outcomes, sustainability of essential service supplies and ensuring financial protection for service users.

Taylor *et al.* (2012) synthesised conceptual studies on partnerships and collaborations and proposed a typology of partnership approaches for the health sector. They posit that health sector partnerships can take the forms of 'contribution, instrumental, empowerment or developmental approaches' (Taylor *et al.*, 2012, p. 508). Contribution approach has been explained as a phenomenon where community members on their own volition contribute to a project that would be of benefit to them. Under this approach, there is no form of inducement or any prior agreement between the actors to engage in any form of partnership. The instrumental approach focuses on the involvement of stakeholders as an instrument of achieving stated health sector outcomes. In this approach, communities are involved in implementing predetermined health programmes in order to guarantee community ownership of the programme. The empowerment approach,

however, explains partnership as a means of realising better knowledge and capacity of community members by providing them with the necessary information and power to increase control over their own health. This approach is mostly enshrined in capacity building theory. Closely related to the instrumental approach is the developmental approach, which conceives partnership as a means to achieve both specific and broad goals, and address the social determinants of health (Laverack, 2003)

Pratt, Gordon, & Plampling (1999) advanced some key conditions that would necessitate success in any partnership arrangements. They argue that relationships must be allowed to build over time by allowing actors involved to explore the purpose for the partnerships. By so doing, members of the partnership would see themselves as parts of the total system and thereby avoid the tendency of engaging in blame games. Such a phenomenon can emerge from a change in mental maps. In addition to these, a sufficient mix of people from diverse levels of the organisational hierarchy would permit emergence of new possibilities. Besides the diversity in the composition, there must be a leadership that facilitates common ownership among the partners and provide incentives for future possibilities that the people would identify with. Above all, it is expected from partners to understand that partnership is an iterative process that may involve several attempts before a successful result is realised. Building on the works of Pratt *et al*, Ranade & Hudson (2003) argue that collective goals in any inter-agency collaboration must be clearly defined than those of individual organisations to ensure that the collaboration is successful.

When two or more organisations recognize that some of their needs can be met by each other, they engage in what Sagawa & Segal (2000) refer to as partnerships. As stated earlier in this dissertation, a partnership is a form of collaboration to pursue common goals, while leveraging joint resources and capitalising on the respective competences and strengths of both partners (Jamali & Keshishian, 2009). As any other collaborative relationship, partnerships do not succeed fortuitously. There are several issues that are significant and deserve careful consideration when contemplating any partnership arrangement. Samii, Van Wassenhove, & Bhattacharya, (2002) made discussions on some of these factors as resource dependency, which signifies the recognition by the partners to achieve synergy, commitment symmetry, common goal symmetry, alignment of cooperating capabilities, intensive communication and convergence in working cultures[4]. Kanter (1994) also provided that a partnership arrangement can be classified as successful provided salient attributes that I would like to describe as '8Is' are present. The 8Is include the **individual** excellence of the partners, **importance** attached to the partnership by the partners, the degree of **interdependence**, **information** sharing to maintain the relationship among the partners and the extent to which partners treat each other with **integrity**. The other 'Is' include **investment** of time and other resources in each other, **integration** through the development of linkages for smooth operation and the **institutionalisation** of the process by formalizing structures for the partnership arrangement[5].

[4] For further elucidation on these factors of successful partnerships, see Samii *et al.* (2002)
[5] Kanter (1994) provides a vivid illustration of how each of the 8Is impact the workings of partnerships.

Another element that has been expanded in the literature to guide any inter-agency relationship is trust. Trust has become a concept that is well discussed in public and academic discourses and considered as a key element in any relationship (Welch, 2006). Grunig & Hon (1999) analysed trust from the dimensions of integrity, dependability and competence. These dimensions offer some form of prescription that trust and truth are symbiotically related. Further analysis of trust as a concept imply that it serves as an instrument of lubrication that facilitates separate organisations to work together (Bennis & Nanus, 2003) because the relationships between organisations and their stakeholders require a medium through which they can relate effectively, devoid of suspicion. This is more relevant because partnership relationships come with certain vulnerabilities and risks but the only currency that can create the confidence in partners for each other's reliability and integrity is trust (Morgan & Hunt, 1994). Thus, the social complexity associated with partnerships could be minimised via the acceptance of the vulnerability that come with cross-sector engagements (Baier, 1986; Blois, 1999).

Partnerships confront seven organisational challenges, which are succinctly described as 'the seven C's of strategic collaboration' (Austin (2000) cited in Reich, 2002: 10) and it is not easy to navigate these seven C's. One of these challenges of particular importance is the challenge of creating value. Partnerships, it is argued, are difficult to create value because of the inherent desire by the partners to derive as much benefits as possible from partnership. These challenges include the establishment of clear purpose for the partnership and ability to find a fit between mission, strategy and values of the partners. To guarantee a sustainable collaboration, the value created through it must be useful to society and the value must reach out to all core partners. Effective

and constant communication between partners and their unalloyed commitment to the partnership are very crucial to its success. Moreover, creating a partnership is a continual learning process, with the potential for unexpected lessons. For any partnership arrangement to be considered successful, these challenges have to be subdued sufficiently. Table 2.5 captures the seven C's of successful partnerships.[6]

Table 2.5. The Seven C's of successful partnerships

Clarity of purpose
Congruency of mission, strategy, and values
Creation of value
Connection with purpose and people
Communication between partners
Continual learning
Commitment to the partnership

Source: Reich (2002)

2.12 Summary

This chapter is an attempt to make discussions on the extant literature on public-private partnership concept in general. It starts by taking a closer look at the various conceptualisations of the phenomenon, the necessity for engaging in such alliances and networks and the various forms and typologies of the collaboration model. As a basis for determining the frontiers of knowledge in the collaborative literature, the chapter also makes discussions on the foundation of partnerships, collaborations and alliances for health delivery in general and the specific case of Ghana. The

[6] Detailed discussion on the seven C's can be found in Austin (2000) and Reich (2002).

success or failure of partnerships, especially in the health sector depends on both micro- and macro-level factors. A careful analysis of these factors that are essential to make the arguments for, and against partnerships were also presented in this chapter.

CHAPTER THREE

HEALTH SECTOR REFORM AS THE PROPER DOMAIN FOR IMPROVED SERVICE DELIVERY

3.1 Introduction

In the previous chapter, discussions were made on PPP and its relevance to this study. As stated throughout this dissertation, the thesis is about PPP in the context of health sector reform in a developing country. This chapter focuses on literature review on health sector reform as the proper domain for improved service delivery. Together with the previous chapter, they form an interlocking basis for constructing the theoretical lenses for this study, which would be discussed in the next chapter. The chapter initially provides an overview of public service delivery in general with specific attention to developing countries. It also makes a critical survey of the health policy architecture in Ghana prior to health sector reform and discussed reforms as a policy instrument of change in the delivery of public services. Reforms are usually political decisions and this element is also discussed in this chapter with some specific features that make structural changes qualify as reforms.

Since this study is about Ghana, the country context is also discussed with focus on the justification for health sector reforms, its forms, dimensions and the different levels at which they are usually implemented. The chapter also discusses how health reforms differ in character from other forms of change in the provision of social services. It concludes with a summary of the main issues that were highlighted in the chapter.

3.2 Overview of public service delivery

In developing countries, globalisation and liberalisation have imposed NPM-style reforms as preconditions for economic development and good governance (Asian Development Bank, 2004; World Bank, 2002). The main elements of good governance include transparency, accountability, control of corruption and efficient public expenditure and revenue creation and management (World Bank & DFID, 2009). Accountability is an important means for establishing criteria to measure the performance of public officials, and for creating oversight mechanisms to ensure that the quality of public services is improved for the longer term benefit to the larger society. In situations where there is lack of accountability, governmental institutions become weak and public management systems usually become dysfunctional. Consequently, it is a major concern observed that the ratings for transparency, accountability and control of corruption are the lowest in developing countries (Janvry & Dethier, 2012). Country studies have shown that whereas accountability in the developed countries is relatively better than in developing countries, the corresponding effect on the state institutions also point to similar undesirable scenarios. In this regard, many public service delivery in developing countries have received wide condemnation, both from within and outside the country.

In an empirical study on accountability practices and public sector reforms in Southeast Asian countries, Samaratunge, Alam, & Teicher (2008) found that political history, the pattern of economic development, the nature of political leadership, the capability of the administrative system, the capacity of existing institutions, and the state of civil society are the most significant contextual factors influencing accountability practices in the countries studied.

3.3 Architecture of health policy prior to health reforms

The direction of global health policy has gone through different phases over the centuries. These include the various stages of epidemiological and demographic health transitions across different times in human history. This is also true for Ghana as a country that traversed several economic, geographical, social, demographic, epidemiological and political changes that impacted its health system. These factors dynamically affected the organisation of health services over the years, dating back to the pre-colonial era through the days of the colonial authorities and the post-independence arrangements. Smithson, Asamoah-Baah, & Mills (1997) have reviewed the country's health system development from the colonial era to 1993. However, for the purpose of this study, I would limit the discussion of the country's health policy prior to the health sector reform to the period just after independence in 1957 to the time structural reforms commenced in the late 1980s[7].

The health system of Ghana experienced its first major restructuring in 1953, just before independence, when the then colonial Medical Department became the Ministry of Health (Sakyi, 2007). At independence in 1957, the new government took charge of the health policy for the country by embarking on vigorous restructuring to shed off the vestiges of colonial administration. This experience was characterised by the anti-colonial struggle hence the need to decolonise the health system of the country albeit there were many weak structures and apparent lack of capacity to administer some of the state departments. Expansion of health services through rapid increases

[7] For detailed discussion on the health system's policy architecture prior to Ghana's independence, see Smithson, Asamoah-Baah & Mills (1997) and Yeboah (2003).

in the numbers of health centres and hospitals took centre stage. This period reflected the perception of health with the lenses of the biomedical model in that, the focus of the country's health policy was curative care owing to the relative large presence of infectious diseases at the time. The structure for preventive health services at the time was quite weak whiles major attention was directed at the construction of hospitals for curative clinical care. The first 7-year national development plan drawn for 1963-1970 actually summarised this position in its health sector objective: 'Extension and modernisation of existing hospitals – 30 out of the 37 government hospitals were to be expanded and be better equipped' (Yeboah, 2003, p. 14).

The first forceful military take-over in 1966 abandoned this initial development plan, which was replaced with a two-year development plan for 1968-1970. The government of the National Liberation Council, through this plan, made a conscious attempt to reverse the urbanised health system by expanding health services to the rural areas with some sense of rapidity. The state then adopted such strategies enshrined in social equity philosophy of health by embarking on rura-biased national health resource allocation. This period witnessed the training of more community health nurses, the construction of more health posts and community clinics in deprived regions and districts and the strengthening of inter-sector linkage with the Ministry of Education to cultivate school health programmes (Yeboah, 2003) in all parts of the country. Subsequent governments (both military dictatorships and democratically elected governments) have followed through these initial policies in various forms until the late 1970s, where there was a global call for a change in health policy direction.

A landmark point of departure was arrived at in 1978, during the Alma-Ata Conference, where ministers from 134 countries in association with WHO and UNICEF called for 'Health for All by the Year 2000' (HFA 2000) and selected Primary Health Care (PHC) as the appropriate tool to achieve that ambitious goal. This was the point that decentralisation of health shifted to the district health administrations for the first time. Unfortunately, the ultimate dream of PHC never came to pass, even though there were some modest gains in many countries' health outcomes. Important achievements of health care in developing nations during the preceding years included the movement towards universal childhood immunisation; expansion of oral rehydration therapy; and the approaching eradication of polio in the Latin America and Africa (Berman & Bossert, 2000). There was also increased recognition of new challenges in reproductive health, management of child health, HIV/AIDS and most recently, a pandemic such as Ebola haemorrhagic fever. The health status of populations in developing countries has not seen noticeable improvements over time. In many cases, it has rather deteriorated further, making useless the goals of HFA 2000. Some of these situations, however, may be attributed to other political and socio-economic factors that are not within the purview of the ministries of health.

The World Bank, in 1993, dedicated its World Development Report to health with the theme: 'Investing in Health'. In this report, the bank re-echoed the need to reform the health services, especially in developing countries by proposing a substantial rethinking of health sector strategies (Berman & Bossert, 2000). The strategies proposed include decentralisation in the health sector, the quest for embarking on cost recovery strategies whiles not compromising on service quality and efficiency in the sector. The call for investment in health does not only urge governments to

spend more resources on health sector priorities but also calls for a comprehensive involvement of the private sector actors. The appropriate public-private mix must, however, be carefully chosen to reflect the priorities of the country including its cultural, political, social and economic situations of the people. This calls for targeted interventions by identifying relevant segments of the society to reflect their specific situations. The peculiarities of Ghana in relation to these variables make conditions ripe for partnership between government and the non-profit private sector.

Currently, the entire world is facing global health crisis, characterised by growing inequalities within and between countries. New threats to health are continuously emerging with difficulties in finding antidotes to them in time. This is compounded by negative forces of globalisation, which prevent the equitable distribution of resources necessary for people's health, particularly the poor. The medical anthropology perspectives amply demonstrates the direct relationship between poverty and health status among the various segments of the world's population. Within the health sector, failure to implement the principles of primary health care, as set out in the Alma-Ata declaration, has significantly aggravated the global health crisis. It would be presumptuous to blame any institution or group of stakeholders for how events have turned over the years. That notwithstanding, collective decisions of governments and organisations may be regarded as the usual suspects.

3.4 Reform as an instrument of change in the public sector

Reforms have been defined differently by scholars in public sector management. Reform, generally defined, implies planned change which could be in the political institutional system or

in any specific field of its activities. It means a positive change in an existing phenomenon to guarantee the improvement in services delivery (Andrews & Entwistle, 2010). Policy decision could be in the political, social, economic area and/or in the manner in which certain activities of the state are carried out (Nwankwo, 2010). In other words, reform is a consciously planned change in polity and, or policy. In any society, reform is centred on the existence of contradictions between the powerful and the powerless, the rich and the poor, the strong and the weak, the privileged and underprivileged, etc. These are ever present in all societies including the so-called developed ones (Nwankwo, 2010). What is important is that genuine reform cannot take place where there are no differentiations and contradictions, where there are no cleavages and such other lines of conflicts or where the lines of conflicts are blurred. Of all differentiations, class is most formidable for effective reform. Moreover, no genuine progress can take place without opposition, without conflict and without antagonistic groups (Nwankwo, 2005).

Archetypally, reform emanates from crisis in social constructions. Such crises involve the clash of interests between competing forces in the social ladder of every community, region or country. The crisis becomes ostensible either when the existing rules and regulations have ample evidence to be functionally powerless of regulating relations of the shared influences between the affected sectors of the society, or when a prominent social group, with the capacity to attain its demand refuses to accept such rules and regulations as frame for its resolutions, or begin to make demands for more recognition, or for more power or for increased participation. In such a situation, the reform becomes the next line of action, and in fact an inevitable option to pursue since ignoring such a vital group could only be at the risk of causing more damaging crisis in the society (Kohli,

1986). The reforms in virtually all sectors in Ghana have been characterised by demands and pressures of one or more segments of the society.

Political, social, economic and technological changes are commonplace and permanent features of the present world. Over time, power relations within and between nations, domestic political structures, social processes and institutional structures have had to undergo carefully planned or accidentals changes in response to either internal or external dynamics or a combination of both (Obi, 1999). Many a scholars are interested in understanding those changes that are planned, which are usually referred to as reforms (Nwankwo, 2010). A lot of developing countries including those in Africa have over the years simultaneously embarked on a number of reforms: social, economic and political. In doing that, they have principally viewed reform more as a goal to be attained and less as a dynamic process that is, theoretically speaking, endless. It is argued that reforms mostly do not realise their objectives and when this happens, the unexpected consequences make many citizens aggrieved as in the case of Nigeria. 'Today, reform is a concept, which the ordinary man in Nigeria detests for several reasons, above all, because of previous "failure to achieve expected goals". They fear and in fact dread reform especially when mentioned in connection with the economy' (Nwankwo, 2010, p. 181).

3.5 Reform as a political process

The political nature of reforms have been given a wide attention in the literature on governance and service delivery in the public sector. As a profoundly political process, reform affects the allocation of resources in society, and often imposes significant costs on well-organized, politically

powerful groups (Glassman, Reich, Laserson, & Rojas, 1999). For the political reasons of system changes, the processes leading to major or minimal structural changes must be cautiously pursued. Reform strategies that were applied in some developed countries may not be suitable in developing countries given the differences in political, social and economic contexts. This suggests that to apply the available sector reform models of developed countries, careful adaptation is essential for the developing countries (Srivastava & Kathuria, 2014). Indeed, not all reforms have been successful, even in the developed countries. A very cautious balance of competition and regulation is needed to suit the country specific issues. In most cases, the political leadership forms strategic alliances with the administrative cadres to get reforms implemented. In a study on public sector reform in Malaysia, it was observed that the political leadership of the country has built a positive partnership with political groups, businesses and public management and this created a culture of innovation, productivity and accountability across all levels of the reform enterprise (Srivastava & Kathuria, 2014). By this show of trust by the political leadership, participating groups appreciated the possible benefits of such a partnership in implementing total quality management programmes through information sharing to improve social, economic and administrative development.

Symptomatic of all policy changes, there are bound to be advocates and opponents to policy reforms of any kind (Grindle & Thomas, 1990). Health reforms are of no exemption. They are usually more politically problematic (Glassman et al., 1999) than reforms in other sectors that may require obvious physical infrastructural developments. It has been reported that in many countries considering reform, the most powerful health sector actors are often content with the status quo and therefore resist any change. Some of these resistances are displayed notwithstanding untold

difficulties in the distribution of health services, quality of care, patterns of utilisation, efficiency, and equity. Besides, the proposed policy changes are often considered as politically and economically agonising decisions in the short term. One of the most important and complex problems in the process of health reforms is the management of these short-term, concentrated costs, and of the powerful groups affected by the reform.

Reform proposals create the perception that a major redistribution of the benefits and costs within the health system will occur, but *how* and *when* that redistribution will occur is unclear. In contrast to education reform, which usually entails increasing budgets, building new schools, and hiring teachers, health reform seeks to radically alter the social contract between citizens and the government, changing physician payment schemes, introducing patient payments, and limiting reimbursable services to affluent social groups. Politically, health reform proposals resemble structural adjustment policies, but without the national mandate for change accorded to adjustment. In addition, health reform policies confront more complex obstacles in implementation, compared to structural adjustment policies, because of the nature of the decisions and institutions involved. Both multilateral institutions and national health reform teams have experienced some difficulty in understanding and navigating the political economy of health sector reform (Oyaya & Rifkin, 2003; Reich, 1995; Twaddle, 1996).

3.6 Key features of reforms

The term reform has been used and abused in many contexts and in different situations, sometimes in an attempt to legitimise a particular set of actions. Whereas some scholars regard an

insignificant change to any aspect of a project within a programme as a reform, others contend that reform must be a significant structural change in the planning, organisation, implementation and delivery of services and programme. Symptomatic of any intellectual debate, some fundamental characteristics must associate any phenomenon that may be described as a reform. Frenk (1994, p. 20) describes any reform process as a 'planned, purposeful, and positive transformation' of a phenomenon. Because of this positive connotation of this concept, it is usually associated with obliteration of negative components or a purposive revolutionary action towards certain goals. Reforms, however, are supposed to be incremental in character, exuding very little or no rapidity in their implementation (ibid). In this sense, reforms assume a gradualist approach to processes and actions unlike revolutions, which assume a much more speediness in execution. This exposition on reform presupposes that it is not an activity that emerges as an instantaneous reaction to events in a country, but it must be well-planned over a period of time and should be evidence-based. In the specific case of health sector reforms, they require policy or institutional changes in such areas as cost containment, cost recovery, privatisation (Donaldson & Walsh, 1994), decentralisation of functions and authority, integration of programmes and equity in personnel and other resources allocation (Berman & Bossert, 2000).

Other critical attributes of reform processes include the unbundling of vertically integrated programmes and activities into separate segments of policy planning, policy implementation, programme monitoring and supervision, and evaluation of programmes and policies. In a related study in the utility services sector in India, Srivastava & Kathuria (2014) identified another key aspect of reform as privatisation of some units for the distribution of services. By this action, the

sector was allowed to function on its own, under a regulatory watch by the relevant regulatory body of the state. Reforms also delineate enhanced investments in infrastructure to support improvements in services availability and delivery, even demand may be rising due to ever growing population against dwindling natural resources.

One very characteristic of reforms in the developing countries, particularly in Sub-Sahara Africa was the development of Sector Wide Approaches (SWAp) within the framework of the various ministries in respective countries. The SWAp incorporated alternative mechanisms for aid delivery, including sector budget support, with a particular accent on strategies designed to increase local community leadership and achieve greater combination of development partners' and government's efforts (Penny, Ward, Read, & Bines, 2008). Health sector SWAp in most African countries focused greater attention on budget performances, intra-sector linkages, performance outcomes and service quality. This is done by giving greater weight to improving the policy, budgetary and institutional framework for effective government-funding agency partnership, including enhanced national leadership and ownership of reform plans, and improved mechanisms for joint government-development partner dialogue and performance review (Buchert, 2002; Cassels & Janovsky, 1998; Jeppsson, 2002). This approach focuses on a new way of funding health services. Instead of the hitherto method of financing specific programmes and projects, donor funds are pooled into a common pot for each decentralised unit of the health sector to access on need basis. In general, SWAps have led to raising of more financial resources and better management thereof because the forum for discussing budgets in the midst of paucity of financial resources are usually created, even though some scholars find this approach as a clear

label with unclear content (Sundewall & Sahlin-Andersson, 2006). By this development, stakeholders bring on board, their respective strengths for better management of sector resources. In action, coordination element that drives SWAps is viewed positively since it reduces the risk of duplication of activities. This method of financing health services, in principle, largely seeks to reduce waste in the system by focusing on need-based budgeting. However, its effectiveness largely depends on the local capacity of the institutions to manage these resources.

3.7 Effects of reforms on workers in the public sector

As noted earlier in chapter two, the effect of NPM, the antecedent philosophical ethos of reforms, is to create a lean workforce and capitalistic ethic with improved service efficiency and effectiveness. However, this phenomenon had had consequences on the public sector worker, including health professionals across many regions and countries. Some of them include low worker morale as a result of extra workload and job insecurity. In the specific case of the UK, Maddock & Morgan (1998) reported a considerable low morale among the health and education sector workers. The phenomenon resulted in job losses and early retirement due to high blood pressures because of the anxiety over the unknown future. The acceptance of managerialism as a norm in the public service has not been accompanied with corresponding impact assessment on service objectives and management. Reforms largely led to loss of social capital by the organisations because it created competitive agencies, and the unbridled desire for efficiency and financial savings forced practitioners and support staff into machine-driven relationships with clients and closed 'in-the-box' (p. 240) relationships among themselves (Maddock & Morgan, 1998). It has created undue pressure on managers to meet performance targets but ignoring the

interpersonal and social relations that serve as essential condiments to improving organisational performance. Managers are driven only by the quest to attain their financial indicators set out for them by their political authorities. However, quality service in organisational setups is a function of 'the ability of the organisations to generate a collaborative culture rather than blame culture' (p. 236).

3.8 Health sector reforms

As noted earlier in this chapter, reform implies a positive change in an existing phenomenon. However, health sector reform means more than just any form of improvement in the health system of a population. Berman (1995) captured very key essential ingredients in the definition of health sector reform as sustained, purposeful and fundamental change. Reform must be sustainable in that it is not to be a one-off activity that aims at having temporary results (Berman & Bossert, 2000) but must be an ongoing, continuous programme involving contiguous activities. In other words, reform signifies a going concern with a potential for perpetual existence. It is also purposeful because it must be a product of a rational, planned and evidence-based decision; and fundamental because it must be intended to address substantial, calculated proportions of the challenges of the health system (Berman, 1995). Health sector reform, in essence, encapsulates all forms of changes in the organisation, delivery and financing of health systems with the aim to improve the quality of, and access to health services. These reforms are still ongoing in many countries, whether developed or developing.

In a further attempt to explain what the concept actually entails, (Frenk & Gonzalez-Block, 1992, p. 168) offered a definition as 'changes produced out of explicit intention on the part of government or political groups to transform, for the better, the health sector'. Sikosana, Dlamini, & Issakov (1995, p. 3) define it as 'a sustained process of fundamental change in policy and institutional arrangements, guided by government, designed to improve the functioning and performance of the health sector and ultimately the health status of the population'. Based on this definition, health sector reform is concerned with defining priorities, refining policies and reforming the institutions through which those policies are implemented to improve the health status of the population (Oyaya & Rifkin, 2003) in the short-, medium- and long-term. Glassman *et al.* (1999, p. 115) define health sector reform as 'those activities undertaken cooperatively between the international development banks and a national government to alter in fundamental ways the nation's health financing and health provision policies'. Whichever way it is conceptualised, the fundamental ingredients of any health sector reform include restructuring of public sector organisations, changing resource allocation formulae to both organisations and individuals, encouraging greater plurality and competition in the provision of health care, pursuing increased financing for health services from non-tax revenue sources and increasing the role of the consumer in the health system (Mills, Bennett, & Russel, 2001). Thus, health sector reforms are 'comprehensive approaches to improve efficiency, equity and quality, based on a diagnosis of underlying societal, demographic, political and economic issues' (González-Block, 1997, p. 192)

Health sector reform, indeed, is not a concept that has a single global definition and many scholars have continuously defined it differently. As a guide, Cassels & Janovsky (1995) actually cautioned

by providing a caveat that there should be no attempt to be too specific in splitting hairs over the definition of the concept but rather, what is important to appreciate is the essential ingredients that accompany the definition of the concept. Central to these definitions is the expectation that every health sector reform must show evidence of improvement in the management of health resources to ensure efficiency, effectiveness and equity in the distribution of health services. In addition, it must accomplish financial protection and satisfaction for patients (Berman & Bossert, 2000) at all levels of the social order in health. For the purposes of this study, the definition of Berman (1995, p. 15) is adopted:

> 'Health sector reform is a sustained, purposeful change to improve the efficiency, equity and effectiveness of the health sector'.

In this context, the focus of health sector reform is related to defining priorities, refining policies, and reforming the institutions through which those policies are implemented with clear prioritisation to improve the health status of the population (Janovsky, 1995). The last three decades have experienced discussions on health systems reforms. There are several measures that characterise this phenomenon but the fundamental ones include:

- A shift of the public-private mix of health services
- A decentralisation of management of financial responsibility in the public system
- An increase but also a diversification of fees in the public system
- An improved cost awareness and use of cost-benefit analysis in setting health sector priorities
- Improved workforce capacity through training, retraining, motivation and retention

3.9 The justification for health sector reforms

Even though health sector reforms have been criticised recently for some unintended consequences such as the introduction of user charges beyond the affordability of the vulnerable, abandonment of vertical immunisation and unaffordable insurance schemes in developing countries, many still argue that reforms in the health sector are still needed to improve health outcomes of the world's population[8]. Different reasons have been advanced in the extant literature for health sector reform. These reasons can be categorised broadly as either the need for reform or the opportunities for reforms. However, these two classes have a common intent, which can be summarised as the promotion of the overall health sector objective by improving the health of the populations (Adjei, 2003; Berman, 1995; Franco, Bennett, & Kanfer, 2002; Lundberg & Wang, 2006; Murray, 1995). In addition, Murray (1995) provides an alternative goal for health sector reforms, which is to provide interventions and services that maximize welfare or, in other words, some aggregation of individual utilities. Most reforms in the developing countries are characterised by the need for, whiles most in the developed world depict opportunities for embarking on health sector restructuring. In general, health sector reforms are triggered by a complex array of socio-politico-economic crises as well as epidemiological and demographic difficulties (Cassels, 1995; Oyaya & Rifkin, 2003; Sakyi, 2008).

Frenk (1994) categorised reasons for health reforms into political, economic, ideological and epidemiological. For economic reasons, he argued that most developed countries embarked on

[8] For further discussion on the criticisms of health sector reforms, see Berman & Bossert (2000) and Lundberg & Wang (2006).

reforms to engender cost containment in order to offer real value for the various sums of money that have been allocated for the provision of health care to the general population. However, developing countries have economic reasons beyond cost-containment. Most of the developing countries including Ghana have welcomed health sector reforms as a mechanism to arrest the devastating effects of economic crises in the 1980s. The overall deteriorating economic situation coupled with poor governance and increasing poverty has had devastating consequences for the health status of the populations. In those times, most governments in the developing countries perceived economic recovery as a new dawn for restructuring and the health system, instead of muddling through with the ineffectual arrangements that predate the economic crises (Frenk, 1994), adopted the reforms to salvage their debilitating conditions of the time.

For political reasons, the rise in citizen participation in demanding better service outcomes from the health system, partially as a result of the growing anticipations that technological change and mass media have generated the necessity for reforms. Moreover, the collapse of the bi-polar world led many developing countries to embark on reforms since support from the defunct Soviet Union terminated. Also, the ideological reasons are interlinked with the political ones, especially in the developed world. There has been doubts about the value of state intervention and a belief in the dominance of markets. This led countries to reconsider the optimal public-private participation in health. The epidemiological reasons actually characterise reforms in most developing countries. In most of such countries, the core factor has been the rapid change in the character of health problems. Most developing countries have found themselves at different stages of the epidemiological transitions (Omran, 1971) and this phenomenon warrants adaptation to manage

those quick changes in their health transitions. For example, emerging diseases like HIV/AIDS require different management and care approaches whereas non-communicable diseases require more public health actions. In particular, HIV/AIDS has eroded the health gains of many countries in the Sub-Saharan Africa region.

Political, economic, epidemiological and ideological factors alone cannot be sufficient basis for reform in all circumstances. It has been argued that a country emerging from civil strife would also give good reasons for embarking on a reform, even though there may be institutional and personnel incapacitation for a smooth restructuring (Cassels, 1995). These rationalisations for health reforms have also been echoed by Berman & Bossert (2000) that many developing countries were suffering from unacceptably inefficient and inequitable resource allocation, declining service quality and workers having very low morale. Such events resulted in patients abandoning public health facilities for private ones, which although were of suspicious service quality. Reforms, it was believed, offered some sense of optimism to overturn the debilitating conditions of the health system of many developing countries.

3.10 Typology of health sector reforms

Health sector reforms, like all other reforms that characterised the rise of NPM concept, appear in different forms and shades. The type or form that a particular reform may take could be described as being a part of a continuum. As noted earlier, reforms signify change and a change can variously be typologised in terms of its form, process, structure and other variables. The broadest categorisation is between violent and non-violent forms (Nwankwo, 2010). Violent changes are

usually illegal changes that seek to alter the social, economic, political and administrative processes of a country. They are mostly characterised by the features of abruptness, the abrupt termination of an existing order, whereas non-violent forms are usually characterised by the use of democratic due processes. Usually, non-violent reforms follow laid down procedures and depend predominantly on conviction and the goodwill of the people concerned. Generally, it is argued that non-violent changes do not often lead to fundamental and deep changes in society but rather to slight and incremental changes in the political, social and economic structure of the society.

In the case of developing countries, the extent to which health sector reforms have been implemented vary significantly across countries. Lundberg & Wang (2006, p. 53) 'crudely and imprecisely' categorised them into the supply-side and demand-side reforms. Supply-side reforms focus on those involving the financing, management and provision of services whereas the demand-side reforms are those involving the demand for, and consumption of services. It is believed that most of the health reforms that have been implemented so far concentrated on the supply-side. Some of the key health sector reform[9] types include health service delivery, privatisation, changes in financing mechanisms, decentralisation, delegation (Lundberg & Wang, 2006) and contracting-out (Simonet, 2008). The health sector reforms experienced in Western Europe, North America and Australia involved a more full-bodied application of NPM governance

[9] Lundberg & Wang (2006) made detailed discussions on these and other types of health sector reforms.

models. The bureaucratic reforms were carried out simultaneously with market reforms in those contexts compared to what happened, for instance, in Sub-Saharan Africa.

González-Block (1997) categorised health sector reforms as either bureaucratic reforms or market reforms. Whiles bureaucratic reforms largely focus on the creation of structures that would grant lower-level agencies some degree of autonomy in taking decisions, market reforms focus on the involvement of the private sector in providing services. Market reforms also bring along the introduction of market pressures within the public sector service providers. It makes room for competition within the sector to improve service efficiency through cost-containment, cost recovery (Donaldson & Walsh, 1994) and privatisation.

The model of health reform any particular country pursues would be influenced by a complex array of factors, which Donaldson & Walsh, (1994) categorise as either environmental, institutional or design factors. Environmental factors include such political and economic determinants of a country. The political will of the government coupled with the governance style would inform the feasibility of a reform in the social sector. In some countries, the acceptability of market principles in the public sector by pressure groups could determine the reform typology to opt for whiles the macroeconomic situation and the opposition of political groups to user fees and privatisation reforms have played their respective roles in the initiation and the implementation processes of reforms in general.

3.11 Levels of health sector reform

Frenk (1994) argues that there are four different perspectives of health sector reforms taking place at different policy levels. These are systemic, which focuses on restructuring or redesigning of the health system; programmatic, which deals with reorientation or reprogramming; organisational, which deals with reorganisation of the health system; and instrumental which focuses on reinforcement and implementation of proposed changes. Each of these levels addresses different objectives. The systemic level addresses issues of equity, efficiency and quality in health services. The basic issues that attract attention of policy makers at this level are the basis for population eligibility and institutional arrangements (González-Block, 1997) for exacting the reforms. Such institutional arrangements may include an inventory and levels of public sector agencies to be involved, the segments of the larger population to be affected, the resource generators for health, the type of public-private involvement as well as all other sectors that have some influence on the health of the people. At the programmatic level, however, the main objective is allocational efficiency, which focusses on issues such as cost-effectiveness of intervention and priority-setting in the health sector. Organisational level addresses the issues of incentives for health sector workers, organisational design, values of the sector, productivity, sector performance and organisational development with the ultimate objectives of technical efficiency and service quality. The instrumental level addresses the objective of performance enhancement through attention on human resource development, scientific research, information systems improvement and technological advancement.

Following the earlier works by reforms researchers, Van Eyk, Baum, & Blandford (2001) argue that like many other public sector reforms, health sector reform can be observed either at the system-wide policy level, the local level, the organisational level or at the individual clinic or service delivery level. All of these levels provide opportunities for the development of understanding the outcome of the reform agenda.

3.11.1 The reform experience of Sub-Saharan Africa

Public sector reforms experienced in most Sub-Sahara African countries have been diverse. The main reform experience that cuts across most of them focuses on the decentralisation of planning and management, which aims to push responsibility for at least some decisions down the administrative hierarchy (Gilson & Mills, 1995). There are various forms of decentralisation that are open to adoption by any country, ranging from deconcentration of decisions concerning the administration/implementation of health care activities, through greater 'devolution' of administrative decision-making and broader policy-making, to 'privatisation' of all but legislative and regulatory responsibilities (Ayee, 1994). The preferred management level in a decentralised system is usually the district, where the management of primary and secondary level services can be integrated and planned for a defined population.

Decentralisation may also involve establishing large institutions such as teaching hospitals as self-managing enterprises. It is a critical complementary policy for financing reforms. The attendant benefits of decentralisation, which are widespread in the public administration literature underscores its adoption as a vehicle for health sector reforms, especially in the third world countries. Many scholars have argued its potential of reducing bottlenecks in bureaucracy,

reversing rural-urban migration, enhancing public accountability and tailoring development plans to specific needs of society and organisations at all levels (Bardhan, 2002; Ayee, 1994; Opare, Egbenya, & Kaba, 2009). For example, case studies on decentralisation in some developing countries such as Senegal among others, point to the fact that the concept has made it possible for local government authorities to be involved in vital structures and constituents of development (Opare *et al.*, 2009). Decentralised governance systems also ensure accountability (Antwi-Boasiako, 2010) and tend to be more responsive to the local needs of the people.

Other public sector reforms with which there is some familiarity in SSA include improvements to procedures such as programme budgeting and economic evaluation, and improving the information available to decision makers such as information systems improvement and the promotion of health systems research. Budgetary and accounting reforms are important for decentralisation, providing local managers with a cash-limited budget which they can use flexibly and for the use of which they can be held accountable (Mills, 1994).

3.12 Overview of Ghana's health sector reform

The Ghanaian experience of health sector reform largely spans over several decades. The country's attempts to reform the health service started in the late1980s. The motivation for such reform was to halt the downhill trend of performance of the health sector, with health indicators showing a reversal of gains made in the previous years of the country's relatively young life. This initiative was noted as a bold step to reverse the decline of health services prompted by the economic decline that bedevilled the country since the late 1970s (Ministry of Health, 1996). The

worsening conditions added impetus to improving the health sector. As noted above, the health sector in Ghana has been experiencing substantial reforms overlapping the past three decades. This development forms part of the larger programme of government to reorganise public administration in the country to improve effectiveness and service outputs (Bossert, Bowser, Amenyah & Copeland, 2004). The initial stages of the health sector reform saw a research-based reform, championed by the technical and political leadership in the early 1990s. It was characterised by the creation of the Health Research Unit at the country's Ministry of Health, which started scientific studies on the possibilities of embarking on alternative financing schemes for health care instead of the then widespread user fees-for-service, also known as 'cash and carry' (WHO, 2012). Other areas of research then included the possible public-private mix of health care that could be adopted by the country.

This initiative towards the health sector gained renewed momentum in the early 1990s, when further initiatives were articulated for health sector development as part of the overall long-term vision for Ghana's future growth and development as framed in the document dubbed 'Ghana Vision 2020' (Ministry of Health, 1995, p. 1). The Vision 2020 was conceptualised by policy makers as a neo-liberal policy development instrument intended to achieve a balanced economy by improving the livings standards of the people (Sakyi, 2008). Specifically, the five main development themes of this document were:

- Human development
- Economic growth
- Rural development

- Urban development
- Creating an enabling environment for ensuring full implementation of policies for decentralisation in the public sector.

As its contribution to these development objectives, the Ministry of Health embarked on major reforms of the health sector, which took place under the Medium-Term Health Strategy, 'Towards Vision 2020' and the first health sector Programme of Work, 1997–2001. The objectives of this first programme of work were identical to the objectives of the government's programme of work for health, and it includes improving health status by increasing access to a basic package of health services, improving the quality and efficiency of health services, and forging linkages with other partners in health development. The partners here include the private sector actors and other public and quasi-governmental institutions that do not fall under the Ministry of Health. Other objectives were to improve funding for the health sector by increasing budgetary allocation and attracting more donor funding by improving revenue generation from households. It is worth mentioning that this strategy received overwhelming support from several development partners, which form the bilateral and multilateral organisations, including the World Bank, USAID, DFID, DANIDA, Netherlands Government, European Union (EU), among others.

Subsequent programmes of work have centred on key areas that seek to bridge the inequality gap between various segments of society including regional differences and social and economic classes of people. Owing to the country's situation of double-burden of diseases, attention was also focused on regenerative health, which seeks to create wealth through healthy population by practising preventive health, health education, health promotion and living healthy lifestyles.

These new initiatives acknowledged the first premise that improvement in the standard of health care delivery required a fundamental redefinition of both aims, and in the running of the service. This consideration led to a restatement of health policy, launching a shift away from quality per se to an emphasis on balancing quality against cost (Adjei, 2003). The thrust for reform led to a structural reorganisation of the health system towards the implementation of a viable strategy of health management and criteria of performance. This structure was vertical in nature, resulting in the development of a vertically organized management system for the transmission of information, for financial management, for human resource allocation and for supervision. There was duplication and competition for centrally managed vertical programmes; roles and responsibilities between technical and administrative divisions were confused; and standards and mechanisms for monitoring performance were ill-defined. This situation was the basis for the reorganisation of the MOH, which was undertaken as part of the reform goal to provide a sound management base for advancing the larger aims of the reforms (Adjei, 2003; Ministry of Health, 2005).

3.13 Summary

Reforms are changes to prevailing circumstances in a positive direction. Even though some reforms have not realised the objectives they set out to achieve, there is ample evidence that in the health sector of many countries, health sector reforms have yielded some fruitful results. To this end, reforms have provided the domain for the provision of social services in most developing countries. This chapter also provides some insight into the political processes that surround reforms in such social issues like health. The specific country context involving Ghana's experience has also been discussed in this chapter. Whereas the clarion call for health sector

reforms were heralded by the declining economic trends of the countries in the developing world, the developed countries also embarked on reforms as a means of improving their achievements in health. Reforms, in general, seek to bring about desirable outcomes through institutional renewal. The health sector, which is one of the key indicators of a country's overall performance cannot be side-lined in any reform effort and this has been pursued at different levels. The thesis, therefore, is that reform experiences vary from country to country and at different levels and degrees of structural change. While some may involve significant changes in the governance of a country, others reflect gradual processes of change in the planning, implementing, and monitoring and evaluation stages in respective sectors.

CHAPTER FOUR

THEORETICAL PERSPECTIVES FOR THE STUDY

4.1 Introduction

This chapter is a product of the previous two chapters and it constitutes a very important part of the study. It attempts to construct the theoretical framework for the thesis in order to make the study stand on the appropriate theoretical tripod. The discussions in this chapter are more relevant in the sense that they provide a clearer story, linking the tenets of theoretical orientations underlying this study, the methodology and the data gathered for this study. Besides, it provides the opportunity for exploring the integration of theories of different contexts, particularly the public, non-profit, voluntary and social services sectors.

The chapter begins by discussing the various theories that have shaped research into inter-organisational actions, giving an array of how some of these theories have affected organisational learning in cross-sector partnerships. It also discusses the institutional theories and the neo-institutionalism movements. The latter parts of the chapter are dedicated to expositions on stakeholder theory, resource dependency theory and transaction cost theory, as determinants of collaborative actions in the public sector. It concludes by adopting a conceptual framework for interrogating the issues that emerged from the data gathered since 'there is nothing more practical than a good theory' (Lewin, 1952, p. 169).

4.2 Theories of inter-organisational collaboration

Research into partnerships, collaboration, networks or alliances have been largely influenced by diverse theoretical underpinnings. There are several theoretical lenses that make discourses on strategic decision making in organisations that help explain the incentive to form inter-organisational networks and alliances (Gazley & Brudney, 2007). While some focus on the need to minimise cost and maximise benefits by ensuring efficiency, others focus on the need to compete for the scarce resources within the environment that organisations operate. Other theories are also concerned with the necessity of ensuring that organisations that operate in the same sector collaborate to maintain a set of identities. Some of the theoretical stands also argue that partnerships afford partners to learn from each other in order to add value to themselves whereas the situation of constellations drive members to align their interests with each other so as to minimise environmental uncertainty. Finally, other theories also posit that organisations have stakeholders who are mainly owners with diverse interests in the organisation's operations and thus, any decision by the managers of organisations must be in the interest of the stakeholders. This chapter discusses some of these theories that have widely shaped scholarship in partnerships and cross-sector arrangements in the next sections.

It is established in the literature that there exist a continuum of collaboration, which are loose and tight collaborations existing at both ends of the scale. Cross-sector collaboration occurs only at the mid-range of the continuum and any distance further to the extreme ends may see partners hardly relating to each other, especially when sector problems become complex (Bryson *et al.*,

2006). For this reason, it is crucial for partners and would-be partners to assess closely, the relative importance of collaboration as opposed to single-stand orientations.

4.2.1 Institutional theories of organisations

The study of institutions has a very long history that dates back to Selznick's (1948) study of organisations and their social environments. Institutionalism is understood to have emerged as a response to the theory of individualism, where people were more centred on maximising profits and returns on their individual efforts (Ven & Hargrave, 2004). Institutional theories that describe conformist or isomorphic behaviour may explain why some organisations ally with one another. To the institutional theorists, collaboration is viewed as a desirable behaviour and may even be required or expected by influential actors such as the regulators, donors or financiers (Meyer & Rowan, 1977) since it promotes some important attributes that individualistic theories do not offer.

Institutional theories posit that collaborations and partnerships are a desirable outcome of a process. Generally, institutional theories describe conformist and isomorphic behaviours of organisations (Gazley & Brudney, 2007) by perceiving the organisation as operating within a framework of norms, values and assumptions that have been taken for granted to constitute acceptable behaviour. These essential elements define the culture and institutional cognitions of the organisations (L. G. Zucker, 1987). This set of theories is of the view that collaboration is a behaviour that is desired and expected by influential actors like service regulators and donors (Oliver, 1990) and not merely a conscious effort by partners to collaborate for collaboration sake. The theory emphasizes the impact of actors' environments on their individual preferences, decisions and behaviour, by suggesting that patterns of action by individuals and organisation are

shaped by institutions and are not solely the result of instrumental calculations (DiMaggio & Powell, 1983; Meyer & Rowan, 1977). In this regard, the modes of behaviour of participants reflect their need to be regarded as appropriate in their institutional environment (Keshet, 2013).

In the 1980s, institutional theory was largely applied to explain the semblance of organisation's characteristics within its environments through association with factors essential to the functioning and survival of organisations. However, the conceptual paper of DiMaggio & Powell (1983) suggested that rational agents, who seek to change their organisations usually make them increasingly similar to other organisations that are perceived to have realised some success and legitimacy. They describe this process of organisations becoming identical as isomorphism. Isomorphism is a process that causes a constituent of a population to resemble other units in the population that face similar or the same set of environmental conditions (Carpenter & Feroz, 2001). Because of isomorphic pressures, organisations will become increasingly homogeneous within given domains and conform to expectations of the wider institutional environment. DiMaggio and Powel identified two types of isomorphism, which are competitive and institutional. Competitive isomorphism relates primarily to the free and open competitive market forces' situations hence it may not be of interest to this study because the analysis in this research focuses on the public sector and the private not-for-profit sector organisations.

They identified three isomorphic processes that make organisations identical. These are the coercive isomorphism, mimetic isomorphism and normative isomorphism. Coercive isomorphism evolved from political influences and the problem of legitimacy (Dickinson & Glasby, 2010;

Keshet, 2013). Units in the population that are perceived by the others as lacking some 'form of legitimacy' tend to be compelled to abide by the directives of the dominant unit in the population.

There is unceasing demand on non-profit organisations to cooperate with the public sector in their operations since there are so many similarities in their activities. As this pressure continues to mount whiles organisations continue to work together, neo-institutional theorists (for example, Meyer & Rowan, 1977; DiMaggio & Powell, 1983) intimated that they become more and more similar in their structure, output and culture (Scott, 1998; Ramanath, 2007). Neo-institutional theory (NIT) or neo-institutionalism emerged in the late 1970s as a response to views that organisations are rational entities, which respond exclusively to economic pressures for resources (Suddaby, Seidl, & Le, 2013).

Neo-institutional theory is grounded on some central constructs, which assume that organisations are very attentive to social and symbolic pressures arising from their institutional environment (Suddaby, 2013). One key construct is the notion of rational myths (Meyer & Rowan, 1977), which is a widely held but yet to be proven assumption about appropriate behaviour in organisations thought to contribute to effective organisational functioning. Organisations often adopt practices not for performance but legitimacy effects in that they provide the appearance of economic rationality. In contrast to classical economic theory, NIT sees organisations as responding to socially constructed beliefs about what constitutes efficient and effective organisational behaviour. Such rationalized myths of performance are readily adopted and diffused

throughout populations of organisations, regardless of whether they improve performance or not (Zucker, 1987; Tolbert & Zucker, 1983).

Building on the constructs of rational myths and diffusion, DiMaggio & Powell (1983) introduced the concept of isomorphism, noting that, as organisational fields become more structured, organisations within them increasingly converge in structure and processes, thereby becoming more alike in order to guarantee acceptance by their peers. They proposed two types of isomorphism, which are competitive isomorphism and institutional isomorphism. The former is not the focus of this thesis since it addresses issues of free market competition among businesses. The latter, however, focuses on the structural issues of organisations, which constitute the focus of issues that are addressed in this thesis.

Even though organisations face multiple logics that may not necessarily be compatible with each other, institutional logic (Thornton & Ocasio, 2008) is most often considered indispensable. For this reason, most organisations comply with institutional logic in order to gain endorsement from important stakeholders (Greenwood, Raynard, Kodeih, Micelotta, & Lounsbury, 2011). Neo-institutional approaches to the study of NGOs suggest that as more NGOs cooperate with the state, they become isomorphic in their structure and processes whereby such cooperation threaten inventiveness and initiatives of the NGO sector, including its spontaneity, variety, and unpredictability (Ramanath, 2007; Smith & Lipsky,1998).

It is argued that such isomorphic approach (also referred to as institutional isomorphism) emerges because of formal and informal pressures exerted on organisations by other organisations upon which they depend. In addition, cultural expectations dominant in the society within which organisations function also inform its occurrence. However, mimetic isomorphism results from standard responses to uncertainty. Mimetic behaviour emerges as a derivative of ambiguous organisational goals that cloud the organisation's environment with symbolic uncertainty. In these cases, organisations may model their structures and behaviours on those of other organisations. Normative pressure stems primarily from professionalisation, which is the collective struggle of members of an occupation to define the conditions and methods of their work. Normative isomorphism is indicative of the similarities that organisations share following the diffusion of professional ethics, which have been legitimized through standardized education (DiMaggio & Powell, 1983).

Following the works of pioneers such as Meyer, Rowan, Powell and DiMaggio, Scott *et al.* (2000) further developed three mainstays of the institutional imperative: regulative, normative, and cultural-cognitive. Regulative elements emphasize rule setting and sanctioning; normative elements contain an evaluative and obligatory dimension; while cultural/cognitive factors involve shared conceptions and frames through which meaning is understood. Each of these new pillars offered a different rationale for legitimacy either by virtue of being legally sanctioned, morally authorized, or culturally supported. These two key treatments of institutional mechanisms underscored that it is critical to distinguish whether an organisation complies out of expedience,

from a moral obligation, or because its members cannot conceive of alternative ways of acting (Powell, 2007).

The works of early proponents of neo-institutional theory to understanding organisations and collaborations have been supported by many authors. Scott & Thurston (2004) have identified structural power asymmetry between actors in the social context of collaboration for health and it is recommended that public expectations require change in order to help properly develop frameworks for social services partnerships (Beckert, 2010; Selsky & Parker, 2005). However, Beckert (2010) made critical assessment of those earlier propositions and provided an extension to their claims by contributing to a more integrated perspective on institutional development. He demonstrated that mechanisms identified by earlier proponents of institutional theory as sources of isomorphic change can support processes of divergent change as well. His critical views notwithstanding, there still remains a theoretical challenge in relation to identification of conditions under which these new mechanisms add impetus to institutional change toward homogenisation or divergence.

Despite the wide acceptance and adoption of institutional isomorphism in the study of organisational processes and structure, other researchers have found reasons to limit this theory. In a study of NGOs operating in the field of housing in India, Ramanath (2007) found that path-dependency and variations in resource environments of NGOs constrain those organisations from easily becoming isomorphic. He identified path-dependent factors such as organisational commitment to founding values, and entrenchment in tried and tested operational routines. These

constraints are compounded by internal political struggles (between those in favour of a more or less confrontational strategy) and the extent of leadership commitment toward realising goals that are directly related to delivery of work. In addition to these path dependent factors are other constraints that are described as variations in resource environments. Variability in the resource environment of the NGOs, on the other hand, includes employee turnover and the variety of different mechanisms that NGOs deploy to overcome financial constraints in the external social context.

4.2.2 Principal-agency theory

Another important theory that has been aptly applied in cross-sector partnerships is the principal-agency theory. This theory posit that health providers act as agents for their principals, in this case governments, when there exist a contract for the provision of services. Leonard (2002) applied the principal-agency theory to assess the involvement of the non-profit sector in health delivery as a suitable alternative to the state and market forces in the African context. Results from his work show that health sector NGOs differ in great depth from the other two sectors. It was reported that they apply implementable contracts even in the event of non-verifiable outcomes in the treatment of patients. Also, their apparent ability to apply hierarchical control to reward and punish health practitioners adds to the large inventory of value that they jealously protect after building strong reputation over the years. The relevance of this theory, therefore, is that as agents of the government to delivery health services, the health sector NGOs feel obliged to accomplish the goals of their principal after undertaking a contract to do so, even if that calls for sacrificing the interests of other stakeholders outside the principal-agency partnership.

4.2.3 Resource dependency theory

One of the many theories that have been applied to understand inter-organisational relationships is the resource dependency theory. This theory takes its root from the open systems framework, which suggests that all organisations must depend on exchanges with the external environment to generate resources they require for their operations (Bartholomew, 1997; Barringer & Harrison, 2000). Resource dependency theory assumes that an organisation makes active choices to achieve particular objectives and these choices are hinged on the rationality of the decision makers to depend on resources external to the organisation. A major tenet of resource dependency theory is resource scarcity, resulting in multiple organisations competing for the same or similar sets of scarce resources. Its proposition underscores the inability of organisations to generate all the resources needed for their operations hence the need to interact with their environment to complement what they have already gathered. This position is echoed by Aldrich & Pfeffer (1976, p. 83) as follows:

> '…that organisations are not able to internally generate either all the resources or functions required to maintain themselves, and therefore organisations must enter into transactions and relations with elements in the environment that can supply the required resources and services'.

A very important contribution to understanding the rationale for partnerships and collaboration among organisations is offered by Benson (1975) in this theory of resource dependency. This theory argues that collaboration helps organisations to increase their resource base and thereby helping them to decrease competition for the limited resources among the partnering organisations.

Benson outlines two states of organisations which are the equilibrium and non-equilibrium situations. In the former, single organisations are capable of maintaining sufficient supply of material resources and authority without any antagonistic enterprise whereas the latter focuses on the situation where organisations are compelled into stiff competition for resources due to insufficiency. The inference from this analysis is that an organisation's existence is characterised by incessant struggle for survival and control over resources (Ranade & Hudson, 2003) and this is based on the general premise of resource dependency theory, which argues that the social context of organisations matter (Pfeffer & Salancik, 2003). For this reason, partnerships are only plausible where there is the potential for mutual benefit that could reduce the tension between organisations operating in the same industry. This theory further posits that actors in a collaboration process maximise their gains in the sense that their agreement to work together gives very little room for antagonism and needless rivalries that characterise free and open market competitive economies (Pfeffer & Salancik, 1974, 1978).

Pfeffer & Salancik (1978) propose five ways organisations can minimize environmental dependencies and these include: mergers or vertical integration; joint ventures and other inter-organisational relationships; boards of directors; political action; and executive succession. The inter-organisational relationships aspect holds promise for this study. Two critical concepts that guide such arrangements and serve as central pillars of resource dependency theories are perceived need and organisational willingness (Bazzoli *et al*., 1997). Perceived needs may include human and financial resources, organisational capacity or goodwill, and reputation. Alter & Hage (1993) made discussions on a range of dependencies – the need for human and financial resources by a

partner organisation, the need for working capital, the need to manage risks associated with businesses and the need to maintain flexibility to allow adaptation in volatile competitive market economies. These needs emphasise what may drive any organisation to collaborate with the other and they largely influence the willingness of an organisation to collaborate (Bazzoli *et al.*, 1997). The willingness to collaborate is highly influenced by the nature of products and services the organisation produces. From this economic stand point of rational choice, public-private partnership is a form of a collective action, where otherwise independent organisations pull resources in order to achieve common goals (Olson, 1976). These collective actions usually occur when it is obvious that there would be synergistic effect in benefits to the partners in the collaboration.

4.2.4 Transaction cost theory

One of the theoretical perspectives that has shaped the study of cross-sector collaborative arrangements is the transaction cost economics. This theory is originally developed and applied in economics but has received an extensive application in other areas in the social sciences. For instance, Carroll & Teece (1999, p. 3) arguing that transaction cost economics is, 'perhaps the single most influential theory in the social sciences' is a testament to the vast acceptance and application of this theory in the social sciences. Transaction cost theories argue in relation to partnership arrangements that collaboration is a vehicle that increases organisational efficiency by minimising the time, effort and other resources that are usually spent on inter-organisational negotiations (Rugman & Verbeke, 1992).This theory goes further to explain that when assets of a firm are specific and there is uncertainty and volatility in economic indicators in addition to transaction frequency, these factors would symbolize the crucial transaction attributes that would

shape governance structures among collaborative partners (Ebers & Oerlemans, 2013). Examples of transaction costs identified in the literature include costs incurred in contracting, monitoring, enforcement and adaptation to endogenous and exogenous environments. These costs are also associated with embeddedness, which signifies 'the nesting of economic and strategic activity within an institutional environment' (Oliver, 1996: 164).

Ebers & Oerlemans (2013) applied transaction cost theory to examine the different types of hybrid governance structures that exist in dyadic exchanges in the German construction industry. They found that the transacting parties utilize three distinct types of hybrid governance structures beyond market and hierarchy types for governing their transactions. The first is the traditional intermediate hybrids, as described by standard transaction cost theory and two other governance structures that deviate from intermediate hybrids in significant respects. They label them as safeguarded management and selective risk management. These governance labels, though may be relevant to organisational studies such as the one under discussion, only the safeguarded management may hold promise to explain the partnership behaviour of non-profit health providers in this study. Safeguarded management provide a low-cost substitute for formal administrative controls and safeguards, as reputation effects and the possibility of social sanctioning discourage transacting parties from opportunistic behaviour. One critical finding they made is that safeguarded management is more likely to be chosen by an organisation over selective risk management, where trust and uncertainty are lower in the relationship.

4.2.5 Stakeholder theory

Some theoretical explanations for inter-organisational relationships have been adduced by the stakeholder theory, which is mainly an organisational theory with deep-seated moral content (Freeman, 1999; Jones & Wicks, 1999; Phillips, Freeman, & Wicks, 2003). Its tenets are anchored on the fact that organisations are located at the centre of interwoven relations of stakeholders. To this end, organisations have the responsibility to consider the interest of the stakeholders in doing any legitimate business (Freeman, 1985). Organisational decisions, for that matter, must be based on the legitimate claims of its stakeholders. The normative rationale of this theory to inter-organisational relationships is that organisations form alliances or networks in order to align their own interests with those of other stakeholders. By this arrangement, uncertainty and risks in the external environment would be minimised. In analysing how stakeholder theory should be applied, Murdock (2004) argues that an organisation has relationships with many constituent groups known as stakeholders that affect and are affected by its decisions and in this relationship, it is assumed the interest of no particular stakeholder should dominate others.

The normative principle of this theory is anchored on the premise that all stakeholders in an organisation or a network are accorded equity and fairness in any form of organisational transaction (Clarkson, 1995; Donaldson & Preston, 1995). Moreover, the theory posit that the responsibilities of a firm extend beyond the profit motive of its owners to the interests of many groups of people, who are affected by the actions of the organisation and the organisation is also affected by their actions.

4.3 Relevance of these theories to the study

Resource dependency theory and institutional theory are both concerned with the relationship between an organisation and a set of actors in the external environment. Both theories assume choices of an organisation are constrained by multiple external pressures and that organisations are concerned with building legitimacy and acceptance vis-à-vis external stakeholders. The two theories have greater predictive power when applied together (Sherer & Lee, 2002) to explain the relationship between the public health sector organisations and their non-profit counterparts in this study. Resource dependency theory focuses on the organisation's need to access resources from other actors in the environment and describes how resource scarcities compel organisations to pursue new innovations that use alternative resources (see for example, Pfeffer & Salancik 1978; Sherer & Lee 2002).

Institutional theory, on the other hand, describes how an organisation adopts practices that are considered acceptable and legitimate within its organisational field (Scott, 2000). Specifically, the institutional isomorphic dimensions influence the natural behaviours of organisations. Resource dependency maintain that some organisations have more powers than others due to the peculiarities in their interdependence, which may relate to their location, the amount of resources they have or the power of their owners and sponsors. This philosophy is also reflected by the coercive isomorphism of DiMaggio & Powel (1983). Thus, both theories describe how organisations face competitive pressures and may depend on, or be impacted by other actors in the external environment in which they carry out their day-to-day activities.

However, the two theories differ in the explanations offered as to why organisations may be impacted by other actors. While resource dependency theory argues that dependence on other actors is related to need for resources, institutional theory expects that organisations are inclined to imitate the behavioural norms of other actors in the organisation field. It is expected that these theories would be particularly relevant in explaining the interactional behaviour of the partners in this study. First, due to resource constraints, health providers in Ghana are particularly dependent on other actors in the environment for obtaining resources. Second, as these health organisations tend to have many collaborative partners and are more susceptible to knowledge from external actors than their larger counterparts, they are expected to be strongly influenced by the behaviours of surrounding actors. Third, by the normative regulatory framework of MOH, which is the institution that serves as a policy maker and a regulator, these organisations are bound to work in tandem with the guidelines of the public sector health organisations. These environmental forces, inevitably may influence the organisational behaviours and collaborative structure of the partners involved in this study.

The transaction cost economic explanation of governance structures has been challenged on the grounds that it delineates an under-socialized view of economic action that disallows any impact of social relations and the wider social structure (Granovetter, 1985). Although transaction cost[10] and resource dependency theories have been largely criticised for their insufficiency in addressing embedded constraints on strategic choices in institutional environments despite their explanatory

[10] For detailed critique of the transaction cost theory, see McMaster &White (2013)

powers (Oliver, 1997; Guo & Acar, 2005), some aspects of these theories are found to be very useful in providing answers for some of the questions this research sought to answer.

Regarding the stakeholder theory, it is imperative for organisations to align their interests with those of their stakeholders by forming networks or constellations. These constellations are regarded as crucial methods by which efficacy of systems in delivering services can be improved through the stakeholder groups (Aveling & Martin, 2013). The network of mission hospitals could be explained by this theory since they exist in different forms of networks. Some of these would be discussed in chapter six of this dissertation, where results of this study are presented. Stakeholder theory is, therefore, found to be partly useful in achieving some of the objectives of this research.

4.4 Contextual factors associated with choice of collaboration forms

Guo & Acar (2005) identified factors such as resource sufficiency, network effects, institutional factors and other factors that fall outside these three as the main environmental and contextual factors that predict the choice of any form of collaboration. In their analysis using institutional, resource dependency and network perspectives, when two or more partners realise that their collective resources are sufficient to cater for their needs in any collaborative process, they tend not to extend membership of the network to other actors that may be interested in joining except their needs increase in scope. Similarly, the relative contribution of, and dependency on resources of partner organisations inform the nature of collaborative arrangement that would be actualised. Meanwhile, collaborations between formal organisations and identity groups usually lead to the

identity groups being overwhelmed by formal organisations (Yu, 2012). This position could help explain how mission hospitals, identified by their faith, collaborate with public sector health providers, who do not necessarily share in the same faith as the identity groups.

The network effects also have consequences on collaboration typology of partners. For partners, whose association would offer them some opportunities with respect to access to certain critical services and products, the collaboration becomes better institutionalised. Other institutional factors such as the individual capacity of the organisation, physical infrastructure, human resource strength and organisational procedures and processes also have their place in how partners collaborate.

4.5 Conceptual framework for the thesis

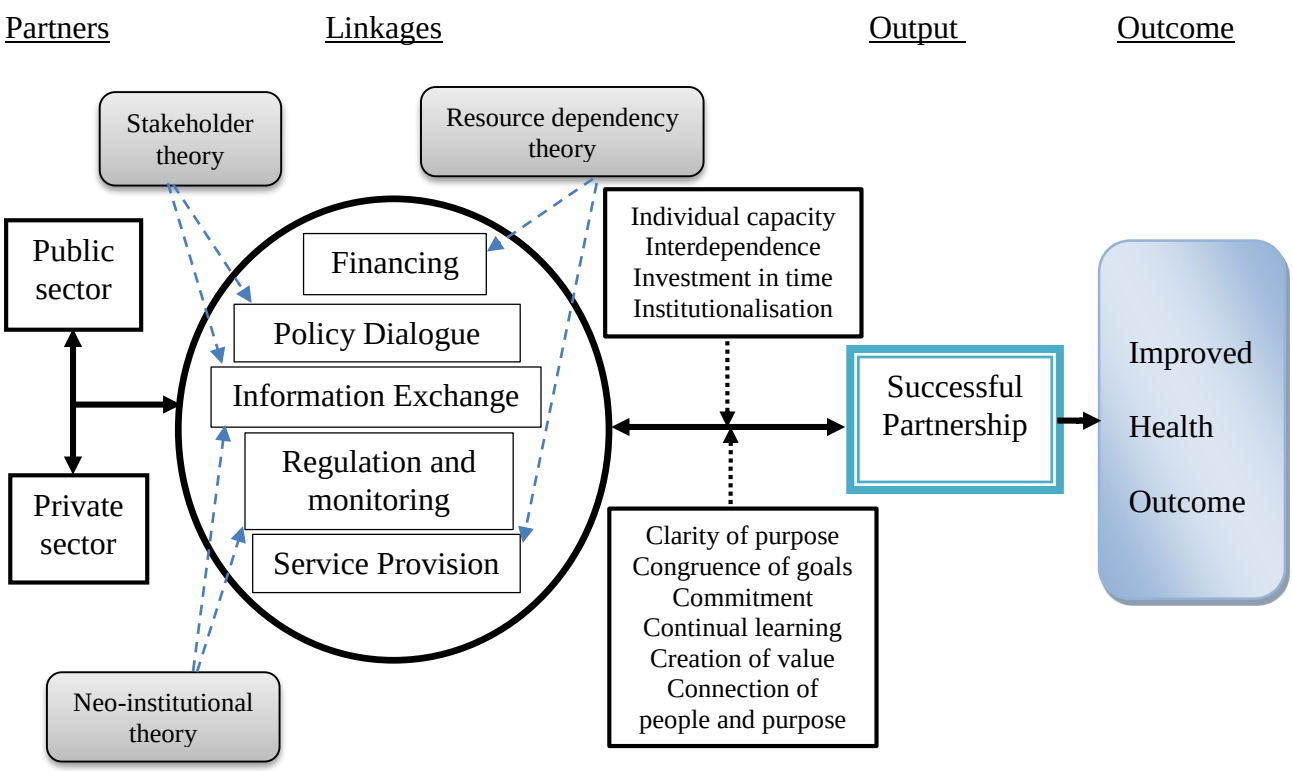
For any research, it is important that a model or a set of theories guide how issues are explained and presented. Specifically, it has been argued that theories should be used to address social or practical problems and practitioners and researchers in the social sciences should make use of available scientific theories (Vansteenkiste & Sheldon, 2006). Given this background, the present study was guided by the conceptual framework that is depicted in figure 4.1 on page 106. This framework is the product of the literature reviews in chapter two and chapter three, which are collectively intertwined with the theories that were discussed earlier in this chapter to serve as an anchor for this study. The theoretical anchor, therefore, is the institutional isomorphism embedded with elements of the transaction cost theory, resource dependency theory, principal-agency and stakeholder theories.

In the model, private and public sector health sector organisations operate within a larger social context. This social context is replete with resources that these organisations compete for. Moreover, there is the need to provide health services to the people using the most efficient, cost-effective methods within the larger policy framework of the Government of Ghana through the Ministry of Health. In order to work closely together, they exchange information, they engage in policy dialogue, they share some common financing arrangements for their operations, they also subject themselves to monitoring and service regulation by the same regulators to provide health services to the community. By jointly participating in these activities that are influenced by the institutional forces described earlier, there is bound to be a successful partnership through isomorphic forces of the environment that shape the joint activities of the partners in this study. The successful partnership between the private and public health sector actors is the central objective that this study seeks to explain in the context of health sector reform of the country. The ultimate aim of the health sector reform is to improve the health status of the population. As a process item, the successful partnership then leads to realisation of improved health status, which is the ultimate rationale for the health sector reform.

The successful partnership, however, can be largely determined if these actors invest their time in the joint operations, and depend on each other's respective strengths and capacities within a formally instituted partnership arrangement. Moreover, the purpose of the partnership should be clear and the goals of both partners must be shared in that there is goal congruence. In addition, there should be the inherent commitment on both partners towards achieving those goals through a continual learning process. Above all, the purpose of the organisations must connect with the

people within them since they would serve as agents that would be very instrumental in achieving those goals to provide a wider public value. The public value created through this partnership would be largely determined by the community that the partnership sets out to provide services for. The ultimate outcome of the successful partnership should be the improvement in the health status of the people but before that could fully materialise, the successful partnership influences how the collaborative arrangements would interact among the partners.

Figure 4.1. A conceptual framework for explaining partnership between public and private health sector actors



Source: Constructed by author from literature review (2014).

4.5.1 Conceptual definition of items in the framework

The conceptual framework in figure 4.1 depict five elements that were used to examine the partnership working of public and private health organisations in Ghana. For each element, different theoretical explanations affect how the elements are actualised in practice with respect to the engagements of the organisations engaged in the collaboration. In addition, other elements that serve as pre-requisites for successful partnerships were applied to understand the relationship under study. It is important to note that these elements are not mutually exclusive in explaining partnership working. The next sub-sections are dedicated to the conceptual definitions of these terms in the framework.

4.5.1.1 Service provision

Service provision is conceptually defined as the act of delivering health services and sanitation to the people in a defined geographical area. These services may either be for curative or preventive purposes and delivered in hospitals and clinics (Musgrove, 1996). Service provision here focuses on the direct delivery of patient care to patients in hospitals and clinics as well as other public health actions such as mass vaccination and immunisation activities in the communities (Musgrove, 1996; Harding, 2003; Taylor, 2003). They also include health education and school health programmes that seek to minimise the risk of illnesses and diseases.

4.5.1.2 Information exchange

Information describes easily codifiable knowledge that can be transferred from one person or entity to the other without diluting or compromising its integrity (Guenter, van Emmerik, & Schreurs, 2014). Health information exchange, however, has been defined as the process of sharing patient-

level health information, whether manual or electronic, between different organisations (Vest & Gamm, 2010). The process of sharing information through face-to-face conversations such as meetings, conferences, seminars and workshops indicate to some extent, the information exchange between the partners in the study. Beyond the above, information exchange involves correspondences between organisations in this partnership including letters, memos, emails and other documents. Also, the exchange of clinical records and health statistics using electronic or hardcopy media reflect the level of the partners' involvement in information sharing. Normatively, information exchange includes the sharing of documents and ideas between two or more organisations or their constituents and it must be a mutual interchange.

4.5.1.3 Service regulation, monitoring and supervision

Regulation involves the processes of applying coercion by state institutions to alter the behaviour of service actors in the health system (Roberts, Hsiao, Berman, & Reich, 2008). These actors include both the private and public sector organisations. It involves the enforcement of guidelines with respect to capacity of service providers to maintain and improve the quality of services and contain cost (Harding, 2003). In addition to the primary objectives that it serves, service regulation is used to pursue a much broader set of objectives such as reducing inequality and disparities in geographic or economic access to health services, improve technical and allocative efficiency and reduce waste and corruption. Monitoring and supervision deal with the periodic inspection of the processes of the partnership to ensure that the actual activities correspond with the procedures established in the beginning. It also focusses whether the implementation protocol is in the direction to realizing the intended objectives. Monitoring, supervision and regulation also facilitate

cost containment by contributing to the financial sustainability of the health system in totality (Harding, 2003; Musgrove, 1996).

4.5.1.4 Financing

Health financing involves all arrangements by state institutions and the private sectors towards the provision of funding for all activities that go in planning, organisation and delivery of health services in a country. As one of the essential components of a health system (WHO, 2007), health financing is very important to the success of any health system. Financing mechanisms for health include out-of-pocket user fees, waivers, health equity funds, prepayment in the form of insurance premiums (Witter, 2012), government funding through taxation and donations from other benefactors outside government (Green, 2007).

4.5.1.5 Policy dialogue

The existence and functioning of an ongoing consultative mechanism between the private and public sectors have been documented as crucial for successful implementation of partnership arrangements that are geared towards successful partnerships. The development and implementation of policies to support private sector participation in health require discussion and cooperation between the government and the relevant private sector stakeholders (Chakraborty & Harding, 2003). Policy dialogue involves the constant, ongoing interaction between the public and private health sector players to shape policies for the health sector. It reflects an ongoing, transparent communication between government officials involved in health policy and private health care providers (Harding, 2003). It was reported by Taylor (2003) that in the health sectors

of many developing countries, however, there are often no forum for dialogue between the public sector, especially policymakers, and private health service providers.

4.5.1.6 Successful partnership

For any partnership to be considered successful, some key elements must be evident. Normatively, Austin (2000) cited in Reich (2002) provides the seven Cs[11] as indicators of successful partnerships. Kanter (1994), earlier, proposed '8Is'[12] as the determinants of success partnerships. Also, Hudson & Hardy (2002) posit that a successful partnership must be measured against six key principles, which are acknowledgement of the need for partnership; clarity and realism of purpose; commitment and ownership; development and maintenance of trust; establishment of clear and robust partnership arrangements; and monitoring, review and organisational learning. Successful partnership in this thesis refers to a combination of seven Cs and 8Is in a collaborative arrangement to engender improved health status of the people. Partnerships become successful, when the intended outcomes established by the partners at the beginning of the partnership relationship are realised, and it is regarded unsuccessful, when the stated objectives deviate significantly from the outcomes of the relationship.

4.5.1.7 Improved health status

Improvement in health implies improved health status of the general population. Several indicators exist to measure improved health status across countries. Some notable ones include

[11] Detailed discussion on seven Cs is provided in chapter two under section 2.11.
[12] I have discussed 8Is in section 2.11 of chapter 2 of this thesis.

life expectancy at birth and the mortality and morbidity statistics of women and children. Improved health status in this thesis implies general improvements in these health indicators, which are generally occasioned by larger investments in health since health improvements signify increased consumption of health services (Berman, 1995).

4.5.1.8 Other elements in the model

Capacity of an organisation in this study refers to the individual health facility's skill-mix of personnel, work procedures, ability to raise funds, vision and strategy, work ethics, organisational culture, material resources and other intangible assets (Kaplan, 2000). Interdependence relates to the establishment of joint, cooperative activities with other organisations (Aiken & Hage, 1968). Institutionalisation refers to the processes by which societal expectations of appropriate organisational action influence the structuring and behaviour of organisations in particular ways (Dacin, 1997; Meyer & Rowan, 1977; Scott & Meyer, 1994; Zucker, 1987). This process involves the institutional standpoint of the health organisations concerned regarding the collaborative actions as expected by forces within the environment that are external to the organisation. It focuses on the formalised structures that constitutes the organisation's identity (Kanter, 1994). The other elements involve clarity of purpose of the partnership, which implies that the objectives that the partners decide to achieve in the collaborative process must be explicitly clear to both. Also, the individual goals of the partners must find points of interconnection, both partners must be committed to learning from the partnership on continuous basis to create public value (Reich, 2002). Above all, the workers in both organisations must identify with the purpose for the collaboration in order for the objectives to materialise.

4.6 Summary

Scientific research such as the one involving a doctoral studies is assumed to be founded on theoretical trivet. The premise that theory informs research has been widely documented in literature. This chapter provides expositions on the many theories that have shaped organisational studies relating to partnerships and collaboration in recent history. It provides descriptions on the theories and some empirical works they have been applied to. Given this context, their relative importance to this study have been explained and the interconnections of the relevant aspects have also been presented. As a result, a conceptual framework was developed, which served as a guiding frame for how issues were interrogated in this research process. To this end, this study adopts a theoretical triangulation approach, where aspects of resource dependency, stakeholder and neo-institutional theories collectively explain the collaborative behaviour of private and public sector health organisations in the Volta Region of Ghana. The next chapter presents the methodology of the thesis. It naturally follows from this chapter by linking the theoretical anchor with the objectives and research questions that shaped the study.

CHAPTER FIVE

RESEARCH METHODOLOGY

5.1 Introduction

This chapter presents the methodology of the thesis. It provides intellectual discourses on the knowledge claims within which the research is based and the research protocols associated with them. It also focuses on the study areas, the scope of the research project and the methods employed in carrying out the entire research project. Specifically, the chapter discusses the data collection process, data management and analysis approach, the roles of the researcher and the processes that were followed in ensuring ethical clearance. Having provided the above without the study limitations would take away from the quality of the thesis. For this reason, the practical challenges encountered in the study coupled with methodological weaknesses were also addressed in this chapter. The chapter concludes with a summary of the key issues that were discussed with a direction to the main issues in the next chapter, which presents the results of this study.

5.2 Epistemological orientation of the study

There are several ways of knowing what ought to be known within the philosophical framework of science. These are sometimes referred to as research paradigms (Lincoln & Guba, 2000) or philosophical assumptions, epistemologies and ontologies (Crotty, 1998). Not too long ago, (Neuman, 2000) generally classified them as research methodologies. Some of these knowledge claims include positivism, post-positivism, pragmatism, constructivism, advocacy (Creswell, 2003), interpretivism (Tuli, 2010) and post-modernism (Thomas, 1993). Each of these alternative knowledge claims have their strengths which make them very relevant in specific contexts. Their

importance may be mainly based on the kind of research questions that answers are being sought for, the main objectives that a particular study is seeking to achieve or the type of research participants involved in the study. In addition to these are the nature of the research being carried out with respect to the theories of knowledge embedded in the assumptions, the plan of actions that links methods to outcomes, and the techniques and procedures that would help achieve the objectives of the study (Crotty, 1998). Given these factors in relation to this research, the interpretivist philosophy of science was considered apposite for this study.

The interpretivist research paradigm emerged as a critique to positivist and post-positivist approaches in social science research. Despite the dominance of positivism research paradigm in social science research, it is described by some researchers as the fading approach (Guba, 1990; Ritzer, 1991). Interpretivism is an approach that relies comprehensively on naturalistic methods of gathering data such as interviewing, observation and analysis of existing texts. These methods facilitate the process of ensuring satisfactory dialogue between the researcher and those with whom he/she interacts in order to collaboratively construct a meaningful reality (Bhaskar, 1979; Blaikie, 2004).

5.3 Choice of strategy and research design

The terms methodology, method and research design are often associated with any scientific study. They are often times used interchangeably because they are actually associated with how research objectives are achieved or how research questions get answered. That notwithstanding, researchers have shown emic and epic distinctions between them (see for example, Bogdan &

Taylor, 1975; Creswell, 1998; Silverman, 2013). They contend that methodology relates to the theoretical and philosophical underpinnings of a research work whiles methods focus on the procedures and techniques applied in the collection and analysis of data. Research design, on the other hand, covers the interlocking capacity of methodology and methods. In this regard, the linkages between research questions, study objectives, theory, data and the use of data is the domain of research design. Nonetheless, research design has been used extensively by researchers to describe the entire process of carrying out a research from the initial steps of conceptualising research problems through to writing the final reports. This implies that research design goes beyond the processes of data collection, data analysis and report writing.

According to Guba (1990), the choice of research methodology should be a product of ontology and epistemology because methodology is evolved in awareness of what the researcher considers knowable or potentially knowable in a particular discipline. In that case, what is researchable or is unresolvable by practice alone should emanate from an awareness of the nature of the relationship between the researcher and the knowable phenomenon or event. Over time, two main research paradigms have emerged in the scientific world of scholarship. These are the quantitative and qualitative research protocols. The quantitative conformists articulate assumptions that are consistent with what is normally referred to as positivist research paradigm and they believe that social observations should be treated as entities in much the same way that physical scientists treat physical phenomena. This class of researchers assume the world of rationality, universality, reason and the 'scientific method' (Creswell, 1998, p. 255) to understanding social phenomena. They contend that empirical facts exist apart from personal ideas or thoughts and are governed by laws

of cause and effect. To them, patterns of social reality are stable and knowledge of them is additive hence researchers must follow conscientiously, these patterns (Crotty, 1998; Healy & Perry, 2000; Neuman, 2003; Tuli, 2010).

To the contrary, the qualitative purists, also called interpretivists or constructivists, by rejecting the positivist assumption, contended that reality is subjective, multiple and socially constructed by its participants (Bryman, 1984; Corbin & Strauss, 2008; Krauss, 2005; Lincoln & Guba, 2000; Marshall & Rossman, 2011) hence there is the need to apply a more socially constructed method of understanding that reality. According to the latter paradigm, the nature of inquiry is interpretive and the purpose of inquiry is to understand a particular phenomenon, not to generalize to a population (Farzanfar, 2005). Researchers within the interpretivist paradigm are naturalistic since they relate to real-world situations as they unfold naturally. More specifically, they tend to be non-manipulative, unobtrusive and non-controlling in the natural settings. By doing so, qualitative researchers choose to allow the questions to emerge and change as one becomes familiar with the study content and setting (Krauss, 2005). Since this study is about understanding the process and experience of collaboration between government-owned health facilities and private-not-for profit health organisations in detail (Bazeley, 2011), the qualitative research protocol is considered appropriate as it helps to build a complex and holistic picture of events or phenomena. It analyses words and reports the detailed perspectives of the research participants in their natural setting (Creswell, 1998). A further support to qualitative research protocol has been advanced by (Daymon & Holloway, 2002) that it enables researchers to:

> '…explore people's intentions, motivations and subjective experiences. They appreciate that people do things based on the meanings they hold, which they attribute to their actions and actions of others' (p. 4).

Given the above specific attributes of qualitative studies, Creswell (1998) disaggregated qualitative research protocol into five generic traditions, which have received a wide acceptance among researchers and distinguished in history of qualitative studies. These are biography, phenomenology, grounded theory, ethnography and case study designs. This study adopts the case study design in the sense that it identifies a specific case for the study, it is bound by time and space, it also employs multiple sources of data collections and a considerable amount of time is dedicated to describing the context and the setting of the case (Creswell, 1998). Case study design was chosen also because it is the technique that affords the researcher to explore the processes, the activities and events (Creswell, 2003; Daymon & Holloway, 2002) that are inherent in the partnership and collaborative enterprise of the public sector and private sector actors for health delivery in the Volta Region of Ghana. The partnership experience investigated in this study is limited to the period after the passage of the Ghana Health Service and Teaching Hospitals Act, 1996 (Act 525), that is from 1996 to the year 2013. This is more important because it is the legal instrument that provides the agency status of the network of private not-for-profit organisations (CHAG) and the government-owned health facilities (GHS) separately. Also, the Memorandum of Understanding (MOU) between MOH and CHAG was signed in 1996. The period thereafter would be important to interrogate the relationships that exist between the two partners.

Generally, case study is the preferred strategy when a contemporary phenomenon is being investigated. Public-private sector collaboration, especially with respect to policy issues in developing countries and for that matter in Ghana is a contemporary phenomenon, as it has become more important now than ever, following the emergence of Ghana's Health Sector Reform programme and the recently adopted National Policy on Public-Private Partnerships by the Government of Ghana. The study is, therefore, about investigating a contemporary phenomenon in a real life context. The extent of government commitment, community involvement and participation of non-governmental health organisations towards achieving improved health status of a population is explored in the study.

It is worth stating that all methods of social science research have their distinctive weaknesses and limitations. To opt, therefore, for a case study approach is not intended to deny the value of other ways of collecting evidence, analysing data and reporting research results. Other research strategies such as biography, phenomenology, grounded theory, ethnomethodology or ethnography may be applicable, or more appropriate in given situations. Besides, case study is the appropriate strategy when a researcher is dealing with events over which he has very little or no control (Yin, 2002). The choice of the case-oriented strategy is thus related to the nature of the event under study. Public-private sector collaboration, especially in the region selected for this study is an event over which the researcher has no control. In this case, the relevant behaviours of participants in the study cannot be manipulated. Public-private participation in health delivery through collaboration in the districts across the region has been studied in its natural setting with

no manipulation of the natural setting on the part of the researcher. This, in effect, provides some internal validity for the study[13].

5.3.1 Selection of case(s) and unit of analysis

As noted earlier, case study design is an exploration of bounded system by time, setting or place, which defines the case being studied. One of the critical decisions in qualitative case study design is the selection of case(s) and its/their definition. A case may connote several things but it generally refers to an event or an object of study, a whole national society or geographical region or community (Hammersley, 2004; Stake, 1995). It may also refer to a programme or process that is observed at a given point in time or over a period of time, place or a context (Creswell, 2003; Miles & Huberman, 1994; Yin, 2002). As a note of caution to researchers, Stake (1995) puts forth that for intrinsic case studies, cases are not usually selected but they present themselves. In this regard, such cases are less useful in providing understanding of events and phenomena or building and explaining theory. On the other hand, embedded and collective case(s) are usually selected to provide empirical evidence in evaluating or explaining a phenomenon, in that the case(s) selected will represent a population of cases.

The unit of analysis is a critical factor in any qualitative case study and a crucial determinant in the choice of an appropriate unit of analysis is the decision on what unit the researcher is interested

[13] Further discussions on the internal validity of this study in discussed in section 5.6 under data management and analysis.

in studying. Thus, meaningful and reasonable conclusions can be made about the unit at the end of the research process. In this study, Volta Region was selected as the case from the population of ten administrative regions that have experienced some form of partnership or inter-sector collaboration for health in the context of Ghana's health sector reform. The Volta Region has twenty-five administrative districts representing 25 district health management teams. The region, thus, is the principal unit of analysis in this study. It is worth mentioning that until 2012, there were eighteen districts. Some of the seven-newly created districts actually do not have properly constituted District Health Directorates at the time of data collection for this study. In the whole region, there are ten mission hospitals in eight districts. The decision to select six was to reflect the topographic belts and vegetation zones of the region. There have been various forms of collaboration or partnerships for health in Ghana since the country's colonial historical era. More importantly, partnerships have been in practice in diverse forms and dimensions, and with different motives. However, the partnership of government with non-profit health facilities in the region, using the six districts selected for this study have been considered as the sub-units for analysis. The two units of analysis, however, are not mutually exclusive as this is demonstrated throughout the dissertation in subsequent discussions. The reasons for this decision have been explained throughout this dissertation (see for example, chapter 1 for details).

The decision to study the partnership of government health facilities with non-profit health providers in the region from a population of other non-state health providers has been justified in chapter one. However, the next sections would provide some overview of the case study region and the rationale for its choice over other regions in the country. In addition, the reasons for

selecting the corresponding districts over other districts in the region for the study are also explained.

5.4 Study area

The study was conducted in six districts of the Volta Region of Ghana, which is one of the ten administrative regions located at the eastern part of the country. The region is bound to the north by the Northern Region, to the south by the Gulf of Guinea and the Greater Accra Region, to the west by the Volta River, Brong-Ahafo and the Eastern Regions, and to the east by the Republic of Togo. Figure 5.1 delineates these boundaries. The region occupies a surface area of about approximately 20,570 square kilometres. The population of the region based on the national population and housing census in 2010 is 2,118,252 with an average annual growth rate of 1.9% (Ghana Statistical Service, 2012). However, the population growth rate varies in extent across the various districts. There are twenty-five administrative districts in the region as at the time of this study. The largest populated district is the Ho Municipality and the least populated district is South Dayi (ibid).

The selection of Volta Region as a case study is based on several factors. First, it is one of the three regions in Ghana that has the largest number of private not-for-profit health facilities alongside the Ashanti and Brong-Ahafo Regions. Second, the topographic belts and vegetation zones of the region reflect the three main vegetation zones of Ghana. This would make it relatively appropriate to generalise the study findings for Ghana. Finally, the study location was chosen because of the researcher's relative familiarity with the region, which made access to the region

for data collection relatively flexible in terms of advantages associated with linguistic determinism.

Topographically, the region is divided into three natural geographical belts namely the southern, middle and the northern belts. The middle and northern belts are mainly mountainous, spotting the highest mountain in Ghana, Mount Afadzato located in the Hohoe Municipality and other scenic attractions of tourist value. The south is relatively flat with wetlands and sandy portions. Vegetation in the region is strapped up into three zones, which are savannah grassland along the coast, semi-deciduous forest in the middle zone and the semi-savannah woodland in the northern zone (Volta Regional Health Directorate, 2012).

In terms of industrial development, the region is less endowed with manufacturing industry with few most important ones like the Diamond Cement Factory in the Ketu South Municipality and the textile factory at Juapong in the North Tongu district with its state of existence being continuously threatened by the competition from the presence of cheap and smuggled clothes on the market. The region also hosts the Aveyime Farms, which are engaged in commercial production and processing of rice for export and domestic consumption. The middle belt of the region, mainly parts of Hohoe and Kpando municipalities, has witnessed the growing activities of fruits farming for export in recent times and this has contributed to the establishment of a fruit juice factory (Kingdom Fruits) at Tafi Abuife in the Hohoe municipality. Also, some communities in the southern and middle zones are involved in some forms of pottery activities and vegetable farming for commercial purposes.

Communication development in the region is progressing steadily but at a very slow pace. Public telephone-link between the regional capital and other district/municipal capitals has not been fully completed. With the introduction of mobile phone services on the Ghanaian market, the problems of communication have been considerably minimised because most of the districts/municipalities and majority of the sub-districts in the region can now be reached via telephone. Road links between the major towns have considerably improved mainly in the southern and middle belts of the region. The situation is, however, not improving in the northern parts of the region. Of the total network length of feeder roads in the region by condition mix, 15.6% are in a good state, 43.9% are in a fairly good condition whilst the remaining 40.5% of the Region's feeder roads are in a very poor state (Department of Feeder Roads, 2010).

With respect to health facilities, the region has a total of 326 health institutions of which 242 are GHS-administered ones. Eighteen of them are owned by Christian religious organisations. One facility is quasi-government (that is the military hospital) at the Medium Mortar Regiment in Ho, and 65 are purely private-for-profit health organisations (Volta Regional Health Directorate, 2012). It is worth noting that many of the GHS-run health centres were community-initiated, which is a further testament to the private sector participation in health services in the region. With the exception of Krachi-East, Nkwanta-North, Ho-West, Akatsi-North and Adaklu-Anyigbe, which are some of the recently-created districts, every district has a hospital that is either owned by government or the missions. The focus of this study, however, is limited to districts that have mission hospitals because of the research objectives outlined in chapter one. In terms of regional demarcation according to health facilities, the region is divided into north and south. The north is

made up of the northern topographical belt and parts of the middle topographical belt. The south is comprised of the southern topographical belt and parts of the middle topographical belt. By this classification, six of the ten mission hospitals are located within the southern zone while the rest are in the northern zone. Four of the six districts in the study were in the southern zone, depicting a proportional representation of the facilities in the region.

5.4.1 Selection of districts for the study

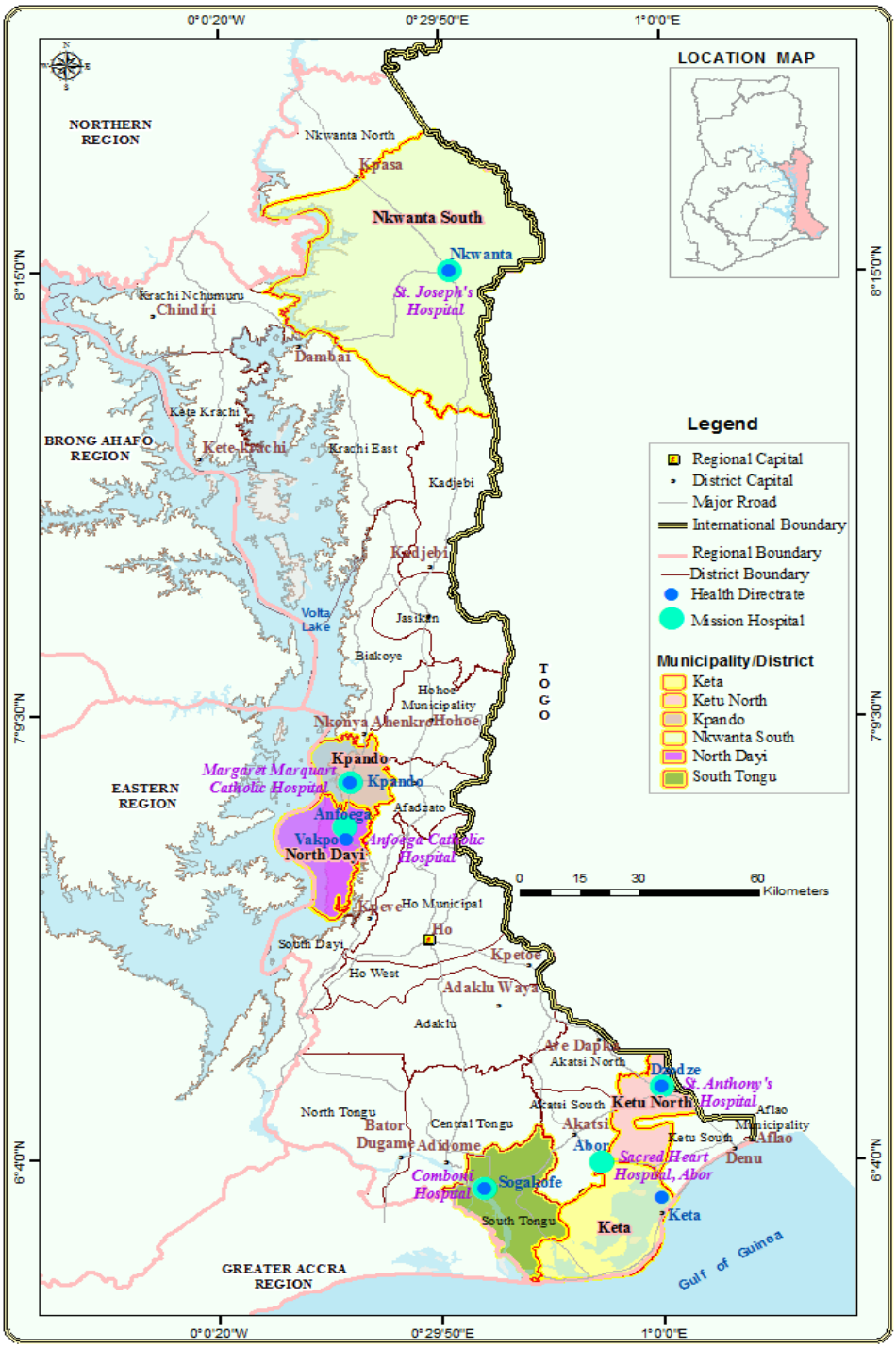
A crucial decision in case study research is the selection of case(s) to study. In doing so in this study, the researcher first made a list of all the private not-for-profit hospitals in the region and their respective districts. Ten hospitals made the list but these facilities are located within eight districts of the region. The choice, therefore, of the six districts was purposive based on their unique characteristics that reflect the divergence of inter-organisational relationships in the region. Three of the districts do not have any government-owned hospitals but only mission hospitals that serve as *de facto* district hospitals. The other three districts have essentially, government-owned district hospitals as well as mission hospitals each. The selection of these districts was made in order to allow the researcher to observe the relative differences in interactions with the district health directorates of the respective districts. In addition, the facilities were also chosen to reflect the three vegetation zones of the region as well as the three topographic belts that cut across the region. At least, a hospital was selected proportionately from each zone as shown in figure 5.1. Details of these data sources with respect to interviews and documents for analysis are described in tables 5.1 and 5.2 on pages 129 and 130 respectively.

Beyond the representative justification for the selection of the districts is the theoretical rationalisation, which is the choice of 'critical case' sample (Flyvbjerg, 2006, p. 230-231) that mirrors pragmatism and serendipity. That is, the contextual conditions in the selected cases differ considerably in ways that following the theoretical and empirical literature cited in earlier chapters, might result in divergent consequences, when an 'intervention' such as partnership-working is implemented. This theoretical justification would be well positioned to identifying the 'deeper causes' (Flyvbjerg, 2006, p. 229) behind the form(s) that partnerships-in-practice take, including whether and how contextual differences affect the potential health benefits of partnerships for the partner organisations and the community that the health services are being provided for.

5.4.2 Pilot study

In order to sharpen the definition of the research problem and the associated research questions, a pilot study was conducted in two districts. One in the Greater Accra Region and the other in the Volta Region. In the pilot study, ten interviews were conducted in a group of professionals homogenous to those planned to be involved in the study. All the interviews were carried out by the researcher. One of the aims of this study was to ensure that the data collection instruments would help in collecting the appropriate data to assist in answering the research questions, hence the necessity to pre-test the interview guide. This process also helped in estimating the average length of time the data collection period would actually take. The pilot study also assisted the researcher to revise some of the questions that did not convey the message that they intended to elicit from the respondents. In all, the pilot study covered a period of three months (September to December 2012). This was done alongside a supplementary review of extant literature and discussion of the research with experts and professionals in the field.

Figure 5.1. Map of Volta Region showing the districts covered in the study



Source: Author (2014)

5.5 Data sources and methods of collection

This is a qualitative study using data from multiple sources to allow empirical investigation into the research questions and answer the what, how and why types of questions (Saunders, Lewis, & Thornhill, 2009; Yin, 2002). Semi-structured individual in-depth interviews through purposive selection of health workers[14], who have been involved in the mainstream work of health delivery through collaborative arrangements in the region were carried out. Each participant was interviewed at least once whiles some were engaged in multiple sessions of interviews. The largest number of interview sessions per participant was four, depending on the depth of data gathered and the necessity to seek further clarification since theoretical sampling formed the bedrock of analysis in this research. Also, some relatively large part of the data was collected from the reports and other text documents of the institutions that were studied.

5.5.1 In-depth interviews

One of the methods, which has been widely accepted in the scientific world, and used for gathering the relevant data for this study was in-depth interview. In-depth interviewing is a qualitative research technique that involves conducting intensive one-on-one conversations with a small number of respondents to explore their perspectives on a particular idea, programme or situation (Kvale, 1996; Boyce & Neale, 2006). This technique is very useful, when the researcher wants detailed information about a person's thoughts and behaviours or wants to explore new issues in more depth. Besides, interviews are often used to provide context to other data, such as data

[14] For the details of the categories of health workers involved in the study, please refer to Appendix C.

collected using survey techniques to offer a more complete picture of what happened in any specific programme or project. It also helps to explain why a particular phenomenon occurs. Fontana & Frey (2003) describe interviewing as 'one of the most common and powerful ways in which we try to understand our fellow human being' (pp. 61-62). In this study, the interview technique that dominated the research process is the elite interviewing. In this technique, 'elite individuals that are considered to be the influential, the prominent, and the well-informed people in an organisation… are selected for interviews on the basis of their experience in areas relevant to the research' (Marshall & Rossman, 1995, p. 83). The officials that were selected for the interview in this case were considered 'elites' because they are better positioned to provide answers to the questions and clarify some of the critical issues that were under investigation. Moreover, in their official capacities, they are more engaged in any form of collaboration between the two sets of organisations that are involved in the partnership arrangement in the region.

The individual interviews were conducted by the researcher and two experienced research assistants, one of them serving as the moderator whiles the other as a recorder. A digital recorder was used to record all responses except for two participants, who declined to be recorded. However, field notes were taken during all interviews and this made up for the two interviewees that declined to be recorded. The duration of the interviews varied from one participant to the other. Whiles the shortest interview lasted thirty-seven minutes, that of the longest duration took one hour, twenty-seven minutes to complete. In addition to in-depth one-on-one interviews, the researcher was involved in observations in the work settings of some of the partners and sat through one meeting session involving DHMT and some other private partners. These methods were

complemented with informal discussions with people, who in the views of the researcher, have some insight into the phenomenon that is being studied. Table 5.1 summarised the details of interviewees in the study. For ethical reasons, the names of the districts and the institutions involved in the study were assigned code names in the presentation of results and subsequently throughout the study.

Table 5.1 Summary of interviewees in the study

District/Municipality	Public	Private	Total
Kpando	3	3	6
Ketu North	4	5	9
Keta	3	3	6
South Tongu	4	3	7
North Dayi	2	3	5
Nkwanta South	2	2	4
Other institutions:			
CHAG HQ.		1	1
GHS HQ.	1		1
Total			**39**

Source: Author's compilation from data collection (2014)

5.5.2 Documentary data collection

Among the very important data collection methods that are usually used in typical qualitative research protocol is document analysis. Silverman (2013) argues that texts and documents are very useful sources of data for qualitative and quantitative research works. In this study, several documents were also collected from the various institutions that form the actors in this research. Some of the documents include the annual reports of the District Health Management Teams of the affected districts, the Ministry of Health's five-year and annual Programmes of Work, annual reports of the participating hospitals and CHAG, the network of private not-for-profit hospitals

owned by Christian religious organisations in Ghana. Others include the Memoranda of Understanding between the Ministry of Health and CHAG, minutes of management meetings of the hospitals and the DHMTs and despatches exchanged between these organisations in the study. Table 5.2 gives a summary of documents that were gathered for analysis in this study.

Table 5.2. Summary of documents that were gathered for the study

Type of documents selected	Number of selected papers
Ministry of Health POW (five-year and annual)	11
Annual reports of DHDs and MHDs	15
Annual reports of CHAG facilities	17
Memoranda of Understanding	2
Minutes of management meetings (both DHDs and CHAG facilities)	18
Total	**63**

Source: Author's compilation from data collection (2014)

5.6 Data management and analysis

There are several data analysis techniques available to researchers in the social sciences. Although Silverman (2003) admonishes that researchers should refrain from using text-based materials as proxies for other forms of evidence, all the data obtained through interviews were transcribed into texts for analysis because they are both linguistically-mediated data. The transcription forms the first stage of data processing, which produced the processed data from the raw data (spoken words) of the interview partners. Moreover, given the qualitative nature of this study, the researcher was restricted to the analytical approaches for qualitative enquiry. One of them is thematic content analysis (Boyatzis, 1998; Braun & Clarke, 2006), which was used to identify key themes that

emerged from the data gathered for the study. Thematic analysis is widely used to identify, analyse and report patterns or themes within qualitative data, in order to detect repeated patterns of action and meaning. This analysis was conducted by reading through field notes, transcripts and articles to develop a set of codes through memos according to which the structure of the data was organised. General themes emerged after an initial 'survey' of the data set but later sub-themes developed after deeper understanding of the texts (Miles & Huberman, 1994). Thereafter, the researcher went back to some of the research participants to confirm some of the preliminary issues that emerged and filled in the gaps that were also created.

In some cases, theoretical sampling was applied in collecting and analysing some of the data. It is a technique, where concepts are derived from data. This technique enables researchers to discover relevant concepts to a problem and the population and paves way for further exploration of the concepts in-depth. In this technique, 'the researcher takes one step at a time with data gathering, followed by analysis, followed by more data gathering until a category reaches the point of saturation' (Corbin & Strauss, 2008, p. 146). As noted earlier, case study designs are appropriate for subjects that are relatively unknown to the researcher or for issues that the researcher has very little or no control. Similarly, theoretical sampling allows for discovery in studying uncharted or new areas of research.

Coding is the lifeblood of whole-text analysis of any kind and it involves preliminary analysis of data (Bazeley, 2011). It compels 'the researcher to make judgements and meanings of contiguous blocks of texts' (Ryan & Bernard, 2003). Codes were applied to common words and phrases and

subsequently sorted in order to condense the data. The analysis involved moving back and forth within the entire data set and the coded extracts of data. The codes were then arranged according to higher level categories or themes and analysed to identify relationships between themes. That is, from descriptive codes to inferential codes (Miles & Huberman, 1994). In the words of Miles & Huberman (1994, p. 56), 'coding is analysis' and it involves data reduction. For the purpose of this thesis, the researcher concentrated on codes that articulate the actions of the officials of participating organisations in the study as well as the inferences made from the annual reports and other documents that reflect the objectives of the study and would help find answers to the research questions stated in chapter one. It is important to emphasise that the coding process in this study was a very useful means to an end, the conclusions drawn from this study that are largely articulated in chapter eight of this dissertation.

The data analysis involves asking questions of the data and thinking of ways of answering them from the data. It is a process that focuses on generating, developing and verifying concepts through acquisition of data over time. When there is no clear way forward, the researcher visits the literature and theories that influence the research design for renewed stimulation (Bazeley, 2011). Throughout the study, theoretical sampling was employed mainly for data collection and for some parts of the data analysis. This technique involves the practice of deliberately selecting further research participants and the data that is sought from them based on their ability to elaborate further on issues that keep emerging in the already gathered data (Bazeley, 2011; Corbin & Strauss, 2008).

The data management process in a nutshell involves scanning the data for items that appear to relate to the particular topic within the framework of collaborative advantage that relates to the central theme of this study; creation of more generic interpretations of the key issues; clustering apparently similar data items and interpretations; giving labels to the clusters; and successively trying out ways to frame and write about the emerging issues (Creswell, 2003; Huxham, 2002). For a comprehensive description of this methodological process, Huxham (2002) may be very useful. Reliability and validity are rather, terms that some qualitative scholars find uncomfortable to use. However, in this study, internal validity was assured by the triangulation of sources in the data collection phase, which include archival records, face-to-face interview data and personal observations of the researcher. The next sub-section provides a more practical approach by which reliability and validity were guaranteed.

5.6.1 Data validity and reliability

Even though qualitative researchers reluctantly use the words, validity and reliability to describe the process of understanding reality in social constructions (Corbin & Strauss, 2008) because of their traditional usage in quantitative research, these terminologies seek to ensure the credibility of the research process is devoid of any doubt. The veracity or the credibility of the data used in this study is documented in an audit trail involving tape recordings, interview transcripts, archival documents and correspondence between the researcher and other institutions that have any part to play in the entire process of conducting this research. In addition, the multiple sources of data

collection (also known as triangulation) (Yin, 2002) ensured internal validity and reliability of the information in the study.

5.7 The role of the researcher and ethical clearance

Consistent with all qualitative studies, the role of the researcher cannot be separated from the research participants, especially given the fact that relativist ontology and transactional epistemology are embedded in interpretivist epistemological orientation. The value-laden, axiological and ontological assumption of studies such as this one and the biases of the researcher have been admitted (Creswell, 1998) in this research. In this study, the researcher acknowledges that the facts in this thesis are the author's presentation and interpretation of the words of the participants in the study. The same applies to the archival records that were analysed to guide the drawing of conclusions. However, much care was taken not to misrepresent what was spoken by the interviewees or words contained in the reports that were analysed. Moreover, extreme care was taken to ensure that the biases of the researcher with respect to socio-cultural beliefs as well as work and personal life experiences were largely minimised in the course of the interviews as well as the data analysis process. These steps were taken in cognisance with the researcher's scientific responsibility vis-à-vis his moral duties to the research participants (Kvale, 1996).

A number of steps were taken by the researcher in this research to ensure that ethical guidelines were followed, since most of the participants in this research were human beings. Specific steps were taken to ensure that there was respect for the people, non-malfeasance in the research process, justice and beneficence (Kvale, 1996; Marshall & Rossman, 2011) towards them as well. In the

first instance, the research protocol was approved by the University of Ghana's Ethics Committee for the Humanities (ECH) and given the protocol number ECH 039/13-14. This was after an application was submitted to the committee, seeking approval for the study to be carried out. Thereafter, a letter of application was sent to the institutions identified to be included in the study. The letter indicated the purpose of the study, the duration for it and how the study results would be disseminated. Letters of introduction were also obtained from the Department of Public Administration and Health Services Management, University of Ghana Business School and the Volta Regional Health Directorate of the Ghana Health Service. These letters were presented to the management of the institutions identified for the research. See appendix D for samples.

In addition to these arrangements, each participant in the study was given an explanation to the study with respect to the purpose, the nature, the estimated length of the interview and the potential harm that may be associated with participation in this study before the actual interviews commenced. This explanation to the participants also indicated the necessity for the study and why their participation in the study was important. Moreover, participants were told that their involvement was absolutely voluntary and they would not suffer any consequences for opting out of the research. Besides, they were assured that their names or respective official positions and the names of organisations they work for would not be disclosed in the dissemination of findings of this research. In fact, pseudonyms were assigned to their organisations in the writing up of this report. Having being assured of the confidentiality and protection of their rights of anonymity,

each participant gave their consent to be interviewed and tape recorded[15]. It was only two participants that agreed to be interviewed but declined to be tape recorded. After interviews were processed through transcription, the transcripts were referred to some of the participants, who were willing to read through and confirm that the transcripts reflect their opinions and views expressed in the interview. These steps were taken to ensure that ethical guidelines in scientific research, especially those relating to this study and the University's ethical procedures would not be breached.

5.8 The nexus of the conceptual framework and the methodology

The case study design adopted for the study is justified by the replication logic, which is explained by the conceptual framework described in chapter four. Replication would take place if the results of the study would be the same as those obtained from a similar study carried out in a similar setting (Yin, 2002). This replication is theoretical in that the conclusions from this study would not be any different should the study be repeated all over again. The important step in this replication is the construction of the comprehensive theoretical framework explained in the previous chapter. Given the conceptual framework, when it is applied in another setting to answer the research questions that guided this research, the result would not be significantly different from those of this study.

[15] Kindly refer to Appendix B for sample consent form that was completed by the research participants.

5.9 Some practical limitations of the study

The data for this study was largely collected from staff of government health service institutions and mission hospitals. This may limit the generalizability of the research results over other private not-for-profit health providers that are not owned by churches or faith-based organisations. Also, the hospitals identified in the study incidentally are owned by one particular church denomination. This proprietary status of private organisations in this research may also limit the results to be extended to other health facilities that are owned by other churches because of doctrinal and traditional differences that may impinge on their governance and administration.

The study largely employed interviews as the means of data collection, even though there were some archival records and personal observations that supported the data sources. Despite the practical advantages of interview data in qualitative studies, the emphasis on qualitative research method therefore limited the opportunity for undertaking critical comparative analysis of the issues raised in the study, thereby rendering the possible replication of the study in other districts difficult.

The use of thematic content analysis and theoretical sampling methods in qualitative research have their inherent weaknesses, which may have impacted the results of this study. The data processing procedure was largely manual and this could carry with it, some human limitations that are inescapable. Specifically, the large volume of data transcribed may not warrant equal attention to be accorded all the issues that emerged from the study. It must be acknowledged that greater attention was given to issues that were directly related to the objectives and research questions of

the study. Finally, the coding procedure was very cumbersome and took several weeks to be completed.

5.10 Summary

The central objective of this chapter was to present and justify the various iterative processes of research in this study. In this chapter, the major research paradigms and their assumptions were presented as well as the methodologies that reflect these assumptions. The choice of research strategy and its justification has also been elucidated in this chapter. These were interrelated with the study location, with vivid description of the areas involved in the study. The processes involved in the entire research process with respect to data collection, their management and analysis have also been given detailed attention. This chapter concludes with ethical guidelines that were followed in the research process. This becomes more relevant in the face of the fact that this is a qualitative study, where the personal biases of the researcher as an instrument of portraying the events can be largely influential. However, the necessary steps that were taken to guard against this practice were also discussed in detail. The next chapter provides the results that were obtained from the study and their implication for policy and practice of partnerships in health services delivery.

CHAPTER SIX

PRESENTATION AND ANALYSIS OF THE STUDY RESULTS

6.1 Introduction

In the previous chapter, the methodology employed in arriving at the findings in the research was discussed. This chapter presents the results of the analysis conducted in this research and therefore serves as the product of the methodological processes discussed in chapter five. First, this chapter gives the chronological account of the involvement of church missions in health delivery in Ghana by providing the experiences of some notable cases. Second, it goes on to discuss the results of the study according to the objectives set out to be achieved and the research questions that answers were sought for. The major themes that emerged from the interview data as well as the archival records formed the clusters of issues that were interrogated and are noted in the chapter.

The study results discussed in this chapter also include the contextual factors of the case study organisations that emerged in the course of the study. The contributions of the study organisations, the public value of the partnership and some of the challenges that are still militating against the actual realisation of the objectives of the collaboration have also featured strongly in this chapter. Since the study is about PPP for health in the context of HSR, the policy context of health sector reform and its relationship with the partnership have also been discussed. The chapter provides ample evidence to support a positive partnership working between the actors that formed the focus of this study. However, the full potential of the partnership arrangement is yet to be realised and

this can be achieved through finding practical solutions to the challenges identified in this study[16]. Finally, the chapter concludes with a summary of the issues that were discussed in the preceding sections and provides a direction to the discussion of these findings against extant literature in the next chapter.

6.2 Roles of actors in the partnership

Partnerships usually occur because the partners mutually agree to the performance of some specific and general roles. In the partnership arrangement under investigation, there emerged from the archival records and interviews, some specific roles that are expected by each of these partners. These roles generally include the provision of health services at different levels, training of human resources for health, equitable distribution of health resources, sharing of health information and joint-financing of health programmes and activities. Others include the respect for the ownership and governance structure of the partners, applying appropriate health technologies that are consistent with internationally-accepted standards in their operations and the joint-participation in health systems research and development.

These roles have been expressly stated in the first MOU that was signed by the partners and anchored on the Ouagadougou Declaration on Primary Health Care and Health Systems. In the wake of these developments, there appears to be a serious commitment by the partners to abide by the established rules and regulations that guide their involvement in the partnership arrangement.

[16] Some of the suggestions to improve the partnership are listed in chapter eight as recommendations for policy consideration.

It is this drive that resulted in the signing and operationalisation of the MOU, which serves as the institutional framework for partnership working. This position is echoed by a senior level participant in the study as follows:

> 'We are very committed to this partnership and we believe [they] are also committed, even though we have our differences. That is the beauty of the partnership.' _____KTHD/2

The commitment of the partners is also evident in the joint programmes that they participate in and the objectives set out to be achieved. For instance, the first objective outlined in the 2011 Annual Report of CHAG is 'to foster a close partnership between Church-related health services and the Ministry of Health to promote health care in Ghana' (CHAG, 2012: 2). Analyses of the annual reports of the hospitals involved show that at least five joint programmes have taken place between the hospitals and either the Regional Health Directorate or the respective District Health Directorate annually in each case. In some of the years covered in this study, as many as eleven joint programmes took place. Some of the joint programmes include skills training for health staff, strategic planning meetings, programme implementation reviews, performance assessment reviews and validation of financial accounts. Other areas of joint engagement include an educational exchange programme with some public training institutions, community health education programmes and other public health activities such as reproductive and child health outreaches to the communities. These activities were done jointly as a testament to the commitment of the organisations to the partnership arrangement.

However, despite these joint-actions to delineate the commitment of the partners, there still remains a large presence of suspicion among the health sector workers within the partner organisations in relation to the commitment of their respective counterparts. Specifically, private sector participants assume that their public partners are not committed to the partnership and the vice versa. For instance, an officer of one of the case study hospitals noted that:

> 'The partnership is just a window dressing phenomenon. We don't think they [public] are committed to helping the partnership process. They are only interested in our clinical data to negotiate for more resources at the headquarters for themselves but not interested in our welfare.' ____KNSA/2

Similarly, it has been observed across the views expressed by officials of the district health directorates that the disclosure practices of the mission hospitals is not the best. It is widely believed that the private facilities are not transparent with their public counterparts in terms of donations and financial support they receive from other sources. However, they present budgets to the government for funding. The following is an extract of a comment by a senior public official at MOH.

> 'We know they do not want to disclose their financial data but they keep on asking for more resources. How can you be asking for something when you are not prepared to disclose your true position?' ____GHHQ/1

6.3 Chronology of faith-based health services in Ghana

The previous section addressed the roles of partners in the collaboration arrangement between government and private not-for-profit health providers as found by the empirical data for the study. However, before any further discussion on the collaborative arrangements between the actors involved in this study, it would be important to provide a chronological account of the works of missionaries towards the development of Ghana's health system.

The partnership between missionaries and the colonial authorities (now Government of Ghana) started informally in 1828, when the first missionaries arrived in the then Gold Coast to embark on evangelistic assignments through planting of churches. This relationship emerged from the prostestanistic ethic that was rooted in the early nineteenth century Protestant evangelism (Swiss Network for International Studies, 2010). It has been reported that the fundamental objective and vision of the missionaries was to convert the indigenes from their traditional worship to Christian religion. However, their arrival was met with some major unexpected difficulties that needed to be surmounted before their evangelistic mission could be achieved. These were the language barrier and the hostile environment of the time. There was no linguistic means to convey their message and the presence of infectious diseases such as malaria and yellow fever did no good to these missionaries. Many of them died of these diseases. Yeboah (2003, p. 16) noted that between 1829 and 1914, '138 Basel Missionaries died in the Gold Coast'. In order to transcend the obstacles associated with language, schools were established for the local people to attend and this subsequently facilitated their work greatly.

On the diseases front, some of the missionaries relied on indigenous medicines during this period of hostility from pathogens by engaging herbalists and Traditional Birth Attendants (TBAs) to offer them their services. This was mainly because in those days, very little was known about the epidemiological profile of their 'new-found land'. Together with the colonial administration in those days, effective tropical medicines were provided to the missionaries and their local counterparts to help safeguard their health. This trend actually helped in stemming the tide against the infectious diseases of the time.

In 1884, the first mission clinic in Gold Coast was built at Aburi by Dr. Fisch, who superintended over this health facility and offered both preventive and curative health care. He was noted as the first physician that introduced the quinine prophylaxes against malaria in the country. His exploits at the time also covered research into infectious tropical diseases and alcohol abuse. Following this initiative, other health services started springing up in the Gold Coast. The German physician, Carl Eckardt started his health services provision in Accra in the year 1887 and succeeded in building a clinic at Odomase-Krobo in 1891. This modest beginning and progress was, however, impacted on negatively by the emergence of the First World War (WW1), which compelled many Germans and Swiss missionaries to leave the Gold Coast because it was then a British colony (Swiss Network for International Studies, 2010; Yeboah, 2003). This phenomenon actually brought the health programme at Aburi to an abrupt closure, even to the displeasure of the local community members.

The Scottish Mission and the Presbyterian Church of the Gold Coast, founded in 1918, took over the Basel Mission's activities (Swiss Network for International Studies, 2010) . However, the return of the Basel missionaries to Gold Coast in 1926 gave some hope to restoring mission health services. Even though their services were being patronised highly, the church was cautious in expanding from dispensaries to hospitals owing to resource constraints. Meanwhile, it was difficult to disregard the growing demand for hospital services by the people so the necessary resources needed to facilitate the continuous progress in this area had to be pursued in order not to disappoint the many trusted local folks.

The first mission hospital in Ghana was then established by the Basel Missionaries in 1931 at Agogo in the Ashanti Region (Yeboah, 2003). This hospital, even as at now, remains the oldest and one of the largest mission hospitals in Ghana. The success story at Agogo made it possible for other mission hospitals to emerge across the entire country. The 1950s and the 60s recorded significant numbers of mission hospitals in Ghana. Specifically, four out of the six mission hospitals involved in this study were actually started in that period. Until the 1950s, government's policy towards the mission health facilities could best be described as laissez-faire in that there was no proper collaborative mechanism between the two sectors. Moreover, there was the perception of the time that since mission hospitals are owned by churches and missionaries, government's interest was non-existent hence their financial independence. However, global recessions and economic challenges of the country during the years just after independence brought untold pressures on these hospitals. Their financial muscles took a nose dive and due to pressure, personnel were placed on comparative salaries and allowances of their counterpart

government employees. Donor support from foreign organisations to the mission hospitals plummeted gradually, necessitating the intervention of government to provide some form of subventions to the mission hospitals through the payment of personnel emoluments. This marked the beginning of a common ground for partnership between mission health facilities and the government. In spite of this, the relationship between them remained very informal with no documented collaborative arrangement. Their roles and responsibilities remained unclear until the 1990s, when there came a formal arrangement by signing the first Memorandum of Understanding. The next sub-sections are dedicated to discussions on the formal arrangements of the partnership.

6.3.1 The formation of Christian Health Association of Ghana (CHAG)

Due to the increasing number of mission-based health service providers and the differences in their operations coupled with unclear structures to relate with government, a group of health professionals in these hospitals decided to form an umbrella organisation, which would be national in character to coordinate their activities. This initiative was at the instance of Dr. Hans Meister, the Medical Officer in charge of the Presbyterian Hospital at Agogo in 1960. It was in 1967 that the network was fully constituted and registered under the relevant laws at the time as Church Hospitals Association of Ghana (CHAG) (CHAG, 2012; Yeboah, 2003); specifically, under the Trustees (Incorporation) Act, 1962 (Act 106).

It was initially constituted by six different church denominations comprising the Catholic Church and the five Protestant churches (Methodist, Evangelical Presbyterian, Presbyterian, Baptist and Anglican) that represent the Christian Council of Ghana. The name changed to Christian Health Association of Ghana (CHAG) when its membership went beyond the founding church

denominations to include the Pentecostal and Charismatic churches. It is now made up of 21 different church denominations that are involved in either the direct provision of health services or training of health professionals. Over the years, CHAG membership has grown from 25 health institutions in 1967 to 182 in 2011 (CHAG, 2012). These institutions are comprised of 58 hospitals, 114 health centres and clinics, and 10 health training institutions. As a faith-based network organisation of 21 Christian church denominations, its activities have gone beyond the provision of curative and preventive health services to include the training of health professionals.

The member institutions are located predominantly in the rural areas and are aimed at reaching the marginalized and the poorest of the poor. A few of them are also present in big towns but were built there when the towns were originally small and rural in nature. Currently, some few of such facilities can also be found in the slum areas of some of the cities in the country. It is a body through which most, if not all, of the Christian church-related health facilities and programmes liaise with MOH to ensure proper collaboration and complementation of the government's efforts at providing for the health needs of Ghanaians. The first formal relationship between the government and CHAG occurred, when the latter were required to submit their annual reports and financial statements to the MOH for review and scrutiny. In the efforts to formalise the collaboration between government and CHAG members in order to establish clearer relationships, the Adibo Committee was constituted[17]. The next section summarises the work of the Adibo Committee.

[17]The Adibo Committee was chaired by Dr. Moses Adibo, a former Deputy Minister of Health.

6.3.2 The work of Adibo Committee

To date, mission hospitals and other CHAG facilities accord the Adibo Committee an enviable place in their annals since the committee's work marked a significant landmark in their relationship with the government. In 1975, the Adibo Committee was appointed to examine the unclear relationship between the government and mission health services providers and make recommendations for a clearer, and properly-structured mechanisms for the collaboration process. This section presents the major findings and recommendations of the committee. It was recommended that:

- Mission hospitals should be integrated into the mainstream national health services;
- As the first step, the government takes over the payment of salaries and allowances of Ghanaian employees of all mission hospitals across the country;
- The practice of trade unions negotiating separate wages and salaries of employees in the mission hospitals from the public sector employees should be halted immediately;
- Beginning 1976 fiscal year, the medical and drug consumables of the mission hospitals should be provided by the government;
- The accounts of mission hospitals should be audited by the Auditor-General's Department periodically;
- Mission hospitals should be encouraged to recruit staff on need basis but should be done in consultation with the relevant Regional Director of Health Services;
- Where there are no government hospitals in a district that has a mission hospital, that mission hospital would be accorded the status of a district hospital and the doctor in charge of the hospital shall be the District Medical Officer;

- A mutually accepted package of allowances for members of religious orders and other officers on contract be decided upon by representatives of government and the churches;
- Ghanaian employees in the mission hospitals should be considered alongside their counterparts in the Civil Service when promotions were being made and opportunities for further training and development arose;
- In order to improve the staffing situation in mission hospitals, Regional Directors of Health Services be requested to post staff to these institutions as and when necessary;
- The management and advisory boards of mission hospitals be reconstituted in order to strengthen the position of the Regional Director of Health Services in directing the affairs of the hospitals; and
- Any further capital development in any mission hospital be carried out within the context of the overall regional requirements and plan. In such events, the cost of the construction should be borne by government unless the individual mission hospital has funding from overseas for that purpose.

6.3.3 The Memoranda of Understanding

The recommendations of Adibo Committee signified a remarkable milestone in the partnership of government and mission health service providers and training institutions. Over the years, most of the committee's recommendations have seen their implementation in various forms and degrees. For example, it took up to 1991 for employees of CHAG hospitals to be placed on the payroll of government, even though the recommendation was made sixteen years earlier.

'Until 1991 CHAG members were not on government payroll' ____ KNSA/1

As at the time of decoupling the policy and agency roles of MOH in 1996 through the creation of Ghana Health Service, which was legitimised by the promulgation of the Ghana Health Service and Teaching Hospitals Act, 1996 (Act 525), some of the recommendations were still not implemented. In the light of this change, the mission hospitals, through CHAG, signed its first MOU with the Ministry of Health in 1996. Among other things, this MOU recognises CHAG as one of the implementation agencies analogous to the Ghana Health Service, Training Institutions and Teaching Hospitals. CHAG from that time, has been accorded the same status at the ministry as other policy implementation agencies and training institutions. This milestone heralded the recognition of mission hospitals in the country as critical and indispensable partners, whose contributions to the health system could no longer be considered as ancillary but rather core and essential to national development.

By the structure of CHAG, it is a network that has a national headquarters and deals directly with member organisations in the districts, mostly in the rural areas of the country. However, the agency roles of government are organised in a hierarchical structure, where Regional Health Directorates (RHD) serve as intervening units between the central government level, GHS Headquarters and the districts and sub-districts. This difference in structure, somewhat, did not lead to the realisation of the full benefits of the collaboration. There have been duplication of roles and there is very little or no institutional framework that connects the workings of these key players in the health sector. In the light of this development, CHAG signed another MOU with GHS in 2013. This guideline spells out clearly, the structure, roles and mechanisms by which the units and agencies of GHS would engage CHAG members at all levels. These agencies happen to be

the largest service delivery agencies within the ministry and have been operating parallel programmes.

Among other things, the partners commit themselves to the overall policy, guiding principles and institutional arrangements of GOG for PPP, the National Health Policy and sector development plans. In line with this, both CHAG and GHS are enjoined to respect the autonomy of each other but perceive themselves as partners providing complementary functions towards the advancement of the health sector agenda for the country. The MOU was borne out of the rationale for pooling resources together, realigning health programmes and sector operations by the partners to prevent wastage and improve efficiency. It is also intended towards leveraging inter-agency competencies to promote synergy for improved health outcomes. Having discussed the MOU that brought into fruition, institutionalisation of the partnership under study, the next section provides some of the main drivers that drew the partners into the formal collaboration.

6.4 Drivers of the partnership arrangement

The collaborative relationship between the public and the private health sector providers prior to 1996 could be described as informal and restricted. It became more formalised and expanded after the promulgation of the Ghana Health Service and Teaching Hospitals Act, 1996 (Act 525). The passage of this law gave specific roles to the district assemblies and other community members in the formation of the district management teams to formalise decentralised health systems. In the same law, the hitherto policy formulation, implementation, monitoring, evaluation and other agency roles of MOH were decoupled. As stated earlier in this chapter, this point signified the

recognition of mission health service providers and training institutions as major forces in the entire health sector.

This partnership, for that matter, was driven by some key factors including the necessity by government health sector to learn from CHAG facilities, given the reported efficiencies in managing their resources as well as the search for a credible partner to deliver social goods to the people. Specifically, CHAG facilities constitute 5.3% of all health infrastructure in Ghana but these institutions account for 20.0% and 19.2 % of all outpatient care in 2011 and 2010 respectively in the country (CHAG, 2012; MOH, 2012). Similarly, they provide 33% and 37% of all in-patient care in 2011 and 2010 respectively. These statistics are indicative of efficient management of health resources through minimisation of wastage compared to the public sector organisations.

Inasmuch as the above information provide a justifiable ground for government to appreciate the necessity for collaborating with these private institutions on a more formal basis, the partnership resulted from the willingness to work with identifiable institutions that provide similar services to the people of Ghana. Moreover, the need to combine limited health resources to achieve synergy in health outcomes was a major driver for the partnership. This is reflective of the resource dependency theory, in that the partners depend on each other for the performance of their activities. It also depicts some of the advantages the transaction cost theory espouses in the literature. These main positions are captured below from the interview of a participant in the research.

> ‘CHAG has been at the forefront of leading in innovations by using very little to generate more outcomes. Somebody may ask: how are they able to do this? This

> emanates from that desire to be efficient, the desire to learn and the desire to achieve a universal health coverage.' ____CGHQ/1

The health sector reform programme that the country embarked on also required that partnership for health was one of the key vehicles for realising the objectives enshrined in the policy document. The health sector, following the principles of PHC, believes that it was necessary to involve all stakeholders in health and other sectors that affect health delivery to work towards the realisation of universal health coverage. Ghana's endorsement of PHC concept forms part of the policy context for health sector reform and one of the key objectives of the reform is the fostering of closer partnership and collaboration with relevant stakeholders in health. One of the strategic stakeholders identified by MOH as a credible partner is CHAG.

The human resource for health deficit in the country requires further capacity development and CHAG institutions are playing very key roles in this direction. It was necessary that government provides support for such agencies in order to ameliorate the insufficiency gap by training more health workers and retaining the existing ones. In order to ensure there is uniformity in the training curricula and conditions of service for the staff of training institutions, it was necessary that the public sector collaborates with CHAG training institutions. These determinants in this section impact the nature of the partnership, which forms the discussion in the next section.

6.5 The nature of the partnership arrangement

Partnership or collaborative arrangements between actors may take different forms. Whereas some may be described as loose or tight, others may be observed from a continuum of formality and informality. Over the years that public and the private sectors have been engaged in working together towards improving national health outcomes, the collaboration has gone through various forms. From the days before the Adibo Committee's[18] recommendations to date, the partnership has been gradually graduating from stages of informality to more formal arrangements. The characteristics of the collaboration between the partners in this study can be categorised into the following broad partnership arrangements.

1. Formalised arrangements for policy decision making

The partnership can be best described as very formal. This is evident in the two major MOUs that were signed by the partners. Moreover, CHAG has been recognised by MOH as one of the corporate entities within the ministry and are accorded due recognition by involving them in all policy deliberations at the ministerial level. CHAG has representation on all the standing ministerial and inter-ministerial committees and working groups for health action. In addition, they are also co-opted to ad hoc committees for any major decision that impinge on health service delivery in the country. This position is copiously captured by one of the annual reports of CHAG below.

[18] Discussions on the key findings and recommendations of the Adibo Committee were made in section 6.3.2 of this chapter.

> 'Externally, CHAG's partnership with the MOH is formalized under a Memorandum of Understanding (MOU). The CHAG secretariat is invited to and participates in current regular meetings of the Ministry with its agencies and development partners' (CHAG, 2012: 14).

2. *Administrative linkages between the two sectors in the partnership process*

Administratively, CHAG member institutions belong to various church denominations with doctrinal and traditional differences. However, they are coordinated by the CHAG secretariat, although they are directly administered by the Health Department of their mother churches. However, CHAG connects these separate denominational health organisations through a network arrangement to work with the public health sector. Similarly, the Regional/ Municipal/District Director of Health Services (R/M/DDHS) also coordinates all health organisations, especially the government ones to collaborate with relevant CHAG health facility in the locality.

3. *Operational linkages at all levels but at varying degrees among the partners*

At the operational level, where the actual health services are delivered, CHAG members collaborate effectively with RHDs and DHDs for joint policy planning, co-provision of some health services, monitoring and supervision through peer reviews, and determination of financing arrangements for health services.

The collaborative arrangement can be described as formal in the sense that the government health providers, which is owned and governed by MOH superintends over every health sector

organisation, whether private or public. The private not-for-profit health providers belong to a network, CHAG, and this network serves as a liaison between the member health facilities and the ministry. All requests in terms of personnel or logistical needs to be supplied by government are routed through the same channel. Resource distribution is also channelled through the parent network organisation. That is the kind of arrangement that exists with the partners and this undoubtedly, influences the behaviour of the institutions. The coercive isomorphic elements embedded in this arrangement largely influences the structural arrangements for the partnership between the private and public sector health providers. This was echoed by a participant as follows:

> 'We actually belong to a network of health facilities called CHAG and it is a corporate body recognised by the MOH. CHAG negotiates with government on behalf of its members and there is no way MOH would entertain any demand from any of the CHAG members unless you route your request through the CHAG secretariat. ' ____KPMM/1

The operational level collaboration is not specific to the case study districts. It is widespread and this is reflected for example in the 2010 and 2011 annual reports of the Volta Regional Health Directorate of the Ghana Health Service respectively as follows:

> 'The Region continued to enjoy a cordial working relationship with its Partners in our health care delivery efforts. CHAG institutions in particular collaborated with us very well.' (VRHD, 2010 Annual Report, p. i).

> 'The Volta Regional Health Directorate collaborated with all partners, especially CHAG, Volta Regional Coordinating Council, Municipal/District Assemblies and the non-governmental organisations to strengthen the structures at various levels to improve quality of service to our people.' (VRHD, 2011 Annual Report, p. 2).

4. Identical health services provision

There is very high level of professional activities involved in relation to the various professions within the two sectors. Whenever some skills are lacking in any of the partner organisations within the district but present in the other, for example laboratory services, these services and skills are shared by the partner organisations. CHAG, particularly has the strength of importing highly specialised skills such as urologists, neurologist and orthopaedic surgeons from outside Ghana, who come to perform specific operations. During these visits, GHS facilities are usually notified for relevant cases to be referred for attention. The identical nature of the services they provide reflect the mimetic isomorphic forces in the environment shaping their respective lines of business. As noted earlier in this chapter, the establishment of mission hospitals was necessitated by the need for expatriate missionaries. However, over time, their services were extended to the community members of the general public just like government health service organisations.

5. Similarities in sources of revenue

The partners in this study have identical sources of revenue. They usually generate revenue through homogenous mechanisms for the payment of services rendered. These include capitation, NHIS and out-of-pocket user fees (cash and carry). Even though there are some varying degrees

of challenges with two of these payment methods, both partners share in the problems as well. The main problem associated with NHIS includes too much delays in reimbursement after services were provided to patients. At the time of data collection, the health providers reported claims are in arrears for seven months, which makes it difficult to efficiently run the facilities involved. The other displeasure associated with this method of financing has to do with high rate of claims rejection. It is quite remarkable that between 15% to 25% percent of claims presented by health services providers to the authorities get rejected due to errors and mistakes in the compilation. Examples of the errors include over-invoicing, multiple billing and clerical errors in computation. These problems identified above are testament to the common problems of the health sector partners in most developing countries.

6.6 Arrangements for the partnership

In the previous section, the nature of the partnership was described as both formal and informal in various respects. This section discusses the various means by which the partners collaborate. As noted throughout the study, the objective is to understand the collaborative arrangement of the partners in this partnership. The DHDs interact with the mission hospitals in different ways and at different times. Their interactions also cover diverse dimensions. This section presents some of the various aspects of partnership and collaboration that were identified in the study, which involve information exchange, policy dialogue, service provision, financing, service regulation, human resource development, regulation, supervision and monitoring of activities.

6.6.1 Information exchange

The partners are involved in considerable degrees of sharing information with each other. Information is the lifeblood of any organisation since it forms the powerbase of decision-making. From the interviews and archival records analysed in this study, information exchanges were in the areas of disease surveillance, submission of periodic reports on key performance indicators including the clinical and the non-clinical data, joint-participation in regular and extra-ordinary workshops, conferences and seminars, human resource data and information on reproductive and child health. There is also regular reports on morbidity and mortality data for decision making at the diverse levels of authority. This interview extract amplifies this position.

> 'We attend the same workshops, seminars that are organised by the Regional Health Directorate … and information flow is perfect. The Municipal Health Directorate is also part of our facilities management to some extent... Information is actively exchanged during these interactions.'___ KPMM/5

The exchange of information is not limited to the dissemination workshops and seminars that are regularly organised by the RHD or DHD. They include the collection, processing, analysis and sharing of clinical data, which are subsequently transmitted through the appropriate channels for decision-making at the national headquarters of GHS and CHAG. The District Health Information Management System (DHIMS) is a platform that is shared by both public and private health service providers, even though this was developed by the public sector. The data availability and accuracy are very crucial to health decisions in relation to resource allocation for service delivery, coverage and utilisation. The DHIMS application is not only a platform for sharing information but it also

facilitates the capacity development of individual staff and the health sector organisations as a whole. The MOH has supported all health facilities, through the RHD and the DHDs to operationalize DHIMS into a guideline for data utilisation by the health sector agencies at all levels. This also includes the mission health facilities. The following is an extract from a document of MOH to confirm this position.

> 'The District Health Information Management System' (DHIMS) was upgraded to DHIMS2, a web-based application available online with improved security. The development of the capacity of the districts to do analysis of their data and use it for management decision-making was initiated with the development of the Data Utilisation manual for districts.' (MOH, 2012).

Despite the evidence to support exchange of health information between the partners, there are, however, some misgivings about the timing of the delivery of some information. For example, there were issues with delays in receiving invitation to some important meetings at either the Regional Health Directorate or at the District Health Directorate. This, according to the management of the private hospitals, makes it difficult to be represented at those meetings and fora, especially when the invitation is received just too close to, or after the date of the scheduled event. The stakeholder interests of partner organisations explain some of these phenomena in that because of the differences in ownership, there is the tendency to be selective in what type of information to share with each other.

There is evidence of information sharing among the partners. However, this can be improved with respect to proper timing and further openness in disclosure. The information exchange mechanisms, normatively, is a very strong means to achieving successful partnerships. The evidence from this study support this proposition but goes further to show that there is the need for more openness in information disclosure to help the partnership to be more effective.

6.6.2 Policy dialogue

Policy dialogue between the partners is acknowledged as one of the strong indicators of partnership between the partners. In this study, it emerged that there is a strong engagement of the private sector in policy formulation, implementation and review. This is done through periodic time-tables for meeting and disseminating sector issues on policy direction of the sector. The activities that are carried out during this process include joint planning for the achievements of set indicators and targets for performance measurement. This formal arrangement makes room for partners sharing their responsibilities for performance in specific periods of time. During these meetings, the organisations present their vision, mission, priorities and operational programmes of work for the year to engender discussions. Table 6.1 shows some of the training workshops and conferences in which personnel of both public and private sector organisations jointly participated.

In addition to the regular planned meetings and workshops that have been agreed between the partners, there are intermittent and *ad hoc* fora for engaging in policy deliberations. This is more important because health needs of the communities do change from time to time and the health of the people is not a service or commodity that can be deferred. As and when issues arise, the

necessary consultations are done among the relevant partners to develop guidelines for going about the 'wicked issues'. From the interviews, a participant reinforced this position as follows:

> 'We meet as and when it becomes necessary. And this sometimes involves the Chiefs and other opinion leaders in the community.' _____KPHD/1

Table 6.1 Selected workshops and conferences that were jointly attended

Date	Organising Institution	Participants	Workshop/Training	Venue
Jan. 11, 2012	Regional Director of Health Service	Medical Superintendents/ Nurse Managers/ Heads of Maternity Units	Regional Maternal Death Audit	Regional Training Centre, Ho
Feb. 15, 2012	District Director of Health Services	Community Health Nurses	One-Day Orientation on 2nd Dose Measles	Kpando Health Centre
Mar. 30-31, 2012	Regional Director of Health Service	Lab. Technicians/ Biomedical Scientists/Ward In-Charges	TOT Training in Malaria Diagnosis Using Microscopy and RDT	Regional Training Centre, Ho
Mar. 31-April 1, 2012	District Director of Health Services	Medical Officers/ OPD In-Charge	District Level Training of Health Staff on Malaria Case Management	Kpando Health Centre
Apr. 30, 2012	District Director of Health Services	All CHNS/All DCOs/ DHMT Members	Training Workshop on New Vaccine Introduction	Kpando District Assembly
May 8, 2012	District Health Directorate	All CHNS/All CHOs	1st Quarter RCH Review Meeting	Kpando
Jul. 14, 2012	Regional Director of Health Service	Nurse Managers	One-Day Retreat for Nurse Managers in Government and Mission Hospitals	Ho
Aug. 30-31, 2012	Regional Director of Health Service	Medical Superintendents/ DDHS/ Heads of Training Institutions	Half-Year Performance Review Conference	Ho
Sep. 28-29, 2012	Regional Director of Health Service	Medical Superintendents /Nurse Anaesthetist	Anaesthesia and Critical Equipment Workshop	37 Military Hospital, Accra

Source: Anfoega Catholic Hospital *Annual Report, 2012* (pp. 18-21).

Results of the study show that there is an open door approach to dialogue between the partners. It was evident from the interviews that very frequently, the staff of district health directorates can reach out to the management of the mission hospitals in the respective districts and the vice versa. This situation, however, is relative across the study districts. It depends largely on the human relationship between the leadership of the two partner institutions. In areas that demonstrate a very cordial human relationship between a district directorate and the private health facility, the collaboration is effective because of the mutual respect displayed by the partners. However, there are areas that show a relatively strained personal relationships between the leadership of the institutions and it reflects in the cooperation that the partners receive from each other. Some of the research participants echoed these positions in the following extracts from the interviews.

> 'The District Director oversees all health facilities in the district and the Medical Superintendent of the hospital is a member of DHMT. So if we see that there is something that is not going on there, we go to discuss it and do corrections and they also draw strategies as to how things will improve over there. So we just work together as a team.' _____KNHD/2

As to whether there is a document that gave recognition to mission hospitals in the districts as the district hospital, opinions were varied since there were no clear responses from the participants. A District Director of Health Services in one of the districts responded:

> 'I have not seen any document to that effect. Whether it has been done before I came here, I don't know. But what I know is that the Regional Director made me aware that [the mission hospital] was the district hospital. So I don't know whether

they have been given a written document notifying the administration that now they are the district hospital.' _____KNHD/2

There is fair representation of the private health providers on the committees, councils and governing boards for the health sector in the region and districts. The presence of representation is to achieve the aim of joint-participation and inclusion in all management decisions and policies. A senior official of one of the private health providers indicated the following.

'I serve on the Regional Health Council as the representative of CHAG institutions.' _____KNSA/1

This position was re-echoed by a senior official at one of the district health directorates involved in the study as a reflection of what transpires at the regional level manifesting at the district level as well.

'The Medical Superintendent of [the mission hospital] is a member of DHMT. So together, we work and plan for the district. So we always collaborate.' _____KNHD/2

The open-door policy of both partners for engaging each other during meetings, workshops, conferences and training programmes provide a positive avenue for partnership. The difficulty, however, is that this process is relative in extent across the case study districts. The frequency of holding joint meetings and workshops among the partners vary from one district to the other. The 2012 annual report of CHAG also confirms this by indicating that whiles CHAG is virtually involved in all health sector policy deliberations at the ministerial level, the same cannot be said

at the district and regional levels due to the differences in appreciating the spirit and letter of the MOU between CHAG and MOH/GHS by officers in the districts. The success or otherwise of the partnership largely depends on the leadership style and personal relationships between the managers and leaders of the organisations at the lower levels. The policy dialogue factor, therefore, is not a very strong indicator of partnership success in this study.

6.6.3 Service provision

One of the roles of the government and mission hospitals from their onset was to provide health services. This service provision has been established as one of the common grounds in the partnership process. There have been established general and specialist services provision as some of the fundamental common grounds for both mission facilities and public ones. As noted earlier, the foundational purpose for the establishment of the mission hospitals was to continue the healing ministry of Christ through benevolence to the poorest of the poor. This is reflected in the areas that their presence are pronounced.

There is also complementary human resource exchanges between the two partners. For example, specialist health workers and those with critical skills serve as visitors to the facilities that require their services instead of waiting for referrals. This is an arrangement between the management of the facilities to coordinate the visitation of specialists from the Regional Hospital or other better-resourced health providers to those that are short of some specific skills. The annual report of one of the case study private hospitals noted that:

> 'There were two visits of a Gynaecologist and an Obstetrician Specialist to the hospital from the Regional Hospital in Ho.' ____ (2012 Annual Report of *Hospital SA*)

The major form of joint-service provision is within the domain of public health activities. During mass immunisation, the district health directorates jointly carry this out with the staff of the mission hospitals. By this arrangement, more skilled personnel and other resources such as transport and cold chain equipment are made available to ensure efficiency in the exercise. Hitherto, these programmes were being run as parallel activities, whereby each partner determines their own time and routes within the sub-districts for the vaccination. Also, some of the mission hospitals have allowed the district/municipal health directorate to establish and operate public health units within the hospitals to facilitate the joint actions of the partners in the health sector. A director of one of the case study districts mentioned the following:

> 'We have established a PH unit in the hospital, which serves as a window of entry for us. We send staff (CHNs) there and we go there anytime to monitor their activities.' ____KPHD/2

Another participant in a CHAG hospital noted the following:

> 'During EPI, we pool resources together to do it more efficiently than it would have been done by just one party. Together, there are more qualified personnel for supervision and we bring in more vehicles to enable us cover all the geographical areas of the district.' ____KNSA/2

Beyond the public health activities, health facilities borrow drugs and other non-drug consumables from each other, whenever there are shortages in supply. For instance, in moments of epidemics or disease outbreaks, partner organisations share their vaccines, drugs and other non-drug consumables on loan to provide care to patients in critical conditions. These loans are usually made good after supplies were made to the borrowing health facility. This arrangement can only take place in a collaborative setting that is mutually respected by the collaborators. The manager of one of the case study hospitals mentioned this during an interview:

> 'We went to the health directorate to borrow some IV infusions recently during the cholera outbreak when we were in short of supplies but we returned it as soon as our stock arrived. We have also done it for them before so…' ___NSSJ/1

There is a blend of PH activities and curative services. In districts that have no functional government hospitals, the Medical Officer in charge of the CHAG hospital offers technical support to the sub-district health facilities through supervision and monitoring of the works of the Medical Assistants in the rural areas of the district. This is done regularly to ensure that quality of health services is not compromised. This practice is illustrated by a research participant as follows.

> 'One specific good thing the Regional Director has done, which is very helpful, is that the Medical Director at the CHAG facility is supposed to organise regular monitoring for all Medical Assistants in the health centres of the municipality. He does this by inspecting their performances with respect to the quality of care they provide.' ____KPHD/2

Based on the results of the analysis in this study, service provision appears to be one of the key mechanisms by which the organisations collaborate in the partnership arrangement, even though the strong areas of collaboration are in the public health activities. This is also more important because public health is the proper domain for determining the health status of any society. For this reason, it is reasonable to have a strong linkage between the partners in the area of public health than curative, clinical services.

6.6.4 Financing for health services

Funding for services is one of the major drivers of health in all countries. The situation of Ghana is not any different and this is confirmed in this study. Financing arrangements for health service play very crucial roles in the collaborative process. The major financial support the private health providers enjoy from the public sector is the payment of compensation to majority of their employees. Since the work of Adibo Committee in 1975, the government has been paying the workers of mission hospitals, which forms a substantial portion of such organisations' recurrent expenditure. Table 6.2 shows the proportion of government contribution to the payment of emoluments of the mission hospitals in some of the recent years. In addition to the payment of personnel emoluments, the government has been supporting the private sector with funding for some administrative services and some capital investments, even though not as substantial as compared to what pertains in the public health facilities.

Table 6.2. Proportion of government contribution in personnel remuneration to the total expenditure for one of the mission hospitals

Year	GOG Salaries (GH¢)	Total expenditure (GH¢)	% of GOG to Total Expenditure
2007	277,960.05	794,112.23	35.00
2008	501,219.38	1,229,452.07	40.77
2009	789,235.47	1,836,780.70	42.97
2010	804,014.61	1,920,912.96	41.86
2011	1,453,266.12	3,236,766.97	44.90
2012	2,204,656.97	4,094,320.73	53.85
2013	2,638,680.63	4,474,034.24	58.98

Source: Annual Reports of Sacred Heart Hospital, Weme-Abor (2007–2013).

For the period covered by this study, central government funding for the private sector has been quite substantial in the areas of services and administration in the earlier years of the health sector reform. For instance, between 1996 and 2003, the results of the annual reports of the case study institutions showed an average rise in the financial support from the central government to the private partners. In the specific case of staff remuneration, health personnel have increased substantially with corresponding increases in their basic salaries. The government has fulfilled its obligations by continuously funding the personnel budgets of these institutions. Further analyses of the financial statements of the private hospitals involved in this study show that for the period delimited for this study, GOG payments for personnel emoluments represent approximately between 35% to 60% of annual income and expenditure figures. Moreover, government

contribution has seen steady rise over the years. Table 6.2 illustrates the situation in one of the mission hospitals involved in this study. This trend signifies substantial contribution of government to the finances of the private hospitals.

The pay structure of staff in the partner institutions are the same, reflecting the normative, mimetic and coercive isomorphic elements in the behaviour of the institutions involved in this study. The resource dependency school of thought also explains the behaviour of these organisations in that the public sector depends on the skills of private sector personnel, their health infrastructure and other ancillary but important services whiles the private sector depends on the public sector for finances, policy and regulatory framework. Similarly, the private sector actors also benefit from infrastructure provisions by government, equipment supply, technical support and financial support that are provided by local authorities (District and Municipal Assemblies). The funding and other infrastructural support provided by the local government authorities also form part of government funding since resources of the district assemblies are sourced from the government's Consolidated Fund[19].

Paupers' Fund exists in all the private hospitals involved in this study. This is a fund that is earmarked for the settlement of financial obligations of persons classified as extremely poor, whenever they receive healthcare at the facility. This phenomenon is reflective of the government's financial risk protection of the poorest of the poor through hospital fees exemptions

[19] Consolidated Fund is the central account of the Government of Ghana, where all budgetary allocations to MDAs are drawn from.

policy. These separate phenomena of the institutions present another manifestation of institutional forces affecting the behaviour of the organisations. Ghana is a country with relatively high level of poverty across the regions and most of these mission hospitals are located in rural, hard-to-reach areas that have large presence of the country's poverty cohort. Exemptions Fee Policy of the government for state health institutions and the Paupers' Fund created by these hospitals reflect the normative institutional isomorphic forces of DiMaggio & Powel (1983). Finally, one other indirect financing mechanism government provides for CHAG health facilities is the tax-exemption policy on imports that are for the use of the health institutions for service delivery.

Financing is also another area for strong collaboration. Even though government supports the annual budgets of the mission hospitals substantially through the payment of personnel emoluments and some other recurrent expenditures, some of the mission hospitals support the corresponding DHD financially by paying for some of their activities from their Internally Generated Funds (IGF). A classical case in point was illustrated by the Director of a Municipal Health Directorate (MHD) as follows.

> 'They [mission hospital] support us financially. Sometimes when I'm short of funds, I call the Medical Director to fund specific programmes for us. Just last week, they provided lunch refreshment for a training programme we organised for all Community and Public Health Nurses in the district.' _____ KPHD/2

6.6.5 Regulation, monitoring and supervision of activities

Regulation, supervision, monitoring and evaluation are considered generally as very essential undertakings for efficient and effective health service delivery. The services of these organisations

are regulated under the policy framework of MOH and other statutory bodies for licensing, certification and approval for services and personnel. In addition to the state agencies that regulate service delivery, the private sector operators are also regulated by the health departments of their respective church denominations. In the specific case of Catholic Hospitals, they are regulated by the National Catholic Health Service (NCHS).

Operations of health facilities that were involved in this study are monitored and supervised at different levels and by different institutions. Whiles some are done by the institutions themselves through quality assurance committees of the facilities, others are done by agencies outside the facilities. Collectively, the public and private facilities participate in monitoring and supervision through the concept of peer-review. This exercise involves the formation of a review panel by the Regional Health Directorate. The membership of this panel is drawn from across the diverse professional groups in the health sector. It is also constituted to encompass a balanced representation of public and private health sector actors in the region. This phenomenon has received a popular acceptance and approval from both sectors and it is highly contributing to the overall performance of facilities in the region. For example, the 2012 Annual Report of one of the private hospitals states as follows:

> 'One major activity the hospital is proud of is the introduction of Peer Review of the hospitals in the Volta Region. This has given an opportunity for other stakeholders to know what we do in our hospitals to promote health care delivery.'
>
> _____ (2012 Annual Report of *Hospital SA*: pp. 42)

Annual performance reviews are done as a member-checking process to ensure that quality health services and governance regimes are maintained. The involvement of the private sector has added a lot of dimensions to it. Evidence from reports show that the private health providers have shown more commitment to maintaining higher quality standards than their public sector counterparts. Several reasons account for this. The religious-centred ethic and the zest to command equity by the mission hospitals have been presented as some of the factors that explain their performance as far as quality of health services is concerned. In addition, the management styles of these institutions are characterised by even-handed commitment to improving health conditions of the people they serve. Management of these institutions perceive these facilities as theirs, which is not really the case with the public health sector institutions. For instance, the Medical Officer in-charge of one of the facilities retorted to the question, *what do you think accounts for the consistent excellent showing of your hospital in the previous peer review exercises?*

> '…You know that we are committed to continuing the healing ministry of Christ and we cannot be half-hearted about it….Every member of this institution understands that cleanliness is next to Godliness so they give their best to maintain the high standards that have been handed down to us.' _____ KNSA/2

The religious ethic that sweeps through the organelles of the private hospitals in this study have largely influenced their behaviour in this collaboration process. From the interview data and archival records that were examined in this analysis, it is evident the legal owner of the private hospitals is the religious leader of the relevant diocese. In this case, the members of the organisation believe that they owe some allegiance to this owner, who is the sole stakeholder of

the facility that was vested in him by the church administration. This structure mandates the management and workers of these institutions to offer unalloyed sense of commitment to the owner. Conversely, government establishments do not reflect any particular religious identity therefore there are liberal views that permeate their organisational behaviours and practices. This phenomenon represents the propositions of the stakeholder theory. Management and staff of government employees do not feel obliged to follow any religious identity but they are committed to providing health services to the population, which is the responsibility of the government. Even though the private counterparts commit to doing same, that inherent disposition to maintain religious identity reflect their practice of taking instructions from the religious leader of the diocese, even if those instructions conflict with the national health strategy.

Service regulation, normatively, should be jointly done. From the analysis of the data, it shows very little point of collaboration, even though there is joint monitoring. The conclusion that can be drawn from the study is that service regulation does not indicate a strong avenue for collaboration among the partners.

6.6.6 Human resource development and distribution

A very critical component of any health system is the human resources for health (WHO, 2006). This has become more critical because the system is non-robotic and therefore requires skilled personnel to function. Available data from the interviews and annual reports show that the mission hospitals are always represented during meetings and fora that carry out human resource allocation to the facilities in the region annually. Moreover, it is now easier for transfer of personnel to be effected among the partners. Hitherto, this process was fraught with untold difficulties such as the

processing of personnel records for the payment of personnel emoluments. Other problems include the necessary changes to be made on the payroll of the receiving partner usually cause undue delays in the payment of salaries to the affected staff. For some of these reasons, it was not so easy for workers to be transferred from one partner to the other. However, the partnership working of these institutions has facilitated the process in a manner that gave rise to mutual benefits to the organisations and the individual health workers involved. Moreover, working together on personnel issues has brought about discipline among health workers. Until recently, it was difficult for GHS facility to obtain personal records of a worker, who is seeking transfer from a CHAG institution and the vice versa. This situation made it easy for delinquent staff to seek transfer to the partner organisation without the personal file records. But now, it is has changed because of the joint participation in postings and transfers of health personnel. These facts were confirmed by the following illustrations of some interviewees below:

> 'Now, working for either CHAG or GHS is a matter of choice. You just have to tell the Regional Director of Health Services or the Executive Director of CHAG that this is where I want to go and that's all. You would be posted there.' _____KNSA/1

Other interviewees intimated the following:

> 'And when the region is distributing staff, the directorate post staff there. So we just work together as a team.' _____KNHD/2

> 'This partnership has brought about some discipline among health workers because it is not easy to just walk out of one institution to the other without the receiving organisation demanding a confidential report on the worker.' _____KNSA/1

This process of collectively posting health personnel and arranging transfers during personnel allocation period reveals the benefits of minimising transaction costs that the partner organisation would incur if they were separately locating their staff for recruitment or for the purposes of transfers. This process also gives credence to the commitment of the partners to the partnership. Moreover, it is because of the common goals that they share to continuously keep improving the general health status of the people they serve. Similarly, this process of human resource allocation depicts the interdependence on each other because the training institutions, though may be owned by either the government or CHAG, their products work in health facilities that belong to either of the two main actors covered in the study. This process could not be any practicable except there is formalised institutional arrangement for the partners to follow. The institutionalisation that emanates from these arrangements depict the influence of normative isomorphic forces.

6.7 Contributions of the private sector to health delivery

The previous section presents the major areas for partnership identified in the study. With these arrangements, this section provides a discourse on some key contributions of the private sector to the overall performance of the health sector of the country. The results of this study show several ways by which the private sector contributes to health delivery in the country. Sampled opinions by the study participants and the documents analysed revealed that the private sector is responsible

for some laudable initiatives in the country's health policy. Other contributions include their bridging the service gaps in parts of the country that are underserved. This resonates with the mission of the private health institutions, which is to continue Christ's healing ministry by reaching out to the poorest of the poor in the hard-to-reach areas of the country. The following sub-sections make discussions on these key contributions to the health system.

6.7.1 Initiation of key national policies

The partnerships between the government and the mission health sector actors have been useful in shaping national policies. Some very key national policies guiding activities in the health sector currently emerged from the private not-for-profit organisations. Some of such policies include the national health insurance programme. This initiative was started by mission hospitals in some parts of the country on pilot basis before it was nationally adopted by the government of Ghana. Today, the major form of health financing in Ghana is through the national health insurance scheme. The success of this initiative by the mission hospitals' pilot scheme paved way for its national adoption. This has added to the major contributions of the private partners to the national policy on health.

Apart from the example given above, the guidelines on the management of maternal health that has been adopted by the Ghana Health Service is an initiative of mission hospitals. This policy has helped largely in the area of managing pregnancy related cases better than previously. In the bid towards achieving Millennium Development Goal (MDG) 5, this protocol has become very important since it has marginally contributed to the reduction in maternal deaths in parts of the country that have adopted it. This contribution is very significant especially in the wake of the

drive to achieve key strategic health sector objectives of the country. An officer narrates how they influenced a national health policy as follows:

> 'CHAG institutions have introduced a lot of innovations that have become the mainstay of the MOH now. Take for instance, some time ago, we realised that MMR was so high in the district so we … developed a protocol to guide … the sub-district facilities in respect of the treatment of maternal health cases. [It] spells out the extent to which midwives in the sub-districts can handle women in labour before referring them to the hospital. When we followed this protocol for the first year, our MMR reduced from 15 per 100,000 live births in the previous year to 3 per 100,000 in the ensuing year. The second year …was 2 per 100,000 live births. At the moment, MOH has adopted that protocol and that is being followed across the regions in Ghana.' ___ KPMM/2

Similarly, the current Under-Fives Child Health Policy of MOH is an initiative of CHAG institutions. It is a policy that took its root from a novel activity in some of the private actors called 'Under-5 Alive Project'. This project was started to reverse the trend of high under-five mortality. It involved a joint-task force of all professional groups in the hospitals, who were meeting very regularly to discuss the various means by which they could minimise the death rate of children under five years old. Over time, a lot of ideas were brought on board in consultation with community members, which ultimately improved the health of children in this age group. With this success story, the ministry realised the necessity to embrace this as a national policy to help curb the death rate of children and thereby achieving MDG 4. The above position was confirmed

by the Director of Health Service in the district that initiated this process. However, this national health policy on children under-five years does not acknowledge CHAG or the hospital or individuals that initiated this process in the list of many institutions and individuals that are acknowledged in the policy.

6.7.2 Bridging the health service gap

One of the significant contributions of the mission hospitals in the region is their provision of health services in places, where there are service gaps. Their presence is pronounced in rural and hard-to-reach areas of the region. In a lot of cases, the mission hospitals' presence replaces the government's responsibility for providing district hospitals in all the administrative districts in the country. By the 1992 constitution of the Republic of Ghana, the state is responsible for providing health services to all citizens and residents of Ghana irrespective of their location, creed, gender, age or by any other demographic variable. It is therefore incumbent on government to ensure that there is access to health facilities with appropriate service quality across the country. However, government has not been able to single-handedly deliver on this mandate. The hospitals owned by the Christian faith institutions in the Volta Region have therefore complemented government's efforts in a very significant way. This position is echoed by one of the respondents as follows:

> '… About 80% of clients receive their health care from the private facilities within the …municipality. Another key role is their outreach services during festivities, durbars, etc., where free health screening and education are offered'. ___ KPMM/5

This position was corroborated by another research participant from the same district.

> 'Their contributions cannot be quantified. The public facilities are either non-existing or are simply inadequate or under-resourced to provide all the services. The private facilities largely complement what the public does. Most private facilities are well equipped to take care of certain serious conditions'. ___KPHD/4

Among the key contributions that helps in bridging the service gap in the country is the provision of critical health infrastructure by the private sector. Apart from the Regional Hospital, which is located in the regional capital, the next largest health facility in the region is a private hospital, which constitutes one of the cases in this study. In addition, its performance indicators reported over a ten-year period is almost close to that of the regional hospital. The presence of such health services has brought health services closer to people, who hitherto, would be required to travel for long distances to access the closest government health facility. Moreover, these private facilities embark on some critical health infrastructure that are non-comparable to those of their counterparts in the public sector. In some cases, the public health service providers duly acknowledge that the existence of the private health providers has accounted for almost all the health gains of the administrative district. For instance, the Municipal Director of Health Services in one of the districts stated that:

> 'They should be given the credit for most of the health gains of the district since they serve as the main hospital for the district. We have opened public health units in the private facilities as well, that are manned by our CHNs.' ___KPHD/2

In addition to the curative health services they provide, they also engage public health activities within and outside the perimeters of their hospitals. They also provide outreach services to the remotest villages through mobile clinics. These contributions do not only bridge the service gaps but have also added to the overall improvement in health status by improved health indicators, particularly those relating to child survival. The administrator of one of the mission hospitals noted this as:

> 'We have twenty-three outreach villages where we go every day because we don't want them to come here but rather go to their doorstep.' _____ KNSA/1

This fact is also acknowledged by a district director of health services in one of the case study districts as follows:

> 'They provide health services at places where the government has not been able to reach. They do outreach programmes, recruit a lot of their own personnel.' ___KTHD/2

This position was confirmed by another senior level member of the District Health Management Team (DHMT) in a different case study district:

> 'They [mission hospitals] are able to reach the very local people.' ___STHD/1

6.7.3 Access to critical services, skills and donor support

Service provision comes in diverse forms. The CHAG facilities, through their networks and connections with donors, benefit from special skill-mix that are not readily available to the public institutions. The visitation of medical teams from developed countries such as Germany, Canada and The Netherlands to conduct some highly technical operations are a testament to the benefits

that CHAG facilities revel in. These services are provided to the community members that these institutions serve. For example, 'The Doctors for Africa' and 'German Rotary Volunteer Doctors (GRVD)' visited *Hospital MM* twice to perform urological operations in the years 2011 and 2012. In that same year, GRVD donated 'sophisticated machines and equipment' (p.11 of the Annual Report) to upgrade the eye clinic of this hospital mentioned above. Table 6.3 provides details of some of the activities carried out by the urologists in one of the hospitals during three separate visits within two years. There were a total of 110 specialist operations in 2011 and 119 of similar operations carried out by the same team of specialists in 2012. In a related development, Help Helpen Vision (HHV), an NGO from The Netherlands, has provided funding for the renovation of a Pastoral Centre to be used as a Nursing Training College. This process is ongoing and is expected to start in 2015. Other such benefits include some microscopic orthopaedic operations that are usually carried out by medical outreach teams in one of the case study hospitals (*Hospital SA*) annually. Composite figures of orthopaedic and urological operations carried out by foreign medical specialists for the years 2010, 2011 and 2012 are 312, 403 and 426 respectively. In 2013, the same hospital experienced specialist visit by foreign urologists. '*There was a team of Urologists from Germany who also visited… in January and June in 2013. They performed about 65 and 66 various categories of surgeries in January and June respectively*' (p. 43). However, most of these types of operations are not usually done at the Regional Hospital due to scarcity of relevant skills. The following is an extract from the 2012 annual report of *Hospital SA*.

> 'The twice yearly visit by a medical outreach team led by Dr. Rompa, a Dutch Orthopaedic Surgeon, still continues. The hospital is now a specialist referral point for orthopaedic cases and sees cases from all over the Volta Region, and by special

> collaboration with the Nsawam Orthopaedic Training Centre, orthopaedic cases are brought from the Central, Western, Eastern, Greater Accra and eastern part of the Northern Regions.' (pp. 10-11).

This position has been corroborated by a District Director of Health Services in one of the case study districts as follows:

> 'Most private facilities are well-equipped to take care of certain serious conditions than the government ones.' ___ KPHD/2

The special situation of another particular mission hospital in the region is that it is noted for their excellence in the treatment of a specific health condition, even ahead of all the public health institutions in the region. Specifically, *Hospital AN* is noted for their specialty in tuberculosis treatment. A senior officer in charge of one of the health facilities noted that:

> 'We are specially noted for the treatment of TB cases so that is a specific area where we give support to the public in general.' ___ NDAN/3

Table 6.3. Special operations carried out by foreign specialists free of charge

Condition	Number/Year/Month		
	2011		2012
	April	October	
Open prostatectomy	12	16	35
Transurethral resection of prostate	12	18	34
Urethronomy	6	9	20
Supra pubic cystostomy	5	5	8
Cystoscopy		9	6
Biopsy of prostate			5
Orchidectomy		2	3
Hydrocelectomy	2	1	2
Urethroscopy	7		2
Stone litholapaxy	4		2
Hernia			2
Urethral catheterisation	1	1	
Total	**49**	**61**	**119**

Source: *2011 and 2012 Annual Reports* of Margret Marquart Catholic Hospital

From the foregoing, interdependence on the expertise of each other in terms of skills and institutional capacity to handle specific cases is evident in the partnership. It also delineates the commitment to achieving common goals by the partners through a connection between the purpose of the partnership and the workers in these organisations. Through this interdependence, the partners are also engaged in uninterrupted learning from each other.

There are many other aspects in which the private participants contribute to the health system and national development for that matter. The productive workforce of the country is facilitated by the healing ministry of the mission health facilities. It has been understood from this study that the persons, who received treatment for their ailments would get back to work and contribute to

nation building in their respective occupations and employments. Similarly, the social capital created through health restoration of the sick in the deprived areas require some acknowledgement. The family bonds that are reconnected after the discharge of patients add unquantifiable social value to the contribution of the private health providers in the country. For example, a participant surmised it as:

> '… We make people who fall sick get well again. By this we unite families and make them happy. Again by restoring health back to the people, we are improving the country's economy and this is a great achievement' ___ NDAN/3

6.7.4 Complementary exchange of resources

Results of the study also indicate several areas by which the partners complement each other in their operations. Areas that have shown strong complementary activities include transportation, drugs and non-drug consumables, laboratory services, and supervision of health personnel. In one of the newly-created districts, the mission hospital is better resourced than the less-than-a-year old DHD. The latter, therefore, depends largely on the 'benevolence' of the management and staff of the former in terms of their operations. As noted earlier, there is no government hospital in some of the districts and the mission hospitals serve as de facto district hospitals. However, there are several health centres, clinics and health posts that are owned by government in those districts. In order to ensure accuracy and precision in medical diagnosis, the laboratories of these hospitals provide support to the Medical Assistants (MA), who preside over the sub-district health facilities mentioned above. Also, the Medical Officers of the hospitals carry out supervisory roles over the MAs. An officer in one of the mission hospitals noted:

> 'With the health sector, we usually go to supervise. We help in terms of transportation of their staff from one place to the other since as a new district, they are not very well equipped. Sometimes we give them drugs when they are short of them. Our lab also serves them as well. …We provide them with vehicle during immunisation week to facilitate their movement.' ____ NDAN/2

The support from the private sector to the public in this particular instance was corroborated by a senior official of the corresponding DHD as follows:

> '[The mission hospital] has been very supportive to us. They give us vehicles for our travels and even transport our staff to and fro work. You know we're a young district so we rely on them for almost everything except our salaries.' ____NDHD/3

6.7.5 General public value of the partnership

One of the major public value created through this partnership is the improvement in disease surveillance. Since the mission hospitals attend to more patients in the district, the medical teams in those facilities liaise closely with Disease Control Departments of the DHMTs by reporting diseases of epidemic potential in time. Most of the identifiable cases are from these facilities compared to their public counterparts and this further signifies their relevance to public health in general.

The collaboration has yielded positive results on the health status of the people in the catchment area. Some key specialist services are often offered by some of the mission hospitals, which are not provided by the government facilities. Even in situations where those services are available at government health facilities or other private-for-profit healthcare providers, the cost to the patient

is rather exorbitant compared to the relatively low prices charged by the mission hospitals. This is made possible through the free specialist visitations embarked upon by their foreign partners. In lieu of the presence of these mission facilities, the government's responsibility to provide quality and affordable healthcare to its citizens and other residents would have been a more serious problem than it currently is.

There is a general perception among staff that the mission hospitals are more caring to the clients and therefore more responsive to patient needs. The 'Poor Funds' or 'Needy Funds' that are created and managed by these institutions attest to the special attention they give to the needs of the poorest of the poor. Even though the government health facilities also have the hospital fee exemption policy in their books, its application is fraught with budgetary constraints of the institutions involved. Some of the participants that highlight these positions have the following to say.

> 'This is because there is more discipline among staff in the mission hospitals than in the government ones. Patients are made to feel more comfortable, staff come to work early enough and the hospitals are better administered than their counterparts in the government side. People from other districts even come over here to treat TB.' ___NDHD/4

> 'The mission hospitals are more caring and the patients attest to this. Even in places, where you have both mission and government hospitals, the patients prefer to come

to us. Some patients also come here instead of the Regional Hospital even after they have been referred to that place.' _____KNSA/1

In addition to service provision, CHAG institutions complement the government's efforts through the development of human resource for health in general. Some training institutions in the country are owned and managed by CHAG. For example, the Presbyterian Nursing and Midwifery Training College at Agogo in the Ashanti Region and the Holy Family Nursing and Midwifery Training College at Berekum in the Brong-Ahafo Region are owned by the Presbyterian Church of Ghana and the Catholic Church respectively. The skilled personnel they produce do not only work for CHAG institutions but also for government health facilities. The contribution through skills training cannot be easily quantified but can be conveniently described as an exercise that is providing enormous public value.

6.8 Organisational performance of the partner institutions

The healthy competition amongst the mission hospitals and public ones is a key contributor to organisational performance. The tripartite management system of CHAG health facilities makes it relatively easier for decisions to be taken compared to the public health facilities. Moreover, CHAG institutions appear to be more decentralised than their counterparts in the public sector. This decentralised nature affords them to involve the community very much in their operations, which is one of the cardinal principles of the health sector reform. Decentralisation, which is seen as one of the characteristics of reforms has been widely practised by the CHAG institutions and this is actually informing the imminent further decentralisation in MOH. It is expected that MOH

would be fully decentralised to achieve greater participation of the communities nationwide. This development, is largely influenced by the organisational characteristics of the mission hospitals, reflecting the institutional isomorphism that forms the theoretical anchor of this study.

Beyond the management structure and the decentralisation of the private health partners, the seeming competition among the partners can be described as healthy and this has improved the physical infrastructure of many health facilities. The personal observations made by the researcher during the data collection stage confirm this assertion. Few years ago, the outward appearance of the physical infrastructure of most of the public health facilities in the regions were unattractive but they have showed remarkable improvements in the last few years. This, according to the research participants, emanates from the hospital peer review exercise that has been instituted by the Regional Health Directorate. Hitherto, the mission hospitals appeared cleaner and more serene to the patients and visitors. But there is apparent improvement in this aspect of public health facilities as well. This partnership has helped largely in shaping decisions of management positively in this direction now than it was previously.

The governance of an institution is very crucial to the organisational performance. Through regular meetings and joint actions, the members of the management teams of the partner institutions share ideas and learn from each other to inform their governance. These changes depict the mimetic isomorphic pressures of the neo-institutionalism. This position was presented by an official from one of the public health institutions in the study.

> 'It helps to improve the performance of the facility. The performance reviews we do at the district and regional levels and the guidelines from MOH have shaped up our ways of doing things. We have improved in our records management, staffing situations and other clinical procedures.' ____NDAN/2

This was corroborated by an official of a private facility involved in the study as follows.

> 'The healthy competition among CHAG and GHS facilities is helping both ways. The peer-review, for instance, is helping the management of the institutions not to engage in the business-as-usual attitude.' _____KNSA/1

The joint fora and meetings that decide policies and programmes for the health sector in the districts and the region are very important to the acceptability of policy guidelines. Health priorities are set jointly through policy dialogues, which in effect minimises opposition to policies that hitherto characterised antagonistic tendencies and behaviours among the partners. A senior member of a DHMT involved in the study had the following to say.

> 'Decisions are taken at District Health Management Team (DHMT) meetings for which the private providers are a part of, and we take ideas from each other' _____ STHD/3

The partnership in planning and implementing health programmes and projects has led to the functional inclusion of public health activities into the core business of CHAG hospitals. Hitherto, community health nurses were not found in hospitals. However, with the constant involvement of

the mission hospitals in such programmes as mass vaccination during the planned immunisation weeks of the larger Expanded Programme on Immunisation (EPI), these hospitals found the need to engage Community Health Nurses permanently in addition to the public health nurses that are already there. Their presence and functions have moved these health facilities from the long-held perception of hospitals as organisations that are concerned only with curative health services instead of preventive and promotive health actions. Even though there is some evidence of improvement in the organisational performance of the partners as a result of the partnership, some challenges were also identified as limiting the progress made so far. The next section discusses some of these challenges.

6.9 Challenges of the partnership arrangement

Despite the many positive indications in the health sector as a result of the partnership under study, there are other issues identified in the study as challenges. These include mistrust, power disproportionateness, the struggle for skilled manpower and disequilibrium in the distribution of health resources among health sector actors. Other challenges identified in the study include exaggerated expectation of some of the organisational members and non-recognition of contributions to policy by the other partner. This section is dedicated to discussing these challenges as identified in the study.

6.9.1 Trust as a challenge to the smooth partnership

One of the key challenges that emerged from the study is the seeming mistrust among the partners. The issue of trust is germane to the success or otherwise of any partnership agreement. The private

sector actors are suspicious of their government counterparts on a lot of issues, especially finances and resources allocation in relation to health equipment. Similarly, the public sector partners are of the view that the private providers have access to some resources that are undisclosed hence they are better resourced. This ostensible mistrust is affecting the smooth collaboration adversely. For instance, a senior level manager of one of the case study districts lamented:

> 'The only thing, which mars our relationship is suspicion. GHS thinks the mission has so much resources and we think they also have so much resources so nobody is ready to disclose to the neighbour what they actually have.' ____KNSA/1

In relation to this, the issue of image management appears strongly as impeding the issue of transparency and credibility of partners. The partners, although acknowledge that they are in partnership to provide services that ultimately lead to the same goal of improving the health status of the population, there is embedded competitive orientation that is so entrenched within the organisational cultures. For instance, since mission hospitals are generally considered to profess Christian values as the motto of CHAG suggests, health data on some activities they consider anti-Christian are usually concealed from the relevant government agency, which is the DHD. This is because of the public perception of such institutions as the epitome of morality and ethics in society. This behaviour increases the extent of suspicion and mistrust among the members in the partnership. For example, a senior officer in one of the DHDs stated emphatically:

> 'I have worked in both CHAG and government institutions and I know that abortions take place there yet, they would never report it in their annual report. Maternal deaths caused by abortions are usually attributed to something else.'

6.9.2 Disequilibrium in the distribution of health resources

Members of the private health facilities are not content with the support that they expect from the government. Particularly, it has been mentioned consistently that there is no fairness in the distribution of health resources among public and CHAG institutions. The distribution of health resources is, however, largely influenced not by any jointly-approved formula or procedure but through the informal relationships between leaders of the partner organisations. Some of the interviewees expressed their opinions as follows:

> '… I once worked with a GHS district hospital… and I know how things get distributed to them. Equipment for the hospitals and incentives for the staff such as private vehicles through hire purchase etc. But since I assumed duty here …, I realise those things don't happen here. However, once a while, they do remember us but our major problem is that they do not give us things as they do to the GHS health facilities. What the government must also realise is that CHAG institutions do not provide health services for foreigners. It is Ghanaians we are also providing health services for.' ____KPMM/1

> 'Even though there is this MOU between MOH and CHAG, it is not being operationalized well because you realise that equipment come and all you'll get to know is that they have been distributed to only GHS facilities. Our member institutions have to lobby for these resources to be given to them on personal basis. Mostly, it depends on the personal relationships managers of our facilities have

with some influential people that would make it possible for them to get some of these things.' ____CGHQ/1

This occurrence, however, is understood differently by some other participants in the study. Even though there is this general perception of unfairness in resources allocation and distribution, some also interpret it to reflect the reality of the situation. It is believed that since the ownership structure is different, it is bound to reflect in capital injection and resourcing. A participant presented his opinion metaphorically as in this interview extract.

'The situation is like you having your own child and then having an adopted child. Naturally, you would tend to lean towards your own child more than the adopted child.' ____ STCN/1

6.9.3 Non-recognition and attribution of novelty in shaping important national policies

Some views expressed by the research participants relate to the fact that private health facilities' contributions are not given the appropriate recognition. They cited some of the current national health policies that emanate from CHAG but have not been given the proper attribution. For instance, the national health insurance scheme was a product of these private institutions. Even though documents from the Ministry give this credit to the mission health facilities, it is expected that their involvement in the guidelines for the management of maternal health care and health care for children under-five years of age in the districts should also be credited properly to the

mission hospitals. As noted earlier, the national child health policy[20] does not even acknowledge CHAG in the list of several institutions and individuals that helped in the process. The seeming discontent among members of the private health providers for the non-recognition goes further to give credence to the long-held opinion of mistrust among the partners. This feeling of ingratitude towards the private sector would inevitably disturb the easiness of the partnership arrangement.

6.9.4 Struggle for health personnel

There is apparent competition for health personnel among the partners. Whiles the public health facilities are in demand for the limited trained staff, the private health facilities are also competing for these same human resources. One other difficulty is the seeming dissatisfaction among the private health organisations in relation to the distribution of critical mass of health sector workforce. They believe the distribution by the regional health authorities is disproportionate to the services they provide as well as capacities of the health facilities. This phenomenon is characteristic of all developing health systems that have human resource deficit. The solution, however, could be expansion in training facilities to accommodate more trainees. This position is also expressed by an interviewee as follows:

> 'There is no clear-cut formula for resource allocation, even human resources. If someone does not have any personal relationship with the influential people, what happens to him?' ____CGHQ/1

[20] National Under-Fives Child Health Policy: 2007-2015 is a national health policy developed to serve as a roadmap to attaining the Millennium Development Goal that addresses child health and child survival (MDG 4).

6.9.5 Exaggerated expectations

Results of analysis in this study indicate that the partners' expectation of each other seem to be a little overly exaggerated. Whiles the private sector actors expect the government to provide more resources to them, especially to those CHAG facilities that have been designated as district hospitals just as it is being done to typical government district hospitals, the government facilities also expect that CHAG institutions could run without necessarily depending on government support beyond the payment of personnel emoluments since they (CHAG) have the wherewithal to source for more funding and donation of capital equipment from local and foreign donors. Indeed, mission hospitals are able to benefit directly from donations from individual and corporate benefactors abroad but the advent of Sector-Wide Approach (SWAp) to health sector planning as part of the reform agenda has significantly dwarfed their potential in this area. The creation of Donor Pool Fund (DPF) at the Ministry of Health has made it not too easy for the mission hospitals to benefit from donor support directly as they used to do previously. A senior management member of a mission hospital puts it this way:

> 'The money the ministry is calling DPF is actually our money. It is for CHAG but we don't get to receive all of it. They made it difficult for us to get more resources from our donors because of the existence of DPF.' ____NSSJ/1

6.9.6 Power asymmetry

Findings in this study show that power relations are also difficult to manage in some instances. The heads of the private facilities, administratively, superintend over institutions that are independent Budget Management Centres (BMC) or cost centres. In terms of power relations,

some of them feel they are accountable to their parent church denomination's health directorate. This position is somewhat justified by their ownership and partly, financing structure. For this reason, they turn to consider the management of the district and regional health directorates as equivalent managerial positions. That, sometimes, makes it difficult in ego management and thereby affect the smooth operation of the partnership arrangement. This phenomenon cuts across the hierarchy of personnel in both partner institutions. A health officer at a district health directorate made this remark in relation to the directorate's work with a private health provider:

> 'Sometimes, there seems to be power struggle when you visit the hospitals because their mind-set about PH is not the same as ours. So sometimes, it is as if you are taking someone's position so you have to be tactful in your dealings with them.'
>
> ____ KNHD/3

The success or otherwise of this collaboration at the district levels is influenced largely by personal and informal relationships among the key stakeholders. Even though some of the mission hospitals assume the roles of district hospitals, they are sometimes not accorded the same benefits and privileges that government-owned district hospitals enjoy in the region. This phenomenon has compounded the problems associated with mistrust between these partners in the partnership arrangement. Resource allocation in terms of equipment and personnel are not satisfactory to the administrations of the mission hospitals involved in this study.

Results of this research have shown that successes attained in the collaboration are not always due to resource inputs by actors but to technical persuasions and camaraderie that exists between the

key stakeholders. This situation, somehow takes some credit away from the perfect connection of the people working in the organisations and the purpose for which the partnership was entered into. It also gives cause to question the commitment of the stakeholders involved in the processes of realising the objectives outlined in the partnership process.

6.9.7 Nexus of national policy and loyalty to faith

As stated earlier in chapter five, the six private hospitals involved in this study incidentally belong to one church denomination. One characteristic of all such private health facilities is their commitment to maintain their religious identity in the delivery of health services and to them, that personal identity and religious philosophy supersede any other policy of state that is adversarial to it. For instance, one of the national strategies to help improve reproductive and child health is the application of modern methods of family planning. As a national policy of MOH taking roots from the Millennium Accelerated Framework (MAF), family planning improves maternal and child health, which address two of the three major MDGs that are directly related to health. However, there is difficulty in accepting modern family planning methods in these hospitals, which rather concentrate on the natural calendar method of family planning. Besides, this latter method has over the years proved not to be very reliable.

> 'The only problem is that because they are faith–based, they do not provide services such as abortion and family planning so we have to find a way of getting those services to the people. The CHAG hospitals decide their own limitations. So though they have come to help, they help to the best of their ability. I am thinking of a way to get these services to the people because they expect to get all the services. And

because they have two masters (CHAG and GHS) they take orders from both sides.'

___KTHD/2

Some of the participants observed that the conflict between faith and national policy requires a serious attention. This is because to them, national policy should take supremacy over faith. However, others think this is a delicate issue that must be approached with all the necessary tactfulness since these private facilities' contributions far outweigh any differences the faith-based conflict brings. A desperate health official of one of the district health directorates recounts:

'… Meanwhile majority of the mothers deliver there [private health facility]… and they only accept the traditional or natural method of family planning and this is a very big challenge to realising our targets.' ___KNHD/3

These facilities in the private category also insist that even though they may not be directly implementing the modern methods of family planning according to the guidelines of MOH, they have their own approaches to addressing those problems the artificial practices intend to address. Some of their approaches include the practice of directing service users, who may request for it to the appropriate district health directorate or its equivalent that is responsible for the implementation in the catchment area. Since the method is against their religious philosophy, its implementation would run counter to their faith and belief systems. The following quotation from the interview extracts of one research participant explains this phenomenon.

'The fact that we don't do family planning does not mean we don't teach. We direct them to where they can find that service and access it from there. Our philosophy

> supersedes whatever we do and that is our DNA and because of that we don't do it. However, it doesn't make us gloss over the sensitisation or the national objective. That is why we tell people to go to where they can access those services. I think our other colleagues in the health sector understand this and they have been cooperative.' ___CHHQ/1

This position is further reinforced by another participant in the study. What is most crucial is that this view is widespread in the operations of the CHAG institutions. It is particularly so because technically, these facilities are not owned by the government. Moreover, they provide health services in areas that the government has not been able to reach in terms of service delivery and training of health workforce. The Head of Administration in one of the private facilities state the following to support their position.

> 'When there are conflicts in our faith and national goals, I would go by what the Pope tells me than what the Minister would say.' _____KNSA/1

The conflict between faith and national objectives, however, requires a careful consideration. Inasmuch as government policy may not be in tandem with religious views of the mission health facilities, it is expected that the human rights issues of freedom of association and religion has to be respected. The Constitution of the Republic of Ghana recognises this development and the MOU signed by the partners also recognises this aspect of the mission facilities. However, public health officers in most of the district health directorates are not very satisfied with this development, mainly because the performance of their work is largely determined by the frequency

of use of the new methods of artificial family planning. Because the potential clients are mainly hospital patients, the rate of application may not sit very well with some of these staff since they are not allowed to meet the potential clients in the premises of these mission hospitals.

6.10 The policy context of health sector reform and partnership for health

The previous section discussed the challenges in the partnerships and concluded with how faith and belief systems influence the behaviour of some stakeholders in the partnership process vis-à-vis national health policy goals. This section, however, focuses on the policy context of health sector reform, which has partnership with other stakeholders in health irrespective of their ownership structure, identity and financing mechanisms as one of the goals of the health sector reform.

Global influences have played significant roles in the changes that have taken place in Ghana's health sector over the last decades, especially post-independence. The changes in health policy and approaches to health systems organisations and management the world over have impacted the reform agenda for the health sector. Particularly, the dramatic change in global health policy and approach occurred in 1978. This global change gave birth to the wide adoption of Primary Health Care (PHC) concept, which was extensively popularised by WHO. As a member of the United Nations (UN) and a participant at the World Health Assembly (WHA) that made the Alma Ata Declaration, Ghana became a signatory to the declaration and subsequently adopted the PHC as a national health policy. In addition to the PHC programme, the Structural Adjustment Programme (SAP) and the Economic Recovery Programme (ERP) the country adopted as

conditions for accessing IMF bailout in the 1980s have also influenced economic reforms in the country in general. The health sector was also affected in the several public sector reforms that were instigated by the Bretton Woods institution. The Ghana's *Medium-Term Health Strategy: Towards Vision 2020*[21] document also added to the policy framework for health sector reforms.

As part of the health sector reform, some important documents set out the health sector reform objectives and strategies. These include the first and second health sector Programmes of Work (POW), which were thought out to be proposals that would contribute to Ghana's development agenda. These documents set out five key objectives for the health sector. These include:

- Increasing geographical and financial access to health;
- Improving the quality of health services;
- Improving efficiency in service delivery;
- Expanding resource base for health; and
- Fostering partnership with stakeholders and building pluralistic health system.

The last objective stated above gave the policy framework for engaging CHAG as a credible partner to deliver health services to the people of Ghana and thereby achieving the objectives of the health sector reform. One of the normative arguments for the partnership was that the public health institutions, single-handedly cannot implement the policy thrusts of the health sector, given the resource limitations and the bureaucratic, monolithic and centralised nature of the health

[21] Ghana Vision 2020 has been discussed in chapter one. Further details that relate to the health sector and the objectives that were set to be achieved have already been provided in that chapter.

system's governance. At the initial stages of this partnership, health sector decentralisation was at its formative stages in the public sector whereas CHAG has demonstrated ample decentralised system within its structures. Moreover, decentralisation was identified as one of the key strategies towards implementing PHC and reforms in the health sector. The already-established decentralised CHAG facilitated the partnership, which sits well within the reform agenda for the health sector. Specifically, some CHAG hospitals have been certified as Budget Management Centres (BMC) of MOH (MOH, 1999). This certification is a further manifestation of the belief that CHAG institutions are capacitated enough to manage government resources.

6.11 Summary

This chapter is the product of chapter five. It presents the analysis of the data collected over the study period and the findings from the entire research. First, the history of the partnership between government and mission health facilities have been presented. Later, the respective roles of these agencies were discussed and the areas of overlap and interconnections include sharing of health information, engaging in joint policy dialogue through regular and intermittent programmes, co-provision of health services, especially public health activities, and complementary funding for their operations. Also, there is joint monitoring and supervision of each other's operations in the region and regulation of activities. In a nutshell, it can be said that the collaboration between the public and private organisations involved in the study is positive, however, there are teething problems that require attention and must be addressed through constant dialogue and revision of the working arrangements. Some of the problems include non-recognition for shaping key national policies, competition for critical human resources, power management challenges and above all,

the very high degree of mistrust resulting from several years of suspicion among the partners. The trust issue is very crucial if the collaboration would have to reap its full potential benefits in the midst of resource scarcity, particularly in these challenging economic times of the country.

These findings reported in this chapter would be situated in the intellectual discourses that preceded this study in relation to the subject matter of this research by discussing the results with the extant literature. The results here would form the fulcrum for the discussions in the next chapter.

CHAPTER SEVEN

DISCUSSION OF FINDINGS

7.1 Introduction

This chapter is a natural follow-up on the previous one. This study seeks to achieve certain objectives and answer some critical research questions, which were generated from the literature review. It is important that the results that were obtained from the field work are juxtaposed against the findings of other scholars in the extant literature. This is what the chapter focuses on. It starts by presenting the objectives of the study, which focus on describing the collaborative activities of the public and private-not-for profit health service providers in Ghana. It goes on to place the study results in the context of academic discourses that predate this present study. This is more relevant because Samoff (2001) has pointed out that 'simplifying findings or "lessons learned" in order to generalise may lead to stating the obvious rather than developing useful guides to action' (Samoff, 2001: 16). This is the call to which this chapter is responding.

7.2 The theoretical appeals of the study

The study is positioned within the neo-institutional theoretical framework with some elements of resource dependency and stakeholder theoretical perspectives. Also, features of principal-agency and transaction cost theories have helped in addressing some of the issues that emerged in the study. The central theme of this study is to describe the collaborative arrangement of public and private health sector organisations and how that relationship is helping the health system generally to realise the planned goals and objectives of Ghana's health sector reform. The influences on the behaviours in organisations have been studied widely. In relation to partnerships and inter-

organisational collaborations, their actions are driven by institutional forces within and external to the organisation (see for example, DiMaggio & Powell, 1983; Meyer & Rowan, 1977; Scott, 1987; Selsky & Parker, 2005). The practice of partnership among the health organisations in the study has been influenced largely by several factors, some of which are internal to the organisations whiles others are external forces that direct the internal affairs of the health services organisations. For instance, the regulatory roles played by the district health directorates towards the mission hospitals show that they (mission hospitals) conform to government policies in order to guarantee legitimacy and acceptance. This is a demonstration of the coercive and normative isomorphic pressures on organisational behaviour. Their involvement in the partnership and other related organisational behaviours are shaped by these isomorphic forces.

7.3 The nature and dimensions of the partnership

The conceptual propositions in the literature point to a variety of collaborative and partnership forms. Broadly, a partnership or a collaboration may either be formal or informal (Guo & Acar, 2005). Wildridge, Childs, Cawthra, & Madge (2004) posit that formal partnerships are those that establish a separate organisation or a process and informal partnerships involve the situation where individual organisations relate to one another as partners irrespective of the formal bonds that they may have established. Murray (1995) further argues that collaboration can be defined as a continuum of interdependence of activities, where there is an exchange of something at one end and the other end signifies a full merger. In relation to Guo & Acar's (2005) description of collaboration types, collaborations are said to be formal, when partners in the process embark on joint provision of services and programmes or function as a merger or a parent subsidiary of other

organisations. On the other hand, collaborations are informal, when the collaborating organisations engage themselves in information sharing, referral of clients to each other, sharing of office spaces or operating an MSO. By these classification, organisations in informal collaboration do not commit themselves to an ongoing partnership but rely on temporary and ad hoc management arrangements that reflect non-permanency. Given the results of this study, the private and public sector partners involved in this research have shown ongoing commitment to the partnership through the signing of an MOU, which provides the institutional framework for long-lasting relationship. However, they are also engaged in other forms of collaborative activities that fall in Guo and Acar's description of informal collaboration such as information sharing and client referrals. The inference, therefore, is that the partnership between non-profit health organisations and the public sector counterparts is both formal and informal. One cannot, therefore, place it in a particular intellectual straitjacket of formality or informality.

Collaboration may take different forms depending on the degree or levels of intensity of alliances (Arsenault, 1998; Murray, 1998). Murray further argued that collaboration can be defined as a continuum of interdependence of activities, where there is an exchange of something at one end and the other end signifies a full merger (Guo & Acar, 2005). The results in this study reveal different degrees of the partnership in the sense that at some point, it is formal and informal at another level.

The works of Kohm, La Piana, & Gowdy (2000), which classified non-profit collaborations into three groups of collaboration, alliances and integration hold sufficient identity with the results of

this study. Given what constitutes a formal collaboration per their definition, information sharing, joint programme planning and programme coordination are apparent. These are some of the major activities that private and public sector health organisations in the health sector of Ghana are engaged in. As a result, this study supports the earlier works of Kohm *et al.* (2000) by making the case that by sharing information freely, participating in joint programme planning and policy dialogue, the collaboration is formal. These elements constitute the formality aspect of the partnership.

Dimensions of partnership identified by Bazzoli *et al.* (1997) include preventive health and education, joint policy planning, coordination of activities, participation in ministerial meetings and co-provision of health services. The results of this study are consistent with these findings. However, other dimensions that emerged from the study include human resource exchanges and sharing of information freely without hindrances. Other dimensions of partnerships in the private-for-profit business sectors identified by Johnston & Gudergan (2007) are the technical rationality of the joint actions, the management and avoidance of risk, and the sociality of the partner organisations. Even though this study is about partnerships involving private not-for-profit organisations, the technical rationality elements are still reflected in the need to share in critical human resource capacities of each other through visitation and outreach programmes. It is also reflected in the joint policy planning and dialogues that characterise the collaboration. However, the sociality and risk pooling and minimisation are not so evident in the collaboration dimensions. Moreover, the obvious mistrust among the partners further show that an analysis for the social context did not result in the normative benefits that sociality brings to partnerships. The non-

profit nature of the organisations studied may be accountable for this since their natural line of operation seem to be non-risky business activities. However, the humanitarian services they naturally provide, normally, should take care of the social elements.

The work of Reich (2002) also has some similarities with the findings in this study. He identified eight forms of health sector partnership. However, three of those eight, which are partnerships for strengthening health systems, private sector coalition for health and partnership for the delivery of health services reflect the partnership arrangement of non-profit health organisations and the government health facilities in Ghana. Through policy dialogue and information sharing, the partners help in strengthening the health system of the country. Similarly, joint service provision is indicative of a partnership arrangement for health service delivery. Results of this study show that the partnership investigated is focussed on strengthening the health system of Ghana through the joint actions of service provision, sharing of relevant information for health sector decision making and actively engaging each other for the development of health sector policies, programmes and priority areas of action.

The formation of CHAG is an epitome of private sector coalition for health. Given the history of private not-for-profit sector's involvement in the health sector of Ghana, the necessity for their collaboration was premised on the challenges at the time that were identified in the study.

7.4 Drivers of the collaboration

Clarity of purpose has been identified as one of the determinants of inter-sector collaboration (Kanter, 1994; Reich, 2002). The purpose of the partnership between the government health service providers and the private not-for-profit health service organisations in this study, is in no doubt, very clear. Health sector objectives are set by the partners and strategies for realising them are jointly pursued. This reflects the proposition of Jutting (1999) that for any activity that qualifies to be described as a PPP, the institutional relationships between the public and private actors should involve joint-participation in defining the objectives, the methods and the implementation of the cooperation.

Several factors have been identified as drivers and determinants of partnership in health services delivery. By virtue of the fact that the two main stakeholders involved in this study did not commence any formalised collaboration from the onset of their creation, it means some factors must have necessitated the partnership that developed later in their respective lines of activity. The general belief from theory and results of the study is that by combining resources and working together, there is bound to be mutual benefits to both parties. Chung (2009) studied the drivers of PPP in health in Australia by conducting an evaluation of a hospital case study. Two main origins emerged as the precursors of PPP for health. Specifically, the macroeconomic agenda to manage government spending are the first main drivers of PPPs. In the health sector, PPPs were widely initiated as a new approach to providing the essential health services without necessarily increasing the debt stock of government. Secondly, PPPs emerged as the growing demand to ensure efficiency in the management of public resources since the relative autonomy of the private sector

and their inherent desire to secure value for money would help minimise wastage in the delivery of social services. Findings of this study partly support these arguments established in the literature. For instance, the joint participation of public and mission hospitals in activities that hitherto were done individually have reduced wastage and improved efficiency in the management of health resources. However, the partnership has resulted in increases in government spending on health, especially the government's commitment to paying the staff remuneration of the private institutions has increased government's recurrent expenditure on health considerably. One may also argue further that the public value generated through these increases in expenditure, though difficult to quantify, merit the amount of expenditure involved.

Other scholars have argued that partnerships emerge in response to the inability of the partners to individually tackle some challenges in their normal line of business such as the 'wicked issues' or 'the wicked problems' (see for example, Sorensen & Torfing, 2010; Torchia, Calabrò, & Morner, 2013; Bryson *et al.*, 2006; O'Leary & Vij, 2012; Koontz, Buckley, & Ruderman, 2004). The partnership experience of CHAG and government health facilities has yielded this result by ensuring that health services are being delivered to areas that government is unable to provide such services to the people. This is the complementarity of the efforts of partners. In some situations, the provision of some health services become politically-sensitive. In such instances, the private actors have saved the state institutions from confrontation or harassment from citizens by providing those services in the areas that they are required. As noted by Macdonald & Chrisp (2005), some organisations usually seek dissimilar partners in order to acquire assets that they do not possess internally. The partnership between CHAG and MOH is a partial manifestation of this

proposition. Even though these organisations are similar in that they both provide almost the same type of social services to the larger population, they agree to partner with each other. In addition, the mission hospitals depend on the government to enrich their asset base in terms of hospital equipment and human resource capacity building. The government also depends on the CHAG health facilities to enrich the quality of health personnel through skills training in the health training institutions.

Gray's (1985) drivers of partnership are rapid change; blurring of boundaries between government, the public sector, civil society organisations and the private sector; and decreased finance from government sources. The present study does not indicate much similarity with these propositions. Rather, the reasons identified as necessitating the partnerships between the actors involved were rather opposed to some of those advanced by Gray (1985). For instance, the changing trend of economic conditions crystallised by global economic downturns drove governments into seeking credible partners for the delivery of health services. Similarly, the dwindling funding for mission health service providers added to the stimuli that brought about the partnership with government as a response.

Among the many other reasons why partnerships exist include the relevance of one partner to the other. Of particular reference to the health sector, it is believed that the private participants show their relevance through greater responsiveness to patients, flexibility in taking management decisions, better understanding of local circumstances and the less-politicized nature of their operations (Filmer, Hammer, & Pritchett, 1998; Griffin, 1989; Harding, 2003a). The results in

this study are consistent with this proposition. As noted in the previous chapter, managerial decision-making is more flexible with the private sector participants because of the decentralised nature of their health structures. Moreover, they are more prominent in the rural and hard-to-reach areas. Their continuous presence with the rural folks afford them the opportunity to understand them better and respond to their health needs accordingly. This process carries with it, their relative responsiveness to the needs of patients, which was noted by the participants in the study as one of the many reasons why patients would prefer to seek care from a private health facility instead of the government ones.

In relation to the health sector, Zajac & D'Aunno (1993) identified inter-organisational relations spanning a continuum of varying extents of autonomy and resource commitment. In a descending order, they made discussions on hospital associations, alliances, joint programmes, joint ventures, contract management, leases, mergers and acquisitions. Similarly, Khom, La Piana & Gowdy (2000) identified three ways in which non-profit organisations work together in decreasing autonomy and increasing formality. These are collaboration, alliances and integrations. Collaboration encompasses information sharing, programme coordination and joint planning. Alliances, however, span such activities as administrative consolidation and joint programming. Finally, management service organisations (MSO), parent subsidiary, joint venture and mergers constitute the integration frontier. After closer analysis and further elaborations, one larger permanent and formalised category emerged by consolidation of alliances and integration into strategic restructuring.

7.5 Mechanisms for collaboration

This section discusses the various means by which rganisations collaborate, including information exchange, policy dialogue, service provision, financing, regulation, monitoring and supervision.

7.5.1 Information exchange

Information describes easily discernible knowledge that can be transferred from one person or entity to the other without diluting or compromising its integrity (Guenter *et al.*, 2014). In this study, the partners have been involved in voluntary sharing of information that are vital to health delivery. Some of these information include correspondences, clinical, and non-clinical health data to aid decision-making. This finding supports the views of Harding (2003) that partnerships are effective provided the partners engage in voluntary information exchange.

7.5.2 Policy dialogue

Policy dialogue involves the engagement of the partners in joint fora for discussions on health policies, sector objectives and priority areas for health action at the ministerial, regional, district and community levels. At each of these levels, there are diverse arrays of stakeholders that anticipate fairness, equity and social justice in the policy discussions of these organisations (Clarkson, 1995; Donaldson & Preston, 1995). Results of this study show that a multi-stakeholders approach is used in the discussions that shape policies for the health sector. As noted in chapter six, sometimes, the DHMTs involve the chiefs, opinion leaders and selected community members in the joint planning of health programmes for the district. This development is a manifestation of the stakeholder theory that point to the need to include the interests of all stakeholders in the decisions of the partner organisations.

The ideals and principles underpinning the health sector reform programme also demand that partnership with non-state organisations should be pursued in order to achieve the objectives of the health sector reform programme. The normative rationale in this policy document is to ensure that health is used as an instrument for development in that all sectors, private and public, become major stakeholders in the planning and delivery of health services. In this study, it is evident that policy planning, monitoring and evaluation decisions are jointly carried out by the partners in the study. This development may be due to the institutional forces enshrined in the health sector reform policy document, which reflects the coercive isomorphic elements in the theory.

7.5.3 Service provision

The results of this study show that the public and private sector agencies collectively provide health services to the general public. As to what extent these are done remain a subject for further interrogation. It emerged that joint provision is mainly centred on public health activities involving vaccination exercises during Expanded Programmes on Immunisation (EPI), school health education and nutritional programmes that require inputs from both partners. Health services are generically classified as either curative or preventive and may be delivered in hospitals and clinics (Musgrove, 1996) or outside built health facilities. Service provision here focuses on the direct delivery of patient care to in-patients and outpatients and other public health actions involving mass vaccination and immunisation activities (Musgrove, 1996; Harding, 2003; Taylor, 2003). Results of this study indicate that the aspect of joint service provision in the partnership predominantly focusses on the public health activities. However, mechanisms for referrals involving curative health services are also found to be common among the organisations in the study. The propositions of resource dependency that inter-organisational relationships minimise

external dependencies (Hillman, Withers, & Collins, 2009; Pfeffer & Salancik, 1978) apply in this aspect of the collaboration. The partners jointly participate in the delivery of public and curative health services, thereby limiting the pressures they may be facing from their external stakeholders. The Directors of the relevant District Health Directorates should provide a better platform for facilitating this arrangement.

7.5.4 Health services financing

Financing for health services have emerged as one of the areas of partnership. Especially the government's support for the private sector in the area of the payment of employee remunerations and the supply of health equipment is evidence of the external dimension of the resource dependency theory. From the study results, a substantial proportion of the annual budget of mission hospitals is financed by the government. In addition, as part of the MOU between the partners, some CHAG health facilities become *de facto* district hospitals in those districts that the government does not own a hospital. By this arrangement, government policies, regulations and guidelines made for their own facilities are passed down to these institutions and they are bound to abide by them, given their status as district hospitals. This phenomenon indirectly demands a conformist orientation from the institutions, which is reflective of coercive and mimetic isomorphic pressures.

The sources of funding for the operations of these health organisations are also homogenous. User fees, GOG support for services, administration and personnel emoluments and NHIS remain the main sources of funding for the operations of the partner organisations. By this arrangement, there is the tendency for the two organisations to become identical in that the forces of financing are the

same hence their external demands in terms of financial records management, validation and other obligations to the same external authority do not differ. This position is supported by the theoretical assumptions of the resource dependency theory (Pfeffer, 1972) as well as coercive and mimetic institutional isomorphism (DiMaggio & Powell, 2013; Provan, 1993; Scott & Meyer, 1994).

In relation to financial management of the institutions, both partners have demonstrated conformity with the Ministry of Health's Accounting, Treasury and Financial Reporting (ATFR) standards. While this compliance is explained by coercive and mimetic isomorphism, the private facilities have shown compliance with the financial guidelines and policies of the Ministry of Health's ATFR standards as well as that of the religious denomination that owns these facilities. In this case, CHS. This latter behaviour by the private health facilities is a manifestation of the agency theory, which posits that as organisations act as agents for larger institutions, their behaviour is generally influenced by the interests of their principals. In this case, the interest of the owners of the private health facilities is manifest in the compliance with their financial management principles. Similarly, the stakeholder theory also explains the tendency of the mission hospitals not to only regard MOH's ATFR as the guiding principle for financial management because there are other stakeholders beyond the government's regulatory agencies.

7.5.5 Regulation, monitoring and supervision

The partnership working, which is the focus of this study has two main partners that have been adequately mentioned throughout this thesis. However, there are other stakeholders, who are beyond the partners in this study. They include other government departments, community leaders

and members, owners of the private health facilities, staff and patients of these health facilities and so on. Each of these stakeholders have an interest in one way or the other in the operations of these organisations and they expect to be accorded some fairness in their transactions (Clarkson, 1995; Donaldson & Preston, 1995).

The normative principle of this theory is anchored on the premise that all stakeholders in an organisation or a network are accorded equity and fairness in any form of organisational transaction (Clarkson, 1995; Donaldson & Preston, 1995). Moreover, the theory posit that the responsibilities of a firm extend beyond the profit motive of its owners to the interests of many groups of people, who are affected by the actions of the organisation and the organisation is also affected by their actions.

7.6 Comparative advantages of private sector over the public counterparts

The results of this study demonstrate enormous contribution of the mission health facilities to the total development of Ghana's health system. Some of the contributions can be generally categorised as helping to reduce the inequality gap in access to quality health services, provision of specialist services at affordable costs to the clients that hitherto were not available in some of the districts, provision of skilled manpower to supplement the efforts of government in training human resources for health, initiating and shaping national health policies and their involvement in the exchange of important health resources. Yeboah (2003) noted some important contributions of the mission health facilities, which include that they are strategically located in areas that are underserved in health services and governments find it difficult to initiate programmes in those

areas. Also, patients or users of health services perceive their services to be of higher quality than their government counterpart, they have the natural ability to mobilise resources and they possess rich experience in rural and remote health provision. The results of this study are consistent with the findings made earlier by Yeboah (2003), which go to affirm the potentials of the private sector to the general health system development.

7.7 Contribution of the partnership to improving the health of the population

The health sector has been identified as one of the social services sectors that private participation is crucial beside education. It has become more imperative and timely in recent times, in light of the challenges the public sector is facing in healthcare financing, management and provision (Nikolic & Maikisch, 2006). The results in this study show that CHAG institutions have contributed immensely to the health infrastructure of the country. For instance, among the six districts that were involved in this research, three of them do not have any government hospitals. Even the other three, which have government hospitals show considerable performance by the mission hospitals in those districts. The health indicators of the districts over time show remarkable improvements and this is attributed to the combined efforts of the two sectors involved in this study. This development manifests the influences of the resource dependency theory, which posit that partners depend on each other's respective resources to complement their own efforts.

In this study, it was also found that the public and private sector partners combine their efforts in terms of human capital, vehicles, vaccines and other logistics in the provision of public health services. This is done not only intermittently but has become an established phenomenon that is carried out consistently in periodic intervals. This phenomenon helps the partners to minimise the

costs incurred in providing these services single-handedly. This reflects the propositions of the transaction cost theory (Williamson, 1993). The management in this relationship, however, can be described as safeguarded management because of the seeming lack of trust in the relationship (Ebers & Oerlemans, 2013).

7.8 Trust as a determiner of collaborative advantage

Two persons or entities cannot walk together except they agree. This agreement must be based on mutual respect and confidence in each other, which culminate into trust among the partners. Trust is a relational notion that generally lies between people, between people and organisations, and between people and events (Gilson, 2003). Even though trust can also be considered within people, that conceptualisation is not considered in this study. Snavely & Tracy (2002) studied trust among non-profit organisations in rural districts of Mississippi Delta and southern Illinois. They found that rural location of organisations positively correlates with building trust among partners. However, results of the present study do not reflect this proposition in spite of the fact that the study areas are mainly rural. Probably, the interaction between the public and private non-profit sector could account for the diversity or the differences in cultures of the United States of America could be the basis for the difference. That notwithstanding, other contextual factors may be responsible and require further examination.

The benefits of trust to health systems have been well established in the scientific literature (see for example, Gilson, 2003; Kramer, 1999; Tibandebage & Mackintosh, 2005). Gilson posit that trust benefits the health systems at two levels, which are the micro and the macro levels. At the

micro-level, trust benefits people by establishing stable relationships because without trust, successful relationships are virtually impossible (Coulson, 1998). The micro level benefits associated with trust apply to the parties involved in any partnership arrangement or any form of relationship. The macro-level benefits rather provide for the larger society in general. Some of the macro level benefits of trust consist of the overall efficiency achievements resulting from reduction in the monitoring of transactions between the partners. In this way, transaction cost become minimal with its resultant effect of efficiency in resource utilisation. Besides, generalised or affective trust (Gilson, 2003) may promote broader redistributive action and solidarity (Rothstein, 1998), spontaneous sociability (Kramer, 1999), a tolerant society and vibrant social community (Ulsaner, 1999). It has also been reported that trust can benefit society by leading to morally well-intentioned unity within society (Weinstock, 1999). Effectually, by institutionalising trust towards partners within a collaborative network, trust becomes the foundation for a well-ordered society, which eventually produces greater public good.

In the specific case for health organisations, trust is imperative for economic and political viability of health service organisations, financial institutions that provide support to the health sector such as insurance authorities, and the health system in general (Tibandebage & Mackintosh, 2005). This is particularly because the trust among users of health services and service providers is *sine qua non* for organisational peace and tranquillity. Just as trust provides all the benefits discussed above, the opposite of trust, which is mistrust, can also be counter-productive to a health system in several ways. Mistrust and poor relationships with partners have the potential to increase the financial burdens related to illness and can obstruct the smoothness in the partnership arrangement

(Tibandebage & Mackintosh, 2005). The bitterness of the mission health facilities against the public institutions has to be extinguished such that the partnership can be strengthened. The full potentials of both sectors can be exploited when the mistrust is curbed by demonstrating fairness in representation on statutory committees and allocation of health resources.

The study results show a deep-seated mistrust among the partners. It is more crucial because health information that is generated by the institutions is the basis for government's health sector policies. Whiles there is suspicion on the quality of data submitted by the mission health facilities, it is assumed that health policies made based on 'inaccurate data' would have consequences for health sector priorities.

7.9 Partnership working and the health sector reform

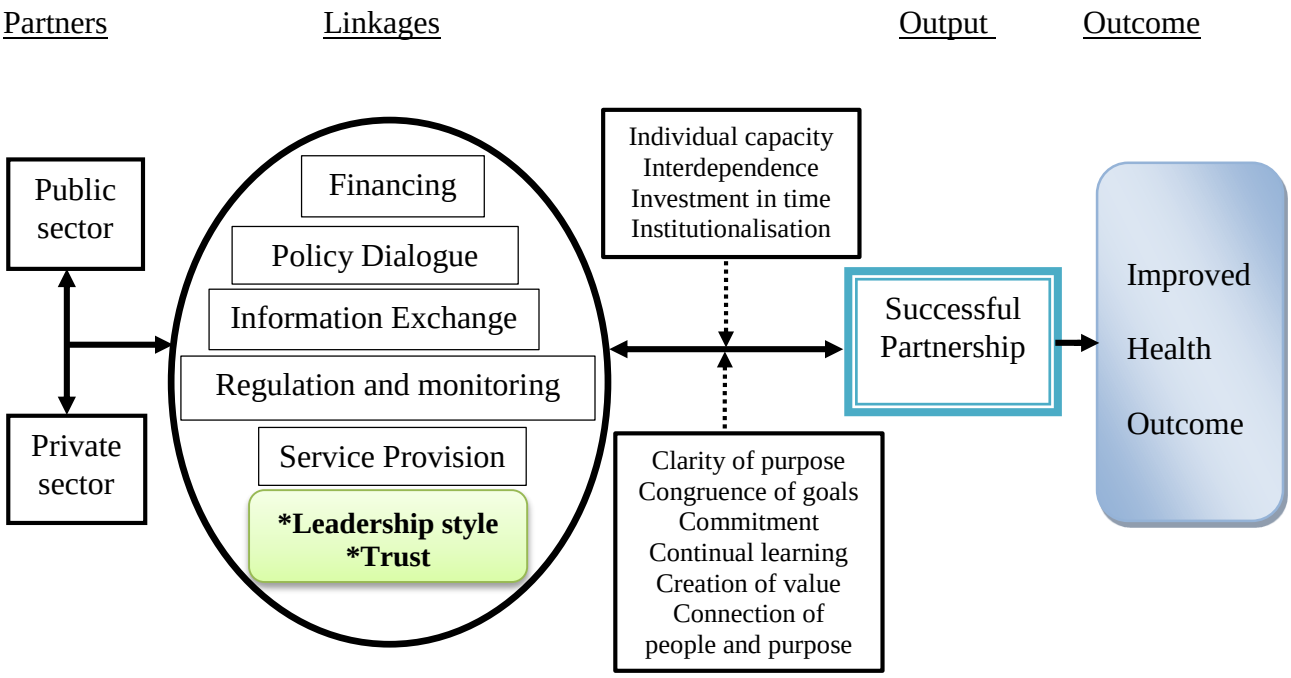
Among the many vehicles for achieving the goals and objectives of health sector reforms is partnership and collaboration among health sector actors. The overarching aim of health sector reform is the improved health status of the population. This overarching aim is portrayed in specific outcomes of health sector reform, which are patient satisfaction, equity in the distribution of health resource, financial risk protection for patients, effectiveness of health interventions, efficiency in the use of health service inputs and the general improvement in health delivery (P. Berman, 1995; Cassels, 1995; Julio Frenk, González-Pier, Gómez-Dantés, Lezana, & Knaul, 2006; Julio Frenk, 1994). Health improvement implies significant rise in the consumption of health services (Berman, 1995), which relates to improvements in the health indicators on life expectancy, mortality and morbidity statistics for the population. Evidence from this research

shows modest gains in the health indicators of the country. This is one of the goals of the health reform. Almost all the participants involved in the study partly attribute these gains to the involvement of the private sector in health sector planning and service delivery. For example, a Municipal Director of Health Services in one of the case study districts puts it this way.

> 'They should be given the credit for most of the health gains of the district since they serve as the main hospital for the district.' ____ KPHD/2

Such developments add to the growing evidence of the positive contributions of the private sector to the improvements in the country's health sector. In addition to the oral evidence by interviewees, the health service utilisation indicators of districts that have both government and mission hospital show that services of private health providers get more utilised than those of government facilities.

Figure 7.1. Operational model for explaining partnership between public and private health sector organisations



Source: Constructed by author from literature and results of the study (2014)

7.10 Reflections on the results and extant literature

From the literature review, the public and private health sector organisations collaborate in diverse ways to improve the health status of the people. As noted by earlier researchers (such as Harding & Preker, 2003; Kanter, 1994; Musgrove, 1996; Reich, 2002), there is a key proposition that PPP for health would be a successful enterprise if there are such action areas as information sharing, policy dialogue, financing, service provision and service regulation. These action areas would be influenced by the 'seven Cs' and 'eight Is' of collaboration to guarantee successful partnership. Evidence from this research, however, show that these elements alone are short of delivering a strong partnership between the private and the public sector health organisations. There is the

need for two other essential elements, which are the leadership and managerial style of the managers in both partner organisations and trust for the partners. The trust must bind all other activities in order to ensure that at all levels, these mechanisms for collaboration do not suffer in any way. Partnerships, generally, do not emerge serendipitously but need to be systematically developed over a considerable period of time. Mutual trust between the partners is a central connecting fibre that the partners must strive to work towards in order to make the partnership sustainable. This can be developed through sharing information voluntarily, full disclosure of financial resources, joint planning and monitoring on more regular but frequent bases and co-implementation of health programmes. This element is essential in that whatever the intentions of partnership working may be, unless it is managed within the framework of mutual trust and respect for each other, the process is likely to suffer some implementation rigmaroles.

Similarly, the leadership style of the managers in the partner organisations play a vital role in relation to the success or otherwise of the partnership arrangement. Results of the study show that despite the MOU and other health sector policies and programmes that address partnerships among the institutions in this study, the sustenance or otherwise of partnerships at the district level depends largely on the human relations of the leaders in both institutions. The human relations between the heads of mission hospitals and the Regional/District Directors of Health Services determine largely what a mission health facility could get from the government sector. This provides further testament to the need for good human relations and behavioural leadership style of leaders in both institutions to ensure that partnerships are sustainable among the public and private health facilities. This development is illustrated in figure 7.1. In conclusion, I propose that

partnership for health services can be successful if and only if there is mutual trust between the partners, and the leadership of the partnering organisations avoid adversarial tendencies but rather pursue conciliatory and peaceful human relations among each other. When this is done, the successful partnership would lead to a general improved health status of the population.

7.11 Summary

In this study, the partnership relationship between the government and non-profit health service organisations have been examined. The purpose of the analysis is to find out what factors necessitated the partnership and how the partnership arrangement is helping to achieve the overall objectives of the health sector reform of Ghana. Several results were identified as answers to the research questions and the objectives that were set out to be achieved. In this regard, this chapter juxtaposed these findings against the results of previous studies in this field. It shows areas of consistency and areas of differentiation from the extant literature. Based on these, the thesis draws conclusions, which are discussed in the next chapter.

CHAPTER EIGHT

SUMMARY OF RESULTS AND CONCLUSION

8.1 Introduction

The main aim for this study is to find out the nature of the partnership between public and private health sector organisations and how they collaborate to achieve the fundamental objective of Ghana's health sector reform, which is to improve the health status of Ghanaians in general. This central objective raised a major research question and some subsidiary research questions that guided the study. This chapter summarises the key findings of the study and draws out conclusions that form the major propositions of this research. To facilitate the discourses in this chapter, the chapter is divided into five main sections. First, the overview of the thesis is presented. Second, the summary of key findings of the study are discussed. Third, the contribution of the thesis is presented, focussing on the theoretical, methodological and policy implications of the thesis. The next section presents recommendations for future studies and finally, the conclusions of this dissertation are presented.

8.2 Overview of the thesis

This thesis is about partnership for health involving the government and private not-for-profit organisations within the context of health sector reform in Ghana. Among other things, the objectives of the thesis include the assessment of the nature and dimensions of the partnership of the organisations involved in this study. Secondly, it seeks to understand the factors that led to this partnership as well as what contributions this phenomenon has made to the improvement in health of Ghanaians. In addition, the study examines the challenges that are faced by the partners

in their working relationship. It also seeks to find out how the partnership has shaped the organisational performance of the institutions that are involved in the partnership. To help the research achieve these objectives, the study employed a qualitative research paradigm, focusing on case study research design technique. The study is located within the neo-institutional theoretical approaches, with emphasis on the institutional isomorphic pressures that shape the behaviours of organisations even though other theories such as resource dependency and stakeholder perspectives helped in the analysis.

8.3 Summary of key findings

The foregoing discussions so far present very important information about the partnership in the delivery of health services in the larger context of Ghana's health reform. The case study location is the Volta Region of Ghana, the reasons for this choice have been explained in detail in chapter five. This section presents a summary of the key findings of the study and draws out conclusion in relation to the research questions posed in chapter one and the objectives that were set in the same chapter. This was realised by interrogating the data collected through interviews, observations and from archival records of the public and private health sector organisations involved in this study.

First, the partnership in this study is based on perceived benefits of both sectors. It emerged from the study that the partners agreed to be involved in this partnership because of the strengths of the other partner, which compensates for the weaknesses of the other. The private sector is into the partnership because the government is in a better position to provide some financial, logistical and

technical support to the private sector. The government is also into the partnership because the private sector is providing health services to the underserved communities, their absence of which the inequality gap in terms of access to quality health service would have been worse than it is currently. Moreover, the private sector has the potential of mobilising critical resources and realising greater efficiency in the utilisation of those resources compared to their counterparts in the public sector. Besides, the human resource requirements for the health sector cannot be met by only the training institutions owned by government. Private health training institutions have contributed immensely to reducing the deficit. The technical expertise of the private health sector organisations have also shaped key national policies on health. Examples of these policies include the social health insurance in Ghana, which is a universal financial risk protection for health users, their involvement in the under-five child health policy, and the maternal health management protocol of the Ministry of Health.

Second, the partnership between the public and the private sector is partly formal and partly informal. The formality of this partnership is anchored on the MOU between the two parties that form the core participants in this study. The MOU spells out the responsibilities, privileges and rights of each partner in clear terms. However, the operationalization of this document is subject to the relative interpretation of the leadership of the two organisations at the district level. In this sense, the personal relations become more of the determinant of how far this process can get actualised at the local level.

Third, the partners have engaged each other through sharing of relevant health information voluntarily, albeit, there are some reservations about this entire process. In addition, there are modes for the joint provision of some critical health services, especially public health actions during National Immunisation Days (NID) and other health education programmes, especially on nutrition and child health. Service regulation, monitoring and inspection are also carried out jointly by the partners. This is normally done through the annual peer review mechanisms that have been instituted in the region, half-year reviews, quarterly performance reviews and other intermittent monitoring and supervision that are carried out by specific units within the larger health system. Policy dialogue is another means of collaboration by engaging each other during discussion fora for setting the agenda for specific periods. The partners engage in regular meetings to set health sector priority every year and keep each other in check. Also, financing is one of the methods of engaging each other. For most part, the public provides more funding for the private sector but in some instances, the private organisations have also supported their public sector counterparts financially.

The management of the private and public health facilities has improved due to the partnership. This is one of the major findings of this study in that the managerial competencies of leadership in both organisations have learnt some core competencies from each other. The seeming competition among these facilities has gingered their counterparts in a bid to outperform each other managerially. This positive rivalry is yielding positive results for the individual organisations and the country's health system in general.

There is, however, a deep-seated mistrust among the partners. Of particular attention is the perception of the private sector that they are not receiving their due from the government counterpart, compared to the health facilities that are directly owned by government. It is considered that while some of the private health organisations are told by word of mouth that they are the district hospitals in their respective districts, there has not been that formal recognition in writing and resources do not get to them as expected. The public sector partners, on the other hand, perceive the private facilities to be economical with information, especially regarding their financial standing and operations. On this mutual suspicion, the full potentials of the partnership are not being realised.

Analogous to the mutual mistrust and suspicion is the perception among the private partners that their efforts in contributing to the health system are not being properly appreciated by their counterpart government facilities. This is explained in the little or no recognition accorded them in the national policies they have initiated or helped in developing, such as the under-five child health policy and the maternal health management protocol. However, this perception is somewhat exaggerated given the findings of this research. This is because some of the District Directors of Health Services duly acknowledge the immense roles of the private health facilities in the planning, delivery and monitoring of health services in their respective districts. What may be the missing link is the failure on the part of the public sector to amply demonstrate this appreciation either publicly by word of mouth or in the relevant documents that result from the initiatives of the private partners. The challenges that are militating against the partnership are summarised in table 8.1 on 233 with corresponding recommendations that could help ameliorate the situation.

Table 8.1. Challenges of the partnership and proposed antidotes

No.	Challenge	Recommendation
1	Lack of trust for each other	Partners should try to build trust for each other through full disclosure and transparency.
2	Disequilibrium in the distribution of health resources	As much as possible, health resources should be equitably distributed with the distribution formula properly communicated to all the stakeholders in the health sector.
3	Perceived non-recognition and attribution for novelty in shaping important national policies	In all circumstances, due recognition and respect should be accorded each partner, especially when it has to do with impact on national policy. This could go a long way to serve as motivation.
4	Ambitious expectation from partners	Partners should try to manage their expectations. This can be achieved through transparency and full disclosure practices.
5	Power asymmetry at the service delivery level	For services that are jointly provided, as much as possible, roles of personnel from each partner should be clearly defined and power lines properly delineated.

Source: Author's compilation from results of the study (2014)

Despite the somewhat few challenges noted above regarding the partnership operations of the actors in this study, the partnership has been very beneficial to both organisations and the general public. The private organisations have been able to increase their resource mobilisation through the financial encumbrances they receive from government while their services in the rural areas have supported government with the health infrastructure of the country. Other examples include the benefits of positive rivalry that engendered improved management practices in their respective institutions and efficiency in resource utilisation, whenever they combine resources in joint service provision. This has to some extent, eliminated duplication of roles in the districts. In general, it is obvious that some notable improvements in the health sector of Ghana emanate from the partnership. However, the partnership has higher potentials that remain untapped. The private and

public sectors are both committed to working with each other, except that they have higher expectation of each other than they currently experience. This partly contributes to the entrenched mistrust among them. Moreover, partnership as one of the pillars of Ghana's health sector reform, has helped in improving the health status of Ghanaians hence the ability of the partners to address the issues of trust would go a longer way to register better health outcomes for the country.

8.3 Contributions of the study

There is consensus among scholars that a doctoral dissertation must make original contribution to knowledge. Such contributions vary in extent with respect to discipline or subject area. Francis (1976) cited in Phillips & Pugh (1998), point out several ways an originality can be made in a doctoral dissertation. Some of these are summarised in table 8.2 on page 235. After some decades, Phillips & Pugh (2010) provide nine various ways by which a doctoral thesis can make an original contribution to knowledge. These modes of contributing to knowledge are listed in table 8.3 on page 235. Collectively, these authors put forth at least fifteen different ways by which a doctoral dissertation can make an original contribution to knowledge. Given this background, this study has made original contribution to knowledge in several ways. However, these contributions would be discussed under different sub-headings in the following sub-sections, which focus on contribution to empirical literature, contribution to theory, methodological contribution and contribution to policy and practice.

Table 8.2. How a thesis can make original contribution to knowledge

No.	Mode of contribution
1	Setting down a major piece of new information in writing for the first time
2	Continuing a previously original piece of work
3	Providing a single original technique, observation, or result in an otherwise unoriginal but competent piece of research
4	Carrying out original work designed by the supervisor
5	Having many original ideas, methods and interpretations all performed by others under the direction of the postgraduate
6	Showing originality in testing somebody else's idea

Source: Francis (1976) cited in Phillips & Pugh (1998)

Table 8.3. Various forms of original contribution to knowledge

No.	Mode of contribution
1	Carrying out empirical work that has not been done previously
2	Making a synthesis of issues that have not been made before
3	Using already known material but with new interpretation
4	Trying out something that has previously only been done abroad
5	Taking a particular technique and applying it in a new area
6	Bringing new evidence to bear on an old issue
7	Being cross-disciplinary and using different methodologies to interrogate some issue
8	Looking at areas that people in the discipline haven't looked at before
9	Adding to knowledge in a way that has not been done previously

Source: Adapted from Phillips & Pugh (2010)

8.3.1 Contributions to empirical literature

The literature review in the course of this research shows that there are several studies that focus on PPP of varying degrees, especially PPP involving the public and the private-for-profit sector organisations. Even though there are some studies involving partnerships of public and private not-for-profit organisations, most of those studies are done not in Africa or developing countries. They focus their attention more on developed countries or developed health systems rather than developing countries (see for example Andrews & Entwistle, 2010; Austin & Seitanidi, 2012;

Bazzoli *et al.*, 1997; Bryson, Crosby, & Stone, 2006; Cappellaro & Longo, 2011; Dickinson & Glasby, 2010; Gazley & Brudney, 2007; Gazley, 2008; Gray, 1985; Hailey, 2007; Ratzan, 2007; Selsky & Parker, 2005). Studies that address partnerships in the developing health systems are relatively scanty. This thesis extends the frontiers of knowledge of this field in the developing countries. It makes a modest contribution by proposing that it is possible for a partnership arrangement to be both formal and informal at the same time. The present case study reveals that the partnership between the public and non-profit health organisations operates at the meso-level of formality-informality continuum of collaboration.

8.3.2 Theoretical contributions of the study

The background and focal theories that guided this research have some precipitating normative rationale. Their application to explain the complex relationships between government and private sector health organisations in this study has made an extension to the theories' applicability. Institutional isomorphic forces that have been widely used in research on partnerships have received further attention by their applicability in this study. The behaviour of the government and private health service organisations in Ghana have not been researched previously using the theories that form the foundation for this study. Proponents of coercive isomorphic forces posit that regulators in an institutional environment discourage innovative competition among partners (Scott, 1987; Zucker, 1987). However, results of this study demonstrate the contrary view in that regulatory authorities encourage competitive innovation. This is a modest contribution to the institutional theory of organisations. Moreover, the theoretical pluralism that characterise this study convey a further addition to knowledge by providing a convergence of diverse theories to explain a particular phenomenon at the same time. This study has been able to analyse the

partnership working of the private not-for-profit health providers and the government counterparts using a combined force of different theories. This extension in the theories in the Ghanaian context add some originality to the theoretical literature. Finally, this study has successfully developed a conceptual framework and an operational model that could help researchers and practitioners in analysing PPP, especially from the perspective of non-profit private sector. The framework and the model could be adapted for studies in other areas beyond the health sector.

8.3.3 Contributions to method

The complexities of health services and health systems in general require methodological pluralism and creativity that utilises the strength of different research approaches. This notion has been established among scholars (see for example, Mesel, 2013; Corbin and Strauss, 2008; Creswell, 2003; Yin, 2002). Although the relevance of methodological triangulation need no belabouring, the theoretical pluralism that characterises this study add to the growing need for combined methods for doing research in the health sector. In addition, most of the studies on PPP have adopted quantitative research designs with positivist epistemology. However, this study successfully makes the argument for the possibility of applying qualitative research design with a more transactional epistemological orientation.

8.3.4 Contributions to policy and practice

The contribution of a doctoral thesis to policy may be to either suggest a revision in a policy document or negate the status quo in the policy. Ghana recently developed a national policy on PPP. The focus of the policy is predominantly on the partnership between government and private for-profit business organisations for infrastructural projects and other services that are mainly of

commercial interest. Very little attention was given to the partnership arrangement between government and non-profit organisations for the provision of social services in the policy. The findings in this research add impetus to revision in the national policy on PPP to reflect the contribution and potentials of non-profit private sector organisations, especially for the provision of social services. In this regard, discussions on PPP in the country should be context-specific in order to create space for all categories of private sector actors to be involved.

Given the background to the partnership between government and non-profit health service organisations, the relationship has improved considerably over the years from strong informality to near absolute formality. However, apart from the MOU between CHAG and MOH/GHS, the Ghana Health Service and Teaching Hospitals Act, 1996 (Act 525) and its relevant Regulations do not state the specific roles of CHAG institutions despite their monumental contribution to the development of the country's health system. The findings in this research would provide a basis for a more solid legal framework for engaging the partners by bringing to the fore, their innumerable contributions to the entire health system of Ghana.

In addition to practice, the element of mistrust, which has dwarfed the gains of the collaboration of the partners involved in this study has been amply brought to the fore for attention of health sector partners. Inasmuch as the organisations decide to work together, their combined efforts can only bring about the greatest possible outcomes if and only if they trust each other (Gilson, 2003; Goudge & Gilson, 2005; Welch, 2006). To this end, it is recommended that the relationship between the partners should be based on trust. It is about time the organisation of the health system

considered trust-based health system. When this is done, it would help improve trust between partners in health and the relational notion of trust between patients, the service provider, donors and government, and other stakeholders in the health sector.

8.4 Suggestions for future research

Even though this study attempts to explain the partnership working in detail and made some modest contribution to knowledge, some aspects within this subject area remain untouched. The conclusion of this study provides a bedrock for future researches involving partnerships for health in developing countries. One major factor that emerged as a stumbling block to the full benefits of the study is mistrust among the partners. This emerged from the deep seated suspicion they have for each other. This study considers trust as a holistic item by proposing that it must cut across all levels and dimensions of the partnership to make it very successful. Future researchers can interrogate the trust concept from diverse dimensions and levels of the partnership.

Also, although the theoretical pluralism approach that was used to explain the complex partnership arrangement in the study, the choice of the specific theories of inter-organisational collaborations may have influenced the nature of the study results. It is further suggested that future researchers should consider the possibility of applying other theories of organisations and administration to address partnerships from their perspectives.

Further studies are needed to include the private-for-profit health service sector in order to extend the relationship between the public sector and the entire private sector. The findings in this study,

although relevant to theory, method, policy and practice, the dimension focusses exclusively on the non-profit sector and the government health sector. Extending this study to cover the commercial health service providers may add to the revelations in this study.

8.5. Conclusion

The conclusion of a thesis means different things with respect to disciplines. Whatever it connotes, there is a common strand of fibre that provides homogeneity in the conclusion of a doctoral dissertation. This, according to Phillips & Pugh (1998), is the central argument advanced by the dissertation. It communicates the philosophy or thesis of the dissertation. The philosophy or thesis in this dissertation is summarised in the succeeding paragraphs.

Partnerships for health are age-old phenomena that have received considerable attention in research. While some scholars advocate their strengths, others posit that they do more harm in the long run than good. This dissertation examines the partnership between government health organisations and private not-for-profit organisations. In this study, it is argued that the partnership came to being as a result of both systemic factors external to the individual organisations and internal organisational factors of the institutions in the partnership. The systemic factors include external economic challenges that resulted in resource scarcity for the organisations in the health sector hence the need for combining each other's strengths. The partnership also resulted from the need to learn from credible partners that have the track record of efficient utilisation of scarce health resources. CHAG institutions have shown the wherewithal in this regard hence government's interest in engaging them as credible partners. In addition, the presence of CHAG

facilities in the hard-to-reach remote areas facilitated the need for the partnership since they provide homogenous health services like the public sector health service organisations. Moreover, the ultimate responsibility lies with the state to meet the health needs of the population, of which resource constraints restrict the extent to which this duty is being fulfilled. It is therefore natural to partner with CHAG, which is already playing those roles in lieu of the state.

Results of this study show that partnerships are very useful to improving the health status of the population, which is the fundamental goal of the health sector reform in Ghana. It is argued that PPP is useful to health delivery, especially as an important approach towards realising the objectives of the health sector reform in Ghana. However, the extent of mistrust among the partners is insidiously hampering the partnership process. The partners should continue to engage each other in sharing relevant information, providing services jointly in order to guarantee efficiency in resource utilisation, carry out joint monitoring and supervision, provide financial support to each other and engage in open and transparent policy dialogue to encourage cooperation among the partners. In addition to these mechanisms, the partners must consciously develop mutual trust to enable the partnership result in better health gains for the country.

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LIST OF APPENDICES

APPENDIX A: INTERVIEW GUIDE

PUBLIC-PRIVATE PARTNERSHIP IN THE CONTEXT OF GHANA'S HEALTH SECTOR REFORM: A CASE STUDY OF PRIVATE NOT-FOR-PROFIT ORGANISATIONS IN THE VOLTA REGION OF GHANA

Introduction to the Study

Thank you very much for taking the time to talk to me today. I am a doctoral student at the University of Ghana, specifically, in the Department of Public Administration and Health Services Management in the Business School. Here is my card with my contact information.

I am conducting research on the nature, impact and outcomes of inter-relationships between public and private sector agencies in the reform implementation in the health sector of Ghana, using private not-for-profit healthcare providers as a case study. I am talking to many experts like yourself, as well as government employees, employees of the private healthcare providers, staff of donor agencies etc. This research is purely academic. It will not be used for any investigative or journalistic purposes. All answers will be kept strictly confidential. I will not use your name or organisation's name in any reports, unless you want your name to be mentioned.

There has been a debate in the extant literature regarding the contribution of the private healthcare providers in the health system of developing countries. While some scholars argue that public-private engagements play a positive role in enhancing the efficient use of scarce resources for health and improve access to quality care, others are of the view that not all government engagements with the private health sector are good and result in a rip off on the citizenry. This research seeks to resolve this debate by assessing the contribution of the private sector in the health sector.

I would like you to answer as frankly as possible. Answers will not be treated as a reflection on either your reputation or that of your organisation and it will not be possible to identify respondents from the results.

I would be very grateful, if you could spare some time with me to engage in this interview, which may last between 30 to 45 minutes.

PART A: Officials at RHD/DHA of affected districts

Organisation Name:
Person Interviewed:
Address:
Telephone Number:
Email Address:
Date:

1. RESPONDENT BACKGROUND

First, I'd like to learn a little bit more about you and your work here at _____.

(a) What is your position, title?
(b) How long have you been working at _____?
(c) How did you come to work today _____?
(d) What are your main responsibilities/research projects?

2. BACKGROUND OF THE ORGANISATION

(a) How old is this health facility (DHA)?
(b) Can you please tell me a little bit about the history of this institution? (when it was established and when a formal collaboration started between your organisation and the mission hospital in this district)
(c) Is there existence of partnership between your organisation and the DHA/other government health facilities? What is the scope?
(d) What is the level of formality with respect to this collaboration? reasons for partnership,
(e) At the onset of the collaboration, what were the linking mechanisms? (E.g. powerful sponsors/general agreements on problems/existing network etc.)

3. MECHANISMS FOR COLLABORATION

Policy and dialogue

(a) Do you have an existing policy for engaging with the public sector/non-public service providers?
(b) What can you tell me about the implementation of the engagement policy? (is it being followed religiously or otherwise)
(c) What are the roles of your organisation in this mechanism for dialogue with public sector/non-public service providers?
(d) How often do you activate this mechanism for collaboration?

Information exchange

(a) Is the private sector included in information exchange? How?
(b) Are the CHAG institutions included in Disease Surveillance (IDSR) Program? How are they involved?
(c) Is the private sector required to provide information to MOH/GHS/DHA beyond disease Surveillance? How is this done?
(d) What kind of information is the private sector required to provide the government agencies?
(e) Do you provide updates to the private sector organisation on disease surveillance? How is this done?
(f) What other information do you share with them and the vice-versa?

Regulation

(a) Can you please tell me about which unit/department that is responsible for maintaining standards in the private health facilities?

(b) Can you please tell me about the process of carrying out quality assurance in these facilities?
(c) How would you describe the quality of private health sector provider's registry/records management?
(d) Do you have any reported judgment on the quality of their services?
(e) Do you usually follow through with these regulation as intended? How is that done?
(f) What are the standardized rules for starting a private health facilities?
(g) Are the quality control mechanisms the same for private and public health facilities?
(h) What are the processes of license renewal? Can you please provide me with the key ingredients in the requirement?
(i) How would you generally describe the governance structure of this partnership?

Financing

(a) Do you (government institutions) engage the private sector with service contracts?
(b) Do you provide any financial incentives for private health sector operators?
(c) What are the major methods for financing health services in the private facilities?
(d) How much are the private health sector providers included in national health insurance?

Public provision of services

(a) Do you (DHA) and other private service providers receive vaccines, medicines or similar items for distribution? What is the process like?
(b) Is there a functioning public-private referral process?
(c) How is this process initiated and coordinated?
(d) What are the key roles of your organisation in this collaborative process?

4. CONTRIBUTIONS OF THE PRIVATE SECTOR TO HEALTH DELIVERY

(a) What can you describe as the major contribution(s) of the private sector participants (CHAG institutions) in the health delivery process?
(b) How do you think these contributions have enhanced the overall health status of the people?
(c) Are there any specific cases of the private organisations supporting the public sector?
(d) Do you think this collaboration has created public value? How?
(e) Do you engage in regular reassessments? Can you please tell me a little more about the process?

5. CHALLENGES OF THE COLLABORATION

(a) Are there any challenges that you have identified since working in collaboration with the private sector?
(b) What are some of these challenges?
(c) How do these things hinder the collaboration process?

6. OTHER AREAS OF INTEREST

(a) What are the values of your organisation in this collaboration?
(b) What re your expectations in terms of benefits and risks associated with this partnership?

(c) How are power relations between the two partners? (Who can do what?)

Closing: Thank you very much for your time today. As you probably know, things in Universities do not usually move very fast as in the business world. Yet I will try as much as possible to make my final research report available to you when it is finished. But for now, please you can contact me if you have any questions or any additional information you'd like to share. All the same, I may call on you again if I need any further clarification on the answers you provided me today.

PART B: Administrators/Managers of CHAG institutions

Organisation Name:
Person Interviewed:
Address:
Telephone Number:
Email Address:
Date:

1. RESPONDENT BACKGROUND

First, I'd like to learn a little bit more about you and your work here at _____.

(a) What is your position, title?
(b) How long have you been working at _____?
(c) How did you come to work today _____?
(d) What are your main responsibilities/research projects?

3. BACKGROUND OF THE ORGANISATION/COLLABORATION PROCESS

(a) How old is this health facility?
(b) Can you please tell me a little bit about the history of this institution?
(c) Is there existence of partnership between your organisation and the private health providers? What is the scope?
(d) What is the level of formality with respect to this collaboration? (reasons for partnership)
(e) At the onset of the collaboration, what were the linking mechanisms? (powerful sponsors/general agreements on problems/existing network etc.)

4. MECHANISMS FOR COLLABORATION

Policy and dialogue

(a) Do you have an existing policy for engaging with the public sector service providers?
(b) What can you tell me about the implementation of the engagement policy?
(c) What are the roles of your organisation in this mechanism for dialogue with public sector service providers?
(d) How often do you activate this mechanism for collaboration?

Information exchange

(a) Is your organisation included in health information exchange? How?
(b) Is your organisation included in Disease Surveillance (IDSR) Program?
(c) Is the private sector required to provide information to MoH beyond disease Surveillance? How is this done?
(d) What kind of information is the private sector required to provide the government agencies?
(e) Are you provided with updates by the MoH and/or its agencies on disease surveillance? How is this done?

Regulation

(a) Can you please tell me about which unit/department at the ministry that is responsible for maintaining standards in the private health facilities?
(b) Can you please tell me about the process of carrying out quality assurance in your facilities?
(c) How would you describe the quality of your organisation's registry/records management?
(d) Do you have any reported decision on the quality of your services?
(e) Do MoH and/or its agencies usually follow through with these regulations as intended? How is that done?
(f) What are the standardized rules for starting a private health facilities?
(g) Are the quality control mechanisms the same for your organisations and public health facilities?
(h) What are the processes of license renewal? Can you please provide me with the key ingredients in the requirement?
(i) How would you generally describe the governance of this partnership?

Financing

(a) Do government agencies use engage private sector with contracts?
(b) Do you provide any incentives for private health sector operators?
(c) What are major methods for financing health services in the private facilities?
(d) How much are the private health sector provided included in national health insurance?

Public provision of services

(a) Do you receive vaccines, medicines or similar items for distribution?
(b) Do we have a functioning public-private referral process?
(c) How is this process initiated and coordinated?
(e) Which other ways are you involved in the provision of public health services?

5. CONTRIBUTIONS OF THE PRIVATE SECTOR TO HEALTH DELIVERY/PERFORMANCE OF THE ORGANISATION

(a) What can you describe as the major contribution(s) of the private sector participants in the health delivery?
(b) How do you think these contributions have enhanced the overall health status of the people?

(c) Are there any reported accomplishments?
(d) Are there any specific cases of your organisation supporting the public sector?
(e) How has this collaborative structure influenced the performance of your organisation over the years?

6. CHALLENGES OF THE COLLABORATION

(a) Are there any challenges that you have identified since working with the public sector?
(b) How do these things hinder the collaboration process?
(d) Do you think this collaboration has created public value? How?
(e) Do you engage in regular reassessments? Can you please tell me a little more about the process?

Closing:

Thank you very much for your time today. As you probably know, things in Universities do not usually move very fast as in the business world. Yet I will try as much as possible to make my final research report available to you when it is finished. But for now, please you can contact me if you have any questions or any additional information you'd like to share. All the same, I may call on you again if I need any further clarification on the answers you provided me today.

APPENDIX B: WRITTEN CONSENT FORM

WRITTEN CONSENT FORM FOR RESEARCH PARTICIPANTS

I, the undersigned, have been given information on a planned study on **public-private partnership for health delivery in the context of Ghana's health sector reform programme.** I have been assured that all materials from the interviews will be treated with anonymity and kept confidentially. Both the tapes and the transcribed text will at all times be handled with strict confidentiality. Only the researcher involved will have access to them. I have also been assured that during the interviews, I have the freedom not to answer such questions I choose not to without any obligation to explain why. Moreover, I am informed that I am free to withdraw from the interview at any time unconditionally.

The researcher has assured me that the tapes and the typed or written text from the interviews will be destroyed after University of Ghana accepts the research report for the award of his degree. At no time during and after this study shall I demand to know the details of the interviews I granted the researcher.

On the basis of the information provided about the study, I agree to sign this document, which implies that I consent to the following (Tick as appropriate):

☐ I give my consent to be interviewed

☐ I give my consent to be tape-recorded

Name_____
(Research participant)

Signature_____ Date: _____

_____
Francis A. Adzei (Researcher)

APPENDIX C: LIST OF CATEGORIES OF INTERVIEWEES

Community Health Nurses
Disease Control Officers
District/Municipal Directors of Health Services
Hospital Accountants
Hospital Administrators
Medical Superintendents/Medical Officer In-Charge of Hospitals
Nurse Managers/Hospital Matrons
Pharmacists
Public Health Nurses
Senior Administrator at MOH/GHS
Senior Manager at CHAG Headquarters

APPENDIX D: ETHICAL CLEARANCE AND SAMPLES OF LETTERS FOR PERMISSION

Appendix D – 1: A letter granting ethical clearance for the study

UNIVERSITY OF GHANA
ETHICS COMMITTEE FOR THE HUMANITIES (ECH)

P. O. Box LG 74, Legon, Accra, Ghana

My Ref. No.....

14th March, 2014

Mr. Francis Anderson Adzei
Dept. of Public Admin. & Health Services Mgt.,
University of Ghana Business School
University of Ghana
Legon

Dear Mr. Adzei,

PROTOCOL ECH 039/13-14: PUBLIC-PRIVATE PARTNERSHIP FOR HEALTH DELIVERY IN THE CONTEXT OF GHANA'S HEALTH SECTOR REFORM PROGRAMME: A CASE STUDY OF PRIVATE NOT-FOR-PROFIT ORGANISATIONS IN THE VOLTA REGION OF GHANA

This is to advise you that the above reference study has been presented to the Ethics Committee for the Humanities and the following actions taken subject to the conditions and explanation provided below:

Expiry Date:	11/03/15
On Agenda for:	Initial Submission
Description:	21/02/14
ECH Action:	Approved
Explanation:	The proposal was approved subject to the investigator providing information on the selection of subjects.

Please accept my congratulations.

UG/ISSER/ECH VALID UNTIL 11 MAR 2015 APPROVED DOCUMENT

Yours Sincerely,

Rev. Prof. J. O. Y. Mante
ECH Chair

CC: Director, ISSER

Tel: +233-303933866 Email: ech@isser.edu.gh

Appendix D – 2(i): Sample letter of introduction from the Regional Health Directorate

In case of reply the number and the date of this letter should be quoted

My Ref No. VRH/ORD/46

Your Ref. No.....

Our Core Values

PEOPLE-CENTRED
PROFESSIONALISM
TEAMWORK
INNOVATION/EXCELLENCE
DISCIPLINE
INTEGRITY

GHANA HEALTH SERVICE
Your Health · Our Concern

Regional Health Directorate
GHANA HEALTH SERVICE
P. O. BOX 72
HO. V/R.
Tel: (03620) 28210
Fax : (03620) 28244
rdhs.vr@ghsmail.org

April 29, 2014

LETTER OF INTRODUCTION

This is to introduce Mr. Francis A. Adzei, a PhD[Public Administration] candidate at the University of Ghana, Legon.

As part of the requirements of the programme, he has chosen to research on the topic: Public-private partnership for health delivery in the context of Ghana's health sector reform programme: A case study of private not-for-profit organization in the Volta Region of Ghana.

I shall be very grateful if you will kindly assist Mr. Francis Adzei to carry out his study in your facility.

Thank you.

[REJOICE BLEBU]
AG. DEPUTY DIRECTOR [ADMIN.]
for: REGIONAL DIRECTOR OF HEALTH SERVICES
VOLTA REGION

THE MUNICIPAL DIRECTOR OF HEALTH SERVICES,
GHANA HEALTH SERVICE, KPANDO

THE AG. DISTRICT DIRECTOR OF HEALTH SERVICES, NORTH DAYI,
ANFOEGA.

THE AG. DIST. DIRECTOR OF HEALTH SERVICES, KETU NORTH – DZODZE

THE AG. DIST. DIRECTOR OF HEALTH SERVICES, SOUTH TONGU,
SOGAKOPE.

THE MUNICIPAL DIRECTOR OF HEALTH SERVICES, KETA. ✓

THE AG. DIST. DIRECTOR OF HEALTH SERVICES, NORTH TONGU, BATTOR.

Appendix D – 2(ii): Sample letter of introduction from the University of Ghana

UGBS

University of Ghana Business School

Ref. No.: PAHS/26

17th February, 2014

To Whom it May Concern

Dear Sir/Madam,

LETTER OF INTRODUCTION

The bearer of this note, Mr. Francis A. Adzei is a PhD (Public Administration) candidate at the Department of Public Administration and Health Service Management, University of Ghana Business School, Legon.

As part of the requirements of the programme he has chosen to research on the topic: ***Public-private partnership for health delivery in the context of Ghana's health sector reform programme: A case study of private not-for-profit organisations in the Volta Region of Ghana.***

I would be most grateful if you could give him the necessary assistance to facilitate his data collection.

Thank you.

Yours faithfully,

Prof. E.K. Sakyi
Head of Department

Appendix D – 2(iii): Sample letter seeking permission of entry

UG|BS
University of Ghana Business School

April 1, 2014.

The Municipal Director of Health Services
Keta Municipal Health Directorate
Volta Region

Dear Sir,

PERMISSION TO CARRYOUT AN ACADEMIC RESEARCH

I write to seek your permission to include your municipality in a study we are conducting. This piece of academic work is on the nature, impact and outcomes of inter-relationships between public and private sector agencies in the reform implementation in the health sector of Ghana.

We are talking to many experts like yourself, government employees, employees of the private healthcare providers, staff of donor agencies etc. This research is purely academic and it will not be used for any investigative or journalistic purposes. All answers will be kept strictly confidential. Your name or that of your organisation will not be used in any reports, unless you would like us to do so.

I would be very grateful, if you would kindly permit me to interview some important staff in your health directorate as part of the study sample.

Find attached the Ethical Clearance given by the University of Ghana's Ethics Committee for the Humanities and a letter of introduction from the Regional Health Directorate.

I count on your favourable cooperation.

Yours sincerely,

Francis A. Adzei
[Doctoral Research Student]

Department of Public Administration and Health Services Management
P. O. Box LG 78, Legon, Accra, Ghana
Telephone: +233-302-500593 | Mobile: +233-24-8294824 | Fax: +233-302-500024
***Email*: fadzei@ug.edu.gh**

APPENDIX E: PROFILE OF CASE STUDY DISTRICTS

Appendix E – 1: Ketu North District

The Ketu North District is one of the twenty five (25) Municipalities and Districts in the Volta Region of Ghana. The district shares boundaries with the Republic of Togo to the east, to the west with Akatsi North District, to the south with Ketu South Municipality and to the north with Akatsi North District and the Republic of Togo. The administrative capital of the District is Dzodze. The District was known as the Ketu District until the year 2008 when the Ketu North District was carved out of it. The District covers a land area of 754km^2 with a population of 99,913 according to 2010 population census (Ghana Statistical Service, 2012). The district's population is growing at a rate of 1.9% which is lower than the national rate of 2.6%. The population is dominated by females (53.7%) and has a large labour force constituting 52.5% of the population. Though the dependent population is quite high (45.2%), their effect on the active population could be lower since most of those in the senile age group could still be engaged in one form of agricultural production or the other. There are four traditional paramountcies in the district, which include Dzodze, Penyi, Afife and Weta. These paramount chiefs, however, collaborate in the implementation of most development projects. The people living in the area are petty traders and mat weavers with few public servants interspersed among them. Most of the inhabitants of the district are African traditional worshipers followed by Christians with various denominations and few Moslems.

Appendix E – 2: Keta Municipality

Keta Municipality, with Keta as the administrative capital is one of twenty five (25) Municipalities and Districts in the Volta Region of Ghana. The Municipality lies within Longitudes 0.30E and 1.05E and Latitudes 5.45N and 6.005N. It is located east of the Volta estuary, about 160km to the east of Accra, off the Accra-Aflao main road. It shares common borders with Akatsi South District to the north, Ketu South District to the east, South Tongu District to the west and the Gulf of Guinea to the south. Out of the total surface area of 1,086km^2, approximately 362km^2 (about 30 per cent) is covered by water bodies. The largest of these is Keta Lagoon, which is about 12 km at its widest section and 32km long. Hence, the remaining land area is only 724km^2, a situation which creates severe constraints on access to land for development in the municipality. However, fishing and water transportation potentials exist. The main economic activities are fishing, petty trading by women and peasant farming. There are also some pottery activities for commercial viability in some areas. As 2010, the total population is 147,618 made up of 68,556 males and 79,062 females. The major religions in the area are Christianity and African traditional religion.

Appendix E – 3: Kpando Municipality

Kpando Municipality is one of the twenty five (25) Municipalities and Districts in the Volta Region of Ghana and it is one of the oldest in the country. The Municipality lies within Latitudes 6° 20' N and 7° 05' N, and Longitude 0° 17' E. It shares boundaries with Biakoye District in the north, Afajato South to the East and North Dayi District in the south. The Volta Lake, which stretches over 80km of the coastal line, demarcates the western boundary. The Municipality covers approximately a total land area of 820 square kilometres representing 4.5% of the Volta Region with almost 30% of the land submerged by the Volta Lake. Kpando, the Municipal capital, is about 70km from Ho, the Regional Capital. The location of the Municipality places it at a strategic position with potential for fast economic growth and development. The major economic activities include fish farming, fishing in the Volta River, food crop farming and merchandise trading. Majority of the people are Christians.

Appendix E – 4: North Dayi District

North Dayi District is one of the twenty five (25) Municipalities and Districts in the Volta Region of Ghana. With its administrative capital Anfoega, the district was carved from Kpando and forms part of the new districts and municipalities created in the year 2012 and were inaugurated at their various locations simultaneously on the 28th June, 2012. The District shares boundaries with Kpando Municipality to the north, to the south with South Dayi District, to the west with Afram Plains South District and to the east with Hohoe Municipality. As a newly-created district, it is predominantly rural in that infrastructural development in this district is not very good. The main economic activities include petty trading and farming. As at 2010, the total population is 93,649, representing 44,553 and 49,096 males and females respectively (Ghana Statistical Service, 2012). The main religion of the people is Christianity followed by African traditional religion.

Appendix E – 5: South Tongu District

South Tongu is one of the twenty five (25) Municipalities and Districts in the Volta Region of Ghana. The administrative capital of the District is Sogakofe. The district shares boundaries with the Central Tongu District to the north and north-west, the Akatsi South District to the north-east, Keta Municipal to the south and the Dangme-East District to the west and south-west. The main river draining the district is the Volta, which runs along its western border, but it is also drained by numerous streams, prominent among them being the Chinni and Todzi, with a large number of lagoons in the southern sector of the District. The District lies within the wet semi-equatorial and dry equatorial climatic zones, which are very good for livestock production. The coastal strip is covered by swamp and mangrove vegetation. South Tongu had an estimated population of 87,950 as at 2010 (Ghana Statistical Service, 2012). This is made up 40,019 and 47,931 males and females respectively. The major economic activities in the district are peasant agriculture and petty trading. There are also some nomadic cattle farmers, who are mainly settlers in the districts. There are three main religions, which are Christianity, African traditional religion and Islam.

Appendix E – 6: Nkwanta South District

Nkwanta South District is one of the twenty five (25) Municipalities and Districts in the Volta Region of Ghana. The district is located in the northern-most part of the region. It lies between latitudes 7 30° and 8 45° North and longitude 010° and 045° East. The district is bounded to the north by the Nkwanta North District, to the south by the Kadjebi District, to the East by the Republic of Togo and to the West by Krachi East District. Nkwanta South District was carved out of Kete-Krachi district in 1989. The administrative capital of the district is Nkwanta. The economic activity in the district is mainly peasant farming and petty trading. It is predominantly rural in nature and basic infrastructure in terms of roads and communication are poor. As at 2010, the total population is 117,878 made up of 58,482 males and 59396 females. The major economic activities in the district are farming and petty trading. The main religions in the area are Christianity and Islam.