

*Promoting Healthcare
Delivery Through
Partnerships: Nature
Of The Public Private
Partnership Approach
In The Upper West
Region Of Ghana*

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ABSTRACT

Globally, continuous rising prices, changing disease patterns, and increasing need for sophisticated technology for diagnosis and treatment in healthcare have made PPP an attractive approach in the health sector. However, its content and implementation varies from one location to the other. Using exploratory survey design and a combination of qualitative and quantitative approaches, this study explored the nature and character of public partnerships in the Upper West Region of Ghana. The study revealed that the partnership between the public health regulators and private care providers in the Region is not adequately complementary in the planning and management of healthcare delivery. In terms of completed projects, PPP has been effective in enhancing the health status of the population and efficient in meeting timelines. However, in terms of meeting timelines on overall partnership objectives, attaining cost targets or ensuring consistency with national healthcare goals, there are significant gaps. Besides regulatory lapses, there is generally little policy direction and action. A new agenda of partnership guided by commitment to policy direction and action, strong regulation and integrated approach to stakeholder participation is proposed, for effective and efficient PPPs in healthcare delivery.

Keywords: Public-private partnerships, healthcare, policy, Upper West Region, Ghana

1. INTRODUCTION

The private sector has become prominent in healthcare delivery in both developed and developing countries. In sub-Saharan Africa (SSA), private providers account for about 50% of healthcare provision (International Finance Corporation, 2008). About half of clients in SSA, two-thirds in South East Asia and four-fifth in South Asia rely on the private sector providers (USAID and World Bank, 2014). According to the World Bank Group (2012), out of US\$55 billion which was spent on healthcare in Africa in 2007, 55% was financed by the private sector, especially individual philanthropists. Despite the contribution of the private health sector, defining an explicit role for it remains a controversial issue.

Due to budgetary constraints in the public sector, it has been argued that national health systems can best be served by optimising the private health sector (Berman, 1997; Harding & Preker, 2003; International Finance Corporation, 2008). Recent evidence from sub-Sahara Africa suggests that increase in private sector participation may lead to greater access to services as well as greater equity (Yoong, Burger, Spreng, & Sood, 2010). Consequently, many governments use public private partnerships as a complementary approach through which public and private sector providers can pull resources together in ways that drive positive change in healthcare delivery.

Globally, while some PPP projects have proceeded smoothly, others have had challenges (Moore, 2005). In sectors such as transport, energy and utilities, there have been an increasing number of documented cases in which PPP arrangements have failed to deliver services to meet the satisfaction levels of stakeholders (Dixon, Dogan, & Kouzmin, 2004; English & Walker, 2004; Newberry & Pallot, 2003; Watson, 2003). The experiences in these sectors have led to scepticism amongst many analysts about the assumption that such inter-organisational relationships can be truly equitable (Dixon et al., 2004; Newberry & Pallot, 2003).

The private health sector in Ghana is a large and important actor in healthcare delivery. Nearly all health experts conservatively estimate that between 25% and 50% of total health expenditure is accounted for by private health actors (Bitran, 2011; Ghana Statistical Service, 2005). The immense role of the Private Health Sector in the country's quest to improve access to quality healthcare has been duly recognised and amply demonstrated in the Ministry of Health Private Health Sector Policy (2012). The goal of the subsector policy is to promote a pluralistic health sector to ensure improved access and quality of care for all people living in Ghana. The prominence given to the subsector emanates from recognition of its potential contribution towards achieving large-scale improvements in public health. However, how to best to engage the private health sector in a manner that produces desirable outcomes remains unanswered (Sood, Burger, Yoong, Kopf, & Spreng, 2011).

The private healthcare providers range from traditional healers, informal drug vendors and private for-profit providers, to not-for-profit providers (Marek, O'Farrell, Yamamoto, & Zable, 2005). In Ghana, the private care providers, especially the not-for-profit facilities often concentrate in rural, deprived and underserved communities (Bitran, 2011). The Upper West Region has been consistently ranked among the top three poorest regions in Ghana (Ghana Statistical Service, 2014).

In the Upper West Region, health sector regulators acknowledge that the private care providers play an essential complementary role in care delivery (Upper West Regional Health Directorate, 2013). However, little has been documented concerning the size and configuration of private providers and their contribution to health sector outcomes. Despite the presence of private sector service providers in the Region, their relationship with the public regulator and/provider in healthcare delivery remains blur. Moreover, there is limited data on consumers' perspective in terms of their satisfaction with services provided, the cost of accessing services and the kind of services they receive. This paper explored the nature of public private partnerships in healthcare delivery in the Upper West Region of Ghana.

2. THEORETICAL FRAMEWORK

This section presents the theoretical foundation of public private partnerships. In the healthcare sub-sector, historical epidemiology has shown that effective and efficient healthcare policies should emphasise

populations over individuals (Mitchell, 2008). This is because individual biological responses are influenced by the social and physical environments in which they find themselves. Thus, understanding healthcare as a population (social) rather than an individual issue helps to create policies that give attention to overall micro and macro environmental issues. Although, there are no specific theories on PPPs in healthcare delivery, there are several theories which explain the partnership in general. However, each theory focuses on an aspect of the PPP. So far, there are four main domains which drive the theories in PPP. These are: (i) rationale for partnership; (ii) scope of co-operation; (iii) economy of efficiency; and (iv) critical success factors.

One of the early propositions on partnership in the context of development economics is the New Institutional Economics (NIE) theory. The propositions of the NIE revolve around an understanding of institutions, how they arise, what purposes they serve, how they change and how they should be reformed (Klein, 1998). Thus, the NIE theory provides a framework for analysing the interface both within and among institutions. There are three main dimensions of the NIE theory: (i) the property right theory; (ii), transaction cost theory; and (iii) principal-agent theory. The NIE theory, especially the transaction cost theory, has direct implications for public-private partnerships. For instance, Spiller and Vogelsang (1997) note that the theory reveals the tendency of the public partner to exhibit opportunism in the partnership. Such behaviours demotivate the private sector to make investment.

Additionally, partnership, as the name suggests, involves a number of components that come together to constitute a whole. Thus, partnership can be viewed as an open system. The open systems' theory describes a partnership as a set of interacting elements or sub-systems that make up an integrated whole (Katz & Kahn, 1978). Eilbert (2003) defines an open system as a coalition of shifting interest groups, strongly influenced by environmental factors that develop goals by negotiating its structure, activities, and outcomes. The open systems' theory argues that partnerships maintain themselves through their contact with the environment. This theory is applicable to systems in general and all sectors, including PPPs in healthcare delivery. Generally, open systems theory lacks explanatory power as it views partnerships only as physical entities, ignoring the importance of meaning in any human system (Flood, 2002).

According to Thompson (2011), the institutional perspective builds on the open systems theory by adding that the environment is not only a stock of resources and technical information, but also a supplier of legitimacy and meaning. Thus, partnerships take on patterns of functioning and of meaning from those forces in their environment that influence them, providing them legitimacy and stability where they accommodate the requirements of these influences (Eilbert, 2003). Although the institutional theory provides a good understanding of why parties are interested in partnership by helping partners adjust more efficiently and effectively to increasing complexity (Hatch & Cunliffe, 2012), it fails to explain why partners adopt certain structures and processes. Additionally, it does not adequately address the interrelationships between partners.

Mackintosh (1992) conducted a theoretical examination of the rationale for the formation of partnerships and identified three logics: synergy, budget enlargement, and transformation. In the context of Mackintosh's analysis, partnerships produce synergy by bringing different actors together in order to exploit distinctive yet complementary opportunities and assets. Synergy is ascribed to being able to produce outcomes which neither party could have produced in isolation (Mackintosh, 1992). Gaster (1997) affirmed Mackintosh's synergetic view of partnership in stating that partnership results in synergy and its accompanying benefits, unlike parties acting individually.

Mackintosh's second logic behind partnership suggests that partnership is motivated by a desire by parties to increase budgets, where the ability to tap into a resource stream is contingent on joint working between the parties. The resource dependency theory confirms Mackintosh's 'budget enlargement' argument as a motivation for partnerships, where the decline in state resources has led the state to look to other organisations (Bardach, 1998). Consequently, Srbljanin (2001) notes that, for the public party, partnership makes up for the general resource constraints, while for the non-state party, the possibility of tapping into public resources represents an opportunity to subsidise risk. It appears this logic fundamentally sees partnership as a means to gaining resources or to qualifying for resources, which they would individually not be eligible for.

Mackintosh's third logic describes partnership as transformationary. By this logic, state and non-state sectors are working together with the motive of fundamentally changing the relationship between them. Through the partnership, each party learns to appreciate the objectives, culture and methods of working of the other partner (Mackintosh, 1992).

Although Mackintosh theoretical work on partnership has been cited as one that provides a rare opportunity to shed some analytical light on the dynamics underpinning partnership formation (Srbljanin, 2001), it has not gone uncriticised. For instance, Gruca, Nath, and Mehra (1997) noted that the synergy logic suggests that bringing together diverse interests provides an opportunity to pull the disparate resources distributed between partners and in the process yield benefits which are more than the sum of the whole. However, simply bringing together diverse interests does not automatically mean they yield synergy. As Srbljanin later established, the budget enlargement argument is "cynical and sees partnerships assembled merely to gain resources or to qualify for resources that individually they would not be eligible for" (Srbljanin, 2001, p. 109). Accordingly, the transformation logic merely benefited the private partner without necessarily creating reciprocal relations (ibid).

Generally, there is the need for a comprehensive analysis of how the structures and processes of partnerships facilitate or constrain the outcomes of a partnership; and how the nature of partnerships is influenced by its working environment and the participating parties. The discussion above suggests that a number of factors

may enhance or constraint partnerships, which can generally be grouped under environmental and institutional headings.

3. CONCEPT OF PUBLIC PRIVATE PARTNERSHIP

The aim of this section is not to give universal and final definitions of these concepts, but illustrate the context in which the concepts are used in the study and the assumptions under which the study was conducted. A review of definitions of PPPs shows some common and distinctive features in their orientation and focus. For instance, in a review of 28 PPPs, Andrea et al (2012) established that most definitions identified that PPPs: have different societal backgrounds, share objectives, goals and problems, are for the provision of public goods benefit from complementary resources and have partners which collaborate in an interdependent and interactive way (Netherlands Ministry of Foreign Affairs, 2013). Some gaps related to issues of governance, management and policy design of PPPs can also be identified across most definitions. Common features depicted across many of the definitions include: (1) PPP is always a contract or arrangement between a public entity and a private entity; (2) the arrangement places some obligations and risks on and results in some rewards for both parties; and (3) the arrangement results in some specific good or service. The distinctive features are: (1) some definitions have been more explicit in indicating that the private party provides a service or good that was originally provided by the public party; and (2) the question of whether and how much of private party investment is required in the partnership is not commonly addressed.

In the context of this study, a PPP is conceived as a formal arrangement between a public agency and a private party(ies) to undertake the provision of a good or service traditionally provided by the former, with specific identification of what the arrangement will do, how to proceed, how to measure progress, and what constitutes success. The eternal target of the partnership therefore should be to deliver the contracted good or service more effectively and efficiently, otherwise, the delivery should better remain with the public institution. In healthcare delivery, a PPP should be a formal arrangement because it needs to be a systematic collaboration between the government and the private health sector according to national health priorities (Dugle, 2014).

4. METHODOLOGY

Four districts, namely: Jirapa, Nandom, Nadowli-Kaleo and Wa Municipality in the Upper West Region were purposively selected for the study. These districts have a long history of public-private partnership in healthcare delivery. For instance, the St. Joseph's hospital in Jirapa and St. Theresa's hospital in Nandom have been in partnership with government from their very beginning in 1953 and 1966 respectively. The Wa Municipality has the highest population in the Region and comprises the different categories of people from

across the Region. At the time of the study, besides the Islamic hospital in Wa Municipal, the second most functional Islamic facility was in the Nadowli-Kaleo District (i.e. Ahamaddiya Hospital in Kaleo).

This study used exploratory survey design and the mixed methods for the data collection. An exploratory design is used when there are few or no earlier studies to refer to or when problems are in a preliminary stage of investigation (Cuthill, 2002; Taylor, Catalano, & Walker, 2002). An exploratory survey design is appropriate for this study because it is flexible and can be used to understand the basis and the nature of the PPP in the Region. On first sight, it appears that qualitative and quantitative methods are very different and difficult to combine in a single study. However, it has been established that the two approaches are complementary and this led to the development of mixed methods. Mixed methods seeks to treat qualitative and quantitative methods as complementary, where the strengths of the two approaches are optimised and their weaknesses minimised, and it has been used in several studies (see Alatinga & Fielmua, 2011; Bryman, 2006; Johnson & Onwuegbuzie, 2004).

Interviews were conducted with 5 directors of health and 78 care seekers (patients or their care taker relatives). The directors of health services interviewed are Deputy Regional Director of health in charge of clinical care, and four District Directors of health services in the selected districts. Medical Directors of five private (partner) healthcare facilities also responded to self-administered questionnaires. The categories of private (partner) facilities studied were mission (CHAG and Islamic) facilities and self-financed private (SFP) facilities. In all, five facilities were studied: one CHAG facility each in Jirapa and Nandom Districts, one SFP facility in Nandom District, one Islamic Mission facility each in Nadowli- Kaleo district and Wa Municipality.

The directors of health services and medical directors of private care facilities were selected using purposive sampling. The study conducted key informant interviews with the five directors of health services (one deputy regional director and four district directors), while medical directors of the selected private healthcare facilities responded to structured questionnaires. The survey also used accidental sampling to interview the 78 patients or their caretakers. The strategy for determining the sample size for each facility was 50% of the average daily out-patient-department (OPD) attendance of the facility for 2013. The 50% is applicable where the sample frame (OPD attendance) is between 10 and 24. In facilities where 50% of the average daily OPD attendance was more than 24 patients, 25 respondents was chosen. Where the total average daily attendance was less than 10 patients, the total was studied. Finally, where there was no OPD data for a facility, a convenient sample of nine respondents was surveyed.

Of the 78 patients or their care takers, 50 were from CHAG facilities, 22 from Islamic Mission facilities and 6 from Self-Financed private facilities. Five rounds of surveys were conducted throughout the study period. The first round survey was a form of preliminary interviews to establish the background of PPPs in healthcare in the Region. This was followed by the second survey on the public sector partner/regulator, third survey of

private healthcare partners/providers, patient interviews, and finally, follow-up telephone interviews with directors of health services and medical directors.

5. RESULTS AND DISCUSSION

This section presents and discusses the study results on the nature of public-private partnership in healthcare delivery in the Region. It begins with findings on existing policies and the nature of their implementation. This is followed by an analysis of the contributions of PPPs in healthcare delivery in the Region. Finally, the section reveals the factors that influence the nature of PPPs in healthcare delivery in the Region.

5.1 POLICY AND REGULATION

In Ghana, there has been a Ministry of Health- Private Health Sector Policy since 2003; Christian Health Association of Ghana (CHAG) – Ministry of Health (MOH) Memorandum of Understanding (MoU) & Administrative Instructions since 2003; and CHAG – GHS MoU in 2013. Although both Directors of health services and medical directors of the private facilities demonstrated fair knowledge of policies on PPP in healthcare, the latter had better understanding of the contents of existing policies than the former. Examples of policies under implementation in the Region are the national health policy of 2007, the 2003 Memorandum of Understanding (MoU) between CHAG and Ministry of Health and the 2013 MoU between CHAG and Ghana Health Service, guidelines on MDGs 4, 5 and 6 and Standard protocols and guidelines for private healthcare facilities. All these policies were however developed at the national level with very limited participation from the grassroots.

The study revealed that 3 of the 5 directors of health services surveyed were not sure of the existence of policies guiding PPP in healthcare delivery in the Region. They attributed this to the centralisation of policy design at the MOH headquarters, without adequate participation of administrators at the local level. Responses of medical directors of private facilities to questions on policy were not much different. Of the five facilities surveyed, three medical directors reported of the existence of policy documents, one reported of the non-existence of policy while one was not sure of the existence of policy on PPP in healthcare delivery in their operational districts. All three who reported of the existence of policy in their districts had copies of the policies. In addition, across all health directorates and private facilities surveyed, very little is known of the Ministry of Health - Private Health Sector Policy developed in 2003 and revised in 2012. Consequently, the study submits that policy implementation is less felt at the facility level.

In the districts where directors of health services were not sure of the existence of policies to guide PPP in healthcare delivery, the partnership centred on the professional experiences of these directors and compliance from the private providers. In effect, when measured against national health policy objectives of promoting the use of information for the planning and management of the health sector; and ensuring good governance

and partnership (Ghana. Ministry of Health, 2007), the study submits that there is little policy direction and action in the Upper West Region.

In relation to the regulation, 2 directors of health services indicated that there is weak enforcement of regulations on the operations of private care providers. This supports the World Bank's (2011) position that regulation of the private sector across Sub-Saharan Africa is weak and inappropriate. Directors of health services attributed the weak enforcement to resource and logistical constraints as well as lack of sanctions for non-compliance of some private care providers. This also reflects the conclusion by Raman and Björkman (2008) that the private sector provides a large volume of health services but with little or no regulation. Enforcement of regulatory provisions remains critical to ensure that quality services are delivered to customers.

All medical directors of private facilities reported submitting periodic reports on service and drug utilisation statistics, adverse events such as maternal and/or child deaths, and quality reporting on compliance with standards. Also, 60% reported submitting periodic financial reports to the public regulator. Though the medical directors' responses on periodic financial reporting (on service charges and revenue) contradict those of the district directors of health services, they reflect the regional directorate's response that private care providers send periodic reports on all four variables. Essentially, this reflects different degrees of private care providers' engagements with the Region and District, and better response to the regional than to the district level, hence a decentralisation deficiency in the PPP in healthcare delivery agenda.

While PPP policies in the health sector in Ghana are clear and congruent with national healthcare objectives, understanding and implementing such policies at the local level may be a big challenge. Although public-private partnership in healthcare delivery exists in practice in the Upper West Region, much of the partnership is neither guided by dedicated partnership document nor underpinned by a policy framework. This suggests the need for a broader commitment to the partnership, backed by positive decentralisation actions.

5.2 CONTRIBUTION OF PPPS TO HEALTHCARE DELIVERY

Generally, the inputs that partners should bring to the partnership depend on the partnership policy. In the policy, each partner's responsibilities and rights are specified and this is necessary for successful policy implementation. The study identified that the main inputs that private providers make to PPP in healthcare delivery in the Region are management of the facilities, mobilisation of private finance from internal and donor sources, construction of physical infrastructure, inputs to health sector policies and programmes, recruitment and training of personnel for care delivery, and the procurement of medicines and other medical logistics. This confirms the findings of Mundial (2005) that the private sector healthcare partners could provide numerous complementary means to health programmes through in-kind resources such as people, services and products, project management expertise and knowledge of local markets and customers.

The public partners on the other hand provide funding, logistics, capacity building, monitoring and supervision, human resource, infrastructure among others. However, based on the discussions during the interviews with both directors of health services and medical directors of private healthcare facilities, it emerged that the public partner contributes more than its private counterpart. This suggests that, since the public partner is naturally burdened with the duty of care to citizens, it is relatively prone to committing resources beyond what it has contracted to do under the partnership. As Polackova (1998) argues, PPPs can give rise to non-contractual liabilities, arising from public expectations that create further fiscal risks for the public partner.

It was also observed that although all the five private facilities are National Health Insurance Scheme (NHIS) accredited providers, the public sector's engagement with private facilities in the Region is disproportionate among the three categories of private care providers (i.e. CHAG, Islamic Mission and Self-Financed Private facilities). Other than the significant engagement with the Christian Health Association of Ghana (CHAG), there seem to be no formal public partnership with the remaining categories. CHAG facilities to a greater extent act as an extension of government facilities. For instance, the St. Joseph's hospital and St. Theresa's hospital serve as district hospitals for Jirapa and Nandom Districts respectively. Although CHAG facilities function autonomously, they receive significant government support in term of salaries, equipment, infrastructure and other medical supplies. Islamic Mission and Self-financed private facilities are merely being regulated than engaged in practical partnership with government. These facilities do not get adequate assistance from the public healthcare partner, required for meeting public health goals.

The partnership often comes with costs and responsibilities, including monitoring and supervision, and overlap of activities of public and private healthcare partners. It also has impacts on human resource issues such as staff reductions at public facilities and retraining of staff of private facilities by the public regulator. However, it makes positive outcomes such as healthy competition in healthcare delivery, good customer care, increased geographical access to health service and reduced congestion at public facilities.

In terms of efficiency, 4 of the health service directors indicated that the private care providers deliver value-for money services to their clients. They mentioned that private care was affordable to the communities. While 3 of the directors of health services are of the view that the communities were satisfied with the appropriate level of care provided by private care providers, 2 could not indicate whether customers are satisfied with the services. On stakeholders' perception of whether private providers offered quality care, 3 of directors responded yes while 2 were not sure if this was the case.

Overall, four directors of health services rated the partnership as a success while one disagrees, arguing that the engagement has become more of competition and power struggle than a partnership. In terms of the partnership's contribution to improved health status of care consumers, 4 of directors of health services

identified that PPP in healthcare delivery in the Region has contributed to reductions in key health indicators such as maternal and infant mortality, primary care visits and costs.

For the clients of the health facilities, the focus was on their health problems, the reasons for visiting a particular facility and whether their household members visited the same facility; and the distance covered in order to access health care. From the responses, the health problems for which patients visited the facilities were illnesses, injuries, follow-up for medicines or reviews, prenatal care, deliveries and postnatal care. Of the 78 patients, 65.4% visited the facilities due to illnesses, whereas 12.8% and 1.3% of the visited the facilities due to injuries and postnatal care respectively. Illnesses dominated patients' health problems across all three categories of healthcare facilities.

Patients' reasons for choosing private care facilities are illustrated in Table 1. Generally, 51.3% of respondents chose private (partner) healthcare facilities because of their good quality services. In the context of this survey, quality of healthcare is conceived as the kind of healthcare which is patient-centred in delivering effective and efficient services to care consumers. Thus, this study examined care seekers' perception of the quality of healthcare provided by private facilities. The study revealed that from the care seeker perspective, a *healthcare facility provides a better quality service if healthcare consumers are more satisfied with the care received, feel safe and are involved and respected in the care delivery process*. Of the 78 respondents, 20.5% chose private facilities due to their nearness to the respondents' residence. In both CHAG and SFP facilities, the lead reason for patients' visit was good quality services. The second major reason for the patients' choice of these facilities was nearness to respondents' homes, although respondents could not indicate the actual distance covered. In Islamic Mission facilities, the lead reason for respondents' choice of facility was short waiting time, followed by good quality services. In the CHAG facilities, only 2.0% of respondents chose the facility because of short waiting time. This is expected because of the large number of daily OPD attendance at these facilities. Still with the CHAG facilities, 16.0% of patients were referred from other private facilities and public providers including the regional hospital. Other reasons for respondents' choice of private healthcare facilities included non-existence of any other facility around, goodwill of staff and recommendations from friends and relatives.

Table 1: Respondents' Reasons for Choosing Private Healthcare Facilities by Ownership Structure

			Ownership structure of health facility			Total
			Christian Health Association of Ghana (CHAG) facility	Islamic Mission facility	Self-financed Private facility	
Respondent's reason for choosing this facility	Short waiting time	Frequency	1	9	0	10
		%	2.0%	40.90%	0.0%	12.8%
	Good quality services	Frequency	28	8	4	40
		%	56.0%	36.36%	66.6%	51.3%
	Only facility in my area	Frequency	1	0	0	1
		%	2.0%	0.0%	0.0%	1.3%

Nearest to my home	Frequency	12	3	1	16
	%	24.0%	13.64%	16.7%	20.5%
Referral from another facility	Frequency	8	1	0	9
	%	16.0%	4.55%	0.0%	11.5%
Other	Frequency	0	1	1	2
	%	0.0%	4.55%	16.7%	2.6%
Total	Frequency	50	22	6	78
	%	64.1%	28.2%	7.7%	100.0%

Source: Field Survey, April, 2014

The high indication of better quality of services rendered by private healthcare facilities in the Region confirms Ghobadian, O'Regan, Gallear, and Viney (2004) support for a more extensive use of PPPs since the private sector has more to offer than the public sector in terms of providing better quality. Thus, the adoption of PPP as an innovation to effective and efficient healthcare delivery should aim at enhancing the quality of life of healthcare consumers (Omachonu & Einspruch, 2010).

In meeting timelines, three of the five medical directors of private healthcare facilities noted that completed PPP projects such as Project 5Alives, immunizations, and various physical development projects were implemented within timeframes. While two medical directors agreed that projects were consistent with PPP policy description, one disagreed and two were not sure. Further, 60% and 40% of funding for these completed projects came from government and donors respectively.

5.3 FACTORS THAT INFLUENCE THE EFFECTIVENESS AND EFFICIENCY OF PPPS IN HEALTHCARE DELIVERY

A PPP in healthcare delivery depends on a supporting environment for effectiveness and efficiency. This part of the study examined the forces that directly or indirectly affect or are affected by the existence and functioning of the partnership. It uses the seven conditions that influence successful PPP that emerged from the An Asian Development Bank Institute's (ADB) conference on public-private partnerships in the social sector in Japan in July, 1999 (Felsing, 2008). These conditions include: (i) legal and regulatory framework; (ii) transparency and accountability; (iii) suitable public policies; (iv) commitment to public good; (v) common understanding; (vi) sharing of resources; and (vii) consumers and community involvement. The responses of directors of health services and medical directors of private healthcare facilities on the influence of the above factors on the effectiveness and efficiency of PPP in healthcare delivery in the Region are presented in Table 2.

Table 2: Conditions for Successful Public Private Partnerships

Condition for Success	Directors of Health Services				Medical Directors			
	Disagree	Maybe	Agree	Strongly disagree	Disagree	Maybe	Agree	Strongly disagree
Appropriate legal and regulatory framework	0	0	3	2	0	1	2	2
Transparency and accountability	0	0	2	3	0	2	1	2
Suitable public policies on partnership	0	0	3	2	0	2	0	3

Commitment to public good	0	1	2	2	1	1	2	1
Common understanding between partners	0	0	2	3	0	2	2	1
Sharing of resources (inputs, risks and benefits)	0	0	4	1	1	1	2	1
Consumers and community involvement in planning and monitoring of services	0	0	3	2	0	1	2	2

Source: Field Survey, April, 2014

All five directors of health services agreed that the ADBI's seven factors were critical and relevant for effective and efficient PPP in healthcare delivery in the Region. On the contrary, one medical director indicated that commitment to public good and sharing of resources were not critical for effective and efficient PPP in healthcare delivery. Generally, both partners are committed to public good and this is demonstrated in the private facilities delivery of quality services to patients and the public partner's commitment to regulations on quality, equitable and accessible care by the private facilities. However, there are deficiencies with the remaining six factors. They are either not pursued or are being implemented ineffectively. For instance, apart from CHAG facilities, Islamic Mission and SFP facilities did not have consumer and community involvement programmes in planning and monitoring of services.

Aside ADBI's seven conditions, other factors identified by respondents to be critical for effective and efficient PPP in healthcare delivery were effective communication and information sharing, continuous monitoring and evaluation of partnership, and effective dialogue and conflict resolution mechanisms.

The survey identified that many factors currently pose as key challenges that prevent the private healthcare partners from contributing effectively and efficiently to healthcare delivery in the Upper West Region. They include lack of access to credit, unfavourable policies and regulations, weak financial management and reporting, insufficient supply of skilled healthcare staff, and lack of enforcement and enforceable quality standards. Other impediments are poor investment climate and financial impoverishment of clients. This confirms Bitran's findings that poor investment climate, lack of enforcement and enforceable quality standards, and insufficient supply of skilled healthcare staff are major hindrances to private health sector's contribution to healthcare delivery in Ghana (Bitran, 2011).

The survey further revealed six main challenges of PPP in healthcare delivery in the Upper West Region. They include poor collaboration between partners, poor understanding of the mandates of partners, poor enforcement of regulations by the public regulator, inadequate qualified health staff, material and logistical constraints, and lack of local policies.

6. CONCLUSION

PPP in healthcare delivery in the Upper West Region contributes to enhancing healthcare delivery in such ways as competition in healthcare delivery, good customer care, increased geographical access to health service and reduced congestion at public facilities. However, the above successes are not sustainable in the

face of little policy direction and action, poor collaboration between partners, poor understanding of the mandates of partners, poor enforcement of regulations by the public regulator, inadequate qualified health staff, material and logistical constraints, and lack of local policies.

An effective and efficient PPP in healthcare delivery needs to be guided by appropriate allocation of resources, risks and rewards such that healthcare delivery objectives are achieved in a more cost-effective and timely manner and with less risk to care consumers. This requires that both public and private partners understand their commitments to the partnership in order to honour them. In the Upper West Region, PPP for healthcare delivery is a more informal one in which partners appear to be pursuing uncoordinated health goals. These kinds of non-traditional partnerships often arise as a result of the public sector engaging with varied stakeholders who are providing public goods. Although such forms of partnerships are often not heavily regulated, the practice is neither effective nor efficient for delivering desired healthcare. Due to identified lack of enforcement and enforceable quality standards, private providers may be offering substandard and low-quality care that might not be observable to patients themselves. A new agenda of partnership guided by commitment to policy direction and action, strong regulation and integrated approach to stakeholder participation is proposed, for effective and efficient PPP in healthcare delivery.

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