

PARTNERSHIP FOR HEALTH: THE CONTRIBUTION OF THE PRIVATE NON-PROFIT SECTOR TO HEALTH INFRASTRUCTURE IN GHANA



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Abstract

The debate on whether public-private partnerships (PPP) have occasioned more benefits to society than good still remain unresolved. While some authors argue that PPPs are the third model of governance to ameliorate the inefficiencies of the private and public sectors individually, others contend that PPPs have caused more harm than good to local economies, especially in Sub-Saharan African countries. This paper examines the contribution of the partnership between the government and the private not-for-profit health service providers in the health sector of Ghana. Using qualitative case study design technique, six districts were purposively selected to form the unit of analysis. The analytical method used in this study was the thematic content analysis. Results of the study show major areas of collaboration and the partnership has contributed largely to expansion in the health infrastructure of the country. It was also found that even though the partnership has contributed largely to improving the health infrastructure of the country, the level of mistrust among the partners is limiting the partnership from achieving its full potentials. Implications of this study include a call for revision in the national policy on PPP and a call for a legal framework to direct PPP in relation to health sector. Some inherent limitations of qualitative case studies have been duly acknowledged in this paper.

Keywords: Partnership, Health, Public, Private, Non-profit and Ghana

Background to the Study

The provision of health services requires adequate resources such as health infrastructure, human capital and finance primarily. These resources, normatively, are to be provided by the state. However, the growing resource scarcity resulting from competing needs in the economies of many countries necessitated the involvement of the private sector in the planning and provision of health services. This became more apparent after many developing countries have adopted New Public Management (NPM) in the administration of their public institutions. As a result, Ghana embarked on health sector reform in the late 1980s and one of the objects of the reform is to collaborate with the private sector to provide health services to the population. 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 to 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) hence the need for collective efforts to address them.

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 and achieve equity in service distribution (Selsky & Parker, 2005; Gazley & Brudney, 2007), 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). Despite the diametrically opposed arguments for, and against adoption of PPP in the delivery of public services, its continuous presence in developing and developed countries alike give 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.

Objective/ Framework for the Study

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 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, 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.

The study examines the extent of collaboration and inter-relationships 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.

Methodology

This is a qualitative case study design 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, 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 while 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.

The study was conducted in 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, west by the Volta River, Brong-Ahafo and the Eastern Regions, and to the east by the Republic of Togo. The selection of Volta Region as a case study is based on two major 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 and this would make it relatively appropriate to generalise the study findings for Ghana. 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 1.

In-Depth Interviews

One of the methods, which have 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 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 are considered to be 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 study area.

The individual interviews were conducted by the researcher and two experienced research assistants, one of them serving as the moderator while 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. While the shortest interview lasted for thirty-seven minutes, that with 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 1 summarises the details of interviewees in the study. For ethical reasons, the names of the participants and the institutions involved in the study were assigned code names in the presentation of results and subsequently throughout the study.

Table 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)

Analysis of Data

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 organized. 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. Thus, 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).

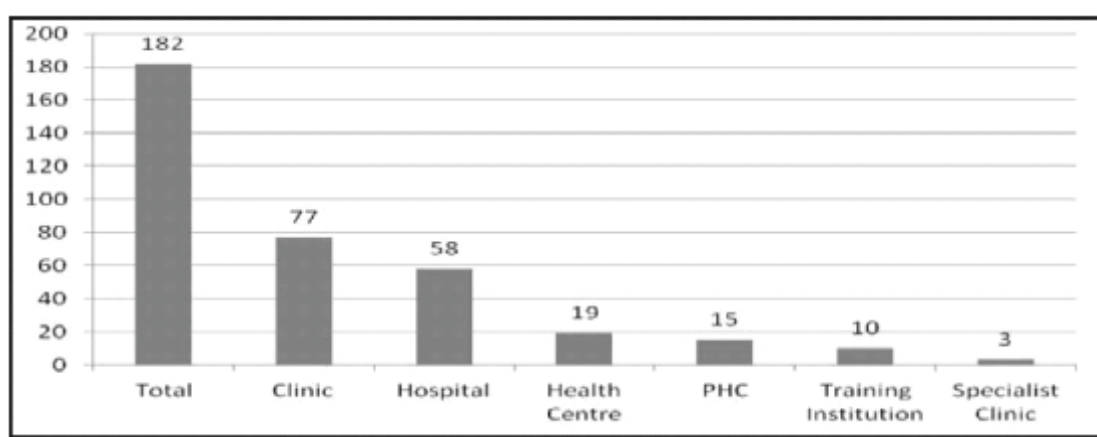
The data management process in a nutshell involves scanning the data for items that appear to relate to the particular topic within the framework of collaborative advantage that relates to the central theme of this study; creation of more generic interpretations of the key issues; clustering apparently 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) would be very useful. Reliability and validity are rather, terms that some qualitative scholars find uncomfortable to use. However, in this study, internal validity is assured by the triangulation of sources in the data collection phase, which include archival records and face-to-face interview data.

Results and Implications

The main areas of collaboration identified in this study are policy dialogue, information exchange, service provision, financing and monitoring and regulation of health services. The results also show several ways by which the private sector contributes to health delivery in the country. One of the ways is the role of Christian Health Associations of Ghana (CHAG) in the underserved districts and hamlets of the country. It is a network of Christian 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. CHAG is a faith-based network organisation of 21 Christian church denominations, involved in the provision of healthcare and training of health professionals. Established in 1967, the Association currently comprises 58 hospitals, 114 health centres and clinics, and 10 health training institutions. Membership has gone up from 25 in 1967 to 182 in 2011. In Ghana's health sector, CHAG institutions account for 5.3% of all health

infrastructure in the country. However, this represents 20.0% and 19.2 % of all outpatient care in 2011 and 2010 respectively in Ghana. CHAG also accounted for 33% and 37% of all in-patient care in 2011 and 2010 respectively (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. Figure 2 displays the health facilities owned and managed by CHAG.

Figure 1: Distribution of Health Infrastructure Contributed by CHAG



Source: CHAG (2012)

Contributions of the Private Sector to Health Delivery

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.

Initiation of Key National Policies

The partnership between the government and the mission health sector actors has 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 successes of this initiative by the mission hospitals' pilot scheme pave 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 guideline 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 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 Services 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.

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 is 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

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 is 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 1 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.

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 capitals 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

Table 2. 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 litholax	4		2
Hernia			2
Urethral catheterisation	1	1	
Total	49	61	119

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

Complimentary 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 presides 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 the mission hospital 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] have 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}

General public value of the partnership

One of the major public values 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.

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, staffs 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 TNDHD/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

Human Resource Development

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.

Conclusion and Recommendation

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. 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.

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