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EXPLORING PUBLIC PRIVATE PARTNERSHIPS IN ZAMBIA

FOCUS: TERTIARY LEVEL HOSPITALS & DISTRICTS

Dissertation Submitted In Partial Fulfillment for

"Degree" of: Masters of Public Health

Chandan Singh Yadav

Declaration

I Chandan Singh Yadav, do hereby declare that the work presented in this dissertation for Masters in Public Health has not been presented either wholly or in part for a Degree or Diploma in any other University and currently not being presented for any other degree.

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Chandan Singh Yadav (Candidate)

I have read the this dissertation and have approved it for examination

Prof. K.S. Baboo

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Approval of Admission of Dissertation

This dissertation by Chandan Singh Yadav is in partial fulfillment of the requirements for the award of the Master of Public Health degree (MPH) by the University of Zambia, Lusaka.

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Certificate of Completion of Dissertation

I Chandan Singh Yadav hereby certify that this dissertation is the product of my own work and in submitting it for my masters for Public Health program and declare that it has not been submitted in part or in whole to another University.

Signature Dated this th day of July 2011

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I Prof. K.S. Baboo having supervised and read this dissertation confirm that the work has been completed satisfactorily and is ready for presentation.

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Dedication

To my beloved wife KUSUM YADAV for being the inspirational spirit

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Contents

List of Abbreviations

CMH	Commission on Macroeconomics and Health
DHMT	District Health Management Team
FBOs	Faith-Based Organisations
HAZs	Health Action Zones
HImPs	Health Improvement Programmes
HLCs	Healthy Living Centres
LSPs	Local Strategic Partnerships
NGOs	Non Government Organisations
NHS	National Healthy Standard
NSP	Non-State Providers
PFI	Private Finance Initiative
PPPs	Public and Private Partnerships
PSBR	Public Sector Borrowing Requirement
SPV	Special Purpose Vehicle
SRH	Sexual and Reproductive Health
STI's	Sexually Transmitted Infections
TRIPS	Trade-related Aspects of Intellectual Property
UK	United Kingdom
UN	United Nations
UNZA	University of Zambia
UTH	University Teaching Hospital
WHO	World Health Organisation

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CHAPTER ONE- INTRODUCTION

1.0 Background

The need for public-private partnerships arose against the backdrop of inadequacies on the part of the public sector to provide public good on their own, in an efficient and effective manner, owing to lack of resources and management issues. These considerations led to the evolution of a range of interface arrangements that brought together organizations with the mandate to offer public good on one hand, and those that could facilitate this goal through the provision of resources, technical expertise or outreach, on the other. The former category includes governments and intergovernmental agencies and the latter, the *not for profit* and *for-profit* private sector. Though such partnerships create a powerful mechanism for addressing difficult problems by leveraging on the strengths of different partners, they also package complex ethical and process-related challenges. The complex transnational nature of some of these partnership arrangements necessitates that they could be guided by a set of global principles and norms. Participation of international agencies warrants that they be set within a comprehensive policy and operational framework within the organizational mandate and involvement of countries requires legislative authorization, within the framework of which, procedural and process related guidelines need to be developed (Nishtar, 2004).

Liquidity Problems in Low Income Countries and New Global Alliances and Funds

Health systems in low income countries often face substantial problems resulting from resource shortages and the inefficient and inequitable use of resources (Mills, 1997; World Bank, 1993). They continue to be plagued by poor service quality and low coverage rates, especially for poor populations. There have been strong pressures to increase health spending in such countries, from a current average of US $131 per capita per year (Commission on Macroeconomics and Health, 2001). At one time, the Commission on Macroeconomics and Health (CMH) called for a massive effort to scale

up[1] priority health interventions and provided an estimate of the minimum cost of financing these interventions, i.e. US $30 to US $40 per person per year (Commission on Macroeconomics and Health, 2001). Additional resources would allow national governments to expand access to high priority programmes such as radiation protection, hospital waste disposal, hospital infection control, immunization and HIV prevention, and invest in the urgently needed improvements in the areas of drugs and general supplies, human resource development, and expansion of infrastructure which underpin these programmes (Commission on Macroeconomics and Health, 2002). However, money alone, as pointed out by Hanson et al, (2003), will not be sufficient to overcome major obstacles faced by health systems in such countries. Additional money needs to be spent effectively and efficiently if it is to result in a significant contribution towards the goal of improving the health status of the population, in particular of the poor. Research about the importance of partnership working in health and the processes this involves is prominent in the public health management literature (Glendinning, 2002; Clarke and Dowling, 2004).

Recent years have witnessed a marked increase in the number of global alliances and institutions aimed at alleviating specific health sector deficiencies, a number of which owe their existence to resources made available by philanthropic organizations[2]. The Global Alliance for Vaccines and Immunization, Vaccine Fund and the Global Fund to Fight AIDS, Tuberculosis, and Malaria are perhaps the largest and most well known. While the Global Alliance for Vaccines and Immunization Vaccine Fund is both a funder and an implementer, Roll Back Malaria is an example of an alliance that is a global partnership without a funding mechanism. Some entities like the Global Fund are purely financial vehicles with little alliance structure. The effect of these new alliances and funds ranges from significant to insignificant in some cases. Since its inception in 2000, the Global Alliance for Vaccines and Immunization Vaccine Fund has raised and spent more than US$1 billion for immunization, and the Global Fund has commitments of more than US$5 billion and has signed grant agreements with more than 70 countries

[1] To expand access to and utilization of priority health services or interventions.

[2] One of the main funding organizations is the Bill & Melinda Gates Foundation, which is investing approximately US$1.35 billion per year, with a considerable portion of that allocated to global health issues.

worth in excess of US$3 billion. Although assessments of global initiatives and alliances are generally positive, some observers have concerns about their effects on health systems and prioritization (Travis and others 2004). Increasing concerns are being expressed about the “verticalisation” of development assistance and the development of separate health system “silos,” each dedicated to specific diseases and activities. This strategy is especially problematic in light of the scarce human resources available for health in many low income countries (Global Health Trust, 2004; Joint Learning Initiative, 2004). As a result of these concerns, the G-7 countries are currently discussing a number of new, broad-based, global financing mechanisms to mobilize and facilitate the transfer of resources from developed countries to low income countries and significant progress has been made in relation to promoting private partnerships from the G7 countries and within nations.

The Private Finance Initiative that is rooted in Public Private Partnerships involves long-term arrangements between the public and private sectors, in which the latter finances the design and build of new or substantially upgraded public facilities and provides some of the services within them. However, there are arguments in terms of the extent (if at all) partnership working contributes to achieving better population health outcomes (Dunaway and N’Diaye, 2004). The Private Finance Initiative emerged in the United Kingdom in the early 1990s as a means of keeping the cost of public sector capital projects off the published total of the Public Sector Borrowing Requirement. For major projects, such as new hospitals, Private Finance Initiative usually involves the creation of a single purpose limited company, a Special Purpose Vehicle, with equity participation of established firms such as construction companies and facilities management firms. It issues bonds and/or negotiates loans from financial institutions. The resulting consortium undertakes to design, build, finance and maintain the hospital building and major pieces of equipment. It enters into a contract with a Hospital Board (a Trust) to supply the services of the building, ‘bed spaces’, and associated nonclinical services—cleaning, catering, security, etc. (Gupta and others; 2001; 2004). It is very clear from this that the essential basket for health care is not all inclusive of critical areas of health service delivery. For instance, the WHO Commission on Macroeconomics and Health estimated that an essential basket of health services that

other stakeholders may not fund wholly like emergency obstetric care, costs approximately US$35 per capita in low-income countries (World Health Organization, 2001). Yet in 2003, 34 of the 46 countries in the WHO African region (inclusive of Zambia) spent less than US$35 per capita, with 29 of the countries spending US$20 or less (World Health Organization, 2006). It is no surprise, therefore, that women in the poorest countries have very limited access to skilled birth attendants and even less access to emergency obstetric care (World Health Organization, 2005).

New international initiatives like the Millennium Development Goals have raised attention to the severe under funding of health systems and other areas of social development in low-income countries. As a result, donor countries are beginning to spend more on development assistance which seems not to be enough. As of June 2005, 16 out of 22 high-income donor countries have met or agreed to meet the target of spending 0.7% of their GDP on development assistance by 2015 (UN Millennium Project 2005a,b). Low-income countries have also acknowledged the need to spend a higher proportion of their own resources on health and yet may not do enough. At the Abuja Summit on HIV/ AIDS, Tuberculosis and Other Related Infectious Diseases in April 2001, African heads of state set a target of increasing health sector funding to 15% of government budgets (Organisation of African Unity, 2001). These commitments are just promises to substantially accelerate progress in achieving universal access to health care.

Public and Private Partnerships

Public-private partnerships have been explored as a mechanism through which additional resources and support can be mobilised for health activities, particularly in under resourced developing countries. Over 80 such partnerships exist, many focusing on combating neglected diseases (Wemos, 2004). The UN and its agencies have been at the forefront of engaging with the private sector in an attempt to foster collaboration that would deliver more resources for health in poorer countries (Buse and Waxman, 2001). The World Health Organization (WHO) has identified partnerships with civil society organisations, philanthropic foundations and the for-profit private sector as key

to the future of global health (Brundtland, 2001). This burgeoning collaboration with the private sector is in accordance with the United Nations' Global Compact which seeks to increase and distribute the benefits of global economic development through voluntary corporate policies and actions in the areas of human rights, labour, the environment, and good governance (United Nations Industrial Development Organisation, 2004).

The last two decades have seen a fundamental change in the shape of public organisations and the governance and management of societal problems, with governments becoming increasingly dependent on the private sector for the realisation of their policy objectives. This paradigm shift in policy is the result of a belief in the efficiency of private entrepreneurs to rejuvenate an ailing and inefficient public sector (Hood, 1991) as well as the emergence of complex and specialized social demands that governments are finding difficult to meet on their own. This is true for both the developed and developing countries. Outsourcing or contracting out has become a popular and preferred choice for the policy makers today. However, as Mills et al. (2002) point out, outsourcing is the beginning of a logical destination that eventually terminates in comprehensive restructuring of the public sector.

In recent years, there has been an implicit assumption among policy-makers that partnerships are a priori 'a good thing', which will aid attempts by various local organizations to improve public health. In England for instance, from Labour's first (post-1997) White Paper on public health on tackling health inequalities, the notion that partnership working is essential to achieving desirable public health outcomes in the UK is never contested. This is evident in the plethora of public health partnerships established during the last two decades, including Health Action Zones (HAZs), Healthy Living Centres (HLCs), Neighborhood Renewal Partnerships, Health Improvement Programmes (HImPs) and Local Strategic Partnerships (LSPs) (Secretary of State for Communities and Local Government, 2006 a,b; Department of Health, 2008). Yet, partnerships incur significant costs (Matka et al., 2008) and their contribution to improving health outcomes is far from clear (Lowndes and Sullivan, 2004). In part, this is because the prominent research literature on partnerships often focuses on process-related issues, rather than outcomes (Dowling et al., 2004). Additionally, while a great

deal has been written about partnerships between health and social care organizations (Coleman and Rummery, 2003; Rummery, 2004; Glendinning et al., 2005; Glasby et al., 2006), far less is known about partnerships for public health. This seems surprising, given that public health problems often involve precisely the kind of complex interplay of factors that single organizations may find difficult to tackle in isolation. The Foresight report on the complex policy challenges posed by obesity is a good example of the rationale underpinning the presumed need to work in partnership to tackle public health concerns (Butland et al., 2007).

1.1 Statement of The problem

The majority of existing research on health partnerships focuses on health and social care, rather than public health. At the moment, very little is known and spoken about the use and outcomes of Public Private Partnerships except in the contracting of cleaning services and catering. Most publications are all more concerned with the processes and ingredients conducive to the success of partnership working (e.g. such as the need for high levels of trust between partners and clear, shared goals) than they are with exploring what are the possible areas of partnerships and what their impact might be. Investment in healthcare has been low in Zambia, with the private sector getting uninvolved. There has been an increase in health sector funding over the years in Zambia. With this increase, priority has been accorded to hospitals in the urban areas while primary healthcare and rural health services have been ignored. Even if there has been this increase, the performance of hospitals in the area of service delivery, qualitative assurance, monitoring and evaluation has left much to be desired. It has been discussed informally among stakeholders that there is need to outsource services in a number of areas if we are to see improvements in this liberalised economy.

Outsourcing the primary healthcare is an attempt to revive the confidence of the general public. However, no one knows which areas may need outsourcing. No one knows if at all hospitals will be willing to enter into public and private partnerships.

1.2 Research Questions

1. What are the perceptions of PPPs among hospitals?
2. In what areas are hospitals willing to enter into partnership?
3. What are the ideal partnership periods hospitals would prefer to engage PPPs?
4. Why would hospitals take particular positions on PPPs?
5. How could this be achieved?

1.3 Research Aim and Objectives

The main objective is to explore the possibility of establishing PPPs among government hospitals.

Specifically the study will set to:

1. Understand the perceptions of hospitals on the need to enter into PPPs
2. Assess the critical elements of PPPs and processes necessary in the functioning of the partnerships
3. Explain the reasons for favorable or unfavorable positions of hospitals as they take particular positions on PPPs.
4. Develop a model that could be used in establishing PPPs in public hospitals.

1.4 Justification of The study

This study is justified for the following reasons:

Zambia just like other developing countries, cannot fully meet the health needs of the people with public resources alone. While universal access to key health services such as family planning, maternal health care, and prevention of HIV/AIDS and other sexually transmitted infections is critical to achieving the United Nation's Millennium Development Goals that access is far from becoming a reality. The private sector is likely to provide a complementary means to expand health services, products, and

infrastructure. However, the private sector is not a replacement for effective public-sector action. In every setting, both sectors have roles to play in addressing the complex and difficult challenges faced by developing countries to expand access to high-priority health services to underserved populations.

The reviewed literature and the clinical and community experience of this researcher strongly suggest that there is a wide knowledge gap on the role of PPPs in shaping health care delivery in our hospitals. From the presentation in this chapter for instance, it is clear that there is a dearth of knowledge and research has not yet rigorously developed PPP variables and appropriate interventions. Among the studies that at least touch on this issue, there is an obvious lack of information, particularly in terms of studies that engage with the views of those who are managing institutions. This is perhaps not surprising given the complex nature of our health delivery system.

If we are to maximize on access to services, customer satisfaction and efficiency, it is research prudent that hospital mangers take into account the need for PPPs. If health care systems are to respond adequately to service delivery problems, it is not enough simply to "add in" a donor component to finance budgetary deficits. The investigation of the need for PPPs from a public health perspective has great potential for improving the lives of our peoples and reducing national health costs. This study has notable significances and the following stand out.

The study will generate first hand data on the issue of PPP based on local experiences, meanings and perceptions. With the information that will be generated, it is hoped that the lessons learnt shall be transferred into hospital plans and strategies for effective action. The second one is associated with exploratory nature of this study. The study will fill in the knowledge gap and add intellectual knowledge to the research fraternity and particularly those who may wish to conduct a wider study. This is because the themes, subthemes and categories that will be developed will act as pattern variables to direct a much wider national study later on.

CHAPTER TWO- LITERATURE REVIEW

2.0 Introduction

In order to build the literature that follows, a combination of the use of the thesaurus tool and free text terms was used in the electronic database searches, in order to retrieve the largest number of results possible. Firstly, key words were used either as guidance to find the appropriate word through the thesaurus tool for the electronic databases (those databases that have one) or as free text. Secondly, the researcher combined the key words with terms referring to: overcoming constraints, effective health care, public and private partnerships. Finally, a list of health care problems that were considered relevant was included in the combination of terms searched. It is important to note that while the focus of the study is the strengthening of the hospital health care system, specific areas of concern were used here in order to narrow down the search to issues of relevance to the study.

Specific criteria for inclusion of abstracts and articles in the review were as follows:

1. Sources: journals, books, reviews, and conferences proceedings and abstracts
2. Country classification: low and middle income, less or least developed and developing
3. Geographic coverage: Africa, Asia, Latin America
4. Target population: poor
5. Publication year: after 1980.

The researcher selected the following electronic databases for searches: Cabhealth, Medline, Healthstar, HMIC, J STOR, Oxford, Blackwell Wiley, Elsevier and Popline. Once the electronic search was done, the title, abstracts and thesaurus (Medical Subheading—MeSH) fields were browsed for relevant terms to refine the search. The researcher attempted to retrieve as many review papers as possible. In addition,

complementary hand searches[3] were performed due to poor indexation of some journals in some electronic databases. The search of grey literature focused on independent (external review) evaluation reports, documents that were peer reviewed[4] and those available on the World Wide Web. In addition, the researcher googled the sites of institutions used for unpublished literature searches and these included: World Bank, World Health Organization, and Department for International Development, Partnerships for Health Reform Project, Quality Assurance Project, Health Systems Resources Centre, Population Services International, and Management Sciences for Health.

In addition to the sources of studies mentioned above, we also received recommendations from experts in the field. The relevance of selected and located studies was reviewed against the defined criteria and focus of the literature review described above. In addition, the overall quality of the research results of the studies was assessed, in particular regarding the existence of bias, the methods used, and the potential generalisability. Due to difficulties in finding a large sample of studies (since UNZA subscribes to very few journals) applying a rigorous study design, the main criterion for inclusion was that the paper should report on an intervention, thus leaving out opinion and critique papers.

The purpose of this review is to gather and analyze existing evidence and experiences, from country reports in the literature, of overcoming the constraints which affect the performance of the close-to-client health system. Of particular concern for this review is the effectiveness of efforts to improve hospital based health care provision and performance in terms of strengthening existing health care packages, introducing some, efficiency, equity gains and quality, evidence which allows a better understanding of how to improve health outcomes.

[3] The hand-searched journals were Health Policy and Planning and the International Journal of Health Planning and Management.

[4] The researcher considered internal peer review as acceptable as long as the paper could fulfill at least one of the other eligibility criteria.

2.2 Definition of Key Terms

Public sector

The public sector in this paper refers to national, provincial/state and district governments; municipal administrators, local government institutions, all other government and inter-governmental agencies with the mandate of delivering 'public goods (Slack and Savedoff, 2001).

Private

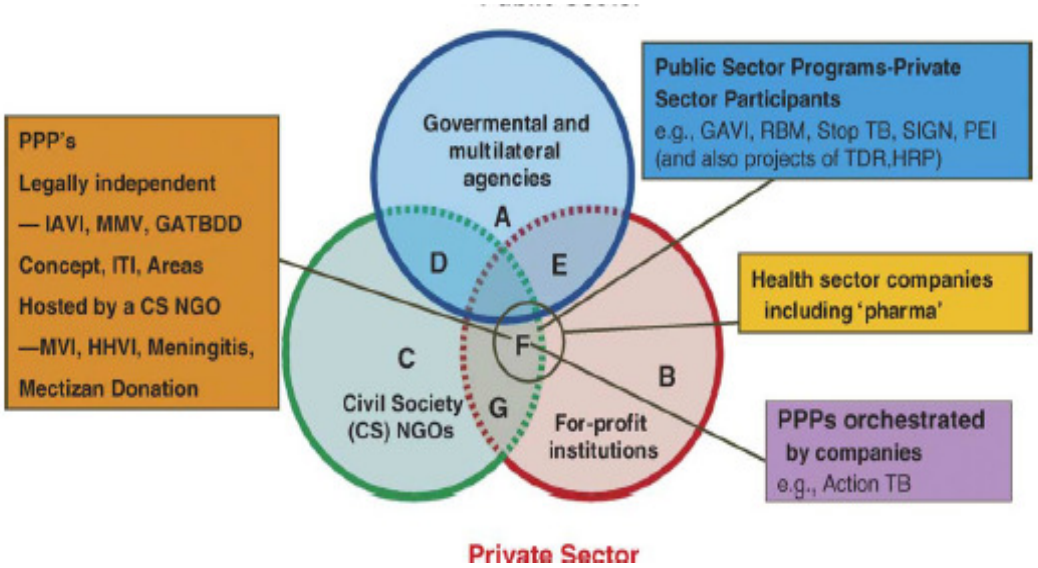
The word private denotes two sets of structures; the for-profit private (both informal and formal) encompassing commercial enterprises of any size (banks, health insurance companies, and so forth) and the non-profit private referring to Non Governmental Organizations (NGOs), philanthropies and other not-for-profits (Slack and Savedoff, 2001).

Partnership

The word partnership in this paper refers to long term, task oriented, and formal relationships. There has been ample critique relating to the convention of using the word partnership to describe such arrangements; much of this debate is valid, given that there are certain requisites for coining such an association. For the same reasons it also needs to be differentiated from privatization, which involves permanent transfer of control through transfer of ownership right or an arrangement in which the public sector shareholder has waived its right to subscribe. A distinction also needs to be made between partnerships and contractual arrangements, particularly with regard to the relationship between the public sector and NGOs (Slack and Savedoff, 2001).

Public Private Partnerships

The term 'public–private partnership' is a difficult one. Arriving at an agreed definition in the health sector has proven problematic. Public Private Partnerships are defined as "the combination of a public need with private capability and resources to create a market opportunity through which the public need is met and a profit is made" (Heilmanand, 1992:197). According to Grimsey and Lewis (2004), the term 'PPP' is used to describe a variety of financing and delivery structures that create a long-term relationship between the public and private sectors which includes the private finance initiative (PFI). Reflecting the definition offered by Grimsey and Lewis (2004: 14), this paper uses the term 'PPP' to refer to long-term, asset-based public service or infrastructure projects in which the private sector provides or underwrites substantial funding.



In this study, we use the term to describe relatively institutionalised initiatives, established to address global health problems, in which public and for-profit private sector organisations have a voice in collective decision-making. Such partnerships vary across a range of variables including their functional aims, the size of their secretariats and budgets, their governing arrangements, and their performance.

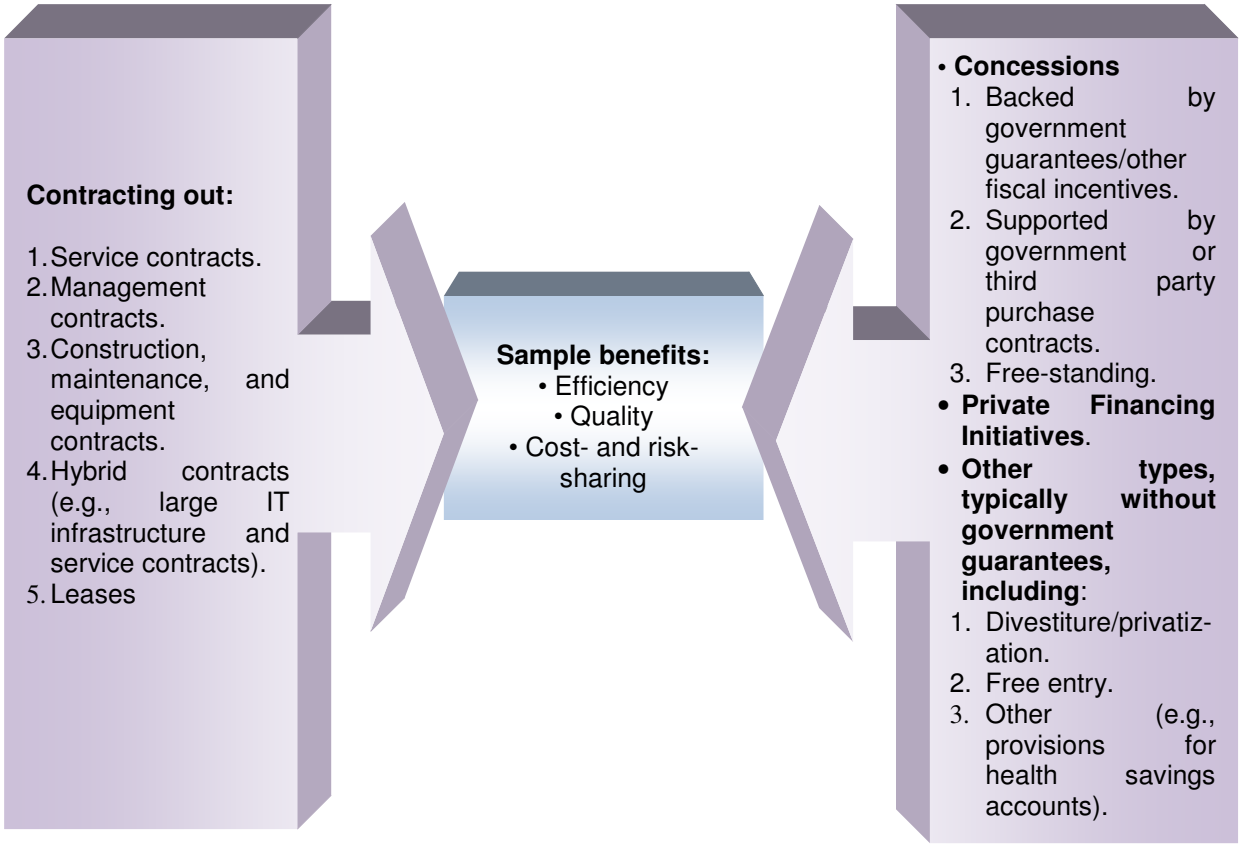
2.3 Public Private Partnerships in Health –a Global Call to Action

Public-private partnerships are being increasingly encouraged as part of the comprehensive development framework. The need to foster such arrangements is supported by a clear understanding of the public sectors inability to provide public goods entirely on their own, in an efficient, effective and equitable manner because of lack of resources and management issues. These considerations have necessitated the development of different interface arrangements, which involve the interfacing of organizations that have the mandate to offer public good on one hand, and those that could facilitate this goal.

Within the health sector, public-private partnerships are also the subject of intensely fueled debate (Health Action International, 2002). Several examples, which fall within this framework, highlight a potential for the creation of a powerful mechanism for addressing difficult problems by leveraging on the strengths of different partners; however, these also illustrate complex issues, as such arrangements bring together a variety of players with different and sometimes conflicting interests and objectives, working within different governance structures (Reich, 2000).

PPPs in the health sector can take a variety of forms with differing degrees of public and private sector responsibility and risk. They are characterized by the sharing of common objectives, as well as risks and rewards, as might be defined in a contract or manifested through a different arrangement, so as to effectively deliver a service or facility to the public. The private sector partner may be responsible for all or some project operations, and financing can come from either the public or private sector partner or both. In practice, several key types of PPPs are frequently encountered in the health sector, as listed in the following figure and discussed in more detail below (Schneider, 2006).

Figure 2.3.1 Key types of public/private partnerships and collaboration in health sector



Contracting-out involves publicly-financed investments aiming to improve efficiency and/or quality by awarding a service contract, a management contract, a construction, maintenance, and equipment contract, or various hybrid contracts to serve a specific need or situation, or a lease to a private partner or partners. Service contracts are entered into by public and private partners for provision of a defined service (e.g., laboratory services, catering) aiming to leverage comparative advantages of a private partner, such as experience or advanced technology, to improve efficiency and/or the quality of the service. Management contracts involve transfer of authority from a public partner to a private partner to manage a public facility and provide services, including full responsibility and authority to manage all necessary functions and staff (e.g., employ and manage staff, procure medicines and equipment), with the objective of enabling more efficient management. Construction, maintenance, and equipment contracts are typically entered into for development, refurbishment, or maintenance of a healthcare

facility (Grimsey and Lewis, 2002). Hybrid contracts may involve a variety of elements of the contracts mentioned above to serve a specific need or a situation, such as an contract providing for both the building and operating of the infrastructure, or a health facility management contract requiring the private operator to also refurbish or upgrade the facility (World Bank, 2003). Leases involve a private partner paying a fee to the public partner to manage and operate a public facility in exchange for revenues from the facility's operation, typically with the objective of improving the facility's financial situation by introducing more efficient management. Under a lease contract, the government typically remains responsible for major new investments in the facility (Price Waterhouse Coopers, 2005).

2.4 The Magnitude of the Problem- Warranting PPPs and Need for PPPs

In outlining the need for PPPs, it is prudent to present the context of the debate. Prompted by fiscal, social, administrative, political and ideological challenges, governments since the mid-1980s have shifted away from traditional line departments and experimented with new forms of service delivery including outsourcing or contracting (Peters and Savoie, 2000). Outsourcing is a purchasing mechanism used to acquire specified services of a defined quality at an agreed price from a specific private provider for a specific period of time (Mills and Broomberg, 1998). Outsourcing in basic public services, including healthcare, is possible where state sets the conditions, specifies the products and policy objectives it wants to achieve rather than directly delivering them through its bureaucratic machinery and can monitor outputs and outcomes (Klijn, 2002). An outside agency, preferably from the private sector, carries out the implementation of policy guidelines (Klijn, 2002; Milward and Provan, 2000; Rhodes, 1997). This may, however, lead to fragmentation of policy and decision making functions. Kadzamira et al. (2004) mentions this general complaint from the providers outside government that it makes policies and takes decisions with little or no involvement from them.

Marek et al. (2005) point out some of the advantages of outsourcing. These are mobilisation of additional resources and borrowing private sector management

approaches to make the public sector efficient and effective. They also spell out three basic conditions for successful contracting. These are knowledge of the services to be contracted, capacity to manage contracts and sufficient funding to cover the economic cost of the service at the projected level of demand. Millset al. (2001) fond certain capacity weaknesses in government while designing and awarding contracts. These are information asymmetries with respect to cost and quality, absence of budgetary frameworks and financial control mechanisms to monitor expenditure against plans, vague performance indicators and ambiguity about the roles, responsibilities of different organizations. Since outsourcing is possible through the interplay of shifting partnerships of both the public and private sector actors, and decisions are made in different arenas by network of organisations (Castells, 2000), this may lead to interesting products or policy outcomes (Osborne, 2000; Kickert et al., 1997; Rhodes, 1997). They, however, ignore the fact that this may also create tensions resulting from divergence rather than convergence of outcomes. These tensions may also emerge from different degree of emphasis given to efficiency and equity by the public and private sectors. Mills and Broomberg (1998) discuss the extent of contracting and in no case; they do find full range of services in the provision of primary healthcare to be outsourced. Mostly there were cases of selective contracting, especially in areas where more qualified and organised workforce was not available (Gilson et al., 1997). Marek et al. (2005) also conclude that the scope is mostly limited to clinical or non-clinic purchase of services from the private providers to complement public provision. This is despite the pressure by donor agencies that have been spreading out word about outsourcing. Batley and Larbi (2004), Mills et al. (2001), De Beyer et al. (2000) and Pfeiffer (2003) discuss the donor pressure, especially in African countries, to extend the range of activities that are contracted out. This failure to adopt outsourcing at a systemic level shows the complexity involved in such efforts.

Monitoring is crucial to protect against potential opportunistic behaviour of a contractor in PPPs (Kamensky and Morales, 2006; Goldsmith and Eggers, 2004). Effective monitoring will ensure proper translation of policy guidelines, and goals and targets into action and precludes the possibility of an agent taking advantage from its principal. Travis and Cassels (2006) underscore the need for a key role to be played by the public

sector in the design and supervision of monitoring programme. Effective Monitoring leads to decrease in total family expenditure (Soeters and Griffiths, 2003). There is also evidence that contracting mechanisms do not work well in situations where monitoring arrangements are weak (Ayeni, 2002; Mills et al., 2001).Literature review by Liu et al. (2008) on the effectiveness and impact of contracting out primary healthcare services finds that it is not possible to determine the systemic effects of outsourcing. They can either be positive or negative. The review suggests that although contracting has improved access to services in many cases, the effects on other performance indicators such as equity, quality and efficiency are not clear. However, the context of contracting out and how the intervention has been designed are likely to influence the chances of success. Loevinsohn and Harding (2005) discuss the pros and cons of contracting out to non-state actors as a means for improving health care delivery. The analysis is done with the help of ten case studies from around the globe. They conclude that contracting with nongovernmental entities is likely to provide better results than government provision of the same services. Loevinsohn (2008) is a toolkit that describes the best practices associated with contracting out healthcare services to non-state providers in the context of developing countries. The theme is performance-based budgeting whereby a series of objectives and indicators are identified that serve as benchmarks for assessing the extent of success/failure in the contracting out arrangement. The toolkit draws on lessons of experience based on 14 case studies of contracting healthcare services and concludes that performance based contracting can lead to rapid improvements in the coverage and quality of publicly financed health services. Palmer et al. (2006) bring another perspective to this debate especially within the context of fragile states, which neither have the capacity to ensure effective delivery of neither healthcare nor effective monitoring if a service is outsourced. In such weak states, donors contract out services in response to lack of government infrastructure and the need to expand services rapidly. As a result, paradoxically, the weaker the country's government capacity, the more likely it is that contracting is adopted. The notable example given is that of Afghanistan. Zaidi (1999) also reinforces this point when he concludes that stronger and more effective the developmentalist state (such as Singapore, South Korea), less the need for such development-oriented NGOs. However, when state and market institutions are inadequate, NGOs emerge to fill the

gap. The outsourcing of primary healthcare facilities to NGOs in Pakistan also shows the absence of an effective developmentalist state (Palmer et al., 2006).

2.5 Challenges for Improving Global Health Equity in PPP Arrangements

Concerns about the viability of public-private partnerships to improve global health equity revolve around several issues including the profit motives of the private sector. Private companies seek to maintain profitability in order to survive and thrive as business entities. However, with the push to give globalisation a human face, these companies want to be seen as socially responsible in their quest for profit. While in public most of them are keen to demonstrate their "good corporate citizenship" credentials, particularly how they are helping poorer nations to access drugs at affordable prices, in private they may take actions that are largely motivated by profit and contradict claims of good corporate citizenship. Regarding access to HIV/AIDS medication, for example, although prices of antiretrovirals have dropped significantly in poorer countries, it took strong political pressure and campaign by AIDS activists for pharmaceutical companies to reduce prices. There is evidence suggesting that several multinational drug companies still engage in policies that restrict universal access to antiretroviral drugs. For example, the World Trade Organisation recognises the importance of access to essential medicines in times of public health crisis and gives governments some freedom in the Trade-related Aspects of Intellectual Property (TRIPS) to bypass patents on drugs in emergency situations. However, several pharmaceutical companies involved in public-private partnerships have also promoted policies limiting the capacity of governments in developing countries to use TRIPS flexibility to improve drug access (Caines and Lush , 2004). The recent row between the government of Thailand and Merck, Abbott and Sanofi-Aventis over the planned manufacture of generic copies of the antiretrovirals Efavirenz and Kaletra and the heart drug Plavix under the TRIPS flexibility provision illustrate the desire of pharmaceutical companies to limit access in order to maximise profit. Without underestimating the importance of patent rights, such actions do not promote global health.

Another challenge regarding global health equity is the limited transparency and accountability surrounding public-private partnerships. Often, partnership arrangements with the private sector are not open to public scrutiny. The process of selecting private partners, the setting of targets to be achieved and the formulation of management guidelines are anything but transparent. Partnerships involving UN agencies, including the WHO, and private corporations usually fail to involve poorer developing nations who are often the main beneficiaries of such collaborations. The apparent lack of openness makes it difficult to assess what equity targets are set and who should be held accountable for achieving those targets, if any. It is also difficult to hold private companies accountable for failed public-private partnerships given their complex structures and governance, and the different processes of accountability within the public and private sectors. While public sector organisations are theoretically accountable to the population and could be held responsible for issues such as equity, private companies are answerable to shareholders who are typically more concerned about returns on investments than improving equity (Asante and Zwi,2007).

2.6 Brief on Operations of PPPs in Developing Countries

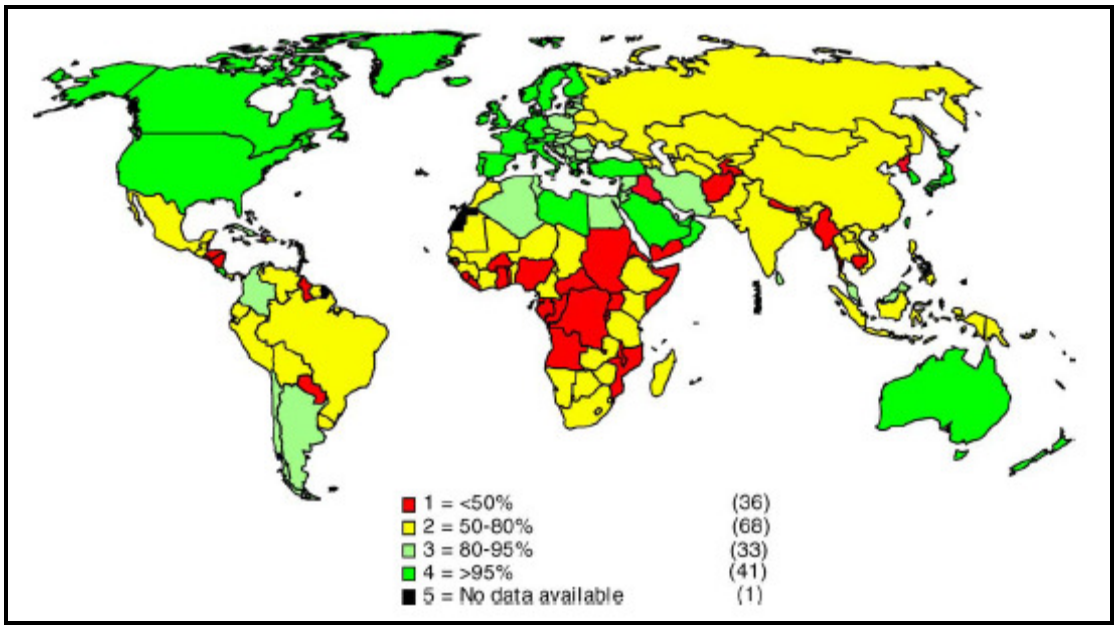
Private providers play a significant role in the provision of health services in developing countries, particularly for ambulatory health care (Berman and Rose, 1996; Hanson and Berman, 2000; Waters et al,. 2003). A large portion of Sexual and Reproductive Health (SRH) services in developing countries is also provided through different types of private providers. Private providers are a highly heterogeneous group, including for-profit and non-profit organizations, practitioners of modern and traditional systems of medicine, traditional birth attendants and other informal sector providers, as well as public sector practitioners who also work privately. In recent years, health policy analysts and governments have recognized that the private health sector has been neglected, and are increasingly looking for ways to better deal with private providers (Bennett et al. 1997; Mills et al., 2002; Peters, 2002). There are many reasons for addressing the private sector, but the most common set of public policy objectives is to find ways to increase the coverage and quality of health services, and to reduce the harm caused by unregulated private providers. Although a wide range of strategies

have been developed to deal with the private sector, there has not been a systematic effort to document how these strategies have worked for sexual and reproductive health.

When examining questions about the private health sector in developing countries, it is important to understand both the type of private provider and the type of health service involved. Most countries do not have reliable data on the number of private practitioners, particularly on those in the informal sector. Unqualified private practitioners are the largest source of health care in countries such as India and Bangladesh (Peters, 2002; Peters and Kayne, 2003), while pharmacy vendors and traditional healers form a major source of health care, particularly for outpatient conditions, in many African countries (van der Geest, 1987; Oshiname and Brieger 1992). It is also clear that different types of private providers make up significant segments of the market for different types of SRH services.

In a vicious circle, poverty is a major cause of health inequality in developing countries, and ill health perpetuates poverty. There are an estimated 11 million premature deaths per year in the world's poorest populations, and 80% of these are due to infectious diseases (Gwatkin and Guillot, 2000). In the age of globalization, many people still lack access to essential medicines (Figure 2.6.1).

Figure 2.6.1 Many people still lack access to essential drugs



Source: Gwatkin and Guillot (2000)

The UN Millennium Development Goals, adopted in September 2000, set targets for progress in health were to halt and begin to reverse the incidence of HIV/AIDS, malaria and other major diseases by 2015. At present, however, it is very doubtful that these targets can be achieved in most of the poorer countries. The problem is that the array of 'tools' currently available to meet the international targets on child mortality, HIV/AIDS, tuberculosis (TB) and malaria are inadequate for the poorer countries. There are no vaccines against HIV infection or malaria and there is no vaccine to prevent the majority of TB cases (in adults). Existing diagnostic tools or therapies for most diseases disproportionately affecting the poor are old and/or difficult to use. First-generation vaccines against pneumococcal pneumonia may be too complex and expensive for use in developing countries. Vaccines against rotavirus diarrhoea are only just emerging. Other childhood killers lack prevention.

Most drugs are threatened by increasing resistance. In an ideal situation, products developed for global use move steadily along the research development access continuum. Research is translated into product concepts, these are developed into

proven products and manufacturing takes place. The products go through regulatory approval to ensure consumer safety and are then introduced and used in well-functioning health systems. The reality for the poor of the developing world is very different. Products developed for global use have a relatively slow introduction into poor countries, usually caused by lack of planning and high initial cost. Meanwhile, the development of products specifically needed to combat diseases disproportionately affecting the poor has been sorely neglected. Pharmaceutical companies are, after all, commercial concerns with shareholders to consider. New medicines are very expensive to develop. Poor populations do not, by definition, provide a good return on this investment. The solution to this deadly conundrum is 'partnership'. Public-private partnership (PPP) brings together funders such as philanthropists and governmental and inter-governmental agencies with academics, industry and not-for-profit organizations.

Public-private collaborations are needed to tackle diseases of the developing world because no single sector — the for-profit private sector, the not-for-profit private sector or the government agencies of the public sector — has all the skills and resources needed to make an impact on its own. Independent efforts by the public sector or by non-governmental organizations (NGOs) have mostly failed. Public-private partnerships however, result in a complementarily of skills and resources that can accelerate the discovery, development and delivery of new products to those in need.

2.7 Defining the Three Sectors

The non-state sector in primary health provision may be defined as including all providers that exist outside the public sector, whether their aim is philanthropic or commercial, and whose activities are intended to treat illness, prevent disease or provide a service. Health care in developing countries like Zambia is characterised by unorganised markets, and regulated to unregulated pluralism of provision. Standing and Bloom (2002) argue that the public and private, and the organised and unorganised sectors intermesh across the range of health activity. Within the literature on primary health care, state interventions in relation to Non-State Providers (NSP) are not

prominent, but salient issues raised include the quality of care provided by informal NSPs, the unequal relationship between provider and consumer, and weak government capacity to regulate and contract NSPs. Health service provision is multiple, with a vast range of services involved, and many small and diverse providers, from one-person traditional birth attendants and formally trained nurses to large institutions. The non-state sector is involved in health promotion and prevention through provision by Non Government Organisations (NGOs) and Faith-Based Organisations (FBOs) to under-served areas, and through for-profit private institutions.

2.8 Notable Events

Although it is recognized that the reasons for partnership working are multiple and varied, it was neither the aim of the literature presented here to explore these differences, nor is it part of our objectives to measure the extent to which partnerships had (or had not been) successfully forged. Evidence synthesis Systematic review methodology enables researchers to establish the full extent and quality of research evidence on a given question in order to highlight gaps in the evidence base and thus inform the direction of future research. Given the status of partnership working exists in Uganda, Ghana and the University of Zambia is advocating this as seen in The Road map document to develop the University of Zambia, our systematic review of the health impacts of public health partnerships should be beneficial and timely to policy-makers and researchers. Below we present notable studies that have focused on Public and Private Partnerships to forge development related programs in health care provision.

2.9 Health Improvement Programmes

Two qualitative studies considered the impact of health improvement programmes (HImP) partnerships (Table 2.1). The study by Powell et al.(2001) reported that there was a lack of clarity among key stakeholders in three case study HImPs about what partnership working could contribute to public health outcomes. Similarly, in Benzeval and Meth's study (2002) managers reported they felt that, while HImP had moved health inequalities onto the agenda, there remained a need for a coherent strategic

framework addressing inequalities to be built into local policy. The critical appraisal process suggested that these studies were of a good quality, but they did not offer much information on health outcomes.

2.10 New Deal for Communities

Two high qualities prospective studies evaluated New Deal for Communities partnerships (CRESR, 2005 and Stafford et al., 2008) did not find an intervention Effect of PPPs. The large-scale, mixed methods study (comprising a large n longitudinal study of New Deal For Communities areas and equivalently deprived non- New Deal For Communities comparison areas, secondary data analysis, documentary analysis and 78 focus groups with participants) CRESR (2005) reported small improvements in lifestyle indicators (e.g. smoking fell by 2–38%) and morbidity rates (1.93– 1.77, no ***p*** value) after 3 years. However, non- New Deal for Communities areas experienced similar decreases. The focus group data suggested that residents believed that services had improved in the New Deal for Communities areas. Similarly, the quantitative study by Stafford et al. (a longitudinal survey comparing New Deal For Communities residents and non- New Deal For Communities residents in comparator areas matched for deprivation) found that, although there were small improvements in New Deal For Communities areas (e.g. in relation to employment or smoking prevalence), these were mirrored in the comparison areas and so no consistent differences between intervention and comparison areas for any health-related outcomes were identified. Residents with the lowest educational attainment and poorest health at baseline experienced the smallest improvements in outcomes. Again, these trends were also apparent in non-New Deal For Communities areas, although the relationship between the level of education and take-up of education/ training opportunities was less pronounced in New Deal For Communities areas, suggesting that inequalities were 'growing less fast' in areas covered by this intervention type.36 However, as with HAZs, the complexity of New Deal For Communities interventions and the number of other factors involved (such as the extra resources made available to these areas) make it impossible to conclude to what extent partnership working contributed (or not) to the differences in health outcomes observed in these studies.

2.11 National Health Standard

An evaluation of the National Healthy Standard (NHS), a partnership involving the Department of Health, the Department for Education and Skills and the Health Development Agency, employed mixed methods to assess the extent to which the NHS was reducing health inequalities through PPPs (TCRU and NFER, 2004). However, only the qualitative component met the systematic review inclusion criteria (the quantitative element was cross-sectional, not longitudinal). Interview data suggested that, in terms of indirect outcomes, the NHS partnership led to the introduction of specific health-related initiatives (such as drinking water, addressing mental health and emotional well-being issues and healthy eating); raised awareness among local professionals of links between health and educational attainments; led to the development of named 'health governors' in schools and helped develop and implement a validation and accreditation process for healthy schools.

Below therefore is a summary in table 2.11.1 of some of the notable studies that have looked at PPPs in health.

Table 2.11.1 Research Designs of Most cited Public and private partnership Research

Author	Methods	Key findings
Bauld et al.	Quantitative: secondary analysis of routinely collected data from the Compendium of Clinical and Health Indicators (comparing intervention and comparison areas longitudinally).	Improvement in all cause mortality and CHD mortality in HAZ areas (e.g. in 15–64 age group CHD mortality decreased by 22% in second wave HAZs compared with 18.3% in deprived non-HAZ LAs). Findings not consistent, however, as mortality from accidental falls increased by 31.3% in first wave HAZs compared with 17.1% in comparator areas, despite a focus on accident prevention in some of these areas. Overall no evidence that HAZs made greater improvements to population health than non-HAZ areas between 1997 and 2001.
Bauld et al.	Qualitative: (1) face-to-face and follow-up telephone interviews with all 26 HAZ directors/coordinators; analysis of national HAZ documents; (2) face-to-face interviews/focus groups with 'key stakeholders'; (3) local documentary analysis in 8 case study areas.	Interviewees felt that HAZs' activities had made health inequalities more visible on the local agenda.
Benzeva	Qualitative: (1) initial mapping of HAZ strategies (document analysis and questionnaire survey of all HAZs); (2) 57 interviews with key stakeholders and HAZ managers in three case studies (Sheffield, North Staffordshire, East London).	The impact of HAZs on health inequalities was felt by interviewees to be minimal. Some reported that local projects embedded within HAZ had been positive, 'changing some individuals' lives'. Higher profile of health inequalities on local policy agenda and increased understanding of the wider determinants of health.
Burton and Diaz de Leon	Qualitative: case study of benefits advice intervention in GP surgeries: (1) document analysis; (2) interviews with project stakeholders and some clients (June/July 2001).	Benefit advice services resulted in an increase in client incomes. Clients reported feeling less stress and anxiety and increased feelings of wellbeing as a result of the services. Some of the elderly people interviewed identified 'being able to buy a wheelchair', 'keeping the heating on in winter' and 'eating more healthy food' as a result of receiving attendance allowance.
Benzeval and Meth	Qualitative: (1) review of all HImP documents; (2) telephone interviews with key players in the eight NHS Executive regional offices; (3) case studies of five places (interviews with 64 key informants in total).	Respondents felt that health inequalities had been moved onto the agenda but there was a need for a coherent strategic framework addressing inequalities to be built into local policy.
Powell et al.	Qualitative: three case-studies rural, urban and 'mixed urban/sub-urban' were selected. (1) Documentary analysis and observation at policy meetings; (2) interviews with a wide range of stakeholders (43 individuals across 3 case-studies).	Lack of clarity about how the partnership could contribute to public health outcomes.
CRESR	Mixed: (1) longitudinal household surveys comparing New Deal For Communities areas and equivalently deprived non-New Deal For Communities comparison areas (2002 and 2004), clients survey (n ¼ 1000) and business survey (n ¼ 2000); (2) secondary data analysis in relation to educational attainment per pupil, police recorded crime, and exits/entrances from benefits; (3) analysis of 39 partnership level reports for the 3 years: 2002/03, 2003/04 and 2004/05; (4) 78 focus groups, two in each New Deal For Communities area, one with participants drawn from the general population and one from a more targeted group such as beneficiaries of particular projects.	Small improvements in some lifestyle indicators: e.g. smoking fell by 2% to 38% in intervention and comparison areas. Morbidity rates improved slightly (2001–2003 compared with 1999–2001) from 1.93 to 1.77, similar to comparison areas. No evidence that New Deal For Communities areas were improving their relative position with regard to mortality rates or hospital admissions. Focus group findings revealed that users were positive about efforts to improve health service provision in their area. Indeed, participants from eight focus groups specifically said they had noticed an improvement in local health services during the previous 3 years.

CHAPTER THREE- RESEARCH DESIGN AND METHODOLOGY

3.0 Introduction

One of the most common and well-known study designs is the cross-sectional study design. In this type of research study, either the entire population or a subset thereof is selected, and from these individuals, data are collected to help answer research questions of interest. It is called cross-sectional because the information about the sought phenomenon that is gathered represents what is going on at only one point in time. Cross-sectional research involves the measurement of all variable(s) for all cases within a narrow time span so that the measurements may be viewed as contemporaneous. Essentially, data are collected at only one point in time, comparing different participants at different ages (Bates et al., 1998). One advantage of cross-sectional research is that it is more economical in time and cost than other designs. For the participants, there is only one period for data collection, and the researcher is not faced with the difficulty and cost of maintaining contact with subjects over a long period of time.

3.1 Population and Sampling

The study population included government hospitals along the line of rail. These hospitals were selected because the government has granted them authority to contract ad subcontract PPPs. In addition, it is along the line of rail that the largest (tertiary hospitals are located). In this study, only key managers (Chief Executive Officers and their deputies, operations and human resource managers in each hospital were eligible for the study (see appendix I). All senior and middle-ranking staff in the selected hospitals were enlisted. The researcher administered a questionnaire and interviewed all eligible staff thereafter. The researcher conducted one or two interviews with the same interviewee, at different times during the research period in the event that the staffs were busy. This made it possible to collect data on the responses of interviewees to important events as they unfolded.

Due to the sensitivity of the questions, interviewees were assured of anonymity. When respondents agreed, interviews were written down. Each direct quotation used in the paper was approved by the interviewee. Due to the sensitivity of some of the responses, the researcher has decided not to use the names of any interviewees.

3.2. Elements for Interviews and Questionnaire

The data collection tools addressed issues traversing;

1. Who are likely to be partners?
2. What services could be considered for PPPs?
3. Reasons for the positions in 1 and 2.

3.3 Data Analysis

Each transcript was analysed by the researcher and the text coded to identify key themes. The transcripts were further reviewed against the list of themes, to identify common and untypical responses. The coding and review process identified some gaps and ambiguities, and these were clarified by telephone or e-mail contact with the interviewees. Quantitative data was coded and analysed using the Statistical Package for the Social Sciences (SPSS) version 17.

3.4 Ethical considerations

A written consent was obtained from the respondents after explaining the purpose of the research and ensuring that they understand clearly the issue at hand. This will only take place after clearance by the UNZA research ethics committee and permission obtained from the Ministry of health. The details appear in Appendix II.

Information obtained from the respondents during the study was kept strictly confidential as it bordered on personal information which most people would rather keep to themselves. Envelopes were provided for the respondents to put in their completed questionnaires. The answered questionnaires were kept by the researcher in the strictest of confidence.

CHAPTER FOUR — RESEARCH FINDINGS

4.0 Introduction

This paper is based on the analysis of 24 of the 41 interviews and 41 survey questionnaires. The study sites included:.

1. UTH
2. Lusaka Health Provincial office.
3. Chainama Hills College hospital
4. Lusaka District Management Team
5. Arthur Davison Hospital.
6. Ndola Central hospital.
7. Copper belt Health Provincial Office.
8. Ndola DHMT.
9. Kitwe DHMT.
10. Kitwe Central hospital.

The research findings are organised under the themes drawn from the research questions. The framework used to present the research findings here is informed by Denzin and Lincoln (1998). Denzin and Lincoln integrate qualitative and quantitative data, looking at them in combination to get a deeper insight into the problem under study and possibly inspire a deeper and more rewarding analysis. The researcher presents first the quantitative data and this is preceded by qualitative data.

4.1 Social Demographic Characteristics

The study drew 31 (75%) males and 10 (24% females. The sample under study was rather youthful of mean age 42 ± SD 6.2 (mean + standard deviation).

4.2 Awareness of Public Private Partnerships

In order to establish knowledge of the concept and practice of Public Private Partnerships, respondents were asked whether or not they were aware of them and whether or not Public Private Partnerships improve health care service delivery? Barely 49% were aware as compared to 51% of whom 15% not aware and 36% had some knowledge (figure 4.2.1).

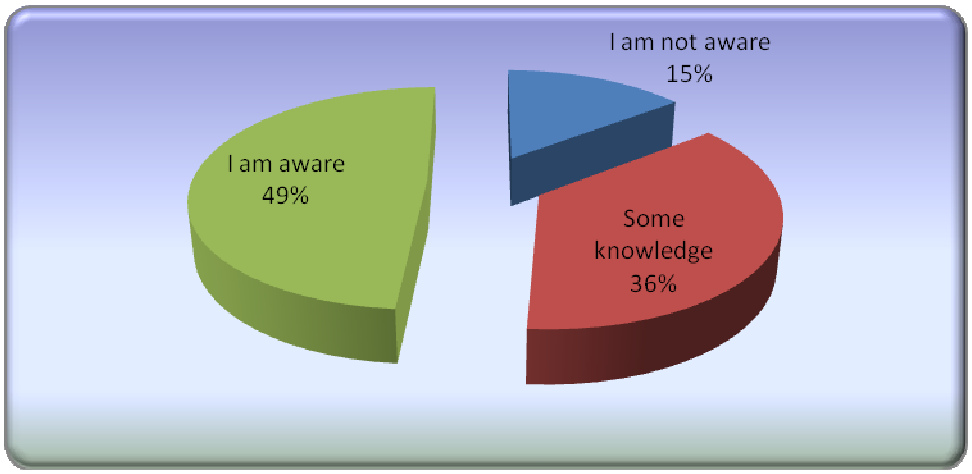


Figure 4.2.1 Awareness of PPPs

Not withstanding the lack of awareness of PPPs, when a follow up with interviews was made at an appropriate time, to determine whether following the health reforms hospitals had crafted portfolios for development, it was observed that portfolios were not thought of at all by most management staff during the reforms. The excerpts below attest.

> Yeah….it was very clear from the beginning that it was not going to be possible for hospitals to do everything by themselves. After the retrenchment of general workers, one portfolio that was imminent related to contracting cleaning services.
>
> (Finance Director)

> You see, those retrenchments paved the way for PPPs. The writing was clear on the wall. For those boards that wished to explore this new approach, turning to the private sector was the best alternative to help address specific cost and investment challenges, deliver improvements in efficiency.
>
> (Human resources manager)

> We did not envisage engaging the private sector because the leveraging of partnerships and collaboration with the private sector to address the challenges governments face in healthcare today may not be easy. These PPPs tend to take a long time to establish and bring to fruition, and in many cases may not be the most effective or efficient option available.
>
> (Social worker)

> We did not want to rush into these arrangements. They work better in the West and in poor economies like ours. We have traded a careful path so far and you know if you mess up…...
>
> (Acting Director)

4.3 Areas in Which Hospitals are Willing to Enter into Partnerships

Nearly all respondents n= 40 (98%) were generally willing in the immediate future to engage a private organization to subcontract some services as compared to n=1 (2%) who were unwilling.

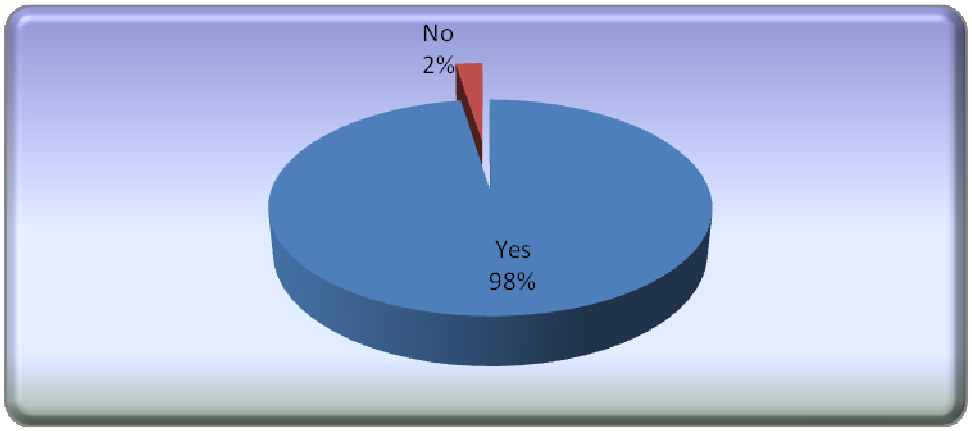


Figure 4.3.1 Willingness to engage PPPs

While it was generally taken that PPPs would be beneficial to engage if there were improvements in service delivery, there were only three areas that were perceived to be ideal for engagement and these included (i) training hospital staff in priority areas (strategic planning, financial management, human resource planning and marketing planning) (ii) refuse or waste disposal and (iii) building new or substantially upgrade public facilities and provide some of the services within them. The frequency preferential scores in these three areas are remarkably high and stood at 65.9%, 68.3% and 63.4% in this order (Table 4.3.1).

Table 4.3.1 Areas Perceived Ideal to Engage into PPPs

Domain for Partnership	Response type			
	Very Much	Much	Somehow	Not at all
Would you consider contracting an organization to deliver family planning?	3 (7.3%)	7(17.1%)	10(24.4%)	21(51.2%)
Would you consider contracting an organisation to deliver general patient counseling?	5 (12.2%)	14(34.1%)	14(34.1%)	8(19.5%)
Would you contracting an organisation to deliver STI diagnosis and management?	6(14.6%)	12(29.3%)	11(26.8%)	12(29.3%)
Would you consider contracting an organisation to deliver immunization and child care?	1(2.4%)	1(2.4%)	19(46.3%)	28(48.8%)
Would you consider contracting an organisation to train hospital staff in priority areas (strategic planning, financial management, human resource planning and marketing planning)	**27(65.9%)**	7(17.1%)	6(14.6%)	1(2.4%)
Would you consider contracting an organisation to treat minor ailments?	2(4.9%)	10(24.4%)	13(31.7%)	16(39.0%)
Would you consider contracting an organisation to provide laboratory services?	5(12.2%)	10(24.4%)	12(29.3%)	14(34.1%)
Would you consider contracting an organisation to provide radiology services?	0(24.4%)	6(14.6%)	13(31.7%)	12(29.3%)
Would you consider contracting an organisation to provide waste disposal services?	**28(68.3%)**	10(24.4%)	2(4.9%)	1(2.4%)
Would you consider contracting an organisation to provide pharmacy services?	2(4.9%)	11(26.8%)	14(34.1%)	14(34.1%)
Would you consider contracting an organisation to build new or substantially upgrade public facilities and provide some of the services within them?	**26(63.4%)**	8(19.5%)	2(4.9%)	5(12.2%)
Would you consider contracting an organisation to render business skills?	2(4.9%)	11(26.8%)	14(34.1%)	5(12.2%)
Would you consider contracting an organisation to undertake strategic planning?	15(36.6%)	14(34.1%)	8(19.5%)	14(34.1%)
Would you consider contracting an organisation to undertake human resource planning and marketing planning?	11(26.8%)	12(29.3%)	11(26.8%)	7(17.1%)

4.4 Potential Partners

It was observed that hospitals were not highly selective in the types of partnerships they wished to engage. Potential partners that were identified and linked to the provision of a defined service (e.g., laboratory services, radiology) (e.g., employ and manage staff, procure medicines and equipment) included professional associations, cooperationist, faith based organisations with the objective of enabling more efficient

management. Noting that the types of partners that are proposed cut across the typical PPPs , it is evident that the respondents are advocating for a generic model.

Table 4.4.1 Types of Preferred Partners

Type of Partner	Response type	
	Yes	No
Would you consider partnering with professional associations like the medical association?	40 (97.6%)	1(2.4%)
Would you consider partnering with corporations?	38 (92.7%)	3(7.3%)
Would you consider partnering with Faith Based Organisations?	38 (92.7%)	3(7.3%)
Would you consider partnering with NGOs?	39 (95.1%)	2(4.9%)

4.5 Period of Partnerships

Interviewees and responses from the questionnaire indicated that PPP contracting should not be for longer periods but at most up to 5 years (Table 4.5.1).

Table 4.5.1 Period of Partnership

Preferred Partnership by Domain	Response type		
	Up to 5 years	Up to 10 years	Over 10 years
Contracting an organisation to deliver family planning	37 (90.2%)	4(9.8%)	—
Contracting an organisation to deliver general patient counseling	29 (70.7%)	7(17.1%)	5(12.2%)
Contracting an organisation to deliver STI diagnosis and management	31(75.6%)	10(24.4%)	—
Contracting an organisation to deliver immunization and child care	32(78.0%)	7(17.1%)	2(4.9)
Contracting an organisation to train hospital staff in priority areas (strategic planning, financial management, human resource planning and marketing planning)	24(58.5%)	8(19.5%)	9(22.0)
Contracting an organisation to treat minor ailments	34(82.9%)	3(7.3%)	4(9.8%)
Contracting an organisation to provide laboratory services	26(63.4%)	8(19.5%)	7 (17.1%)
Contracting an organisation to provide radiology services	24(58.5%)	9(22.0%)	8(19.5%)
Contracting an organisation to provide waste disposal services	22(53.7%)	10(24.4%)	9(22.0%)
Contracting an organisation to provide pharmacy services	23(53.6%)	7 (17.1%)	11(26.8%)
Contracting an organisation to build new or substantially upgrade public facilities and provide some of the services within them	19(46.3%)	12(29.3%)	10(24.4%)
Contracting an organisation to render business skills	27(65.9%)	10(24.4%)	4(9.8%)
Contracting an organisation to undertake strategic planning	23(56.1%)	15(36.6%)	3(7.3%)
Contracting an organisation to undertake human resource planning and marketing planning	20(48.8%)	18(43.9%)	3(7.3%)

The shorter periods of engagement were the most preferred. This is notable as the respondents did not want to be constrained longer in the event there was poor performance or breeches in the contract. The detailed reasons are reflected in the preceding sections (to avoid repetitions)

4.5 Reasons for favourable or unfavourable positions on Public Private Partnerships

When asked to give support or to discredit PPPs, the respondents gave mutually exclusive responses. However, more respondents gave unfavourable positions than favourable conditions. To begin with, we shall examine the favourable positions.

4.5.1 Favourable Positions

Three themes came out pointing to favourable positions for PPPs and these included: the private sector already plays a large role in health care provision, patients often prefer the private sector and the private health sector can increase the scope and scale of services.

The Private Sector Already Plays a Large Role in Health Care

> We cannot deny the fact that we are not doing well in providing health services. Look at the number of patients versus the numbers of staff that we have. We just have to allow coexistence with the private sector. We could for those that have money subcontract services to the private sector and we could get some royalties.
>
> (Nurse Manager)

Patients Often Prefer the Private Sector

> We all know that patients like the private sector. Why don't we bring this sector in the public domain? Household decision makers often choose private providers because they respond more to patients' needs or preferences. People value the convenience, flexible payment plans, and ease of access to health care providers and drugs at private health services. This fast tract thing could be extended to be a PPP.
>
> (Human resources manager)

The Private Health Sector Can Increase the Scope and Scale of Services

> In many districts in Zambia now, the private sector owns and manages a significant number of the country's infrastructure (but not so in the health sector) but is becoming significant employer of health care professionals. Many of these institutions are located in urban areas. Take Lusaka; there are numerous hospitals and Clinics. I believe that the public sector can extend its reach by contracting with these providers or by undertaking quality-enhancing activities such as quality assurance and accreditation.

4.5.2 *Unfavourable Positions*

Though most of the respondents were for PPPs and not in the clinical areas like: STI diagnosis, surgery, gynecology and obstetrics, it was observed that Zambia was not yet ready to fully get into PPPs. The reasons were rather numerous but the following stand out:

> It is possible that in our PPP arrangements, we may not specify roles and responsibilities very well. Poor specificity can lead to failure to deliver critical inputs as well as to misunderstandings—both of which undermine collective working arrangements and impede performance monitoring and accountability.
>
> (Director Finance)

> We have a problem in this country when it comes to dealing with selecting partners after soliciting expressions of interest. Look at the procedures governing partner selection, the management of conflicts of interest, and performance and material auditing. I hope you remember the ZAMTEL problems!!!
>
> (Social Worker)

> At the moment, as a country, we have an inadequate regulatory framework or low institutional capacity, which may need to be addressed either through special provisions built into the PPP contract or through separate reforms undertaken by the Ministry of Health (e.g., enhancing accreditation systems, updating patient rights policies, enabling transparency in health providers' performance). If the Central Board of health was not abolished, we could have achieved this by now.
>
> (Public Relations Manager)

> Although the use of public–private partnerships has been effective when used to finance infrastructure maintenance (but even here there have been some high profile failures), this success has yet to be repeated in the health sector. The challenges of implementing a public–private partnership have been greatest in the case of tertiary hospitals major teaching hospitals. If I could recall during my post graduate training in the UK, my hospital accepted a wide range of referrals and provided services for various types of patients. There were also many

different types of stakeholders….There were marked difficulties in reaching agreement with all of these stakeholders, combined with the high costs of the partnerships. All these led to the collapse of this major teaching hospital. Failure results in very large losses in terms of fees and prepayments. These experiences raise questions as to whether this model can be simplified sufficiently to be used for very complex situations like ours. I am very mindful of UTH.

(Executive Director)

4.6 A model that could be used in establishing Public Private Partnerships in public hospitals

When the respondents were asked what the practice was and what they would prefer the PPP arrangement to be, it was evident that some hospitals and DHMTs had already engaged some partners after identifying essential service components that are needed in order to deliver quality care. Hospitals and DHMTs were in partnerships with NGOs, local authorities, private practitioners and corporations. In terms of what they thought the future arrangements to be, most of the respondents identified who could be the main partners in a collaboration or partnership.

I feel that we could add on to the present list some partners. There is need for building contractors to come on board you know. The government is not in a position to build hospitals or labs…. I do remember in the UK, the government contracted a company to manage the hospital. But I am not of the idea where a private company takes over management of a hospital.

(Hospital Director)

You could see for your self the state of dilapidation. We need cash injections. We could only get funds from some of these companies take the mines for instance.

(Hospital resident engineer)

We have always partnered with private labs. We do send our specimen to Nkhanza laboratories. We also work with a number of VCT centres and private pharmacies. We could have a net work of dependencies you know. The local authority has for some time been sidelined in the provision of health care. We feel we could work with them in a much more formal way.

(Nursing Services Manager)

> We do receive patients who were seen by private practitioners. The main reason for patients going to them was to have easy, direct and personalized contact. You see in public hospitals there is unlimited waiting time. So we need to link up with them in some cases. In private clinics and hospitals, all services and procedures are dealt with in one place. Through this linkage, and that, if they needed examinations and referral to public services, this could be efficiently facilitated by the private physician.
>
> (Executive Director)

From these descriptions, we show below a generic model linking the partners and the components. This model is then used to describe and analyse successful partnerships currently in existence and those who may be brought on board by identifying those features that could produce a successful outcome. In the generic model, some of the respondents who are very eager to engage PPPs propose that partnerships are combined schematically. A typical realization of the generic model is given in Figure 4.6.1. The main potential partners are denoted by rectangular boxes, forming the cornerstones of the model. Additional partners are represented in the model by an oval linked to the partner to whom there may be some responsibilities. A heavy border shows the partner who coordinates the PPP. Arrows are used to indicate the flow from the provider of a service component to the user of that service, and/or line management functions.

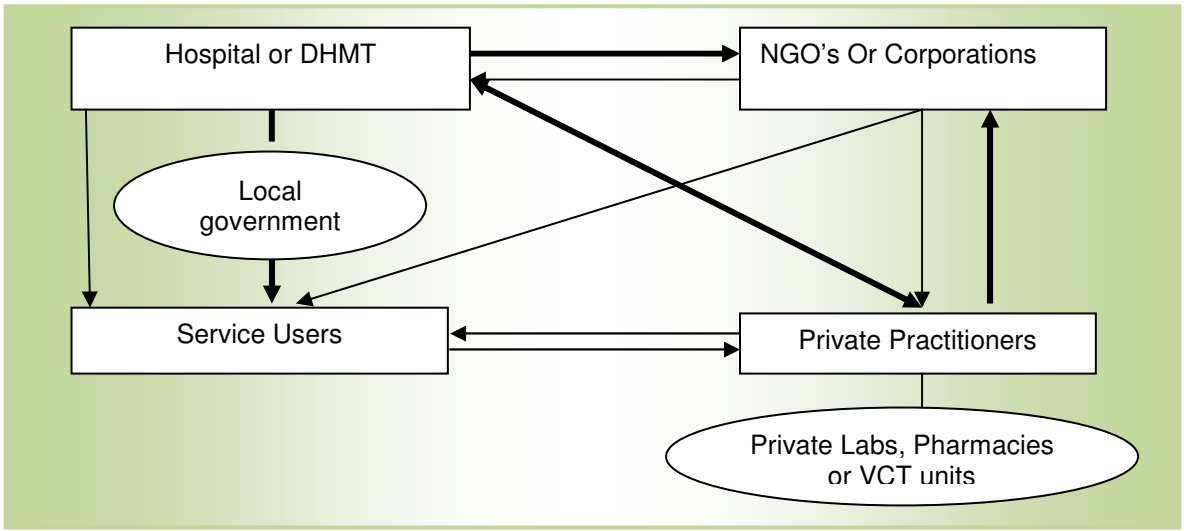


Figure 4.6.1. A typical realization of the generic model indicating partners and service components

CHAPTER FIVE — DISCUSSION

5.0 Introduction

This chapter discusses the findings and presents conclusions of the study and not forgetting the strengths and significances of this research. This chapter winds up on the limitations of the study since these play an important role in making suggestions for future research and recommendations.

The findings in chapter four tend to show the need for PPPs in Zambia. The phenomena are seen in Africa, the West and elsewhere. For instance, the Private Finance Initiative (PFI) in the United Kingdom is a design, build, finance and operate (DBFO) model. It has been the primary means of financing major capital investments in health (Atun and McKee, 2005). In the British model, which could be the case in Zambia, a company — usually in the construction sector — will create a "special purpose vehicle" to bid for a contract with a health authority to build and provide non-clinical services to a hospital. The successful contractor will enter into three types of subcontract: one with banks to finance the project; one with a construction company to build the hospital; and one with facilities management company to manage it over the lifetime of the contract, typically 30 years. However, this may not be the case if look at the 0 to five years contract period which the chief executives would prefer. There are numerous examples we could site.

Paddington Health Campus, London, England

A private financing initiative approach was chosen as the mechanism to consolidate several world-class teaching hospitals on a single site in west London (Lethbridge, 2004).

La Trobe Regional Hospital, Melbourne, Australia

La Trobe Regional Hospital (Parliament of Australia Senate Community Affairs Committee, 2000) was built by a private company to replace older public hospitals, having entered into a confidential contract with the government of the state of Victoria to provide hospital services for 20 years.

Sweden and Taking over a Public Hospital

In Sweden, a private company took over management of an existing public hospital (Sveman and Essinger, 2001) (including the sale of a public hospital to a private company). A unique model has been developed in the Alzira Hospital, in Valencia, Spain, which is managed by a private consortium that accepts responsibility for the health care for a defined population in return for an annual per capita payment.

Uganda

Uganda is one country that has had a wide range of service providers and services offered on the basis of PPPs. According to (Mugisha et al., 2005), the following are notable:

1. Uganda Catholic Provision of a range of RH services except modern contraceptive.
2. Family Planning Association of Uganda: Safe motherhood, family planning (FP) and counselling; STI diagnosis and management; immunization and child care; postnatal care; post abortion care; treatment of minor ailments; training; advocacy and community-based services; ANC; malaria treatment in pregnancy; laboratory services; voluntary counselling and test (VCT); addressing harmful cultural practices, e.g. female genital cutting, gender-based violence, adolescent health services, etc.
3. Medical Bureau: These include ANC and postnatal care; sexually transmitted diseases (STD) diagnosis and management; and deliveries. Providing information and technical advice to affiliated units.

4. Uganda Private: Antenatal and post natal care; deliveries; FP; immunizations.
5. Midwives Association and well baby care; syndromic management of STD, HIV counselling; health education; minor curative services; training in infection control, post abortion care, life saving skills and business skills and income generating activities etc.
6. Association of Ugandan: Adolescent health: health education for youth; STD treatment.
7. Women Medical Doctors: VCT; contraceptives distribution to adolescents; general gynaecological examination; post abortion care; cancer examinations etc.
8. Straight Talk Foundation: HIV/AIDS counselling; adolescent sexual and reproductive health (SRH); adolescent-driven newspapers; service through straight and young talk newspaper insertions accessible to literate youths in 15 000 schools; radio shows in the countries main languages; etc.
9. Marie Stopes Uganda: Reproductive Health and Family Planning; counselling in FP, management of STD and other conditions; antenatal care, postnatal care, post abortion care, curative care; vaccination; STD diagnosis and treatment; VCT, Diagnosis and treatment of other medical conditions etc.
10. Uganda Muslim: Affiliated clinics provide FP; ANC, and post natal care; Medical Bureau deliveries; immunizations, STI/HIVAIDS management and counselling; health education; minor curative services etc.
11. Uganda Protestant Affiliated clinics provide FP services, ANC and post natal care; Medical Bureau post abortion care; STD diagnosis and management; perform deliveries; coordinates capacity building projects in Reproductive health etc.

Though PPPs have scored successes in other situations, a review of literature shows that there is still relatively little experience with these models of hospital provision, and governments have yet to undertake rigorous evaluations. Thus the merits of these models compared with the traditional model of provision remain highly contentious but it is already possible to identify several key issues that have emerged since the PPPs

became a trade mark. These are cost, quality, flexibility and complexity. This brings us to outline reasons for not favouring PPPs.

In the private financing initiative approach that was chosen (described above) as the mechanism to consolidate several world-class teaching hospitals on a single site in west London (Lethbridge, 2004), it collapsed terribly. In 2000 an Outline Business Case estimated a cost of £300 million with completion by 2006. When the scheme eventually collapsed the budget had risen to £894 million, with completion projected by 2013. Preparation of the failed project cost £15 million. The official report highlighted the extreme complexity of the project, unclear lines of accountability and a failure by central government to clarify whether it actually supported the scheme.

In the La Trobe Regional Hospital case described above, in 1999 it lost AUS$ 6 million and was projecting ongoing losses. The Victorian health minister reported that the scale of losses was such that the hospital could no longer guarantee its standard of care. In 2000 the company was released from its contract in return for an agreement to drop legal action against the government. It sold the facility to the government for AUS$ 6.6 million (about half of its estimated valued) and made an additional payment of AUS$ 1 million.

Although the use of public–private partnerships has been effective when used to finance transport infrastructure (but even here there have been some high profile failures) (Monbiot, 2001) this success has yet to be repeated in the health sector. The challenges of implementing a public–private partnership have been greatest in the case of major teaching hospitals. These institutions accept a wide range of referrals and provide services for various types of patients. As such, these projects involve many different types of stakeholders. They also require the active participation of universities and research funders. The difficulties in reaching agreement with all of these stakeholders, combined with the high costs of the projects, have led to the collapse of a major teaching hospital (the Paddington Health Campus) (Vince and Niven, 2005). Failure results in very large losses in terms of fees and prepayments. These

experiences raise questions as to whether PPPs could be simplified sufficiently to be used for very complex projects.

CHAPTER SIX — CONCLUSIONS

For health care to be delivered optimally, it inevitably requires many partnerships between the public and private sectors. Here, we have seen the situation where public authorities contract with the private sector to run — and sometimes to build — a hospital. The theoretical justification for private financing of public facilities, although debated, has come to be widely accepted. However the practical results seem not to have lived up to what was expected. The respondents in this study have accepted PPPs in spite of their shortcomings. Unfortunately, the debate on PPP approaches has been characterized by ideology. This study suggests that the use of PPP is being hampered by the public sector's lack of understanding of what potential private sector would offer improved service. Unless the public sector has a clearer understanding of the operations of PPPs, it risks failing to engage the private sector.

Strengths and Limitations of This study

This paper has made a distinctive contribution to the research fraternity. First; The study has made the case for the utility of developing a public and private partnership model. Secondly, the fieldwork included interviews of a wide range of officers and appears to be the broadest stakeholder review of PPP undertaken in Zambia in the health sector to date. However, the research arguably has limitations arising from, first, its narrow focus and small sample of senior managers that were targeted. Second, it is being based on research that looks into the future and ignores significantly what is happening. The third limitation was the fact that only two executive directors agreed to be interviewed and all others were either busy or just ignored the researcher. Nonetheless, they made arrangements for another person to provide information. Though access was inevitably easier with junior members of staff, this may have resulted in an over-representation of respondents who were not in policy formulation

Recommendations

Future studies need to focus on chief executives and such research must be commissioned by the Ministry of health. The sample ideally needs to include both junior and senior staff. More focussed research is needed to further allow triangulation of methods, in particular to validate the decision-making and risk management processes described by interviewees.

To ensure that efficiency gains made by the PPP are shared between the public and private partners, contracts may need to include variable payment levels that allow appropriate benefits to be captured by the public sector. Transparency in the bidding and contracting process, as well as the contract arrangements themselves, should help eliminate incentives for any potential asset-stripping and rent-seeking behaviours by the private partner. At the same time, the sharing of risks and rewards is a key driver for a quality private partner to enter into a collaboration/partnership, and the public partner should ensure that contracts are based on realistic evaluations of the situation and do not transfer unmanageable risks to the private partner or excessively curtail performance incentives.

The choice of private partner should be guided by well thought-through criteria in accordance with the specific need or situation (e.g., financial stability and a proven track record of experience and expertise in the field), and international best practices should be leveraged in the process of soliciting bids and awarding contracts. In addition, while taking existing best practices into account, contract provisions should be carefully tailored to the situation at hand. Thus, for example, if a PPP is intended to reduce waiting time on the waiting lists, then the contract should address not only the aspects mentioned above, but also specifically reference the objectives and set forth transparent waiting list management procedures and criteria.

Appropriate monitoring and managing of quality and performance are particularly important in healthcare PPPs. Monitoring and evaluation mechanisms, performance indicators, targets and outputs, as well as any performance bonuses should be

discussed upfront, built into contracts, and refined at the pilot stage if possible. It is critical that the public partner has sufficient capacity for oversight and for making timely adjustments as needed. External oversight methods can also be utilized (e.g., licenses to practice or to operate a facility or a specific health technology, and accreditation according to agreed quality standards). In ensuring continuity in the monitoring and managing of quality and performance, it is helpful that a single task force, advisory board, and/or project management office is established for the duration of the project. It would be ideal to develop a PPP driver- a unit to spearhead the process and further, there is need for more contracting out oriented partnerships.

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Appendix I- List of Hospitals

University Teaching Hospital - Lusaka
Chainama Mental Hospital - Lusaka
Kitwe Central Hospital - Kitwe
Ndola Central Hospital - Ndola
Arthur Davison Hospital - Ndola
Lusaka Province Health Office - Lusaka
Copperbelt Province Health Office - Ndola
Lusaka District Health Management Team - Lusaka
Kitwe District Health Management Team - Kitwe
Ndola District Health Management Team - Ndola

Appendix II- Expert Questionnaire

SECTION A: DEMOGRAPHIC DATA

1. Sex (a) Male ☐ (b) Female ☐

Age

3. Age range ☐

25-34	35-44	45-54	Over 55

1. What is your position in the hospital?.....
2. For how long have you been working on this position in this hospital? .....
3. To what extent are you aware of public health using the Private Finance Initiative (PFI) or Public Private Partnerships in improving heath care service delivery?
4. Would you be willing in the immediate future to engage a private organisation to subcontract some services? Yes ……No .....…….

I am not aware	Some knowledge	I am aware

Would you as an executive officer of this hospital consider?

	Very much	Much	Somehow	Not all
5. Contracting an organisation to deliver family planning				
6. Contracting an organisation to deliver general patient counseling				
7. Contracting an organisation to deliver STI diagnosis and management				
8. Contracting an organisation to deliver immunization and child care				
9. Contracting an organisation to train hospital staff in priority areas (strategic planning, financial management, human resource planning and marketing planning)				
10. Contracting an organisation to treat minor ailments				
11. Contracting an organisation to provide laboratory services				
12. Contracting an organisation to provide radiology services				
13. Contracting an organisation to provide waste disposal services				
14. Contracting an organisation to treat minor ailments				
15. Contracting an organisation to build new or substantially upgrade public facilities and provide some of the services within them				
16. Contracting an organisation to render business skills				
17. Contracting an organisation to undertake strategic planning				
18. Contracting an organisation to undertake human resource planning and marketing planning				

Whom would you consider to partner with?

	Yes	No
19. Professional associations like the Medical Association		
20. Co operations		
21. Faith based Organisations		
22. NGOs		

What arrangement would you consider for each of the following?

	Duration in Years		
Contracting an organisation to deliver family planning	5	Up to 10	Over 10
Contracting an organisation to deliver general patient counseling			
Contracting an organisation to deliver STI diagnosis and management			
Contracting an organisation to deliver immunization and child care			
Contracting an organisation to train hospital staff in priority areas (strategic planning, financial management, human resource planning and marketing planning)			
Contracting an organisation to treat minor ailments			
Contracting an organisation to provide laboratory services			
Contracting an organisation to provide radiology services			
Contracting an organisation to provide waste disposal services			
Contracting an organisation to treat minor ailments			
Contracting an organisation to build new or substantially upgrade public facilities and provide some of the services within them			
Contracting an organisation to render business skills			
Contracting an organisation to undertake strategic planning			
Contracting an organisation to undertake human resource planning and marketing planning			

Appendix III- Expert Interview Guide

1. Please describe to me your position in the hospital on PPPs?
2. What reason do you have for ± engaging a private organisation to subcontract some services?
3. What reasons do you have to consider contracting an external organisation (Probe for the selected and deselected options)
4. Contracting an organisation to deliver family planning
5. Contracting an organisation to deliver general patient counseling
6. Contracting an organisation to deliver STI diagnosis and management
7. Contracting an organisation to deliver immunization and child care
8. Contracting an organisation to train hospital staff in priority areas (strategic planning, financial management, human resource planning and marketing planning)
9. Contracting an organisation to treat minor ailments
10. Contracting an organisation to provide laboratory services
11. Contracting an organisation to provide radiology services
12. Contracting an organisation to provide waste disposal services
13. Contracting an organisation to treat minor ailments
14. Contracting an organisation to build new or substantially upgrade public facilities and provide some of the services within them
15. Contracting an organisation to render business skills
16. Contracting an organisation to undertake strategic planning
17. Contracting an organisation to undertake human resource planning and marketing planning
18. What reasons do you have for the selected partners and the arrangement for subcontarcting?
19. How would you go about engaging these partners?

Appendix IV BUDGET

An estimated budget of all the requirements for the study

Unit	Cost per unit (Kwacha)	Quantity	Total
Fuel	6,000 per Liter	400 Liters	2,400,000
Communication	500,000	-	500,000
Lodging	600,000	12	7,200,000
Food	200,000	4	800,000
Stationery	3,000,000	-	3,000,000
Production of tools and thesis	2,500,000	-	2,500,000
Ethical fees	500,000	-	500,000
Sub total	-	-	16,900,000
Contingency	5%	-	845,000
Total(Kwacha)	**-**	**-**	**17,745,000**