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# Risk Sharing and Governance Through Public–Private Partnerships in Africa:

# Evaluating the West African Public Health Sector Experience

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Requirements for the degree
Doctor of Public Administration

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ABSTRACT

**Background:** The gap between preserving and improving infrastructure to meet the needs of citizens has led governments and policymakers to rely on public–private partnerships (PPPs) for the delivery of public services.

**Purpose:** The purpose of the study was to analyze the risk sharing and governance in the West African public health system while focusing on health care PPP drivers through a critical analysis of the approach to health care PPPs in West Africa. It explored the perception of health care recipients and key informants on the collaborative processes, challenges, successes, and failures.

**Methods:** The study used the phenomenological approach of the qualitative method by conducting semistructured, open-ended interviews with health care recipients and key informants in Nigeria, Côte d'Ivoire, Ghana, and Togo. Data were analyzed using NVivo, a qualitative data analysis tool, to discover emerging themes.

**Results:** The analyzed data revealed that the delivery of public health services in these countries is hindered by inadequate risk assessment and issues with accountability, management, and governance. The rural dwellers must travel many miles to access public health care, and their community health centers are manned by health care aides otherwise called *auxiliary nurses*. These factors and the unavailability of doctors have resulted in ineffective and inefficient service delivery. The study also revealed the ineffectiveness of the National Health Insurance Scheme (NHIS) and the PPP model in use. As a result, the current risk sharing and governance method is ineffective. The findings equally revealed that these countries have the same drivers of PPP and that

institutional and innovative changes are possible and can lead to better service delivery because PPP had previously led to effective service delivery.

**Conclusion:** Best practice recommendations for risk assessment, sharing, and governance in public health care delivery in West Africa are beneficial for the sustainability of positive institutional and innovative changes from successful PPPs. The challenges with accountability, understanding the drivers of health care PPP and a suitable PPP model for the delivery of health care services were revealed by this study. A suitable PPP model has been suggested.

*Keywords*: Innovation, public private partnerships, risk sharing, governance, healthcare, institutional changes

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# DEDICATION

This dissertation is dedicated to my father, who encouraged me to continue this doctoral journey even when I was not sure I could do so. His experience with the West African health sector and his eventual passing became a motivation to carry out this research. I also dedicate this dissertation to my family. This hard work is for you.

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# CHAPTER 1: INTRODUCTION

The growing gap between the cost of preserving and improving available infrastructure to meet the rising needs of the citizens and the associated limited funds available for such projects has left many economies struggling to meet demands. In some cases, evidence of the lack of dedicated public funding sources and the burden placed on existing infrastructure by a growing economy can be seen. This has however, prompted governments and policymakers to adopt alternative ways to finance and deliver the needed infrastructure. As a result, several countries have resorted to engaging the private sector in the form of public–private partnerships (PPPs). PPPs now represent a wide variety of project financing and delivery approaches to access capital markets; implement new technology; and expedite project delivery, operations, and maintenance in a more cost-effective manner (Savas, 2000; Spackman, 2002).

Colverson and Perera (2011) posited that although PPPs were initially restricted to public infrastructure building such as prisons, railways, roads, power, and water generation, it has increasingly been used to solve issues regarding the maintenance and provision of schools and health services. As noted by Snyder and Choi (2012), the main element of PPP is that the public sponsor of infrastructure projects engages the private sector to a greater degree in the performance of certain functions previously handled by the public sector. These may range from contracted maintenance services to full financing, development, operations, and maintenance. This research was intended to examine accountability as well as institutional and innovation practices and their application related to risk sharing and governance through PPPs in the West African public health sectors.

In theory, accountability as a foundational concept of public administration implies the duty not only of a government toward the citizens but also of transparency and timely communication of intentions and dealings to the citizens. Institutional and innovation theory on the other hand examines the governmental structures, policies, practices, and patterns of social relationships while examining the necessity of developing a new and original concept as a driver for reimaging the public health delivery systems in West Africa. Previous empirical studies on this research have found that whereas accountability is to remain constant, institutional changes in the form of innovation are inevitable. In West Africa, it appears that poor maintenance and the lack of proper risk sharing and governance may have caused a strain on the overused infrastructure. For effective risk sharing and risk governance, several countries have engaged the private sector for support in the form of PPPs. With the many benefits of PPPs, the United Nations (2008) as well as the National Council for Public–Private Partnerships (2016) advised that PPPs are not problem free but with the right legal and regulatory frameworks, adequate technical skills, and proper design of PPP projects, many benefits can be derived from the implementation of PPP. Currently, a wide selection of public projects includes innovative approaches to expedite the delivery of public services through PPPs.

Accordingly, the World Bank Group (2014) noted that PPPs all over the world are known to accelerate economic growth and if PPPs are properly implemented, issues like poor infrastructure that constrain economic growth, especially in developing countries, can be overcome. As poor infrastructure can reflect several constraints faced by governments, some of which include insufficient public funds, poor planning or the

lack of it, poor choices on project selections, corruption, and poor maintenance culture, it is hoped that appropriate infrastructure investment will accelerate the much needed economic growth in these countries. However, many projects have failed, especially in the West African health sector. Thieriot and Dominguez (2015) postulated that PPPs are shrouded with uncertainties causing an ultimate failure. They note that improper risk evaluation and allocations is one factor and that the maximum benefits of a PPP can ultimately be achieved only if each risk is properly evaluated and handed to the actor most suitable to handle such risks. Properly allocated risks can create incentives for the development of mechanisms for reducing them and thereby lowering the project's overall cost. Precise risk evaluation can also help to determine grounded insurance premium fees.

However, the process of risk assessment is complex and requires advanced technical capacity that may not be readily available. In addition, Thieriot and Dominguez (2015) noted the lack of grounded evaluations to be the other reason for PPP failures. This occurs when PPP is simply perceived as a means of accessing financing thereby increasing the risk of selecting inappropriate projects. PPP should instead be seen as a convenient way to benefit from the innovation and knowledge from the private sector. In other words, a PPP project should be selected only if it brings advantages relative to the traditional government construction-and-management model.

However, in evaluating value for money, an efficient assessment method is required. For these reasons, the study posed the following research questions: What are the drivers of PPP in the public health delivery systems in West Africa? What enhancements can successful PPPs contribute toward the delivery of public health

services in West Africa? To answer these questions, semi structured interviews were conducted in four of the 17 West African countries, namely Nigeria, Ghana, Côte d'Ivoire, and Togo. PPPs that are now characterized by joint planning, risk sharing, and governance are opportunities to leverage resources, encourage innovations through fresh ideas on projects and for development expertise, and most importantly, for the longevity of such projects (Lawson, 2013). PPPs have become the important tool for improving and maintaining economic competitiveness and infrastructure services.

## Background

Different studies have revealed that countries like the United Kingdom, the United States, Australia, Hong Kong, and Canada have proven that PPPs can be used as effective tools to maximize government spending and allow the inclusion of both private and public sector experts in most public sector projects. Since the introduction of PPPs in the early 1990s, some studies (C. R. Baker, 2003; Strauch, 2009) noted that the afore-mentioned countries now boast of enhanced and established mode of public service delivery. Although PPPs have been practiced in West Africa for some years now, they are often confused with privatization of public companies. This has created a lot of misconceptions about the benefits of PPPs in West Africa as with other developing countries.

Adetola et al. (2011) posited that since 2007, there have been some remarkable PPP projects initiated in Nigeria by some federal and state governments alike; however, these PPP projects have been recorded as having been terminated early. Some of these projects include the renovation of the Murtala Muhammed International Airport Terminal project in Lagos, the rail transport, and dam irrigation projects at the federal government

level. At the state level, Cross River state, through a partnership with Jack Rouse of Cincinnati, handled the Tinapa resort project to boost tourism in the state. Similarly, the Rivers state government continues to put in deliberate efforts to improve the public health and housing programs through partnerships with banks and other private bodies. Although these partnerships have demonstrated the implementation of PPPs in infrastructure building and maintenance, PPP projects in the public health sectors in West Africa appear not to meet the desired purpose of affordable and accessible public health care. Also, most of the projects are concentrated in the urban areas while the rural areas are left without basic necessary infrastructure or accessible public health care services. For these reasons, some studies (W. E. Baker, 1984; Suberu, 2001) advised that increased allocation to local governments would provide an improved and adequate delivery of public services in Nigeria. However, there is evidence (Ushie et al., 2010) that this will only promote non transparency and blur accountability in public service delivery. PPPs in the West African public health sector as posited by Okpani and Abimbola (2015) has been less than successful. They noted that the health insurance scheme that was introduced in 1962 and later amended in 1999 by the National Health Insurance Scheme (NHIS) Acts 35 and launched in 2005 was intended to address these inadequacies in the Nigerian health sector. However, several years later the delivery of public health care services has not improved because of the lack of accountability and innovation in service delivery. Adua et al. (2017) in like manner noted that although there has been increased expenditure in the health care sector by the Ghanaian government, which has significantly reduced out-of-pocket expenses on health care, the unprecedented population growth, the lack of financial protection, and inadequate insurance coverages

have made the NHIS ineffective. The African Development Bank (2019) noted that the universal health coverage (UHC) which most developing countries including West African countries seek to establish is intended to effectively abolish the out-of-pocket expenses when it comes to health care. They however state that UHC involves varying types of health systems, financial and operational systems as well as difference in governance models. They added that because they evolve over time and in line with the source of financing, where the governments fail to adopt UHC, health care systems are likely to become fragmentated and disorganized.

The financial and operating systems in this case are the varying health insurance schemes and policies to control the risks in the health sector. To ensure an effective measurement of these risks, certain factors need to be ascertained in relation to the health systems in question. Kaye (2005) posited that for a reliable risk measurement, several requirements need to be satisfied. These requirements include

1. [Given the] different levels of interest . . . the perspective of the decision-maker is important.
2. The approach taken to measure risk needs to be suitable for the purpose for which it is being used. This refers to the properties of the risk measure selected as well as the risk tolerance(s) selected for a given measure.
3. The risk measure [needs to be] understood by the decision-maker . . . [because] the complexity of more sophisticated measures may create a barrier for a decision-maker. (p. 4)

In the United Kingdom (UK), PPPs have contributed to improved standards of public service delivery including well maintained highways, public transportation, public

finance initiative (PFI), and health care services through the National Health Service (NHS) and have gone as far as affecting the grassroots through collaboration with local communities in the form of local strategic partnerships (LSPs). LSPs were introduced in 2001 to oversee policy-specific partnership activity in English cities. Initially introduced in the 88 most deprived localities, partners are from the public, private, voluntary and community sectors (HM Government Cabinet Office, 2011). They are charged with identifying local needs, developing community strategies, and coordinating local spending. One of the advantages of multisector partnerships practiced in the UK is that they have the potential to leverage additional resources, pool existing resources together, reduce duplication in resource use, and share risks (Lowndes & Squires, 2012). In the past, researchers investigated the success factors or the drivers for adopting PPPs and noted that they mainly focused on the developed world such as the UK (Li et al., 2005), Australia, the United States (Jefferies et al., 2002), and Hong Kong (Chan et al., 2009; Yuan et al., 2009). The studies suggested that many of the PPP projects in the developed countries are regarded as being successful, and the drivers of success are now subject of extensive investigation (Cooke-Davies, 2002; Jefferies et al., 2002; Keene, 1998; Qiao et al., 2001; Toor & Ogunlana, 2008). However, it appears that little is known about the relative importance of these success factors in developing countries because the outcomes of the application of PPPs have varied. Successes have been recorded in some instances and there have been several other attempts which have not been successful.

Similarly, some studies have noted incongruence between the cross-cultural features (Eaton et al., 2007; Gunnigan & Eaton, 2006; Gunnigan & Rajput, 2010) and risk factors (Ibrahim et al., 2006b) of PPPs, which suggests possible inapplicability of the

UK PFI model in other countries. The demonstration that PPP success factors are similar in form but genetically different (as between the UK and Nigeria) suggests considerable potential for useful cross-country learning regarding PPPs. However, Eaton et al. (2007) contended that the development of a generic and internationalized PPP approach is almost impossible to achieve and that nonrecognition of existing exogenous features of a local area is a recipe for potential operational failures. Therefore, despite the evidence of similarity in PPP success factors, it is important that adequate attention is given to the identification, understanding, and management of the specific drivers at national and sectoral levels.

## Statement of the Research Problem

The delivery of public health services in most West African countries has remained ineffective despite the introduction of PPPs through the NHIS in each country, and out-of-pocket expenses continue to increase even with the unaffordable, ineffective, inefficient, and inaccessible services. The effects and consequences of this problem can be seen in the overburdened infrastructure and the increased death rate among the citizens because of the inaccessibility of services and unaffordable public health care. Of greater consequence is the migration of young and talented human capital from the West African region to other continents for better health care and generally for a better quality of life. In most cases, there has been antagonism from the youths in protest of the quality of life they currently experience, thereby leaving these countries in a state of unrest.

## Purpose Statement

The purpose of the study was to analyze the risk sharing and governance in the West African public health system while focusing on health care PPP drivers through a

critical analysis of the approach to health care PPPs in West Africa. It explored the perception of health care recipients and key informants on the collaborative processes, challenges, successes, and failures. Thus, the study aimed to make an original contribution to the field of study and inform on the matter with the hope of improving the public health sector toward a robust and reliable sector, delivering innovative, affordable, and quality health care services to all West Africans regardless of their social status.

## Research Questions

To meet the aim and objectives of the study, the following research questions were investigated in an attempt to provide suitable answers:

1. What are the drivers of PPP in the public health delivery systems in West Africa?
2. What enhancements can successful PPPs contribute toward the delivery of public health services in West Africa?

## Significance of the Problem

Since the transition to democracy by most West African countries, foundations continue to be laid for economic growth and development. The rich material and human resources give it the potential to become a major player in the global economy. Given the drive for development, the governments of these West African countries do not have the requisite expertise and resources to achieve this on their own and have thus among other options embarked upon the use of PPPs to address the challenges constraining the growth of their economies, especially with the provision of health care services (Okpani & Abimbola, 2015). Some of the West African governments' established policies for the approval of and the implementation of PPP. In Nigeria, the government established the Infrastructure Concession Regulatory Commission through the Infrastructure Concession

Regulatory Commission Act of 2005 (The ICRC Act). In Ghana, the use of PPP became a part of the national policy in 2004 with the formation of a national policy guideline (Osei-Kyei & Chan, 2017), and in Côte d'Ivoire there is clear and concise legislation outlined in two decrees, namely, Decree 2012-1151, which outlines the contracting, monitoring, and dispute resolution contract and Decree 2012-1152, which establishes the institutional environment. In addition to the decrees, the responsibility for PPP is shared among three bodies, all of which report to the presidency with staff drawn from different ministries and agencies (World Bank Group, 2017). Also, in Togo, a national law that laid down the frameworks for PPPs and concession contracts was passed in 2014. The established law 2014-014 on modernization of public action of the state economy unfortunately does not have official PPP guidelines or manuals; does not relate to specific sectors; or place any restrictions on partnerships in transportation, water, telecommunication, or the generation or distribution of energy (World Bank, 2017).

Most West African countries have introduced the national health schemes to solve the issues associated with accessing and affording public health care. Their policies on PPP are to the effect that regulatory and monitoring institutions are set up so that the private sector can play a greater role in the provision of infrastructure, while government ministries and other public authorities focus on planning and projects structuring. The private sector would be contracted to manage some public services and to design, build, finance, and operate infrastructure. There is the expectation that private sector participation in infrastructure development through PPPs would enhance efficiency, broaden access, and improve the quality of public services. These policy statements set out the steps that the government would take to ensure that private investment is used,

where appropriate, to address the infrastructure deficit and improve public services in a sustainable way. They would also ensure that the transfer of responsibility to the private sector follows best international practice and is achieved, ideally, through open competition. However, there have been a lot of difficulties to achieve success in PPP projects, and in most cases success has been impossible.

On the other hand, there is evidence that risk sharing and risk governance through PPPs have resulted in sustainable economy with improved, innovative, and effective public health services. As a result, various PPP success factors have been noted by different studies to include

- appropriate risk allocation and risk sharing (Chan et al., 2009; Grant, 1996; Qiao et al., 2001),
- competitive procurement process aimed at reducing total project cost (Jefferies et al., 2002; Li et al., 2005), and
- avoiding delays and cost overruns (Tiong & Alum, 1997) and government involvement by providing guarantees (Qiao et al., 2001; Stonehouse et al., 1996; Zhang et al., 2005).

The respective roles of the private and public partners are neither antagonistic nor identical but complementary. The public sector controls several key legal and regulatory tools to implement a project within the context of an overall development program. As noted earlier in the introduction, the private sector brings external capital, technical expertise, and an incentive structure. The essence is the cooperative and mutually supporting nature of the relationship. Actual partnering therefore involves collaboration and leveraging the strengths of both the private sector (more competitive and efficient in

economic terms) and the public sector (more responsible and accountable to society). PPPs may therefore, under the right conditions and with the right drivers, bring the discipline of the market into public administration and promote a synergistic combination of the strengths, resources, and expertise of the different sectors. Therefore, to answer the research questions, the following objectives were investigated and critically analyzed:

- the risks associated with different health services delivery partnership arrangements in the West African region,
- the factors facilitating or constraining the practice of PPPs in the region,
- the importance and benefits of risk sharing and risk governance within PPPs to the West African economy and public health services,
- the role of PPPs in the introduction and enhancement of innovation in public health service delivery systems through case studies, and
- draw relevant recommendations about appropriate PPP models which can deliver an optimum risk allocation and governance in public health service delivery in West Africa.

## Definitions

**Innovation**. Refers to the examining of governmental structures, policies, practices, and patterns of social relationships (Biginas & Sindakis, 2015) to develop a new and original concept as a driver for reimaging the public health delivery systems in West Africa.

**Public-Private Partnership (PPP)**. The engagement of the expertise of the private sector by the public sector to execute public sector projects (Tiong & Alum, 1997).

**Risk sharing**. Is obtainable through the practice of PPPs because the risks in public projects are partly owned by the private sector during the process (Chan et al., 2009).

**Risk governance**. Mechanisms through which decisions about risks are taken and implemented (Chan et al., 2009).

**Health maintenance organizations**. Medical insurance groups that provide medical care for their policy holders through their network of doctors (Okpani & Abimbola, 2015).

**Drivers.** Factors that necessitate the implementation of PPP (Lorman, 2018).

**Successful PPP projects**. Completed projects with results of appropriate risk allocation and sharing, reduced project costs with the avoidance of delays while incorporating government participation through the provision of guarantees (Freeman & Minow, 2009).

## Organization of the Study

This dissertation includes five chapters. Chapter 1 was the introduction, comprising the background, statement of the research problem, purpose statement, research questions, significance of the problem, definitions, and organization of the study. Chapter 2 includes a critical analysis of relevant literature in the field of study, the review of government documents such as policies, relevant databases, strategic health plans and other academic sources. Chapter 3 contains a restatement of the purpose, research questions, research design, population, sample, instrumentation, and data collection and analysis methods selected for the study. Chapters 4 and 5 are about the

analyzed primary data from interviews with key informants and recipients, data analysis, findings, conclusions, and suggestions for future research.

# CHAPTER 2: REVIEW OF THE LITERATURE

The empirical questions of this study rely on the literature on public–private partnerships (PPPs) and the resultant innovation in public service. Building upon this, the study argues that although the existence of certain conditions and the application of certain PPP models in some countries have resulted in the successful implementation of PPP, the application of the same models within the same conditions elsewhere has not produced any success stories. It elaborates on the existing literature on PPP in Africa, the positive effects (if any) it has created in the public service, particularly in the West African public health sector and the current conditions, drivers, and factors necessitating the need for PPP in the West African public health sector. The region of West Africa is made up of 17 countries, all of which were either colonized by the English or French (except Liberia) and later ruled by the military. Regarding these countries, it is argued that the lack of democratic governance and the presence of dictatorship resulted in public service delivery systems lacking robust delivery mechanisms with over reliance and dependence on foreign aid. The study elaborates on the endogenous and exogenous factors rising from previous governance methods and how they necessitate and at the same time affect the outcome of PPPs in the region. Existing literature has established the link between successful and early termination of PPPs to include improper operation, government default payments, changes in policy, concurrent competitive projects, government decision-making mistakes, insufficient financial capacity, unrealistic demand forecasts, changes in market demand, and oppositions from the citizens.

In the following pages, the study discusses PPP in the health care sectors through the discussion of the history and definition of the concept of PPP, PPP as organizational

and financial arrangements as well as PPP and global health care, all while discussing the importance and positive impact of the implementation and success of PPP in various countries. The chapter further discusses the theories upon which the study relies—institutional and innovation theories. These theories are elucidated in the light of the relationship between PPP and the possibility of PPP being a change mechanism that could lead to innovative processes and policies in health care PPP in various countries. In addition, the misconception of PPP in developing countries, health PPP trends and models, and the key success factors for PPP implementation are discussed in this chapter.

## History of Public–Private Partnerships

The concept of PPPs has attracted worldwide attention and acquired a new resonance in the context of developing countries and is increasingly heralded as an innovative policy tool for remedying the lack of dynamism in traditional public service delivery. However, PPPs have also become mired in a muddle of conceptual ambiguities. According to Lorman (2018), the origin of PPP is unknown; however, records of its existence in the United States dates to the 1700s with the turnpike charter when PPP was mainly used for road and bridge constructions because transportation was a crucial component for national development. Studies have shown that PPPs from the 1950s were analyzed from the point of urban and regional dynamics; however, the dominant framework that was constant in the 1970s explained the PPP as a government regulation for businesses with the rationale being partly economic and the other being a strong sense of maintaining political control. However, in the 1980s a new set of rationales for the New Public Management (NPM) perspective suggested a promising future with potential gains through the use of market and quasi market competitions for infrastructure delivery

(Lorman, 2018). By the early 1990s and following the launch of Private Finance Initiative in the UK, PPP started to gain recognition. In the mid-1990s and because of the shift from NPM to public governance, the focus was on a negotiated framework, the importance of multiple stakeholders within such frameworks, transparency, stakeholder engagement, and sustainability as compulsory paradigms for operation. According to Savoie (2003), NPM was a management theory with the purpose of making the public sector more efficient by applying techniques from the private sector, thereby meeting market conditions for the delivery of public services. Barzelay (1992) also defined NPM as being a more client-focused and service-oriented system that should replace the existing reliance on bureaucratic practices of employee distinctions, tight financial controls, and the reliance on rules and procedures.

Based on the findings of Osborne and Gaebler (1992), that trend and eventual transformation from NPM to PPP with multiple stakeholder engagement and the expectations regarding accountability were inevitable. They noted that the hierarchical architecture of most government bureaucracy impeded growth and transparency and that for accountability to thrive, scrutiny and minimum bureaucracy were required. They further advised that the traditional system of public administration, though with many benefits, is also responsible for the lack of flexibility and nonresponsiveness that stem from bureaucracy. The results of which are stifled creativity, discouraging problem solving while promoting routine with significant resources being devoted to micromanagement instead of achieving policy goals.

Osborne and Gaebler (1993) equally noted that most entrepreneurial governments like private organizations promote competition between service providers. They

empower citizens by pushing control into the community and out of bureaucracy. The performance of their agencies is measured, focusing not on inputs but on outcomes. They are driven by their goals and missions, not by their rules and regulations. They redefine their clients as customers and offer them choices such as schools, training programs, and housing options. They are proactive and prevent problems before they emerge, rather than being reactive. They decentralize authority, embracing participatory management. They prefer market mechanisms to bureaucratic mechanisms. The focus is simply on bringing all sectors—public, private, and voluntary—into action to solve their community's problems.

With the emergence of PPP, it became important to properly define the term. Custos and Reitz (2010) discussed the difficulty that exists in the definition of PPP. They posited that the difficulty in defining PPP is first due to the polysemous nature of the concept and second due to the complexity of the legal structure as it relates to the federal and state laws. They further stated that despite the difficulty with the definition, PPPs in the United States reflect three out of the four PPP approaches, namely the local, regeneration, the infrastructure, and the policy approach. On the other hand, Greve (2007) defined PPP as the cooperative institutional arrangement between the private and public sectors. They added that PPP has replaced the traditional method of contracting by the public sector and has helped many public sectors with the construction and maintenance of their infrastructure.

The PPP concept is indeed commonly used to describe a spectrum of possible relationships between public and private actors for the cooperative provision of services. Admitting that there is no single PPP model and that a diversity of arrangements may be

distinguished and varying regarding legal status, governance, management, policy-setting prerogatives, contributions, and operational roles, it should be emphasized that actual partnering involves collaboration in the pursuit of a common objective. Hodge and Greve (2005) noted the imperfect management and allocation of risks to be one of the major causes for the failures of the private sector to participate in public projects as partners. To give a proper breakdown of the expected risk allocation between the stakeholders, Akintoye et al. (2003) advised that for the public sector partner, the risk management objective is to identify, provide risk quantification, transfer the risks. On the other hand, the private sector is expected to assess and price those transferred risks, allocate and flow down those risks to appropriate channels as well as manage and control those risks. Based on this expectation a variation in objectives among public and private sector partners may lead to varying risk perception and allocation preferences among these partners (Chung et al., 2010). This variation may result to prolonged PPPs contract bargaining and negotiation processes or an outcome in which PPPs are potentially flawed. However, the largest risk allocation stems from creative and innovative thinking as well as customization to unique challenge characteristics (Public–Private Partnership in Infrastructure Resource Center, 2014). M. Meyer (2001), Li et al. (2005), and Demirag and Khadaroo (2008) suggested that the public sector and the private sector do not share the same set of interests, objectives, and expectations with the implication that they have varying perceptions of risk and risk management capabilities. These perceptions can strongly influence the manner in which each stakeholder takes on risks and prices these risks (Ball et al., 2003; Blanc-Brude & Strange, 2007). For these reasons, many studies (Arndt & Lieberman, 2000; Asenova & Beck, 2003; Li et al.,

2005; Weihe, 2008) have noted that perceptions held by different partners about risks, motives, and behaviors of their opposing partners hold significant implications in the negotiations of risk allocation, which would undermine the success of PPP projects. These observations raise interesting questions about equitable risk sharing between public and private sector partners. Therefore, if risks and expectations are managed properly with a true risk-sharing partnership spirit, the betterment of risk allocation is likely to eventuate. Accordingly, Choi and Choi (2012) noted that a relationship becomes a partnership if it involves an agreed definition of specific goals, a clear assignment of responsibilities and areas of competence between the partners in the pursuit of a common endeavor. Thus, PPP may have been defined in a broader sense.

## PPP as Risk Sharing and Governance Mechanisms

Public administration can be described as the process of the implementation of government policies and often is regarded as including some responsibilities for determining the policies and programs of governments. This is with special reference to the planning, organizing, directing, coordinating, and controlling of government operations. In country, public administration is practiced at all levels and given the different functions and expectations; the relationship between the different levels of government makes up a growing problem for public administration. Cavalcante and Lotta (2021) in their findings stated that "infrastructure and productive development sectors relate more with the private sector; security and citizenship with state governments and social/environmental sectors with municipalities in a decentralized context" (p.319). They further noted that bureaucratic skills vary according to the

governance modes, highlighting the core of government as the most qualified sector for collaboration.

In the 20th century, the study and practice of public administration was essentially realistic rather than theoretical and value free. This may explain why public administration developed without much concern about theory. However, by the mid-20th century and at the time of the dissemination of Max Weber's theory of bureaucracy, a lot of interest was placed in a theory of public administration. Most subsequent theories on bureaucracy, however, were addressed to the private sector, and there was little effort to relate organizational to political theory (E. C. Page et al., 2020). In public administration, its principles of accountability, efficiency, transparency, and equity are mostly promoted with the stated objective of administrative reform being the provision of public services at the minimum cost. Despite growing concerns about other kinds of values such as responsiveness to public needs, equal treatment, justice, and citizen involvement in government decisions, efficiency continues to be a major goal (E. C. Page et al., 2020).

Cabrera et al. (2015) contended that given its concerns with efficiency and improvement, public administration has focused greatly on formal organizations, partly because of the need to correct administrative ills. In many countries, mostly developing countries, organizational principles originated with the military rule and others from private business. These principles include organizing departments, ministries, and agencies based on closely related purposes, equating responsibility with authority, ensuring unity of command, and having a distinctive chain of command among others. Furthermore, organizational problems differ, and the applicability of rules to various situations also differs. Similarly, M. J. Page et al. (2021) expatiated on the effectiveness

of the use of budgets, noting that they were developed as principal tools in planning future programs, deciding priorities, managing current programs, linking different arms of government, and developing control and accountability. They added that in the United States during the 20th century, the budget became the principal vehicle for legislative surveillance of administration, executive control of departments, and departmental control of subordinate programs. It has also assumed a similar role in many of the developing countries of the world.

Most world views on PPP indicate that PPPs are established to benefit both the public and private sectors in the sense that while the public sector engages the private for their expertise and ability to finance some projects, the private sector also benefits from the contacts made and monetarily, as a contractor to the government. This relationship could sometimes run for years depending on the duration of the project or even for the monitoring and maintenance phase of such projects after completion. Therefore, the PPP definition by Ham and Koppenjan (2001) gives a very clear and broad explanation because it describes PPP as a durable cooperation between the public and private sectors in which they jointly develop products and services to share the risks, costs, and other resources associated with the project. This definition further strengthens the view that PPP is a risk sharing and governance mechanism. It initially notes the collaboration between both parties to be durable, not of a short period, but long enough to develop trust. Second, it emphasizes the cooperation and partnership to share the associated costs and risks of the project and last, it affords the partnership an ability to develop suitable products and services from which they mutually gain.

Given the benefits of PPP, most developed countries have effectively turned over the responsibilities, risks, and rewards associated with performing a number of public service functions to the private sector through long-term concessions or franchises. Once rare and limited, PPPs have emerged as important tools for improving economic competitiveness and infrastructure services (Lowndes & Squires, 2012). They are increasingly being considered as risk sharing and governance mechanisms and mechanisms to fill infrastructure deficits.

According to C. R. Baker (2003) and Strauch (2009), countries like the UK, the United States, Australia, and Canada have proven that PPPs can be used as tools to maximize government spending and allow the inclusion of experts while curbing the bottle necks that exist in most bureaucracies. Since the introduction of the modern PPP in the early 1990s, these countries now boast of an enhanced and established mode of public service delivery. Currently, PPP is practiced in the majority of the continents; however, in developing countries where this concept has not been fully embraced or utilized to its full capacity, it is often confused with privatization of public companies. This has created a lot of misconceptions about the benefits of PPPs in those countries and in some cases has led to the early terminations of PPPs. In recent times (since 2007), there have been some increased level of the acceptance and knowledge of PPP in these countries with some projects started through a collaboration between the public and private sectors. One common characteristic with the PPP in developing countries, specifically countries in Africa, is the early termination of PPP projects. Quite a number of projects have not been completed because of the early termination of such projects, leading to a waste of resources. Some of those projects in West Africa include the

renovation of the Murtala Muhammed International Airport Terminal project in Lagos, Nigeria (Adetola et al., 2011) and the rail transport and dam irrigation projects at the federal government level. At the state level, Cross River State, through a partnership with Jack Rouse of Cincinnati, completed the Tinapa resort project to boost tourism in the state. In addition, the Rivers State government has continued to put in deliberate efforts to improve the public health and housing program through partnerships with banks and other private bodies.

A study on PPP and infrastructure development in Nigeria to determine the factors militating against the implementation of PPP projects in Anambra State by Okonkwo et al. (2014) revealed that a weak regulatory framework and inadequate allocation of risks and responsibilities are the factors militating against the successful implementation of PPP projects in the state. Their recommendation to the government was the establishment of a strong legal and regulatory framework that would ensure the successful implementation of PPP projects in accordance with the specified agreement.

Similarly, Osei-Kyei et al. (2017) noted that in Ghana, the majority of the PPP projects, though started with the intention to meet an infrastructural need, have terminated quite early during the project cycle or have moved so slowly that the need for such services or infrastructure have been abandoned. Some of such projects in Ghana include the construction of major roads and bridges, airports, and housing to fulfil the needs at the time. They further noted that in 2009, despite initiating PPP, the implementation of the construction of 200,000 housing units was abandoned or terminated early and the need unfulfilled. They added that the first and only completed PPP project in the country since embracing PPP in 2011 was the U.S. $115M Seawater

Desalination Plant Project in Nungua region. Osei-Kyei et al. (2017) posited that despite the huge infrastructure deficit and rapid urbanization growth found in the developing countries, and in some cases, commitments from the governments, other militating factors exist and continue to impede the implementation of PPPs in those countries. They described these factors as challenges and included corruption, risk misallocation, the lack of transparency, public agitations, and unfavorable political decisions/influences.

On the other hand, there appear to be success stories of PPP projects in Côte d'Ivoire, a West African country. Based on data from the World Bank Group (2017), Côte d'Ivoire has maintained success in implementing and completing collaborative projects. The data noted that the country has PPP as the preferred mode of infrastructure financing and has recorded 26 successful PPP projects since its independence in 1960. The anticipation for its 2016-2020 national development plan was an approximate $33.5 billion (USD) of investment from the private sector and PPP. The enabling environment for PPP investments in Côte d'Ivoire is attractive because there is clear and concise legislation outlined in two decrees, namely Decree 2012-1151, which outlines the contracting, monitoring, and dispute resolution contract and Decree 2012-1152, which establishes the institutional environment. In addition to the decrees, the responsibility for PPP is shared among three bodies, all of which report to the presidency with the staff drawn from different ministries and agencies. To provide strategic expertise and support, the national committee (Comite national de pilotage de PPP) is responsible for the strategic oversight and the approval of new PPP projects. The Secreteriat Executif des PPP provides the needed administrative, technical support, and training, and the support

unit otherwise known as Cellule D'Appui des PPP is responsible for project preparations and the monitoring of outcomes.

Togo's national law that laid down the frameworks for PPPs and concession contracts was passed in 2014. The established law 014-014 on modernization of public action of the state economy unfortunately does not have official PPP guidelines or manuals. It does not relate to specific sectors or place any restrictions on partnerships in transportation, water, telecommunication, or the generation or distribution of energy (World Bank Group, 2017). In addition, despite creating the special administrative agency, the Togolese agency for major projects was created in 2016 but still has not been granted the special administrative power to carry out any of its missions, some of which include supporting large public works projects including PPP projects. Also, the internal unit study to facilitate PPPs by the ministry of finance has also not been granted the required funding or staffing for meaningful engagement. This has left Togo without a dedicated or functional PPP agency.

In the UK, PPPs have contributed to improved standards of public service delivery including the maintenance of highways, public transportation, the establishment of public finance initiative (PFI), innovative health care services through the National Health Service (NHS) and positively affected the grassroots through collaboration with local communities in the form of local strategic partnerships (LSPs). LSPs were introduced in 2001 to oversee policy-specific partnership activity in English cities and were initially introduced in the 88 most deprived localities with partners from the public, private, voluntary, and community sectors (HM Government Cabinet Office, 2011). Their primary responsibility is to identify local needs, develop community strategies, and

coordinate local spending. One of the advantages of this type of multisector partnerships practiced in the UK is the potential to leverage additional resources, pool existing resources together, reduce duplication in resource use, and share risks (Lowndes & Squires, 2012).

In the case of Canada, PPP is mainly a collaboration between private businesses, communities, member-based organizations such as the Canadian Council for Public–Private Partnerships (CCPPP), and the government. The Canadian PPP boasts of infrastructural projects ranging from health care, transportation, environment, recreation and culture, education, and justice and correctional services. Currently, Canada has 291 active projects across the provinces and worth over $1 billion (CAD) in market value with health care services emerging as the most targeted sector, followed by transportation (CCPPP, 2020). Some of the projects being executed include West Lincoln Memorial Hospital in Ontario, with the intended services of acute inpatient beds, 24-hr emergency services, day surgical services, increased ambulatory care space, and availability for consultation as well as advanced diagnostics services. PPP in Canada began in the early 1990s; the first recorded PPP started from 1990 to 2000 and the second wave from 2000 to the present. The activities of PPP in Canada are overseen by the CCPPP established in 2009; the establishment is headed by the finance minister (CCPPP, 2020).

## Innovation in Global Health Care

Globalization and technological advances have forced governments round the world to adapt to changes through innovation in the form of PPPs (Martin & Halachmi, 2012; Savas, 2000). PPPs are increasingly being used as instruments of risk management and governance in health services and have also been the reason for positive expansion

through strategies focusing on accountability. Buse and Harmer (2007) noted that PPPs have contributed very positively to the enhancement of global public health by

- stimulating and promoting research and development;
- improving access to effective, efficient, and affordable health care;
- enhancing national health policies and delivery processes;
- establishing globally acceptable standards; and
- promoting certain health issues on to national and international agenda.

According to the International Finance Corporation (2011), health care expenditure by governments have been on the rise and may be unmanageable soon if new sources for financing health care services and projects are not sought. Marques (2021) also advised that while this type of partnership aims to reduce cost and risks, it also encourages the possibility of innovative solutions and active dynamic management of services and infrastructure. One other positive aspect of PPP in health care management is that each stakeholder (public or private sector) must be financially, socially, and environmentally sustainable to engage because this is expected to translate to effective and efficient services. Tucker and Russell (2004) also posited that because efficiency measures the degree of output produced based on certain levels of inputs and effectiveness by the degree of fulfilled proposed goals, these factors sometimes overlap. Tucker and Russell (2004) further noted that having an efficient and effective health care delivery system means successfully attending to and treating all patients satisfactorily in the best way possible with minimal use of the available finance. Although this appeared to have been possible in times past, it is increasingly seen that a mutually beneficial collaboration is needed by all stakeholders to maintain this standard.

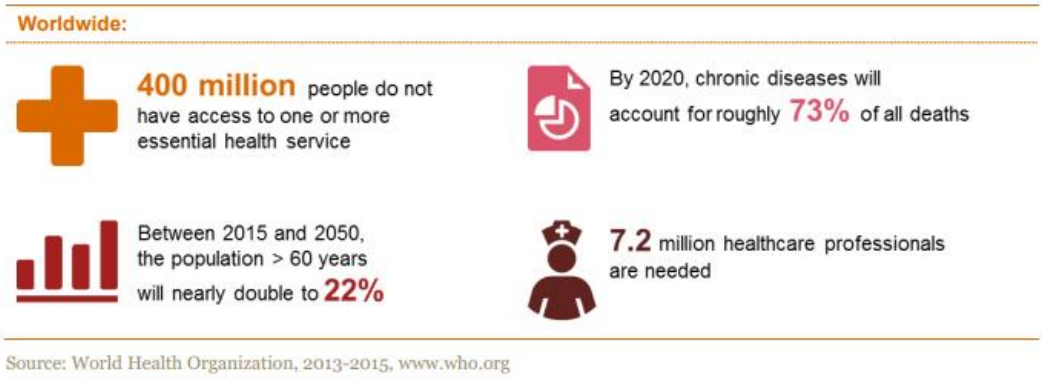
On the other hand, a study by Cruz and Marques (2013) argued that it is more beneficial for public services to absorb less risky projects instead of engaging in PPP because health care services are difficult to maintain, hospitals are complex structures, and forecasting for technology development and citizens' needs can be prone to forced negotiations. Ferreira and Marques (2018) also posited that decisions to engage in PPP in the health care sector are usually skewed in favor of PPPs because of optimism bias and factors such as the absence of transparency, uninformed decisions and accountability, the existence of questionable assumptions, and the overestimated demand for services as well as the potential to base hospital reform needs on the financial need rather than the needs of the citizens. Torchia et al. (2015), however, advised that the introduction of PPPs to public sector services such as health care, changes the government's role from an operator to a regulator, thereby making the motoring of accountability, transparency, and the symmetry of information compulsory. In the same vein, Abuzaineh et al. (2018) posited that global health care systems are struggling to meet with increased and improved quality delivery while controlling cost and that the pressure will continue to increase as they move toward the implementation of universal health care. They further noted that additional investments will have to be made by developing countries in the health care sector as their infrastructure remains inadequate and they lack the necessary skills to manage and adequately care for their patients.

Furthermore, a forecast by the World Health Organization (Dye et al. 2013) estimated an increased spending of more than 65% in health care globally between 2010 and 2020 including an investment of over $3.6 billion (USD) in infrastructure for member countries of the Organization for Economic Co-operation and Development

([OECD], 2008) and BRICS countries (Brazil, Russia, India, China, and South Africa). According to the same study, the projection to arrive at a sustainable and effective global health care can be broken down as shown in Figure 1.

**Figure 1**

*Health Care Spending Forecast*




*Note*. From *PPPs in Healthcare: Models, Lessons and Trends for the Future* (p. 7), by N. Abuzaineh, E. Brashers, S. Foong, R. Feachem, P. Da Rita, 2018, The Global Health Group, Institute for Global Health Sciences (https://pwc.to/2JCrzwr).

Collaborative and networked governance as a form of PPP is also known to provide some innovation in public health care, especially in developing countries. Tellioglu (2008) and Woo (2017) attributed its importance to the need for capacity building between the public and private organizations to enhance an effective public service delivery. The successes of such collaborative efforts are attributed to good communication, a shared common goal, transparent processes, good decision-making processes, and strong relationship building that is devoid of an oppressive and coercive leadership style (Donahue & Zeckhauser, 2011). Ansell and Gash (2008) noted that a collaborative governance can be defined as a "governing arrangement where one or more

public agencies directly engage nonstakeholders in a collaborative decision-making process that is formal, consensus-oriented and deliberative and that aims to make or implement public policy or manage public programs and assets" (p. 544). Collaborative governance has thus in recent years created avenues for inclusive and cooperative developments that involve the government, the public, and private organizations. However, there are reported cases of ineffective and failed collaborative efforts. It has been observed that some of these failures are because of the application of wrong decision-making tools, self-interest instead of the interest of the public, and the lack of accountability, transparency, and a common goal.

In analyzing a collaborative effort between the United States Agency for International Development ([USAID], n.d.) and one of the countries under study, Nigeria, this study noted that specific risk management and governance strategies are required for an effective and successful collaboration. In Nigeria, just like most nations, the Federal Ministry of Health, Nigeria, is the Nigerian Government Ministry charged with the duties of ensuring good health and healthy practices for a sustainable healthy Nigeria. Their goals include the development and implementation of policies that strengthen the Nigerian national health system for an effective, efficient, accessible, and affordable health care system. To arrive at this goal, the ministry notes its core values to include excellence, competence, diligence, innovation, accountability, equity, and teamwork. For the practical provision of services, the Federal Ministry of Health Nigeria, oversees the costs and running of university teaching hospitals available in about 19 states and one at the Federal Capital Territory Abuja. The ministry is headed by a Minister appointed by the president of Nigeria whose portfolio includes the oversight of the Ministry of Health

in each of the 36 states of Nigeria. These state Ministries of Health are headed by commissioners for health in each state. Like any organization, the Federal Ministry of Health Nigeria also operates through a continual process of goal setting, the implementation of corrective actions, and monitoring such actions to detect problems and threats as well as identify opportunities that would ensure the desired outcomes are met. According to Ansoff et al. (2019), strategic planning as a tool can assist policymakers in planning, decision making, and the implementation of such decisions. Smith and Jackson (2000) noted that for a better knowledge of what might be needed for a planning process, the stakeholders should be engaged through the process of a strategic needs analysis for a range of options and solutions to issues bordering on strategic planning. However, there is the lack of proper planning and assessments of these strategic needs in many governmental organizations including the Federal Ministry of Health. Scholars like Savas (2000) and Spackman (2002) noted that currently, PPPs represent a variety of government project financing and execution including their maintenance and operations using more cost-effective means.

The 5-year (2018-2022) strategic plan by the Nigerian Federal Ministry of Health has its vision as "to ensure healthy lives and promote the wellbeing of the Nigerian populace at all ages" (Federal Government of Nigeria, n.d., p. ii). Part of this strategic plan is a framework for the health sector development. This framework includes mobilizing resources for the health sector, medium term expenditure framework, and aligning and coordinating the partner support in health development in Nigeria. Also, the noted objectives for the health sector policy are to improve health services availability, affordability, accessibility, and quality health services; expand health care coverage to the

hinterlands; reduce the infant mortality rate; and provide financing for the health care sector. Therefore, it is understandable that to achieve these objectives, there may be the need for partnership through collaborative processes. One of the collaborative partnerships by the Ministry of Health Nigeria, is with the USAID.

USAID is an international development agency and an active driver for development, especially in developing countries. It is the only single agency of the United States of America that administers aid via various projects to several countries and continents for the purpose of promoting social and economic development. On November 3, 1961, USAID was formed through the passage of the foreign assistance Act. This agency's purpose includes furthering America's interest in the countries where they work while improving lives. The primary duties carried out by this agency contribute toward lifting lives, building safer and healthy communities, and advancing communities. Currently, USAID's presence is seen and felt in more than 100 countries to promote global health, support global stability, provide humanitarian services, catalyze innovation and partnership, and empower women and girls. In Africa, USAID partners with many countries including Nigeria. This agency continues to partner with Nigeria on the eradication of poverty, provision of sustainable primary health care, eradication of diseases, and most importantly overcoming significant governance issues bordering on corruption and the lack of transparency. On the issues of health care, USAID has, through the Federal Ministry of Health and its agencies especially Nigerian Center for Disease Control (NCDC), partnered with Nigeria on the eradication of infectious diseases like human immunodeficiency virus/acquired immune deficiency virus (HIV/AIDS), Ebola, COVID-19, and the eradication of malaria.

Based on data from USAID, more than $10 million (USD) have been expended toward the eradication of malaria in Nigeria. This partnership project includes the donation of malaria prevention kits (insecticide treated mosquito nets) to local government areas in the 36 states (including the Federal Capital Territory) of the country. The current cost incurred from the inception of this project in 2011 to date is $126 million (USD), 50% of which goes to the cost of transporting the nets to the needed locations. In 2018, USAID through the President's Malaria Initiative donated 3.3 million treated nets worth $9.6 million (USD) to a single state (Akwa-Ibom) in Nigeria and for onward distribution to each local government area. In addition, $1.7 million (USD) was for the transportation of these nets to each local government area. The coordination of this partnership and the execution of the project is normally through the NCDC once the identified need is noted, the call for partnership honoured by USAID, and the project is approved by both parties. Although the efforts are laudable and have slightly helped with the eradication of malaria, this success is only applicable to households where the treated nets have been received. Agunbiade and Mohammed (2018) noted that the insecticide treated nets when received by the Federal Ministry of Health through the NCDC most times do not get to the intended recipients because of bad governance, lack of transparency, and communication as well as corruption. In their study, they noted that the lack of economic impact of partnerships or aids and grants from foreign donors is caused by corruption and mismanagement of the aid received because they are not channelled toward the intended cause. Therefore, most collaborative partnerships are ineffective, do not provide the needed public service, and need a suitable strategy to ensure success.

In fact, the USAID strategic plan for 2015-2020 highlighted the justification of the 5-year plan as based on the failing and abandoned sectors of the Nigerian economy including the failure to provide the basic social services such as education and health care. Unfortunately, the weak institutional capacity (with centralization of power and command of the country's resources in the Federal Capital Territory) has distorted transparency and integrity in the delivery of these services. As a result, there are significant under funding and misuse of public resources meant for projects in high demand. USAID also noted in its plan that for a 10-year period, because of weak governance capacity and practice, Nigeria has constantly lagged in development despite the partnerships. For these reasons, USAID's strategic plan for partnership with Nigeria on health related and other sector projects were based on these facts:

- Nigeria is relatively wealthy but suffers from poverty.
- Regional inequalities are evident especially in the health sector.
- The provision of social services by the government will help reduce poverty and increase economic growth.
- Strengthening democracy and governance will complement other strategies.
- Improved monitoring and evaluation will improve outcome.

## Institutional Theory

Institutional theory takes into consideration the process by which structures, rules, routines, and norms evolve or transition into becoming adopted as an established way of operation. J. W. Meyer and Rowan (1977) contended that many formal organizational structures represent reflections of rationalized institutional rules. Such rules in modern states and societies to some extent account for the expansion and increased complexity of

the formal organizational structures. They added that institutional rules function as myths that organizations incorporate, thereby gaining legitimacy, resources, stability, and enhanced survival prospects. Organizations whose structures become similar because of such institutional environments that are in contrast with those primarily structured by the demands of technical production exchange reduced internal coordination and control to maintain legitimacy. These structures are separated from each other and from ongoing activities; consequently, in the place of coordination, inspection, and evaluation, confidence and good faith are employed. According to Toma et al. (2005), using institutional theory, organizations understand and meet the expected needs of the society, thereby emphasizing the normative impact of the environment on the organization's activities. Frederich Von Weiser (1904, as cited in Festré & Garrouste, 2016) expressed institutional theory as an evolution of institutions via the dynamics of leaders and masses. Mahmud (2017) posited that there is always the tendency of the executive part of the government to maximize its benefits from policies with the main argument of rational choice institutionalism. However, to ensure that policies are formulated for public consumption, keeping in mind the sociological need and the need for implementation to be effective through proper use of public resources, it is necessary to consider the sociological institutionalism perspective of policy in the policy cycle. They added that the central claim of institutional theory or institutionalism is whether institutions matter in public policy process or not, and over the years it has been seen that the institutions do matter in policy process. Hendriks (1999) stated that "from institutional perspective policymaking can be observed as a process which is guided along previously beaten tracks by institutional structure, a process in which individual choices are influenced by

structures rather than outcome" (p. 67). The focus of institutional theory, therefore, goes deeper into the various structures of the society and sees how rules, norms, and values become the pathway for social behavior. March and Olsen (2008) noted that institutional theory focuses on the institution and how it matters in policymaking, so the most general way of explaining how institutions affect policy output is by seeing how the institutions (explained through various trends) empower and constrain actors in policymaking.

It is important to note that there are two distinct approaches in institutional theory, old institutionalism and new institutionalism. The study of political science and public administration in the late 19th and early 20th century began the process of identifying the formal institutions of government. The identification of formal-legal and administrative setup in the public sector was given. The old approach noted that apart from economic and social conditions, the functioning of the state equally depends on the design and effectiveness of political institutions (Knill & Tosun, 2012). Following the First World War, the period of old institutionalism, formation of formal institutions, such as constitution, was given importance. Various social and economic problems, such as the Great Depression in 1930s, caused policies to be ineffective. However, after the Second World War and with the creation of new countries and organizations like the United Nations, there was a major shift in the schools of thought in political science. The focus on formal state and rule-based organizational form was shifted to a more society-oriented form. As the social, economic, and political institutions became larger, various problems like unemployment rose up. To rectify this, policymakers started to go beyond formal institutional structures, making way for the new institutionalism, which focuses on the distribution of power and collective action through informal relationship (March &

Olsen, 1984). New institutionalism acknowledges that institutions operate in an environment consisting of various other institutions in the society. Because of changes in behavioral perspectives in the way social and political institutions act, three different approaches of new institutionalism came to be, all of them seeking to explain that institutions play an important role in determining social and political outcomes (Hall & Taylor, 1996). The importance of institutional theory in understanding policy process cannot be overemphasized because it is impossible for the policy process to proceed without the action of the institutions of government that institutionalism argues for. The actors in these institutions also play important roles in shaping the institutions because their actions reflect the outcome from the institutions. There is need for the combination of various institutionalisms and in policy implantation as every institutionalism has its distinct meaning of institutions and its own means of solving the issues. However, it is important to consider that solving the needs of the people is the collective goal of institutionalism in the policy process. Thus, addressing the social need should be the formal agenda of political and administrative decision makers and the implementation must follow the model that would solve the actual need rather than individual or political need.

In relating the institutional theory to PPPs and the need for this type of collaboration, it is easy to see that the need for a change is either prompted by the desire of a leader to improve the services rendered by that organization and in this case, the government to the people, or prompted by the need for a change by citizens through antagonism or unfortunately by hardship or death. For these reasons, just as there are drivers for change, there are also drivers for PPP. Abuzaineh et al. (2018) advised that

PPP typical drivers are geared toward addressing a wide variety of issues in the health care sector, and they include the need for

- additional services and skills/specialty including expanded service capacity;
- improved skills that would translate to improve the quality and efficiency and minimize the cost of health care delivery;
- a stronger and more robust procurement and supply chain network;
- new and upgraded infrastructure; and
- capital budget and/or cash flow constraints.

Given these typical PPP drivers, the results from the application of the institutional theory should lead to an innovative result provided that the desired need for change is positive, addressed and accepted, and will meet the needs of the citizens. Based on this expectation from the institutional theory, the researcher opines that innovation (effective policies, processes, procedures, practices) is a direct result of the implementation of appropriate institutional changes, in this case, the implementation of PPP.

## Innovation Theory

Schumpeter (1942) thought innovation to be the critical dimension of economic change, and he believed that economic change only takes place because of innovation, entrepreneurial activities, and market power. He further noted that creative destruction, which is an economic concept, explains the dynamics of industrial change like the transition of a competitive market structure. In other words, something new and better replaces the older one. Rogers (1962, as cited in Wilkening, 1963) likewise noted in his diffusion theory, which focuses on the factors that determine whether and at what place

an idea or innovation will be adopted by a company, that four elements affect the spreading of an idea: invention, channels of communication, time, and the social system. Innovation in the public sector was described by Torfing (2016) as being crucial and is encouraged by multiactor collaboration, which is relatively unexplored. Unlike the private sector where changes in processes, services, and goods are necessitated by competitions from counterparts, public sector innovations are driven by the need for institutionalized processes of interaction leading to positive and desired changes. PPP can combine the strength and expertise of the private sector to provide an innovative and conducive environment for the delivery of high-quality infrastructure and services. Based on Torfing's (2016) study, the central idea of innovation is that different products, approaches, and ideas are adopted by people, organizations, and governments with the intention of improving their existing process and way of operation.

Kula and Fryatt (2014), in their study of the health care PPPs in the South Africa province of Gauteng, indicated that the existence of innovative ways for the delivery of public services through the elimination of bureaucratic and rigid administrative processes remains a very important factor for success. Igumbor et al. (2014) also noted, in their study of antiretroviral therapy coverage in South Africa, that the failure in achieving a higher success rate was due to high patient load for existing facilities, poor patient retention, and insufficient human resources among others. They posited that reversing the challenge would require continued innovations to enhance access to treatment and reduce patient load per service. Furthermore, in Morocco, the innovative partnership between the public and private sectors as well as other nongovernmental organizations led to the successful implementation of the trachoma initiative in the public health care

sector (Reich, 2002). Similarly, Portugal's health care sector, which was fraught with underperformance and maintenance costs, was transformed by the introduction of a new and innovative procurement model through PPP (Woodson, 2016). This move was intended to positively affect the service delivery methods in all public hospitals. In addition, the UK has recorded several successful innovations in the health care sector, because of the implementation of PPP projects. The UK has recorded innovative processes for service delivery and procurements in the form of improved operations and the implementation of technology use in the NHS. This means that most public hospitals within the NHS can offer a one-stop service from acute care to primary, community, and mental health services (Gov.UK, 2021). Also in Canada, the need for innovation through PPP for improved services is seen as the main reason for desiring PPP. According to the CCPPP (2011), many Canadian hospital procurements exhibit some features that could lead to improved outcomes. They include significant involvement of patients (focus groups) in planning and design, a strong emphasis on clinical functionality, and involvement of international experts in hospital planning. Likewise, the results of innovation through PPP in New Zealand are seen through the adoption of an innovative approach (Health Alliance) for their health care procurement purposes. This strategic approach led to the successful policy insights and implementation.

Although all other countries cited as examples in the previous paragraphs exhibit traits of the government (public) partnering with private sectors in the same country, sadly in West Africa, successful PPP in the health care sector that has led to innovative processes for the duration of these projects has been through the intervention of intergovernmental organizations such as WHO. An example is the case of eradicating

river blindness; Bush and Hopkins (2011) noted that the intergovernmental agencies implemented the use of innovative approaches that included operational research that led to two positive results of the eradication of river blindness and the mass vitamin A administration to the people in the affected communities, thereby eliminating blindness from trachoma.

## PPP in Developing Countries

The concept of PPP can often be confused with privatization, outsourcing, and other forms of risk transfer that do not involve long-term contracts or a sustained relationship between the public and private sectors. This has been the case in some African countries (West Africa inclusive), resulting in failures through the implementation of models that are not PPP compatible. Donor agencies often promote privatization and government subsidies to private entrepreneurs in the name of building PPP. However, privatization and subsidies should not be confused with PPP (Mitchell-Weaver & Manning, 1991). In most developing countries (including West African countries), PPP is seen by a majority as representing a middle path between state capitalism and privatization (Leitch & Motion, 2003). General lack of trust in privatization has led to explicit attempts to engage with the private sector in a different way. Research (Broadbent & Laughlin, 2003; Leitch & Motion, 2003) reveals that privatization indeed did not result in massive reductions in national debts, nor did the private sector demonstrate the universal superiority in running businesses that had provided the philosophical underpinnings of the privatization process.

In the context of developing countries, the recent proliferation of PPP has been attributed to several reasons, including the desire to improve the performance of the

public sector by employing innovative operation and maintenance methods, reducing and stabilizing costs of providing services, improving environmental protection by ensuring compliance with environmental requirements, reinforcing competition, and reducing government budgetary constraints by accessing private capital for infrastructure investments (Miller, 2000; Savas, 2000). Ultimately, the reasons for contemplating a PPP lie in the inherent differences between the public and private sectors. These differences imply that PPP can, under the right conditions, provide an effective mechanism for capitalizing on the peculiarities and strengths of each sector in the pursuit of common objectives.

Public agencies and private organizations can indeed seek mutual advantages in developing a PPP, particularly when the latter is characterized by trust, openness, fairness, and mutual respect. The good faith approach takes as proven that private participation results in a combination of lower cost and less risk for the public sector (Leitch & Motion, 2003; Miller, 2000). Thus, a good return on investment is an essential consideration from the private partner perspective (Scharle, 2002). Policy and Operations Evaluation Department ([IOB], 2013) advised that for PPP to be effective in developmental countries, it has to be clearly defined in term of need, expected outcome, and intended impact.

## Health Care PPP Innovation Trends and Models

To properly implement and obtain the expected PPP outcome, previously reviewed literature has confirmed that suitable models will need to be utilized for the implementation. Therefore, various PPP models exist based on the need. Abuzaineh (2018) noted that PPPs have the following features in common: (a) The contracts are

typically long term—greater than 5 years, (b) There is a transfer of risk from the public to the private sectors or risk sharing between both sectors, (c) The end product of the projects could be equipment/facilities/assets belong to the government, and (d) The contract is usually based upon performance indicators that have been mutually agreed upon.

As outlined in Figure 2, there have been differing opinions by scholars on the success of the models when implemented, specifically the PFI model. Although the PFI model has been referred to as the single and most dominantly used model within the UK's NHS (Torchia et al., 2015), it is yet very controversial because of the noted complexity between the project delivery and operational phases, which results in minimal or no innovations (Roehrich et al., 2014). Other literature (Atun & McKee, 2005; Rechel et al., 2009) has confirmed that PFI is not a suitable health care PPP model because it is not designed to be flexible, is simple and predictable and as such not suitable for fast changing environments such as hospitals or health care facilities, and runs the risk of increased project cost if a project is slightly altered.

In 2017, the Project Finance and Infrastructure Journal (IJGlobal) estimated that there were about 600 PPP health care infrastructure related projects globally, with over 60% being in Europe, a little over 15% in North America, but the Middle East/Sub-Saharan Africa and North Africa made up only about 5% of the projects (see Figure 3).

Accordingly, the World Bank Group (2016) noted that different PPP health care models abound and are specific to the projects, the needs at a given time, and most importantly to the political environment in which these projects are being executed. The three most used PPP health care models are broken down by World Bank Group in the

table below. Most African countries typically considered to be developing countries that have recorded successful health care PPPs have to a large extent only been through the support of the World Bank Group. These supports are usually tailored to their relevance to each country in line with their development goals, and sometimes these supports are rendered in the form of interventions to health care deficiencies in specific countries. Given that these developing countries (of which West Africa can be classed) do not yet have a stable or enabling environment for proper PPPs, the projects are short term and are geared toward creating an enabling long-term health care PPP environment (World Bank Group, 2016).

**Figure 2**

*Health PPP Models*

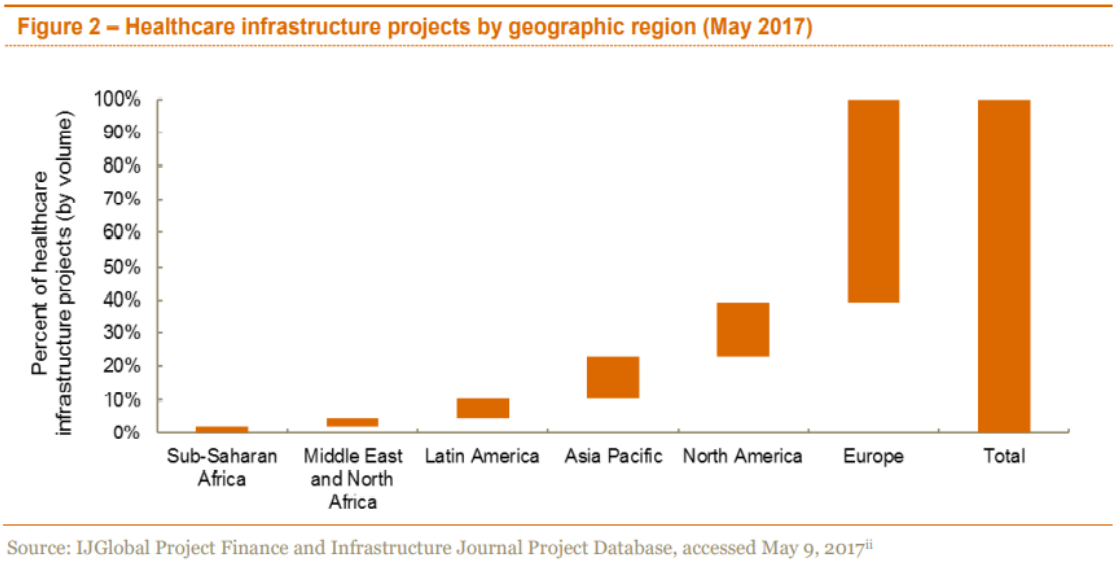
| PPP model | Common term | Definition / Explanation |
|---|---|---|
| Health services only (selective) | Operating contract, performance-based contract (concession, lease) | A private operator is brought in to operate and deliver publicly funded health services in a publicly owned facility. |
| Facility finance (accommodation only) | Design, build, finance, operate(DBFO), build, own, operate, transfer (BOOT), UK's PFI | A public agency contracts a private operator to design, build, finance, and operate a hospital facility. Health services within the facility are (mostly) provided by government. |
| Combined (accommodation and health services) | Twin accommodation/ clinical services joint venture/ Franchising, PFI+ | A private operator builds or leases a facility and provides free (or subsidized) healthcare services to a defined population. |

*Source:* Adapted from Montagu and Harding (2012) and Barlow, Roehrich, and Wright (2013).
*Note: PFI* = private finance initiative.

*Note.* From *Analysis of Critical Success Factors for Health Public-Private Partnerships: A Case of the Managed Equipment Services (MES) in Narok County* (p. 14), by J. O. Miseda, 2020, [Master's thesis, Strathmore University]. http://hdl.handle.net/11071/12020

**Figure 3**

*Health Care Infrastructure Projects by Geographic Region, May 2017*




*Note*. From *Note*. From *PPPs in Healthcare: Models, Lessons and Trends for the Future* (p. 10), by N. Abuzaineh, E. Brashers, S. Foong, R. Feachem, P. Da Rita, 2018, The Global Health Group, Institute for Global Health Sciences (https://pwc.to/2JCrzwr).

Likewise, Barrows et al. (2012) indicated that although the Canadian health care system is known to be part of a public program, it is primarily the case with respect to physician treatment and hospital care. Many other aspects of the Canadian health care system are privately delivered, including the fastest growing component of health expenditures and drug therapies. They noted specifically that sustainability of the current system is under threat because of the rising proportion of provincial budgets apportioned to health care. For example, in the province of Ontario, the health care component was 40% of the provincial budget with an expectation to rise to an unsustainable 70% in 20 years, given the same trend. Therefore, the Canadian government has made attempts to

utilize the PPP approach to deal with budget and infrastructure needs and to enhance efficiency and effectiveness by utilizing the skills of the private sector.

Abuzaineh et al. (2018) reported that besides the collaboration to provide effective and efficient health care services to the citizens and for ongoing accountability, the successes of such endeavors should be measured. They noted that although PPP projects are under scrutiny by government, private stakeholders, and the public, challenges still exist when it comes to measuring and demonstrating the successes of these projects against the original objectives of the project. It may appear that measuring successes of some PPP projects is easier with the application of certain models. For instance, not much is required in measuring the success of an infrastructure-based PPP (facility finance model) because the focus is primarily on building a facility within budget and given time, assessing the resultant improvements in the quality and efficiency of services. However, under health services only and combined services PPP models, assessing success is significantly more complex.

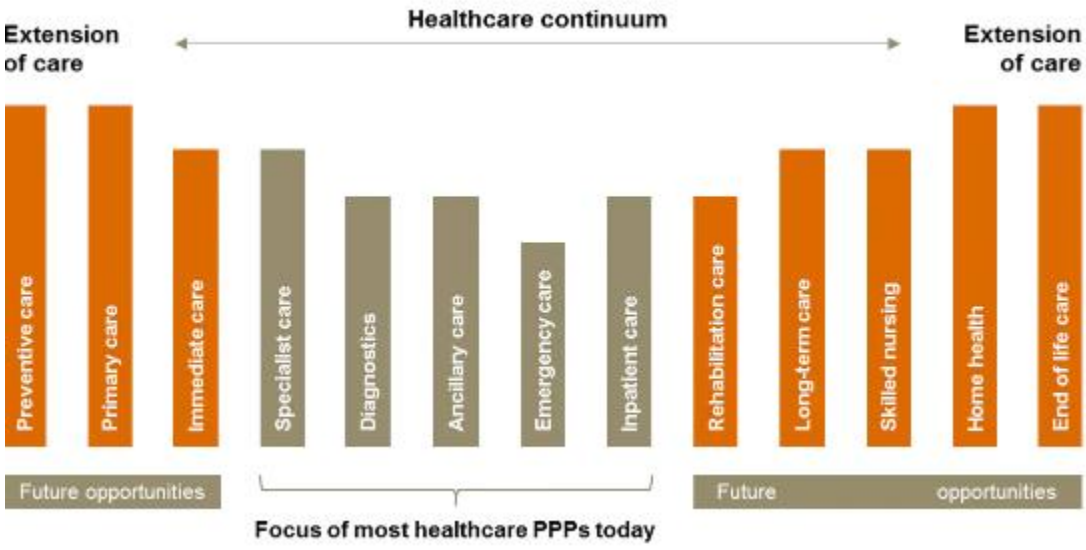
Among health care PPPs, little work has been done to identify or establish clear metrics to measure clinical performance and impact. Additionally, few projects include formal project evaluation as part of the contract. The challenge of evaluating health care PPP projects is further compounded by a general lack of published data on past PPP projects. Manhiça (2021) contended that although there are many publications on the importance of proper institutional setting for the effectiveness of PPP projects in Africa, very few have outlined proper requirements to examine the effectiveness of PPP considering the socioeconomic context. Additionally, a trend indicating a decrease in resources allocated to health care services in these countries makes it apparent that with

the increasing participation of the private sector in health care delivery, the effectiveness of PPP is determined by certain distinct factors. These factors include the quality of institutions, cultural characteristics, community attributes, and physical or material conditions. Because most of these factors are variables without adequate data for comparison, it can be said that limited data collection mechanisms and the complexity of separating the impact of a PPP project from other public health care delivery initiatives implemented simultaneously have made it almost impossible to properly measure the successes and effectiveness of PPP (Manhiça, 2021). A review conducted in 2014 (Abuzaineh et al. 2018) analyzing 1,400 publications on PPPs across sectors and spanning a 20-year period highlighted the difficulty in measuring PPP successes in health care. It was noted that evaluation was difficult because of the lack of accessible benchmark data on public hospitals and reluctance of the public sector to share data. The ability to leverage both public and private data to support objective and robust research is needed. This review also noted that many low- and middle-income countries may require building public sector capacity to securely collect and store financial, operations, and patient data that can be used in baseline studies. Rana and Izuwah (2018) shared the same thoughts as they noted that PPPs in Sub-Saharan Africa remain a very small market with projects concentrated in only a few countries, and these account for 48% of the 335 total PPP infrastructure projects in the region in the past 25 years. They added that some African countries are hesitant to embark on PPPs because of bad experiences with ill-prepared PPPs and with incompetent PPP project sponsors. Consequently, Abuzaineh et al. (2018) advised that there are many PPP opportunities waiting to be realized on the African continent for the benefit of all stakeholders and that PPP research can benefit

from the governments requiring all private health care outlets to publish key data for use by those involved in PPPs. Additionally, governments should seek to ensure that key performance indicators are developed and applied to any health care PPP that includes service delivery for the assessment of the positive or negative impact of an implemented project. Data from such an effort could provide critical evidence to inform future health care investment. They estimated that PPP models will become more integrated in the future; Figure 4 illustrates possible opportunities for the future of PPP in health care.

**Figure 4**

*The Future of PPPs in Health Care*




*Note*. From *PPPs in Healthcare: Models, Lessons and Trends for the Future* (p. 45), by N. Abuzaineh, E. Brashers, S. Foong, R. Feachem, P. Da Rita, 2018, The Global Health Group, Institute for Global Health Sciences (https://pwc.to/2JCrzwr).

## Factors Affecting PPP Implementation

Despite the use of appropriate PPP models, some factors are necessary for the success of PPP projects. As noted by Osei-Kyei and Chan (2017), it is evident that these factors are desired and should be maintained for successful project outcomes. However, the objectives of the different stakeholders in a project can be achieved if certain critical success factors are put in place. Some of these factors are briefly discussed as follows.

### Political Goodwill

According to available literature (Osei-Kyei et al., 2017), the UK and Australia have recorded the highest number of successful health care PFI/PPP projects, and for success to be recorded, the political motive behind the project implementation needs to be reviewed. Two distinct examples are readily provided in the case of Malaysia where the success of the health care PPP is attributed to the unwavering support from policymakers (Phua et al., 2014). The second as noted by the International Finance Corporation (2011) is the case of Ghana where a hybrid health care PPP was used to leverage the expertise of both the private and public sectors for the provision of health care services. The success was attributed to the strong political commitment it enjoyed.

### Contractual Agreement

Although most governments in developing countries see the need to implement PPP for innovative, effective, and sustainable health care services, evidence exists supporting the notion that contractual disputes and a weak contract management have more often than not been the main reasons for the early termination of most attempted PPP project implementations. Stucke (2019), in a recent study on health care PPP in emerging markets, noted that the institutional capacity, which ensures that the public

sector has a place in a well-developed contract with defined outcomes, was essential to success. In like manner, a study on the Canadian health care PPP by Barrows et al. (2012) posited that the stakeholders were in agreement that given the complexity with most health care PPP contracts, a clearly defined and stated contract agreement with structures for accountability was important for a successful execution of these projects.

**Expertise**

As previously stated in this study, PPP between the public and private sectors in any capacity provides grounds in which expertise not readily available in the public sector can be tapped from the private sector. Therefore, as indicated by Taylor and Christian (2016), the experience and expertise from the private sector when leveraged can be instrumental to improving loyalty, trust, and faith between patients and physicians and ultimately lead to an innovative and effective delivery of public health care.

**Human Resources**

Given that PPP to a great extent is a contractual agreement between the public and private sectors, there has been advice by different studies to ensure the improvement of human resources. Asuquo et al. (2017) affirmed the importance of human resource development in their study on the PPP project implemented through the collaboration between Effective Health Care Alliance Research Program, Nigeria National Petroleum Commission, and Mobil Producing Nigeria Unlimited. This was a joint venture that utilized the strengthening of laboratory capacity such as providing high resolution microscope, locally fabricated incinerators, refrigerators, and power generating plants to train supervisors at the National Tuberculosis and Leprosy Control Program. At the end of the project, the supervisors were better equipped to test and treat tuberculosis-related

cases. Also, Vian et al. (2015) attested to the importance of human resource building through training as they cited the design, build, and operate PPP model used by the government of Lesotho to increase the quality and access to health care. A great component of this design involved the training of managers and staff as key drivers of performance improvement.

**Stakeholder Involvement**

The nature of PPP creates an expectation of the presence of various stakeholders who are not limited to the public and private sectors directly involved in the project design, analysis, and implementation. As a result, there are varying influential stakeholders with diverse economic, political, social, and environmental concerns. Accordingly, Florizone and Carter (2013) posited that stakeholder support is critical to the success or failure of any project. They further noted that stakeholder opposition has been the main reason for failures in PPPs and that the situation can only be remedied by understanding and addressing their views. In the UK, the Local Improving Financial Trust, which was a form of PPP using the PFI model, addressed the poor state of health care in communities through the direct involvement of the stakeholders at the grassroots level (Beck et al., 2010). This led to an increase in the success rate of these types of projects.

Also, another positive result from the stakeholder engagement in health care PPP projects through the NHS is the LSPs. LSPs were introduced in 2001 to oversee policy-specific partnership activity in English cities and go as far as affecting the grassroots through collaboration with local communities. Initially introduced in the 88 most deprived localities, partners are from the public, private, voluntary, and community

sectors (HM Government Cabinet Office, 2011). They are charged with identifying local needs, developing community strategies, and coordinating local spending.

## Summary

This chapter discussed PPP in the health care sectors through the discussion of the history and definition of the concept of PPP, PPP as organizational and financial arrangements, and PPP and global health care, all while discussing the importance and positive impact of the implementation and success of PPP in various countries. The chapter further discussed the theories upon which the study relies—institutional and innovation theories. The chapter elucidated the theories, how they relate to PPP, and the possibility of PPP being a change mechanism that has led to innovative processes and policies in health care PPP in various countries. It further discussed the misconception of PPP in developing countries, health PPP trends and models, and the key success factors for PPP implementation.

Given the points discussed and the positive PPP outcome in other countries and continents, it becomes ever so important to evaluate the West African health care PPP experience by attempting to answer the research questions: What are the drivers of PPP in the public health delivery systems in West Africa? and What enhancements can successful PPPs contribute toward the delivery of public health services in West Africa?

# CHAPTER 3: METHODOLOGY

In the preceding chapter, the researcher set out the foundation for the conceptual and theoretical groundwork for the study. In this chapter, the study further elaborates the conceptualization and operationalization of the theories earlier discussed. The chapter begins by detailing the purpose statement, the methods used for data collection, the instrumentation, data analysis, and limitations during data gathering. The key informers in the process were policymakers from the Federal Ministries of Health, professionals from health insurance companies, and health management organizations (HMOs), which include physicians and administrators. Members of the public who have received or attempted to receive health care through the public health sector were the recipients. The chapter also discusses the method of execution of each research instrument.

## Purpose Statement

The purpose of the study was to analyze the risk sharing and governance in the West African public health system while focusing on health care PPP drivers through a critical analysis of the approach to health care PPPs in West Africa. It explored the perception of health care recipients and key informants on the collaborative processes, challenges, successes, and failures. Thus, the study aimed to make an original contribution to the field of study and inform on the matter with the hope of improving the public health sector toward a robust and reliable sector, delivering innovative, affordable, and quality health care services to all West Africans regardless of their social status.

## Research Questions

To meet the aim and objectives of the study, the following research questions were investigated in an attempt to provide suitable answer:

1. What are the drivers of PPP in the public health delivery systems in West Africa?
2. What enhancements can successful PPPs contribute toward the delivery of public health services in West Africa?

## Research Design

The methodology used was the qualitative method. As defined by Bryman and Bell (2007), it is a research design applied to explore issues, answer questions, and understand phenomena. Saunders et al. (2007) also noted that the qualitative method of research can be used in various fields, but specifically, it investigates why and how decisions are made. The main characteristic of this method, according to Bryman and Bell (2007), includes emphasis on words rather than quantification, applies an inductive approach to the relationship between the research and theory in which focus is on the generation of theories, and it acknowledges that individual views could be affected by social reality. The study applied a phenomenological approach because it drew on the experiences of those who utilize and provide health care services through the public health services in West Africa. Their narration of their experiences and expectations provides definite and reliable data for the research. For the study to be reliable and exhibit strong validity, primary data were obtained through participant observation during interviews and a comparison using case studies.

The primary data collected contributed toward answering the research questions by elucidating the factors that drive the need for PPP in the West African Public Health sector as well as the contributions of successful PPPs toward an enhanced and innovative public health service in the region. Two sets of people, the key informants (physicians, policymakers, and health insurance professionals) and recipients (members of the public

who have sought and received health care), were interviewed. This method allowed flexibility and suitability because it permitted in-depth and detailed analysis. This design appears more thorough, transparent, and reliable as it goes through an exploratory, instrument development, and instrument administration process.

For the recruitment of participants, information from company and government websites as well as professional websites such as LinkedIn aided in the recruitment of participants and to gather details on potential research participants before approaching them. However, further recruitment of recipients was through referrals from actual participants.

Telephone calls and emails were used to contact potential participants. The script to recruit and secure consent to participate in the research (see appendix A) were read to the intended participants during the call and a copy was sent by email for those being contacted by email, and once consent was received, a date and time was scheduled for interviews. There were no known risks to the participants as participation was voluntary and participants were not required to answer any questions they did not want to or feel comfortable answering. For this reason, a copy of the interview guide questionnaire (see Appendix B) was sent to the recipients for review 1 week before the interview date to enable them to make informed decisions on participation.

## Population

To give a proper structure to the research design, four (Nigeria, Ghana, Côte d'Ivoire, and Togo) of the 17 countries in West Africa were used for the research study. They were classed based on the strengths and feasibility of their strategic health management plans, responses to deficiencies by the governments, and recent and ongoing

innovations and partnerships in their public health sectors. Face-to-face, Zoom calls, and telephone interviews were the vehicles through which the needed information was obtained. The study aimed to effectively capture, validate, and measure key characteristics through the transcription and analysis of information from the interviews and other secondary data to meet the research objectives. The information was stored in a secured system and in an encrypted file format.

## Sample

Given that governance is centralized in these countries, the sample size of two policymakers in each of the Federal Ministries of Health in Nigeria, Ghana, Côte d'Ivoire, and Togo, two physicians from HMOs in each country and two health care insurance professionals in each country was intended to provide a manageable number of interviewees and research results for analysis while capturing their opinions on the existing risk sharing and governance practices as well as government strategic health plans. The HMOs and health care insurance have very recently become functional and operative in the region, and only a few accredited and functioning providers exist. The key informants were from the three most used HMOs and insurance companies, and they provided in-depth and detailed experiences on the topic (see Appendix C for the interview questions for informants). As earlier mentioned, the interview guide questionnaires were meant for the recipients, and recruitment of the participants continued until saturation (when the same responses/answers are received from most participants) was reached. All participants were assured of the highest level of confidentiality by assigning them random numbers ranging from one to 100, and all reference to participants in the research are to the random numbers and not names.

## Instrumentation

In Nigeria and Ghana, the English language is primarily spoken; therefore, all interviews and interview guide questionnaires were conducted and provided in the English language only. On the other hand, in Côte d'Ivoire and Togo, French is primarily spoken (see Appendices D to G for all translated copies); however, official documents like policies are also accessible and provided in both English and French languages. The researcher can communicate in both English and French languages; however, to eliminate any biases, interpretation services were utilized as required.

### Interview Guide Questionnaires

In Chapter 1, five objectives to be investigated and analyzed while attempting to answer the research questions were stated. These objectives sought to analyze the delivery of health care services, establish the benefits of risk sharing and governance through PPP, and draw relevant conclusions on a suitable PPP model for the West African health care sector. The interview guide questionnaires enabled the recipients to prepare beforehand and to make informed decisions on participation. Consequently, the interview guide questionnaires were sent out to the recipients 1 week before the interview date. For this category, the recruitment of participants was ongoing until saturation (when the same responses/answers are received from most participants) was reached.

### Interviews

All interview questions were different and based on the role or profession of the key informants, and the questionnaires were interview guides for the recipients. The obtained data were intended to express the views and feelings of the respondents. The researcher attempted to avoid prejudging the participants during data collection while

providing great depth and detail by acknowledging the experiences, attitudes, feelings, and behaviors of respondents. The interviews were conducted face-to-face when possible and over video (Zoom) and phone calls at other times. Each interview question was probed further where necessary to allow for an open and broad discussion on the topic and for sharing information in an informal setting. Although these types of interviews can sometimes get out of scope, the researcher was careful to take control of and redirect the discussion back to the intended topic of discussion.

## Data Collection

Primary data gathering was achieved within 3 to 4 weeks of requests and consent received. Because the primary data were gathered from experiences and perceptions through interviews, the participants were advised of the importance of sincerity and transparency in their responses so that the data did not become invalid if they chose to change their minds or responses. The interview guide questionnaires sent to the recipients 1 week before the agreed interview dates allowed for adequate time for a proper consideration on participation and for the participants to be properly prepared for the interview. The interviews with guide questionnaires were conducted with recipients to gather their personal experiences with the public health sector in the studied countries, thereby elucidating the accessibility, affordability, effectiveness, and efficiency or the lack thereof in the public health sector. The individuals' experiences informed on the drivers of PPP in the sector and how practically effective or ineffective the current risk sharing and governance methods were. The other set of interviewees (key informants) engaged in the actual process of risk sharing and the application of the risk governance methods in place. They provided details on how professionally effective and efficient the

current risk-sharing and governance methods and relevant government policies were as well as what in their opinion and experiences would bring about enhanced and innovative practices and drive the need for effective policy making and implementation.

Secondary data from hospital care reforms, information from the World Bank Group website, and the health sector strategic plans for these countries were reviewed. The research also applied a review of relevant literature from academic databases, journals, and periodicals. The review of the secondary data contributed toward the examination of an alternate perspective from the key informants.

## Data Analysis

After data collection, I transcribed the recordings and analyzed the collected data using NVivo, a qualitative data analysis computer program. I reviewed the recordings for the identification of any errors from the transcription. I reviewed notes, document data, observations, and transcriptions, and coded data. I used the codes to discover themes. I utilized coding, as suggested by Creswell (2014), to generate descriptions, categories, and themes for analysis while identifying participants' general perceptions. I assigned numeric codes to each participant to protect their identities. Participant names and organizations remained confidential. The cross-reference between the numeric codes and participant names were known only to me. I removed all identifying information to ensure confidentiality and privacy. I triangulated data by collecting data using multiple sources of information, such as interviews, observations, and document analysis. These data and the interpreted meanings were integrated towards suggesting a suitable risk management framework and an appropriate PPP model for the West African public health system.

I safeguarded participant privacy by ensuring their names were de-identified in the study. Numeric codes between one and 100 were used to protect participant identity. The file name referred only to the assigned alphanumeric code. I was the only person with access to the cross-reference between the alphanumeric codes and participant names. Once the recordings were transcribed and checked, I erased and destroyed all recordings, including video recordings of the interviews. Two years following the publication of the study, I destroyed the electronic documents by deleting electronic files.

## Limitations

As with every study, peculiar limitations to this study exist because of the constraints on the research methodology and design. Limitations of qualitative interviews included reliance on the ability of participants to recall and recount the details of their experiences accurately. To avoid researcher bias from occurring in this research, I allowed the participants to fully express themselves through the open-ended, semistructured interview. I also provided them with the recruitment script and interview guide questionnaire 1 week before the interview date. Another limitation was that the study was limited to four of the 17 West African countries (Nigeria, Ghana, Cote d'Ivoire, and Togo), and the scope of this research on these countries did not extend to include an in-depth review of the health strategic management plans but to capture the aim and objective of the plan for the evaluation of recipients and key informants' experiences and opinions on health care PPP in the region. Last, the recipients were very reluctant in providing their health insurance policies because they are copaid by their employers.

## Summary

I gathered primary data through open-ended, semistructured, face-to-face interviews in addition to documentary analysis for the provision of supplementary research data. While secondary data were gathered through the review of government databases, policy documents and health strategic management plans for each of the four countries studied. For clarity on the languages, during the interviews, because the English language is primarily spoken in Nigeria and Ghana, I provided all the materials in the English language only. On the other hand, in Côte d'Ivoire and Togo, French is primarily spoken; however, official documents like policies are also accessible and provided in both English and French languages. Because I can communicate in both English and French languages, I was able to engage my participants; however, to eliminate any biases, interpretation services were used as required.

# CHAPTER 4: RESEARCH, DATA COLLECTION, AND FINDINGS

## Overview

The previous chapter presented the different methods used in this study for data collection and data analysis. This chapter builds on that discussion and presents the findings through an analysis of the primary data. This chapter begins with the analysis of the 5-year strategic health management plan for the countries studied. The analysis of these documents leads into the findings related to the first research question and explores how the implementation of the strategic health management plan has affected the quality of public health services and their delivery for the recipients. The second part of this chapter focuses on the findings by analyzing the interviews with the recipients and health insurance professionals. Additionally, the second part of the analysis addresses the second research question by exploring the perceptions of other key informants like the policymakers and physicians, and then builds upon the findings and discusses them within the institutional and innovation theoretical context.

This analysis is presented and supported by quotes obtained from interviews with the research participants. These findings represent the substance of what was said by the participants. In some cases, the quotes were modified for conciseness and proper understanding because sometimes participants provided long descriptions or repeated the same point several times, and some were said in pidgin. In cases in which the reader was not likely to gain additional meaning from these long quotes, I included only the main points from them.

## Purpose Statement

The purpose of the study was to analyze the risk sharing and governance in the West African public health system while focusing on health care PPP drivers through a critical analysis of the approach to health care PPPs in West Africa. It explored the perception of health care recipients and key informants on the collaborative processes, challenges, successes, and failures. Thus, the study aimed to make an original contribution to the field of study and inform on the matter with the hope of improving the public health sector toward a robust and reliable sector, delivering innovative, affordable, and quality health care services to all West Africans regardless of their social status.

## Research Questions

To meet the aim and objectives of the study, the following research questions were investigated in an attempt to provide suitable answer:

1. What are the drivers of PPP in the public health delivery systems in West Africa?
2. What enhancements can successful PPPs contribute toward the delivery of public health services in West Africa?

## Research Methods and Data Collection Procedures

The methodology applied to this study was the qualitative method. As defined by Bryman and Bell (2007), it is a research design applied to explore issues, answer questions, and understand phenomena. Saunders et al. (2007) also noted that the qualitative method of research can be used in various fields, but specifically, it investigates why and how decisions are made. The main characteristic of this method, according to Bryman and Bell (2007), includes emphasis on words rather than quantification, applies an inductive approach to the relationship between the research

and theory in which focus is on the generation of theories, and acknowledges that individual views could be affected by social reality. As part of the qualitative method, I applied a phenomenological approach that allowed me to gather experiences of the recipients of public health care services and the key informants in the public health services in Nigeria, Ghana, Côte d'Ivoire, and Togo. Their narration of their experiences and expectations provided definite and reliable data for this research. For the study to be reliable and exhibit strong validity, primary data were obtained through participant observation during interviews and a comparison using case studies.

The sample population comprised two policymakers from the Ministry of Health, two health care insurance professionals, and two HMO physicians from each of the countries studied. Recipients were recruited until saturation was reached. For recruitment, I contacted most participants by sending them private messages asking to know whether they were willing to participate in the study on LinkedIn, and once I received a response confirming their interests and consent as well as their preferred mode of contact, the script to recruit participants was sent to the key informants and the interview guide questionnaires were sent to each recipient. Participant demographics are shown in Tables 1, 2, 3, and 4.

As the primary data were gathered from experiences and perceptions through interviews, the participants were advised of the importance of sincerity and transparency in their responses so that the data did not become invalid if they chose to change their minds or responses. The interviews with the recipients were to gather their personal experiences with the public health sector in the studied countries, thereby elucidating the

**Table 1**

*Nigeria Demographic Data*

| Participant code | Locality | Occupation | Sex |
|---|---|---|---|
| 1 | Urban | Self-employed | Female |
| 6 | Urban | Physician | Male |
| 11 | Urban | Physician | Female |
| 18 | Urban | Policymaker | Male |
| 22 | Urban | IT consultant | Male |
| 33 | Urban | Health insurance expert | Female |
| 34 | Rural | Trader | Male |
| 35 | Urban | Banker | Male |
| 37 | Rural | Farmer | Male |
| 38 | Urban | Engineer | Female |
| 40 | Urban | Policymaker | Male |
| 41 | Urban | Student | Female |
| 59 | Urban | Health insurance expert | Male |
| 62 | Rural | Retired | Female |
| 70 | Rural | Student | Female |
| 90 | Urban | Country program rep. | Male |

**Table 2**

*Ghana Demographic Data*

| Participant code | Locality | Occupation | Sex |
|---|---|---|---|
| 7 | Rural | Teacher | Female |
| 8 | Rural | Teacher | Female |
| 9 | Urban | Physician | Male |
| 10 | Urban | IT consultant | Male |
| 12 | Rural | Civil servant | Female |
| 15 | Urban | Physician | Female |
| 19 | Urban | Health insurance expert | Female |
| 48 | Urban | Hairdresser | Female |
| 49 | Rural | Housekeeper | Male |
| 50 | Rural | Self-employed | Female |
| 51 | Urban | Student | Male |
| 54 | Urban | Program officer | Male |
| 55 | Urban | Risk analyst | Male |
| 56 | Urban | Health insurance expert | Female |
| 57 | Urban | Policymaker | Female |
| 58 | Urban | Policymaker | Female |

**Table 3**

*Côte d'Ivoire Demographic Data*

| Participant code | Locality | Occupation | Sex |
|---|---|---|---|
| 16 | Urban | Physician | Male |
| 17 | Urban | Physician | Male |
| 21 | Urban | Health insurance expert | Female |
| 23 | Urban | Trader | Male |
| 24 | Rural | Student | Female |
| 25 | Urban | Policymaker | Male |
| 26 | Urban | Unemployed | Female |
| 27 | Rural | Program officer | Female |
| 29 | Rural | Self-employed | Male |
| 30 | Urban | Banker | Male |
| 31 | Urban | Civil servant | Female |
| 36 | Urban | Health insurance expert | Male |
| 43 | Urban | Policymaker | Male |
| 44 | Urban | Civil servant | Female |
| 75 | Rural | Professor | Female |
| 76 | Urban | Professor | Male |

**Table 4**

*Togo Demographic Data*

| Participant code | Locality | Occupation | Sex |
|---|---|---|---|
| 2 | Urban | Physician | Male |
| 4 | Urban | Security guard | Male |
| 5 | Urban | Physician | Male |
| 13 | Urban | Health insurance expert | Female |
| 14 | Urban | Policymaker | Male |
| 20 | Urban | Unemployed | Female |
| 32 | Rural | Trader | Female |
| 39 | Urban | Policymaker | Female |
| 42 | Urban | Hairdresser | Female |
| 45 | Urban | Student | Male |
| 46 | Urban | Health insurance expert | Male |
| 47 | Urban | Life insurance staff | Male |
| 52 | Rural | Program officer | Male |
| 53 | Rural | Self-employed | Female |
| 68 | Rural | Self-employed | Male |
| 69 | Urban | Self-employed | Male |

accessibility, affordability, effectiveness, and efficiency (or the lack thereof) in the public health sector. It was expected that their experiences would inform on the drivers of PPP in the sector and how practically effective or ineffective the current risk sharing and governance methods are. The other set of interviewees (key informants), who engage in the actual process of risk sharing and the application of the risk governance methods in place, provided their opinion and recounted their experiences on how professionally effective and efficient the current risk sharing and governance methods and relevant government policies are. They also expressed what in their opinion would encourage institutional changes and innovative practices and drive the need for effective policy making and implementation.

The interview guide questionnaires sent to the recipients 1 week before the agreed interview dates allowed adequate time for a proper consideration on participation and to be adequately prepared for the interview. Those who preferred to be contacted via WhatsApp and email provided their phone numbers and email addresses and were contacted through their preferred methods thereafter. The recipients were recruited until saturation was reached. Upon receipt of their consent to participate and the timeline for the interviews, it became apparent that the time difference of 7 to 8 hr between Canada (my country of residence) and the West African countries created a barrier for interviews to be scheduled successfully, so I travelled to West Africa to conduct the interviews.

It took approximately 3 to 7 weeks to recruit participants and schedule and conduct interviews. In addition to the interviews, policy documents like the 2018-2022 strategic health management plan for each country obtained from each country's official website were reviewed. Other secondary data from the World Bank Group website on

these countries and the West African region were reviewed. After data collection, I transcribed the interview recordings through Otter.ai and analyzed the data using NVivo, which is a qualitative data analysis computer program. This data analysis tool enabled me to create codes and discover themes for the analysis while also identifying the perceptions of the participants.

## Presentation and Analysis of Data

### Analysis of the 5-Year Strategic Health Sector Development Plan

This analysis has been carried out to demonstrate the different perceptions of the policy document by recipients of public health care services in Nigeria, Ghana, Côte d'Ivoire, and Togo, the service providers (physicians), and the policymakers at the Ministry of Health in these countries. The focus of the study was on the policy implementation measures and how they affect the quality of health care provision and delivery and the different perceptions of the participants. As a result, the main objectives of these documents and their interpretations were contrasted with participants' reported experiences, allowing the reader to view the policy issue from the perspectives of the recipients and key informants. Finally, this approach allowed for an understanding of the policy through the eyes of those who have lived it.

### The National Strategic Health Development Plan: Nigeria

The 5-year (2018-2022) strategic plan by the Nigerian Federal Ministry of Health has its vision as "to ensure healthy lives and promote the wellbeing of the Nigerian populace at all ages" (Federal Government of Nigeria, n.d., p. ii). Part of this strategic plan is a framework for the health sector development. This framework includes mobilizing resources for the health sector, a medium-term expenditure framework, and

aligning and coordinating the partner support in health development in Nigeria. Also, the noted objectives for the health sector policy are to improve health services availability, affordability, accessibility, and quality health services; expand health care coverage to the hinterlands; reduce infant mortality rate; and provide financing for the health care sector. Therefore, it is understandable that to achieve these objectives, there may be the need for partnership through collaborative processes. One of the collaborative partnerships by the Ministry of Health Nigeria is with the United States Agency for International Development ([USAID], n.d.).

**The National Strategic Health Development Plan: Ghana**

For Ghana, the 5-year (2017-2021) vision by the Ministry of Health Republic of Ghana (n.d.) includes creating a health system that places each patient at the center of health care and ensuring continually improved and measurable outcomes. More specifically, a collaborative process with the patients, all agencies, and health care providers to create a stronger leadership and coordination from the Ministry of Health toward all its agencies to provide solutions to all identified gaps preventing the improvements toward better patient care and outcomes. This means a direct partnership with patients to understand what truly matters most to them through stakeholder meetings and patients' forums and involving a wider Ghana community devoid of a limitation to just one part or community of the country and to directly solicit input for a successful design and implementation of the strategy in a true spirit of partnership. Its aim is to coordinate the system of health care quality including its delivery at all levels of the health system across both the public and private sectors and all areas of health and to work closely with all its agencies and patient groups for a successful implementation.

### The National Health Development Plan 2016-2020: Côte-d'Ivoire

According to the Cote-d'Ivoire's Ministry of Health (n.d.), the nation's health development plan provides effective responses to health problems characterized by levels of high morbidity and mortality. The document identifies and outlines six areas of focus: governance and leadership health to be strengthened at all levels, improvement of domestic funding and external health systems, reduction of morbidity and mortality from major diseases by 2020 to 50%, strengthening of prevention and promotion of health, and encouraging the participation of the public and private sectors. The policy document noted that to yield productive results, the country's health and development goals require increased efforts to strengthen the evidence base for increased financial and political support, improved capacity of both government and civil society, greater investment by key populations in the country's development, and support of a new costing model for informed health budgeting and planning at the national level. In addition, and mostly in alignment with the purpose of this study, the follow-up and continual evaluation of the policy to enable the achievement of significant progress toward universal health coverage.

### National Health Policy (2017-2022): Togo

The national health policy for Togo is primarily concerned with developing appropriate solutions already identified and the alignment of the implementation of these solutions together with the implementation of universal health care coverage (Ministry of Health, Public Hygiene and Universal Access to Care, 2017). An inclusive approach is applied for utmost achievement of this goal through a participatory process of key stakeholders in the health sector (Ministry of Health and administrations partners,

technical and financial partners, civil society actors, and the private care sector). In addition to the inclusive approach, the plan uses a results-based planning approach by linking expected results with necessary resources. Therefore, a strategic framework for the health sector is based on the following five strategic areas that are in line with national and international priorities. The first is accelerating the reduction of maternal, neonatal, infant, and child mortality and strengthening family planning and adolescent health. Next is strengthening the fight against communicable diseases followed by improving health security and response to epidemics and other public health emergencies. In addition, strengthening the fight against noncommunicable diseases and promoting health and lastly, strengthening the health system toward universal health coverage including community health.

The review of these policy documents was relevant for understanding the national health policies for each country. The analysis of them provided significant insight into the aims, goals, focus, and commitment of each West African country to improved public health care. It also confirmed that all four countries had a common commitment in terms of their strategic plans with the common goals of creating enabling environments for the attainment of outcomes, inclusive of leadership and governance; total community participation; partnerships for health delivery; strengthened health systems for the delivery of public health care; and focus on human resources strengthening, a health information system, and risk financing in the form of universal health care. The analysis further elucidated the purpose of the study because each policy document noted the incorporation of a collaborative process, governance, and PPP. In addition, the analysis gave insight into health policies in each country, the context in which the responses from

the participants relate. The review focused mainly on the matters relevant to the purposes of this study and did not extend to include a full review of the entire health care policy for each country.

Although the reviewed policies outlined significant steps to tackle the public health issues, including the provision and delivery of public health care services, the recipients' experiences and those of the key informants (which are presented in the following section), show that people still face major challenges with the delivery of health care services in the West African region. Specifically, these experiences highlight issues with availability, accessibility, affordability, and even effectiveness of the health care services they receive despite the National Health Insurance Scheme (NHIS) and private insurance in the countries.

## Presentation of Findings

The focus of the data analysis was based on the national health policies for Nigeria, Ghana, Côte d'Ivoire, and Togo, showing the very common goals they share with an evaluation on the implementation of these policies through the perceptions and lived experiences of recipients, their families, and professionals affected or impacted by the policy. This section presents the experiences of recipients of public health services, followed by perceptions of HMO physicians, health insurance professionals, and policymakers. The experiences of the recipients advise on the drivers of PPP in the public health sector, and the evaluation of the delivery of health care services by the key informants provides valuable insights on the enhancements by successful PPP to public health care service delivery. This chapter also presents thematic frameworks (see Tables 5 and 6) for recipients and key informants. These frameworks were compiled after the

comparison of themes from each country and themes that were found to be the most referenced.

## Presentation of Recipient Data: Nigeria

### Theme 1: Access to public health care

#### *Accessibility Challenges*

The first major theme that emerged was the access to the delivery of public health services. All of the 40 participants confirmed accessibility to health care services as a major problem. Seventeen of these participants reside in the rural areas and noted that the community health centers in their localities were less functional than portrayed. The findings of the study revealed a general dissatisfaction with how inaccessible the public health care services in the rural areas are. Further concerns include the lack of trained personnel, lack of medical equipment when the facility was open to the public, very unsanitary conditions in the health care centers, buildings that were not suitable to be used as health facilities because they were dilapidated, and the lack of private clinics or government hospitals even remotely close. One recipient from Ghana stated,

> I live in the rural areas and cannot go to a hospital because it is in town and far away from here, the health center is close but there are no doctors, the only come some days if at all they come and the nurses are auxiliary nurses. I must call my daughter that lives in the town, she comes and takes me to her house and when I complete the treatment at the hospital, I go back to my base.

Another recipient from Nigeria noted she lives in the rural area as a retired professional not because she is poor but because of the peace and tranquility she enjoys there, but she is disappointed that she must travel to town for any medical needs. She said,

> Whenever I feel unwell, I call a doctor who runs his private clinic in town and whom I have known for some years now, to come see me, diagnose and prescribe medications. Otherwise, I must go to the hospital in town for my medical needs. There are no proper clinics here not to talk of a hospital. I don't understand what the government is doing about this. Many people die from this.

Recipients from Côte d'Ivoire and Togo recounted almost the same experiences; they noted they find it difficult getting health services, so if their conditions are not bad or have not deteriorated so that normal daily function becomes a problem, they would not visit the hospital.

Their experiences confirmed that adequate public health services are not available in most rural areas, if not all. They further call the strategic plan to question as it does not appear as though the health centers in the rural areas were properly designed to handle the medical needs of the area. Their experiences also question the current universal health care through the NHIS as one recipient stated,

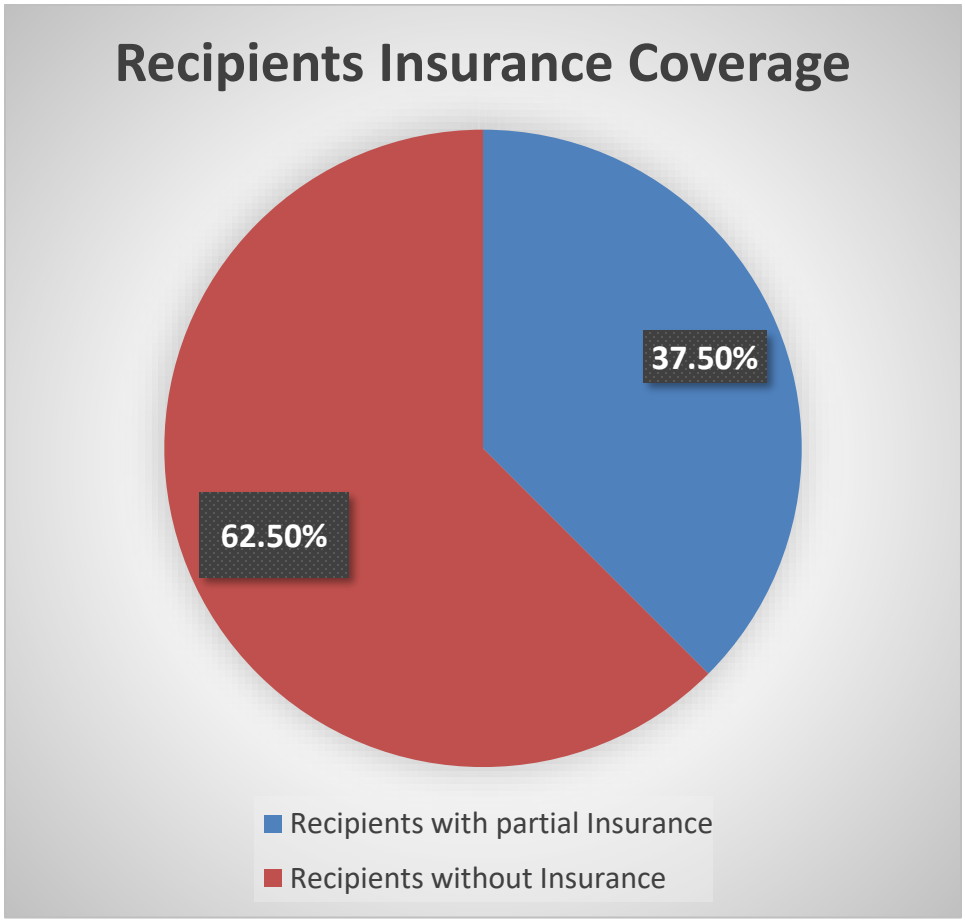
> I am a Nigerian student who lives on campus during the school term, I go back to the village to live with my parents during the holidays. We rely solely on the patent medicine store owners or "pharmacists" as they are called but I know they have no educational qualifications. They diagnose, prescribe, and treat people for ailments they know nothing about. We do not bother to go to the health centers. During the school term, I get medical care on campus which is part of the NHIS I pay as part of my fees. Good thing I have not had any serious ailments or injuries because NHIS only covers the basics like malaria, typhoid fever, small cuts, and bruises etc.

***Affordability of Public Health Care Services***

Affordability is one of the difficulties faced by recipients of public health care. Twenty-five of the 40 participants noted they had no insurance and paid for public health care services out of pocket. The other 15 noted they were either partially covered by private insurance through their employers, had both private and NHIS but still paid out of pocket because NHIS coverage cannot be used anywhere else than where they signed up for the services. The cost of public medical care is not affordable. A visual presentation of the breakdown is seen in Figure 5.

**Figure 5**

*Recipients' Insurance Coverage*



One recipient from Ghana noted,

> Health care services are expensive at all levels and even the NHIS coverage does not even work, I had to abandon it because it is too much trouble. It is cheaper at the government hospitals if I have minor sicknesses but when I have a major sickness or surgery, I must pay cash even if NHIS works. I have to borrow money to be able to afford that type of treatment.

Another recipient from Côte d'Ivoire noted,

> I am a civil servant, but the NHIS is not effective. A lot has to be done to improve this service; it also gives very minimal coverage, but the politicians are able to get the best services because they can travel abroad for treatment.

Yet another recipient from Togo noted, "I am poor; I cannot afford any insurance and most times I rely on herbs to treat myself. I cannot go to the hospital."

Most of the recipients advised that public health care in the government-run hospitals (teaching and general hospitals) was expensive although less expensive when compared to the private ones. They believed that with the NHIS in place, public health care should be affordable, but that has not been the case. These claims were corroborated by a physician who stated,

> I will say that public health care in Nigeria is not affordable because the budgetary allocation to this area is minimal. The disturbing part and the reason why most physicians refuse to be part of the NHIS and why it seems ineffective is the outdated fee guide related to capitation. The government uses a guide that is decades old and pay only 750 naira per life. For medications, antibiotic is capped at 350 naira or so and the patient does not even know they have to pay the rest out of pocket. I

do not currently participate in the NHIS neither am I an HMO physician because both the NHIS and private insurers are not ready to face the truth.

Another physician stated,

> It looks like the government expects us to make health care affordable through our private clinics even though we get no grants from them to run the clinics. The private insurers think they can provide coverage for 40,000 naira a year for a patient. How possible is that? When we refuse to engage the NHIS and private insurance companies, the cost falls back on the patients and with the rising cost of living, health care is almost not affordable by most people. Then we consider those in the rural areas, and we know that there is simply no hope for them.'

***Effectiveness of Health Care Delivery***

Public health care delivery, according to some recipients, is ineffective depending on one's status. Some recipients noted the ineffectiveness to be largely related to the lack of medical equipment in government hospitals. A recipient from Nigeria stated,

> My mom, of blessed memories, was ill and in one of the teaching hospitals, and we were told that both of her kidneys had collapsed, and she needed to undergo dialysis. Now the problem we had was a dialysis machine, the government hospital had just had one dialysis machine for the whole facility. It was faulty and being worked upon at that time. So, I asked him, "So when do I get my mom to do this?" And they said, "If we get the machine rectified by tomorrow, there were about five people waiting to use the same machine." Unfortunately, my mom passed because the equipment for the dialysis had broken down.

Another recipient from Côte d'Ivoire stated,

> I prefer the private hospitals/clinics because the doctors are always available and provide services that are effective. Thankfully, I can afford it because my employers pay part of the private health insurance premium, and the other half is deducted from my salary. When I needed to have a scan done, I used a private testing facility because their machines are functional, and they have very well-trained personnel who are nice too. You cannot get this level of service in a government hospital.

Another from Ghana stated,

> Right now, the government and private hospitals are improving a great deal with medical equipment, but the only problem is that the up to date medical equipment like a scanning machine for the pelvis, based on my experience, are found in the private hospitals. That makes it available but expensive to afford.

***Efficiency in Health Care Delivery***

Recipients also noted their concerns with the lack of efficiency in the delivery of health care services. Their specific references were to government-run hospitals as they advised that based on their experiences, they had to wait for several hours to see the doctors at the hospital. One recipient from Nigeria stated,

> It is not because the doctor was busy with another patient or something else, my appointment was at 9 a.m., and he did not arrive until 11a.m. That is not the first time it is happening; it the same thing every time.

This and other experiences negate the nation's 5-year plan of providing effective and efficient health care services to the citizens. One recipient from Ghana stated,

> Since I use the government hospitals, I take the day off from work anytime I need to go there because I spend more time waiting for the doctor to arrive than getting treatment. When he or she finally arrives, they give you a rush service and don't spend any time discussing your health issues with you.

A recipient from Côte d'Ivoire said, "I prefer to continue attending the private hospital; they know that time is very valuable, so they comply with the appointment time they give." A recipient from Togo stated, "I wish there will be a complete takeover of the government hospitals by the doctors with the private clinics so they can teach the government hospital workers how to keep time."

**Theme 2: Commitment**

***Quality of Service Delivery***

The second major theme for this study was commitment. The experiences of the recipients revealed that most health care providers in the community health centers (when open) or government hospitals are not committed to providing the services. Apart from not reporting to their working units in good time, they do not take the time to provide adequate information to patients. A recipient from Côte d'Ivoire stated, "The services received at the government hospitals are usually very poor; they are very unfriendly and harsh regardless of how sick you are. They need training." A recipient from Nigeria said,

> When I was admitted at the government hospital; my mother had to stay overnight with me, taking care of me. When I vomited, it was her who cleaned me up while the nurses were either shouting at me for vomiting or sleeping through the night while my mother did their job for them.

A recipient from Ghana stated,

> I used my NHIS coverage when I had my baby, though the greater part was free, but I notice the medications being prescribed were maybe of lesser value? The brand was different from what I previously received for the same condition through my husband's private insurance before he lost his job recently.

A Togo recipient noted, "With no electricity power most of the time, medical equipment or clean water, it is unbearable being at the hospital."

***Training and Knowledge of Service Providers***

Recipients who have received health care services from both government hospitals and private clinics (37 out of the 40 participants) noted that those in the government hospitals were quite trained and knowledgeable in certain areas of medicine compared with those in the private clinics. Specific references were made to the specialists and consultants at the teaching and general hospitals. These recipients noted that although the physicians at the private clinics were equally good, they had a higher level of confidence in the physicians at the government hospitals. A recipient from Ghana stated, "I prefer the government hospitals because the doctors they are knowledgeable, and they have their colleagues to consult with unlike the private clinics. They rarely give you a misdiagnosis."

Another participant from Nigeria stated,

> I used to work as a physician at a teaching hospital 20 years ago, but I now work as a country program representative for an international organization in collaboration with the Nigerian government on HIV detection, monitoring, and treatment and still have some relations with the hospitals. The teaching hospitals

have the best doctors with many years of experience, specialists, and consultants, and because they all work together, it is easy to have peer reviews and provide valuable and quality service to their patients.'

In Côte d'Ivoire a recipient stated,

> The doctors are knowledgeable, but I think they require more training than they get in school. I don't think many of them study after they become doctors because you don't see it in the way they talk to us or treat us. In the government hospitals, maybe they further their education that is why some of them are consultants. They can do better with more training.

***Public Health Care Service Delivery Processes***

All of the recipients of health care services confirmed that it takes a shorter period of time to be seen by their doctors in the private clinics than the doctors in the government-run hospitals, not because of the time it takes to attend to each patient but because they are first committed to their private practices. The recipients also talked about the unfriendly customer service they receive from the nurses and front desk staff. The recipients noted they are either yelled at or abandoned at some point. They added that the process of having to queue up and wait hours on end for their paper files to be retrieved is very discouraging and often, a patient's file gets missing and at the point of another visit, while very ill, they are told of the missing file and that they have to pay for another one. Most times, they are not ready for this additional cost. One patient from Nigeria stated,

> It is better to attend the private clinics because all the records are now stored in the computer unlike the government hospitals that still have records on paper

> files. They lost my file once and I was told to pay for a new one, I was ready for that financially, so I left without seeing the doctor and approached a pharmacist for medication. What about the records lost? How will another doctor know all that they need to know about my health?

From Côte d'Ivoire a recipient noted, "Even though the government hospitals are cheaper, but the private hospitals deliver better care every time I go there. I prefer to go to the private hospitals, but I do not always have the money to pay."

From Ghana, a recipient stated, "I like the government hospitals because they are improving, but they can do with managing their time better and be there in good time for their patients."

Another recipient from Togo noted that because he has to travel from his rural area to the government hospital, which is the only one he can afford, he remembers the harsh treatment and prefers to deal with the medicine store and take the medications prescribed; he said it always works.

***Workplace Policies***

Some recipients observed that the workplace policies may not be those that promote or encourage an effective delivery of public health care services in the government hospitals. They noted that the private clinic staff are courteous, friendly, and appear to adhere to their workplace policies while the opposite is the case with the government hospital staff. A recipient from Ghana stated,

> Every time I need to see the doctor at the government hospital, I take the entire day off because I have to wait for hours before the doctor comes to work even though I always get the first appointment time most times. The appointment

would be at 8 a.m. for example, and the doctor will resume work at 11 a.m. It is very discouraging.

Another recipient from Nigeria stated,

> The workers at the government hospitals should be accountable for their actions. Most of them talk condescendingly to the patients, behave however badly they feel like and that maybe because their bosses are either not watching or there are no rules or policies to be followed.

Yet another recipient from Togo noted, "I feel very anxious going to the hospitals in Lome, which is where the government hospitals are, because I think my condition always gets worse there because of the unfriendly way the staff treat us."

A recipient from Côte d'Ivoire said,

> The work policies in the government hospitals need to be changed or put in place if none exists. The environment is mostly unclean, patients are expected to worship the workers or even bribe them to get them to render the services they are paid to render.

For a proper presentation, Table 5 provides a breakdown of the discussed thematic framework: recipients. The table contains the main themes and subthemes and how often they were referenced. It also provides a vivid representation of how important these themes were to the recipients.

**Table 5**

*Thematic Framework: Recipients*

| Theme | Files | References |
|---|---|---|
| Access to public health care | 21 | 34 |
| Accessibility challenges | 18 | 21 |
| Affordability of health care | 17 | 19 |
| Effectiveness of health care services | 14 | 15 |
| Efficiency in health care delivery | 10 | 15 |
| Awareness | 7 | 12 |
| Sensitization | 2 | 2 |
| Inequality in health care delivery | 3 | 3 |
| Commitment to quality service delivery | 25 | 29 |
| Quality of public health service delivery | 21 | 27 |
| Training and knowledge of service providers | 15 | 15 |
| Public health care service delivery processes | 12 | 19 |
| Workplace policies | 8 | 10 |
| Budgetary allocations | 4 | 4 |
| Medical equipment | 1 | 1 |
| Legal cases | 0 | 0 |

## Theme 1: Accountability—Physicians

### *Accountability in Health Care Delivery*

Most physicians noted that accountability on the part of the physicians especially in the government hospitals has been poor. They cited the running of a private clinic in addition to being a public servant as a big problem. These physicians noted that the wait times and almost no availability of these experienced medical professionals was due to the lack of accountability and the government not living up to expectation. They also noted the inadequate budgetary allocation to the health sector to be a major issue. A physician in Nigeria noted,

> The specialists and consultants especially should be held accountable for their actions. How can they continue to be paid for the services that are rendered very

> poorly or not at all? They leave the younger doctors to work on their own with satisfactory training from the experiences of these knowledgeable professionals and that is why we now have a high rate of mis diagnosis and deaths.

Another physician in Ghana noted,

> It is a very big problem when what you require to work is not always there. The health sector in my opinion is not adequately located funds by the federal government. There is still a lot needed to provide sound public health care but I must commend the current effort though.'

Yet another physician from Nigeria stated,

> How can anyone expect a good service? There is no electricity to power any medical equipment it is so bad that in a particular general hospital, women in labor are asked to bear the cost of diesel used to power the general set. That is even in a hospital with the generator set, the allocation for the health sector should be at least 10% of the yearly budget.

From Côte d'Ivoire, a physician noted,

> No one is more accountable for the smooth delivery of public health care than the government. The politicians have enough money to travel abroad from treatment, it doesn't take much to invest in the health sector through adequate budgetary allocation with an allowance for medication monitoring programs.

A physician in Togo stated,

> Even with the heavy presence of international organizations, we still struggle so much with public health care delivery. We are succeeding in the eradication of some diseases, but other countries had left us far behind a long time ago. It seems

> to be getting worse as electricity is now very epileptic. How can you succeed in medicine in such an environment? Who can afford the cost of medical school? The number of patients are far higher than the doctors available.

A program country representative in Nigeria advised,

> Accountability has actually been a watch word for our program, and it is not party as usual. Our agency demands monitoring, evaluation, and reporting services from the government agencies we work with; items needed are handed over to the government agencies for the implementation of the programs instead of cash which was previously the case. We see a lot of projects getting done with very little to no waste recorded. If we find that compliance is an issue, we terminate the project.

***Partnerships in Health Care***

Most physicians agreed that partnerships, especially with international agencies, have yielded good results, not only in the eradication of malaria and HIV but in enabling those at the helm of affairs to see what is greatly lacking in public health care. These physicians shared the same thoughts as they noted that several guidelines and policies on health care services and public health care delivery had not been reviewed in a very long time and that most recent improved practices and services have only been made possible by the partnership with the private sector and international organizations.

One physician from Côte d'Ivoire noted, "It will be most beneficial to find a suitable form of partnership that lasts longer and will take over the entire public health care system, revamp it, and probably management it ongoing."

Another physician from Togo noted, “Effective collaboration with the private sector and the willingness of all arms of government to fully participate will surely result in a partnership that works. For now, it appears as though we are in a trial phase.”

In Nigeria, a physician noted,

> Partnerships have brought about some interventions which in the truest sense of the word is lacking in most of our primary health care centers and secondary health care centers. They supported massive uptake of immunizations and vaccinations, provision of the gold chain of origin mechanisms. They have also supported with the procurement of equipment and the monitoring and evaluation of policies in different hospitals. Now, the United States Agency for International Development works with government, not the private sector except there are some special interest, but in most instances, their support is for health system strengthening in government facilities. They have done some good job towards achieving universal health coverage in Nigeria, but sustainability remains a very big issue in this country.

A physician from Ghana stated,

> Partnership within in my opinion has not yielded much results, I think it is because there is no clear definition of the partnership but partnership international organizations have promoted even accountability because most of the responses are performance based. The results given as feedback on the project determines whether more support will be provided or not. However, a clear partnership with enough political will to see it through will be most beneficial.

***Risk Sharing in Public Health Care***

The current risk sharing method as noted by key informants is through risk financing in the form of NHIS. They note that the triangular partnership is between the federal government through NHIS, health management organizations (HMOs), and physicians. For private insurance, it is between private insurance companies, HMOs, and physicians and for state governments it is between the state, HMOs, and physicians. Most of these physicians have advised that this type of partnership has not yielded positive results because the terms of engagement are very unclear and the proposed amount for capitation per person, medication coverage, and payment for services have been very unrealistic.

A physician from Nigeria stated,

> The first is government's commitment to the processes and even the policy they have put in place. For instance, in my experience, payment for NHIS services is almost never received; we have to follow up vigorously to get paid and sometimes threaten to stop giving treatment to the patient. It just goes to show that things are not properly planned. At our level, we have not failed because of the prudent use of our finance; people already have had experiences with government policies not standing the test of time. So, it's been really, really challenging in that regard.

A physician from Ghana noted,

> In my opinion, I think the best way to go is for us to create a template for a public–private partnership, involving the community, government, and the private sector. From the community, the government can get to the grassroot to learn of what is really lacking or needed while the private sector bring in their

> management and organizations skills. You know, success can only be guaranteed when you have a robust private partnership in place that manages some of these resources, only very few can pay for a full private health insurance. Another way is to ensure that we have a stronger Primary Health Care System, please. If we do that, we are pretty sure that we would have something that's sustainable.

From Côte d'Ivoire a physician stated,

> No, I don't think that purpose has been achieved yet. Because when you look at it more than 80% of the population is not covered by health insurance. And the National Health Insurance Scheme isn't working. Even NHIS provided medication sometimes are not up to par with those administered to people with private health insurance. So my answer would be no, the partnership isn't working. Again, I take you back to the budget allocation. There is a huge gap there where funding isn't readily available, then imagine what services are available. Sometimes I hear that the health insurance providers are not being paid by employers who take on coverage for their employees as at when due so they in turn owe the HMOs. So it's just a cycle that goes on and on and continues to expand. That cycle of ineffectiveness.

***Risk Governance in Public Health Care***

Most physicians maintained the same view that risk governance in the health care system has no clear guidelines, processes, or implementation methods. They noted that for proper risk sharing and governance, the risks have to first be identified, and they do not believe that any arm of government has succeeded in defining their risks. They noted that the policies in place do not appear to properly identify, assess, manage, or

communicate clearly what the risks in the health sector are and how they will be appropriately handled. A physician from Nigeria stated,

> It appears as though the government expects the physicians to take over the handling of the risks instead of sharing, through proper channels. Those of us who are community health care physicians practically buy what we need for the health centers, but we can only buy what we can afford. Some of the things we use, like stethoscope, are our personal equipment we use in our small clinics, even for sonography, we use ours. We have repeatedly requested for these and more, that would make community health care delivery effective but have not received any positive responses.

In addition to this, a physician from Ghana stated,

> I do not believe that there is a risk sharing or risk governance method in place. It is just business as usual; the government comes up with anything and everyone has to comply. I do not think that the NHIS was thoroughly thought through because it provides very basic coverage and has been abandoned by almost everyone I know or patient that I have treated. The government tries to cut corners as such, only generic brands are sold in the pharmacies to NHIS holders and as we do not even have any review on drugs, we are not even sure of these medications.

From Côte d'Ivoire, a physician agreed and stated,

> Due to the presence of international partners, there are some progress and improvements, but we are still very far from achieving the goals noted in the health policy projects 5 years on. About 70% of the population have no health

> insurance but the government has been talking about implementing health insurance for all (Couverture maladie Universelle) for 10 years now. Still no sensible progress.

A physician in Togo stated, "Apart from the partnership with the international bodies, I do not believe any sensible collaboration within Togo has yielded any positive results. The policy documents are what they are–just documents."

**Theme 2: Institutional changes—Health Care Policymakers**

***Sustainability***

Health care policymakers agreed that sustainability has been an issue in the management of public health services. They noted that many positive changes have been noted in terms of processes, time and resource management, staff training, and compliance. They, however, indicated that it is difficult for such changes to be sustainable because they were mostly experienced by the frontline staff and that it is difficult to have changes go from bottom-up; it should be the other way around for sustainability to occur.

One policymaker from Ghana stated,

> We see changes once our international partners are present and working with us on projects in some of our centers, for example the center for disease and control (CDC); everyone on the project reports to work in good time, stay late to attend to their tasks and generally comply. Once the project is over, just barely 2 weeks on, everyone returns to status quo, I am not sure why this happens all the time. I think we need to look deeply to discover what we need to do right and work with that.

A policymaker from Nigeria echoed the same thoughts by stating,

> Top management need to be involved in some of these projects maybe they will learn one or two things. I know a private physician who told me how he was opportune to an international agency work with him. He had four of their staff working directly from his clinic under his supervision and himself and staff learnt very valuable lessons which has sustained his clinic to date. He said he incorporated the practices and processes into the ethics and standard of his business [clinic], and it has sustained his practice to date. This is because, he, the owner of the clinic was involved.

***Equitable Health Care Delivery***

All policymakers agreed that the delivery of public health care has not been equitable. They noted this lack to be concerned with the lack of planning because all hospitals are concentrated in cities while the rural areas have community health centers, which are barely functional. One policymaker from Togo stated,

> My parents live in the village, so I understand what I am talking about. Some of the health centers are managed by local agencies (like Integrate Health) in partnership with international bodies, otherwise, they will be nonfunctional. Now I am speaking like a member of the public not as a government official. I am hoping that a balanced delivery of health care services will be an actual point for review when the next strategic health plan is to be put in place.

From Côte d'Ivoire, a policymaker advised,

> If it is possible to all politicians receive their cares in government hospitals, I will suggest that is done so that they will face what everyone else faces and maybe

> support that the right thing be done especially for those in the rural areas and third sector. It is easy to write up a policy document but without accurate records or even a national health database to start with, how can we plan properly? Instead of providing data to international organizations, they provide to us. How good or even accurate are those data?

***Political Will***

Some policymakers felt that political will is necessary for policy implementation. They felt that it is one of the reasons why public health care issues have not been fully appreciated. The policymakers noted,

> The political will to provide and ensure that the public health care policy is properly implemented should be present in everyone involved in the process. Unfortunately, some of us engage in the policy making aspect of things but the implementation team may favor a part of the policy to another, so the policy gets implemented in silos. There has to be a keen interest from anyone involved in this process, the attitude of the people who are supposed to push these agendas matters. That could be another reason why most aspects of the health care policy is not being implemented and of quite a low quality.

**Theme 3: Innovative practices**

***Budgetary Allocations***

More than 90% of the policymakers advised this has been an ongoing debate when it comes to health care. They note in agreement with other stakeholders that the budgetary allocation for health care is insignificant for what is needed in the sector. A policymaker in Nigeria advised that

> of the entire budget for the 2021 year, only about 4% was allocated to the health sector, despite the 15% recommended in National Health Act and Abuja Declaration. The focus of this allocation was on strengthening primary health care, but this too has received no boost. Human resource and overall health care delivery teams need to be trained but these too remain unattended.

Similarly, a policymaker in Ghana noted,

> The current 8% budgetary allocation for the health sector is insufficient to cater to all the promises in the health management strategic plan. They added that the cost to ensure universal health care through NHIS, maintain hospitals and cater to the fraud within the system makes the 8% allocation very insignificant.

A policymaker in Togo stated,

> The budget allocation to the health care sector I believe is 11% but that is still not enough, the country's GDP value is less than 2%. So, although our economy continues to grow, we struggle a lot, but we are making use of the partnership with international organizations to provide health care services to the people.

***Standard Fee Guide***

The current fee guide has served as a deterrent to most physicians to desist from providing insurance services to NHIS patients. Unfortunately, the knowledge of this fee guide has informed the private insurance companies to set their own fee for service very low.

Most policymakers who participated in the study noted that they would recommend the review of and proper implementation of a fee guide because that could help curb the very high cost of health care in their countries. They also shared the same

thoughts as they noted that there should be uniformity in how billing is done, especially for physicians providing insurance services and that if not properly handled, there will be high cases of fraud and the cost of health care will remain unnecessarily high.

***Records Keeping***

Policymakers agreed that for policy to be effective and to adequately capture all aspects of a problem, accurate data must be in place. A policymaker in Nigeria noted,

> In Nigeria, there is no reliable records management process for our health care systems apart from paper files or notebooks, at least in our government hospitals. These records either get missing or get destroyed over time and the valuable records are lost, we need a good record managing system to effectively manage information the right way. Most policies are set blindly and that is one reason why the implementation has no effect.

From Ghana, another policymaker noted,

> Ghana is not different from other African countries when it comes to health care services or delivery however, we are slowly embracing the digitalization of health care in Ghana. This is slowly gaining grounds with the use of some hospital administration software or applications, and this has made the management of health records easier. A lot still needs to be done especially in the public sector.

**Theme 4: Health insurance services—Health insurance professionals**

***National Health Insurance Scheme***

Although the health insurance professionals noted NHIS to be a form of universal health care formulated and implemented by nearly all the African countries for the provision of public health care to members of the public, they also perceived that the

intention of the federal governments to make it a risk-sharing method will not achieve the purpose if not carefully reviewed. A health insurance professional in Nigeria stated,

> NHIS has been less effective, and I do not believe that apart from the federal civil servants who have compulsory coverage, that anyone else still uses that service. It states its primary aim is to provide health care to all Nigerians but excludes retirees and other vulnerable groups, babies will only be covered during the postnatal period of 12 weeks from the date of delivery.

A health insurance professional in Ghana also noted,

> This is a forced public–private partnership; you cannot call this a partnership when you are forcefully asking the private sector to bare most of the health care cost for people with coverage under the NHIS. The capitation amount is very low per head because of this, physicians have devised a means to only prescribe generic drugs to those seeking treatment under this scheme. The HMOs are not helpful at all as they perpetuate fraud with their role as the middleman between insurance companies and the health facilities.

A professional from Côte d'Ivoire said,

> I don't see how the NHIS will work properly in the absence of an equitable financial base. Only those with registered income can access coverage under the NHIS but this means only 10% of the population is covered. With a premium of about 1,000 West African Franc per month, however many people can afford that without feeling the pinch? They also said the poor and very low-income earners will benefit from a noncontributory coverage but I am yet to see anyone with such coverage.

***Private Health Insurance***

Health insurance professionals noted that health insurance is a relatively new concept in Africa as a whole, as such they struggle with getting the people to see its usefulness and benefits to them and their family. A health insurer from Ghana noted,

> Health insurance is relatively new but slowly gaining its grounds in Ghana. You know, this has not changed our beliefs in traditional medicine, so it is quite difficult to sell health insurance, another reason being that most of them are foreign owned. Most clients we have are employers who pay a part of the premium for their employees and remit the other part from the employee's salaries. We have a good number of employers do this for their employees, in fact, it is a selling point for every employer now.

From Nigeria, a professional also noted,

> Private health insurance can be very expensive, but this depends on who is purchasing the coverage. It is more affordable if purchased by an employer and premium split between the employer and employee, however, we have other basic coverages that are affordable, and individuals have opted for those ones especially for their aged parents. The downside to health insurance in Nigeria is that you are limited to the physician assigned to you by your HMO which means you pay out of pocket if you are away from your location. In addition, some insurers expect the insured to get a generic drug where available in place of those with brand names. I think these should be checked and properly regulated.

***Insurance Premiums and Funding***

A state health insurance professional in Nigeria noted the following about insurance premium and fundings:

> I could stay 6 months without government remitting deductions from civil servants' salaries or paying a percentage of what is expected of them. Secondly, there is a particular component, we call the equity fund, which covers for vulnerable groups, children under 5 years of age, Plateau residents living with disabilities, internally displaced persons by some form of disasters or crises that have plagued them, the elderly greater than 65 years of age and those who have soft retired, these groups of people are not expected to pay more for the next few years. So what we did was, we used the basic health care provision funded by nothing less than 1% of the consolidated revenue of the federal government, shared amongst the 36 states and FCT. With that, we are able to cover up to 25,000 vulnerable people. Now health insurance, is a very difficult thing to sell in Nigeria. Despite advocacy, townhall meetings between sensitizing, the people do not trust the process. Reasons being that the government has failed them repeated.

From Ghana, a professional noted,

> The premiums are based on the package chosen but the policyholder may be sent for a health examination if required. Insurance premiums are high but most times the premiums are split between an employer and employee. Personal and family coverage are usually cheaper than the corporate package, so this is affordable.

> Overall, private health insurance has been preferred to the NHIS because the private coverage is effective.

From Côte d'Ivoire, a professional also noted,

> Health insurance is available in the country but almost nonexistent if you know what I mean. It is not affordable and will be a waste of money if affordable because the health care system needs to be revamped first before anything else. The health insurance companies experience a very high number of fraud cases and are quite helpless as they cannot verify these claims. The health care system as a whole needs to be fixed for things like insurance to work well.

Another professional in Togo noted,

> We do not have a strong health insurance base in Togo and people are usually advised to visit with possible medications they may need. However, there is the presence of some insurance companies in Togo due to the presence of international health agencies.

For a proper presentation, Table 6 provides a breakdown of the discussed thematic framework: key informants. The table contains the main themes and subthemes and how often they were referenced by the key informants. It also provides a vivid representation of how important these themes were to them.

**Connection to Theoretical Framework**

The data collected and analyzed in this study were examined through Frederich Von Weiser's (1904, as cited in Festré & Garrouste, 2016) institutional theory and Schumpeter's (1942) innovation theory. The adopted structures, processes, cultures, policies, and management systems of the public and private sectors as well as their

**Table 6**

*Thematic Framework: Key Informants*

| Theme | Files | References |
|---|---|---|
| Accountability in health care delivery | 25 | 33 |
| Partnerships in health care | 19 | 28 |
| Risk sharing in public health care | 20 | 19 |
| Financial resources | 1 | 4 |
| Risk governance in health care | 15 | 17 |
| Institutional changes | 22 | 24 |
| Sustainability | 17 | 25 |
| Equitable health care delivery services | 13 | 13 |
| Patient education and awareness | 1 | 1 |
| Political will | 10 | 23 |
| Innovative practices | 17 | 21 |
| Budgetary allocations | 8 | 19 |
| Records keeping | 9 | 27 |
| Standard fee guide | 11 | 17 |
| Health insurance services | 22 | 23 |
| National Health Insurance Scheme | 19 | 25 |
| Private health insurance | 16 | 19 |
| Insurance premiums and funding | 12 | 12 |
| Factors affecting the provision of health insurance | 1 | 6 |

evolution were analyzed to allow for an evaluation of the perception of public health care recipients and key informants in West Africa. Based on the findings, the problem constitutes socioeconomic and environmental conditions that characterize the delivery of public health care. These problems are considered public, requiring government action through the application of appropriate risk assessment and management methods including the review of relevant policies to resolve them. These problems result from dysfunctional public health services that attract public attention. Because the definition of a problem is based upon the understanding of a desired situation, the recipients described their problems based on the experiences and understanding of what an effective public health service should look like and provide, especially the desire for sustainable

positive institutional changes and innovative practices. The recipients in this study elucidated the drivers for health care PPP in West Africa and the need for the review of the health care policies to bring about changes. The key informants, on the other hand, examined the situation in line with the current health care policies and other associated practices to consider policy alternatives. Several possibilities for policy action and inaction were identified, assessed, and narrowed down to suitable options. For this study, the policy actions were narrowed down to the need to sustain institutional changes and innovative practices for better health care delivery services. For the desired changes to be considered, the policy problem should not be perceived differently by the policymakers because this would result in a misinterpretation of the desired policy objective changes that may not be achievable. That is not the case in this study; the policymakers agreed that proper engagement with the health care recipients and effective collaborative processes are necessary for an effective policy change.

The key informants noted that the political will to make or implement a policy change considers the political atmosphere, significance of the issues, and how interested the policymakers and implementers are in the issues raised. As was demonstrated in the findings, governmental officials largely influence and shape policy decisions. The findings show political will as one of the drivers of PPP in public health care delivery. According to J. W. Meyer and Rowan (1977), institutional products, services, techniques, policies, and programs operate as myths, and many organizations adopt them even though conformity to these rules often conflicts with efficiency criteria. Using the normative approach, they note that the best way to understand a political behavior is through a logic of appropriateness acquired in the institution. However, these myths and rules also

influence the conduct of public servants by shaping the imaginations of people about alternatives and solutions that eventually lead to the desire for innovation or change. Change eventually results because of changes from political influence or external factors. However, given the public institution and its structure, innovation dispels what they represent because conformity reinforces the public sector's political legitimacy. On the other hand, values recognized by their environment drive transformation more than instrumental rationalities increase efficiency or effectiveness (Kondra & Hinings, 1998). The findings show that partnership and collaboration are important factors for the desired change and that institutional theory is important in understanding policy processes because it is impossible to proceed without the action of the institutions of government. Therefore, solving the needs of people becomes the collective goal in the policy process just as addressing the social need should be the formal agenda of political and administrative decision makers, and the implementation of the solution must follow the most suitable model to solve the need.

The results of this study confirmed Schumpeter's (1942) assertion that an organization becomes aware of innovation then develops an attitude about it before evaluating it. At the end, the organization decides to acquire the innovation and use it, and once the process is a success, the innovation is accepted and integrated into the organization. Some participants talked about the notable positive changes in the private health care delivery system and compared the ability to sustain such changes with the inability of the public sector to do the same:

> Top management need to be involved in some of these projects maybe they will learn one or two things. I know a private physician who told me how he was

> opportune to an international agency work with him. He had four of their staff working directly from his clinic under his supervision and himself and staff learnt very valuable lessons which has sustained his clinic to date. He said he incorporated the practices and processes into the ethics and standard of his business [clinic], and it has sustained his practice to date. This is because, he, the owner of the clinic was involved.

This means that with the right processes and policies in place, a proper risk management framework can be drawn to assist in the implementation of the needed changes as well as sustaining the changes.

## Summary

This chapter presented the research findings obtained through an analysis of the 5-year health strategic management plans for Nigeria, Ghana, Côte d'Ivoire, and Togo as well as the interview with recipients and key informants. The first part of the chapter detailed how the policy implementation measures have affected the quality of public health care delivery services for the recipients. This document analysis focused on the main aims and objectives of the health strategic management plans and the implication for public health care delivery. The second part of the chapter examined the experiences of recipients of public health care services in those countries and the perception of key informants related to the public sector structure, processes, and policies as well as the desired changes.

The chapter concluded with a discussion of the findings of this study from the institutional theory and innovation theory perspective. Chapter 5 explains what the key

findings are with a recommendation to improving the public health care delivery system in West Africa.

# CHAPTER 5: FINDINGS, CONCLUSIONS, AND RECOMMENDATIONS

The purpose of the study was to analyze the risk sharing and governance in the West African public health system while focusing on health care PPP drivers through a critical analysis of the approach to health care PPPs in West Africa. Thus, the study aimed to make an original contribution to the field of study and inform on the matter, with the hope of improving the public health sector toward a robust and reliable sector, delivering innovative, affordable, and quality health care services to all West Africans regardless of their social status. To meet the aim and objectives of the study, the following research questions were investigated with an attempt to provide suitable answers: "What are the drivers of PPP in the public health delivery systems in West Africa?" and "What enhancements can successful PPPs contribute toward the delivery of public health services in West Africa?"

To this end, the qualitative research method with a phenomenological approach was applied, and open-ended, semistructured interviews with recipients and key informants from Nigeria, Ghana, Côte d'Ivoire, and Togo were conducted. Secondary data were obtained from the 5-year health strategic management plan for each country and from relevant literature in the field.

## Major Findings

### Findings: Research Question 1

The current method of risk sharing and governance through PPP in West Africa has promoted an ineffective and inefficient public health care delivery system. The risk financing method through the NHIS and/or private insurance has also not provided the needed relief in that regard. The recipients noted that although the service delivery in the

private hospitals and clinics are more effective, less time consuming, and a better value for money compared with the services at the government hospitals, this private health care delivery remains outside the reach of the recipients. Such experiences provided valuable findings on the drivers of health care PPP in West Africa. These drivers of PPP are expressed in the types of concerns the recipients have from their experiences while receiving public health care services and their perception of the implications of these concerns on their immediate community. Accordingly, it was noted that each 5 years health strategic management plan had solutions that have not been met because of improper risk assessment and ultimately, the lack of a robust risk management framework in the public service delivery of health care. The key findings are illustrated in the Figure 6 and are discussed under headings that better capture the research findings for Research Question 1.

***Physical Environment (Locality)***

Each participant confirmed that one's physical environment is crucial to determine the type of health care service to be received. Participants in the rural areas confirmed the community health centers in the localities were almost nonfunctional and not as portrayed. They noted that recipients in the rural areas had no insurance and must travel many miles to get a proper medical center manned by qualified medial professional and furnished with health equipment. They noted that no form of partnership exists in their locality for the delivery of public health care services. Given that PPP project assessments should include the proper assessments of the location or localities of such projects, it does not appear as though the physical environments were considered when listing the solutions to public health care in West Africa. Xiong et al. (2015) noted that

for properly considered PPP projects, the private sector demands adequate guarantees for suitable profit because of the long-term period of financing and high sums of investment required, and because the consumers want cost-effective public goods and services, the public sector must be seen to be increasing value for money. A thorough analysis of all aspects of the projects including the assessment of the physical environment is required.

**Figure 6**

*Drivers of PPP in the West African Public Health Sector*


***Socioeconomic Environment***

The study revealed that the socioeconomic environment of each recipient determined what level of public health care was available to them. However, the reason for the establishment of the NHIS by the governments was for all residents to have access to affordable public health care at any level. Unfortunately, this method of PPP has not

carefully considered the economy in full and in relation to the employment status of the recipients, which also reflects the current cost of living and the resource economy. In addition, the population in each location versus the available manpower and infrastructure did not appear to have been properly assessed, and last, the personal, family, and community life such as community health, culture, and travel access to functioning public health facilities were not considered. As a result, this factor has greatly affected the level and quality of public health care services provided and received.

***Health Care Operations***

Most recipients confirmed that the mode of operation of public health facilities when compared to the private hospitals or clinics were not up to par. This study revealed that public health care service providers lacked empathy and respect for health care recipients. They also were lacking in providing efficient and effective health services because of distractions by private businesses or the lack of responsibility toward their duties as public servants, which include serving the populace. Most recipients confirmed that doctors in the government hospitals do not keep to time and lack the ability and patience to clearly explain a patient's ailment and the effect to them. This finding also revealed that with better services from the private sector, a partnership between the public and private sector would help to improve public health service delivery.

***Inequality in Health Care***

Another driver of PPP in the sector is the need to bridge the gap currently widened by public health care. Although the key reason for the establishment of the NHIS was to provide universal healthcare coverage to all residents, the aged, retired, and other vulnerable groups have been excluded from healthcare coverage under this scheme.

The study noted briefly that in Nigeria, there is state social insurance coverage established by state governments in 2018 that will include care for this set of people, but it is not fully operational in all the states of the country. However, this insurance has also not been effective because no recipient made mention of this coverage or service. Although those employed in white-collar jobs enjoy the benefits of copayment of private insurance coverage with their employers, the unemployed, small business owners, the retired, and other vulnerable groups continue to pay out of pocket for their health care needs. This is another indicator that the current PPP model is unsuitable for the delivery of health care services in West Africa.

***Access to Public Health Care***

With all the public hospitals being in the cities and major towns, it is impossible for the rural dwellers to have proper access to improved healthcare. The study revealed that recipients in the rural areas must travel long distances to access public health, and most times they spend days outside their homes either with relatives or at the hospitals to enable them to receive the health care service that they need. They sometimes request for early discharge from hospitals for fear of not being capable to afford the increasing medical bills. Besides the rural dwellers, residents in the urban areas who receive medical care by choice or compulsion (health care in government hospitals costs less) through the public sector noted that they either have to take the whole day off work, work excess hours to make up for the time they spent at the hospital, or simply risk not getting paid for the day. They attribute this to the inefficient service in the government hospitals; first they have to queue hours on end to get their paper files, and if they are unlucky, they get to the end of the queue to discover their files were missing. Then they must queue to

get new files, after which they must wait for the doctor to attend to them. This study revealed that processes and procedures toward the delivery of health care services are better in the private hospitals or clinics and that a properly assessed model of partnership between both sectors while considering the factors that affect the delivery of such services to the recipients is desirable.

***Accountability and Affordability***

Accountability is a strong goal and requirement for the delivery of public service, the absence of which can cause significant lack of trust and reputational damage to any government. Accountability encourages transparency, efficiency, and effectiveness for the greater good of all. This study revealed the importance of accountability in health as it relates to ethical accountability, quality of care, and the risks on the lives of recipients as they have to travel many miles in their state of health to access public health care services. In addition, the study revealed the lack of professional accountability by the doctors as they regularly arrive 1 to 2 hr late for their scheduled appointment and are sometimes in their private practice or attending consultations for their private gains during working hours. Some recipients noted that they preferred attending the private hospitals or clinics despite the high cost of service because they were assured of quality health care services. They noted that the private hospitals get the specialists or consultants for consultation with their patients at an additional cost, but this practice eliminates the wait times and ineffective services at the government hospitals. Another factor is the lack of some medical equipment at the government hospitals and those available are either not properly maintained and thus nonfunctional or are not up to date. These factors indicate poor management systems in government hospitals but also prove

that PPP is able to restore accountability in the provision and delivery of public health care services. A model that considers the factors necessary for an effective collaboration would be most suitable.

**Findings: Research Question 2**

Following the findings relating to Research Question 1, key informants provided their opinion related to Research Question 2. As the key informants were physicians, policymakers, and health insurance professionals, they gave their opinions based on their roles and knowledge on public health care delivery in West Africa. They elaborated on the current risk sharing and governance methods, the partnership between the government and private sectors like the HMOs, and physicians as well as the enhancements that successful PPPs have contributed toward the delivery of public health services in West Africa. The findings from these interviews revealed that successful PPPs have led to institutional changes and innovative practices; however, these have not been sustained. They argued that the reason for the issues with sustainability is that the changes occurred at the bottom and were expected to effect positive changes at the management level, but that did not occur. Although the bottom-top approach has been said to be very effective for the inclusion of rank and file in decision making, the public service appears to be different. This section discusses in detail the findings based on the interviews with key informants using suitable headings that capture the key points of the findings.

***Institutional Changes***

The key informants noted that it was possible for positive changes to occur in the public health care sector. According to Nahmias et al. (2010), organizational changes are triggered by internal and/or external factors and come in all shapes, forms, and sizes,

affecting all organizations in all industries. Accordingly, change has to be defined in a context, and "this context can be the combination of multilayered, two-way influences, multiple stakeholders with interpretative schemes, innovation seeking behavior by individuals and groups, and differing absorptive capacity in organizations that produces a situation in which context is an actor" (Fitzgerald et al., 2002, p. 215). As such, and in the context of this study, the context of this change is one that encompasses organizational structure, corporate culture, history, and political factors affecting the achievement of change (Pettigrew et al., 1992). The key informants noted that in the public health sector, the factors that make change not only desirable but inevitable are technological, economic, political, social, legal, and other market factors that drive change. They added that notable changes occur during project partnerships with international agencies; however, the changes were not sustained. These changes caused a brief transformation not only in their daily processes and procedures, but also in their attitude toward increased responsibility and accountability for the public to whom they owe these services. Therefore, it is possible for change to occur, and such occurrences can be sustainable if change occurs in the right context. This supports the view that institutional theory focuses on the roles of social, political, and economic systems in which organizations operate and gain their legitimacy as entities. Because institutions create their rules, processes, and procedures, they can also define ways to either encourage, discourage, or even ignore certain patterns that may lead to positive or negative change. Some suggestions on how these desired positive changes can be incorporated in the public health systems and sustained are discussed in the following sections.

### *Private Institutions Head Some Governmental Institutions*

Change in the public health sector can occur and be sustainable through an integrated PPP model. In this case, the CEOs of a private hospital can head a government hospital for the introduction of new management practices and cultures. This way, the entire governmental institution will partake in the change and learn to embrace it for sustainability to occur. Harris et al. (2012) noted that institutional change can be slow and stately, but it can sometimes break with the past and respond quickly to the changing circumstances.

### *Structural Overlap Can Be Beneficial*

This overlap can be beneficial in the effective delivery of public health care services. With the boundary between the not-for-profit, private, and public sectors getting increasingly thin, it could be beneficial for the public sector to engage the knowledge and expertise of these other sectors. It would also be beneficial in positively transforming old practices that are now obsolete.

### *Policy Reforms*

Changes of this nature, and in this case in the public health care sector, are necessitated by the changing public expectations. It appears that although most policy changes or reforms have been synonymous with cutbacks on government expenditures and a freeze on employment in the public sector, they can also benefit the economy by reducing medical cost if a participatory planning process is put in place.

### *Decentralization of Management Activities*

In West Africa, all political decisions and functions are carried out in the capital city, and in most cases the nation's capital, and this includes public health care. For

health care to be effectively delivered and accessible to all, political functions and officials need to be brought closer to the people. This should increase accountability and discipline in the government hospitals.

### *Sustainability*

For changes to be sustainable, an organization must learn to respond to both the internal and external changes. Flugge (2022) noted that sustainability requires new forms of governance that engages all stakeholders and those entwined factors. It should not only be about adhering to a set of policies but also about implementing a change if needed.

## Innovative Practices

The other key finding from the engagement of key informants is the lack of innovative practices in the West African public health sector. Public health care delivery in West Africa has been characterized by the use of obsolete practices and even medical equipment that, according to the interview participants, has either led to misdiagnoses leading to deaths or inefficiency in service delivery and the inequitable distribution of the public services. The key points based on the research finding that highlight the lack of innovation in the West African public health sector, which if implemented can result in an efficient service delivery, are discussed in the following sections.

### *Central Health Care Database*

In West Africa, no country boasts of a central database for health care. Therefore, requesting previous health records for health claims management and adjudication is almost an impossible task. Similarly, the health care professionals cited their inability to properly class health risks as health records of recipients seeking coverage are either lost

or simply unavailable. The cost of a medical test prior to acceptance becomes an issue because a comprehensive test for the review of coverage eligibility is neither covered under a private insurance coverage nor is it covered by NHIS.

***Effective Records Management***

The findings in this research point to the fact that health care records, especially in the public health sector, are still stored in paper files, and many have experienced the risk of their paper files getting lost with no other backup to their medical records. The study revealed that recipients are forced to bear the cost of new files as well as the unaccounted loss of their medical records. Although Ghana is in the process of digitalizing their public health sector, it has a long way to go in accomplishing that feat.

***Risk Assessments***

The key informants all agreed that a proper risk assessment was not carried out before the hasty implementation of the NHIS, hence its ongoing problems. They noted that the risk-sharing method in place has been anything but effective given that health care delivery in West Africa remains a huge task to be successfully accomplished. The key informants indicated in their responses that the NHIS did not provide coverage enough to attract the populace and that the process and terms were quite unclear to the people. In another light, the fee guide for payment to HMO physicians is outdated because it has not been reviewed since 2006. The other risk factor that was not properly assessed prior to the NHIS implementation was the service delivery to the rural areas. The key informants and even recipients noted that the community health centers did not function as portrayed and that no equipment or medical personal are available when help is needed. Based on these findings, a proper risk assessment and management framework

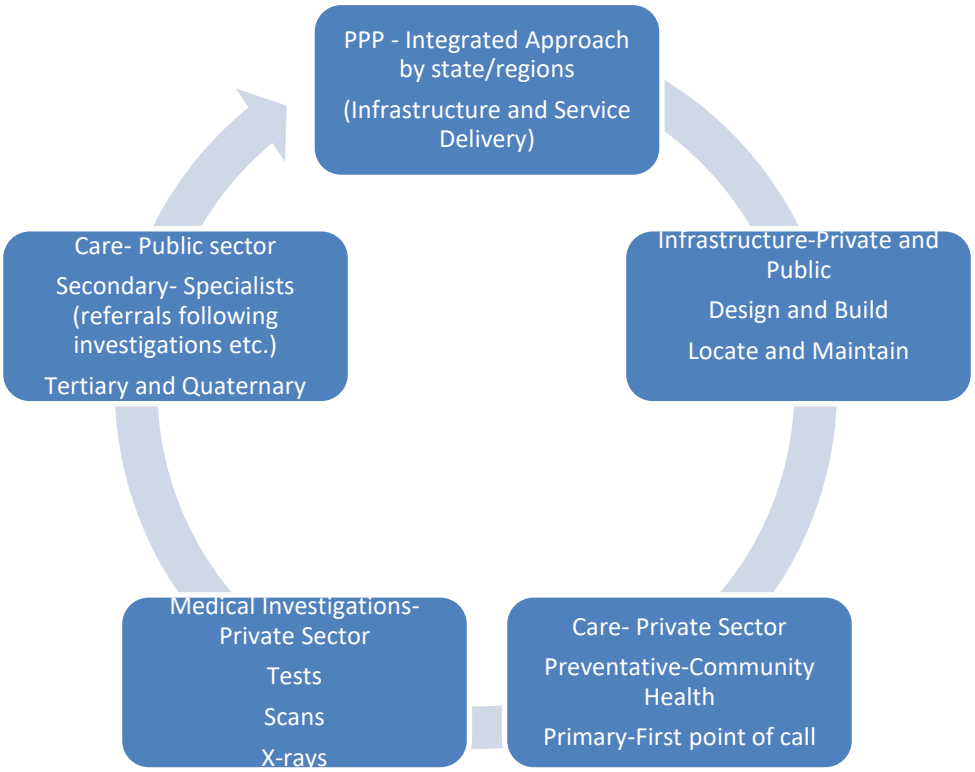
is needed. Also needed is the right model for the implementation of PPP and for the PPP to be successful.

## Recommendations

Based on the discussed findings and the implication for health care service recipients in West Africa, it remains unclear what PPP models are in use in West Africa. However, the study revealed that the NHIS was implemented to make public health care to all recipients accessible and affordable, to reduce health care expenditure on the part of the government, and to reduce out-of-pocket expenses for the recipients. In addition, the structure of the NHIS is such that the registration of recipients is carried out by a government agency, and the sourcing and assignment of a physician to corporate bodies or individuals are executed by the HMOs. Based on this, it appears that the PPP model in use in West Africa is the discrete clinical services model. This model specifically is for the expansion of service delivery capacity. The study also reveals that this model has been less than effective and has defeated the aim of the NHIS. As a result of the research findings, a suitable model of an integrated PPP model that would provide a comprehensive package of infrastructure and service delivery is recommended in addition to the continual monitoring of the risks associated with the public health care delivery. The model is illustrated in Figure 7.

**Figure 7**

*Suggested Integrated PPP Model for West African Public Health Sector*




This PPP model shows the integration of both the public and private sectors with possible overlapping functions in the infrastructure building, design, location, and maintenance of the facility. It moves on to a distinction in health care services in which the community, primary health care and referral for medical investigations services, and the running of the facility are handled by the private sector. Upon completion of the medical investigation and if the secondary care is required, a referral to the specialist would be completed by the primary care physician. The line of communication remains open between both physicians so that upon completion of secondary care, the patient can be returned to their primary care giver. In the case of a referral to the tertiary care, the

patient remains with the public sector until care is complete prior to returning to their primary care giver. This model should bring about the needed institutional change as well as the needed innovative practices for an effective public health care delivery service in West Africa.

Although the implementation of a PPP model and the execution of PPP projects commonly apply an economic approach, this study has not approached PPP from the angle of an economy model. However, it takes into account the effect of proper risk sharing and governance through a suitable PPP model in West Africa. A successful PPP project should meet the objectives and anticipation of most stakeholders, including the end users. Additionally, different stakeholders would recognize project success from different viewpoints while looking for the benefits. For these reasons, it is recommended to build comprehensive indicators to evaluate PPP project performance that can reflect most stakeholders' opinions and what types of projects can be regarded as successful. The suggested PPP model—integrated model approach—can be measured for suitability and validity through decentralization of public health care management, monitoring and evaluation of the PPP projects, adequate risk assessment and management, human resource management, accessibility to public health care by recipients, and affordability of the services provided.

**Decentralization of Public Health Care Management**

Currently, the provision of public health care in the West African region is managed from the capital cities, either with all the staff of NHIS operating from the capital city or employed to the capital city and redeployed to different states/regions. Although this practice appears to provide cost efficiency, ease of management, and

uniformity in action, it promotes personal leadership for projects that take place in different cities, therefore making it ineffective in most cases. On the other hand, decentralization promotes relief to top executives who are already responsible for the entire decision making and running of the institution. It provides motivation to subordinates to improve work performance, properly monitor and control onsite projects, and to afford the institution closeness to the end users in the localities where the projects are sited. Overall, the decentralization of governance strengthens the local governing capacity, especially with the growing distrust of government and the ineffectiveness of centralized government as revealed by the study. The decentralization of public health care in West Africa is a move toward a source of local accountability, affording the citizens and the private sector in each part of the countries an equal opportunity to participate in governance, and for a fair distribution of well-equipped and professionally manned health care facilities in the urban and rural areas.

**PPP Project Management**

PPP projects may take many years to be completed or make their impact felt, so a well-defined scope for the PPP project and the proper understanding of the project cycle are required from all parties. This would reduce the likelihood of risks associated with incomplete and improper scope definition affecting project completion. In addition, communication between all stakeholders is encouraged at all stages, especially the end users. Because of the nature of PPP projects (involving the public sector), stakeholders may include communities, labor unions, regulatory agencies, political party leaders, and monitoring agencies among others. The management of these stakeholders requires adequate and timely communication, the identification and assessment of their influences

and interests, and an understanding of how to engage them to get them to see past their current interest level to the desired interest level. Ultimately, to bring PPP project to desired conclusions, the monitoring and evaluation of the projects by all stakeholders in their varying capacities would enable transparency and accountability during the project life cycle and even after project completion and delivery.

**Human Resource Management**

The proper management of human resources would provide a success base for the suggested model. The study revealed the poor level of service from government hospital staff and in some cases from the doctors; it is therefore imperative that proper training of the public health delivery staff is implemented. In most West African government hospitals, the hospital administrators or heads are physicians with no management knowledge or experience. It is important that these positions across all countries be adequately manned like in the private clinics where an actual health care administrator with the desired education and experience works. In addition, the recommended PPP model allows for the proper use of each human resource capacity, which means the general practitioners are occupied with the community (in partnership with appropriate agencies as available) and primary health care; this affords the specialists and consultants the grounds to improve their knowledge and be competitive like their counterparts the world over in terms of ongoing research and health care treatment innovations.

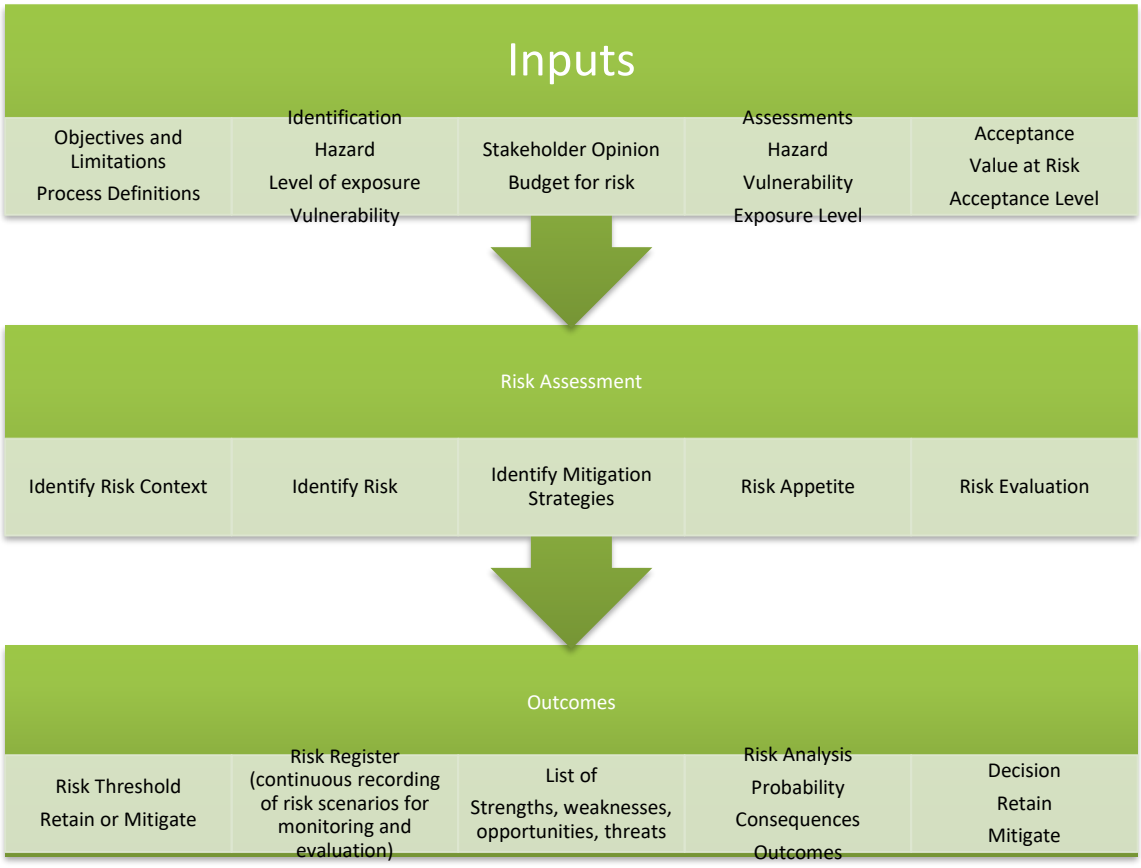
**Risk Assessment and Management**

The proper assessment and management of risks in public health care in West Africa is most desirable. Risks identification, analysis, response, and ongoing monitoring at the PPP infrastructure building and delivery stage and the service delivery stage are

highly recommended for proper and effective public health care delivery. A proper risk assessment process would not only help with mitigating the negative impacts of risks on the project, the budget, or completion date but also with creating a risk register for ongoing risk assessment and monitoring. Accessibility, affordability, effectiveness, and efficiency in the delivery of public health care becomes possible with proper risk assessments, especially in the rural areas. A recommended risk management framework for the suggested PPP model is noted in Figure 8.

**Figure 8**

*Risk Management Framework for Public Health Care Sectors in West Africa*



## Conclusions

This qualitative study was conducted to examine the risk sharing and risk governance through PPP in the West African public health system while focusing on the drivers of PPP in the sector through a critical analysis of the approach to PPPs in West Africa. I explored the perceptions of health care recipients and key informants in West Africa while taking the content 5-year health strategic management plan into consideration. I interviewed a total of 64 participants residing in both urban and rural areas in Nigeria, Ghana, Côte d'Ivoire, and Togo. The breakdown of the participants was10 recipients for each country: two HMO physicians, two health insurance professionals, and two policymakers from each country. The findings of the study revealed that although the NHIS was established to reduce out-of-pocket health care expenditure, the concept has been flawed because it resulted in increased health care spending to most people, especially those in the rural areas. A major finding was concerning access to health care services. There was a lack of the provision of services and access to health care services in the rural areas, and recipients were required to travel many miles to health care facilities in major cities or towns. Additionally, government hospitals are less equipped and with outdated medical equipment. Participants' perceptions were that the health strategic management plan was well written on paper but did not translate to what they currently experience. Overall, there was consensus among all participants that the health strategic management plans were well-drafted but did not address the issues at hand and that the model of PPP currently in place for risk sharing and governance was not effective. The study suggested a robust model—integrated PPP

model—for the effective delivery of health care services in the West African public health sector.

## Implications for Action

The findings from this study could help improve the quality of health care services provided to service recipients in the West African region. The results revealed that it is possible to have institutional changes and innovative practices in the public health sector and sustain any positive changes. However, the current PPP model appears unsuitable, and because it is not effective, a more robust and suitable PPP model for an effective health care delivery has been suggested. To continue to experience success in the public health sector in West Africa through the use of the suggested model, it is advisable that the developed risk management framework which considers all functions of the public health system, be used continuously. A continuous use and monitoring of the risk factors will assist in the proper assessment of public health delivery risks. The themes that emerged from the study might help direct efforts to tailor the policy objectives to the specific needs of public health service recipients.

## Recommendations for Further Research

Following the results of this study, the following are the recommendations for further research:

1. It is recommended that the suggested PPP model be tested for suitability, implementation, and sustainability in the West African health sector.
2. It is recommended that further research be carried out on the new state or regional health care coverage to ascertain coverage for the retired and vulnerable group of people who remain without any health care coverage at this time unless they pay

out of pocket, which is almost impossible given the cost and their meagre pension or allowances if any.

## Concluding Remarks and Reflections

The research process was challenging yet fulfilling. This research revealed major findings with relation to the West African public health sector. The findings revealed access to health care services in the rural areas is a major challenge, and a policy change or reform is needed. It was interesting to note that all countries in the West African region experience approximately the same thing daily when it comes to health care provision and delivery. It was also sad to note that the poor management of government hospitals and the resultant lack of medical equipment have caused families to lose their loved ones to conditions that may have been treatable. Owing to these challenges and families' experiences, the perception of the health strategic plan and the implementation of the NHIS coverage remain negative.

Another crucial point to note from the findings is that institutional changes in the public sector are achievable as well as sustainable. Positive changes can result in economic gains for both the individuals and government alike; this is achievable where government institutions adequately respond to internal and external changes. In addition to this, appropriate risk assessment with clear goals and desired outcomes prior to partnership can result in innovation in public health care. The study afforded me the opportunity to review the current risk-sharing and governance methods in the West African public health sector, assess the risks of the method and current PPP model, and suggest a PPP model that appears to be best suited for the health care situation in West Africa. Although this research was challenging because of the amount of information

that needed to be analyzed, it was equally gratifying for the contribution made to the field of public administration and risk management. My expectation is that this research will be utilized to effect the needed institutional change and for the implementation of innovative practices in the delivery of health care services and to effect a lasting risk management framework for the sector.

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# APPENDICES

APPENDIXA

**Script to Recruit and Secure Consent to Participate in Research**

Interviewer (I): May I please speak to [potential participant]?

Participant (P): Hello, [potential participant] speaking. How may I help you?

I: My name is [Arit Asamudo] and I am a Doctoral student in the department of public administration at California Baptist University. I am currently conducting research under the supervision of Dr. O. McKinney with the title as Risk Sharing and Governance through Public Private Partnerships in Africa: Evaluating the West African public health sector experience. As part of my thesis research, I am conducting interviews with residents and professionals such as physicians, insurance professionals, and policymakers to discover their perspectives on the effectiveness and efficiency or the lack thereof, of public health care delivery in West Africa.

I will be undertaking interviews starting on xxxxxxxxxxxxxxxxxxxx.

The interview would last about 45 minutes and would be arranged for a time convenient to your schedule.

Involvement in this interview is entirely voluntary and there are no known or anticipated risks to participation in this study.

The questions are quite general (for example, what experience do you have of the public health service?) and you may decline to answer any of the interview questions you do not wish to answer and may terminate the interview at any time.

With your permission, the interview will be recorded to facilitate collection of information, and later transcribed for analysis. The data collected will be kept in a secure

location and disposed of within 2 years. All information you provide will be considered confidential.

I would like to assure you that this study has been reviewed by the California Baptist University Research Ethics Board for compliance with federal guidelines for human research. If you have any questions about your rights as a research participant or for additional information on participation, please let me know or contact my supervisor at xxxxx@xxxxx.xxx. The final decision about participation is yours.

APPENDIXB

## Interview Guide Questionnaire

My name is [Arit Asamudo] and I am a Doctoral student in the department of public administration at California Baptist University. I am currently conducting research under the supervision of Dr. O. McKinney with the title as Risk Sharing and Governance through Public Private Partnerships in Africa: Evaluating the West African public health sector experience. As part of my thesis research, I am looking to discover your perspectives on the effectiveness/ineffectiveness of public health care delivery in West Africa, through an interview. The interview should take about 30 minutes in total.

The questionnaire is a guide to the interview and should take you about 15 minutes to read through as well as help you make an informed decision regarding your participation. Involvement in this process is entirely voluntary and there are no known or anticipated risks to participation in this study. The questions are quite general and you may decline to answer any of the questions you do not wish to answer. For the purpose of this interview, University teaching hospitals and General hospitals are referred to as government-run hospitals.

All information you provide will be considered confidential and a random number will be assigned to you to conceal your identity. The data collected will be kept in a secure location and disposed of within 2 years. If you have any questions regarding this study or would like additional information to assist you in reaching a decision about participation, please feel free to contact Dr. McKinney via email at xxxxx@xxxxx.xxx. The final decision about participation is yours.

I would like to assure you that this study has been reviewed by the California Baptist University Research Ethics Board for compliance with federal guidelines for human research.

After all the data have been analyzed, you will receive an executive summary of the research results.

1. Do you identify as male or female?
2. What is your age?
3. Do you mostly go to a government-run or private hospital for your health care needs? Please provide the reason for your choice.
4. Overall, are the services at government-run hospitals better and timely compared with the private hospitals? Why do you think so?
5. Have you been referred to a private hospital from a government-run hospital or vice versa?
6. Were you referred due to the lack of a medical equipment (MRI/Scanning Machines) or the lack the health care professional for the type of care needed?
7. Would you say the government-run hospitals are better equipped with up-to-date medical equipment and reliable health care professionals than the private hospitals? Why do you say so?
8. Do you go to a government-run or private hospital for specialist care? Please provide your response and why.
9. Based on your visits to both governments run and private hospitals, how are your personal data stored/retrieved?
10. Do you live in the rural or urban area?

11. Do you think that your locality affects the quality of healthcare services that you receive?
12. Have health care services including specialist care been accessible, affordable and effective? Please advise how.
13. How do you pay for your medical needs or are you covered by insurance?
14. Have you ever been denied medical services? If yes, please provide brief details as to why.
15. Does your health insurance cover all your health care needs including specialist care (oncologist, gynecologist, cardiologist, nephrologist)?
16. Do you think that the provision and delivery of health care services can be improved upon? If "Yes," what improvements would those be?

APPENDIXC

## Interview Questions

### Physicians

1. Do you work strictly in the government hospitals/private or both?
2. What notable differences are there between the way health care services are delivered in the private and government hospitals?
3. Which would you say is better equipped in terms of up-to-date medical equipment?
4. Would you say government-run hospitals lack good management? If yes, why do you think so?
5. Do you think that partnerships between international organizations for example United States Agency for International Development (USAID) has led to institutional changes and innovative practices within the public health sector? Please provide some explanations/examples based on your answer.
6. Have partnerships such as noted above promoted or blurred accountability in the public health sector?
7. Given the drive to provide universal health care by the government, would you say that the partnership between the government, health insurance providers and physicians has achieved its purpose? Please provide reasons for your answers.
8. Have government health care policies on service delivery been effective/efficient?
9. What improvements would you like to see that would be beneficial for all concerned including those who seek medical care?

**Policymakers**

1. Given the health management strategic plan (2018-2022) found in the country's ministry of health website, would you say that the objectives of the plan have been met/are being met?
2. If no, what do you believe the hinderances to be?
3. Have partnerships between international organizations like that with United States Agency for International Development led to institutional changes and innovative practices within the public health sector? Please provide reasons for your answers.
4. Given the drive to provide universal health care by the government, would you say that the partnership between the government, health insurance providers and physicians has achieved its purpose? Please provide reasons for your answers.
5. Do you think that the policies on the current risk sharing methods especially public private partnerships need to be reviewed?
6. How often are policies on ethics in the public health sector reviewed?
7. In your opinion has the role of risk governance in public health delivery been efficient and effective?
8. Is the input of all stakeholders sought when formulating health care policies?
9. In your opinion are these inputs reflected in the health management policies made?
10. Given the current National Health Insurance Scheme, is there any encouragement for the government-run hospitals to be utilized in the provision of insured health care services?

**Health insurance professionals**

1. Given the drive to provide universal health care by the government, would you say that the partnership between the government, health insurance providers and physicians has been effective? Please provide reasons for your answers.
2. What has been (if any) the greatest hinderance to the provision of health insurance coverage?
3. Have you had to refuse health care services to recipients? If so, why?
4. Have the current government policies on health care provision and delivery been helpful in the provision of health insurance coverage?
5. Will innovative practices (improved records management, improved timeline for reporting and a single database for healthcare professionals) allow for a faster provision of insurance coverage and reduce the imminent bureaucracy within the public private partnership?

APPENDIXD

**Script Pour Recriuter et Obtenir Consentment Pour Participer a la Recherche**

Intervieweur (I) : Puis-je parler à [participant potentiel]?

Participant (P) : Bonjour, [participant potentiel] parlant. Comment puis-je vous aider ?

I: Je m'appelle [Arit Asamudo] et je suis doctorante au département d'administration publique de la California Baptist Université. Je mène actuellement des recherches sous la supervision du Dr O. McKinney sous le titre de Partage des risques et gouvernance par le biais de partenariats public-privé en Afrique: évaluation de l'expérience du secteur de la santé publique en Afrique de l'Ouest. Dans le cadre de ma recherche de thèse, je mène des entretiens avec des résidents et des professionnels tels que des médecins, des professionnels de l'assurance et des décideurs politiques pour découvrir leurs points de vue sur l'efficacité et l'efficience ou l'absence d'efficacité de la prestation des soins de santé publique en Afrique de l'Ouest.

J'entreprendrai des entrevues à partir de xxxxxxxxxxxx.

L'entrevue durerait environ 45 minutes et serait organisée pour une heure convenant à votre emploi du temps.

La participation à cette entrevue est entièrement volontaire et il n'y a aucun risque connu ou prévu pour la participation à cette étude.

Les questions sont assez générales (par exemple, quelle expérience avez-vous du service de santé publique ?) et vous pouvez refuser de répondre à toutes les questions d'entrevue auxquelles vous ne souhaitez pas répondre et peut mettre fin à l'entrevue à tout moment.

Avec votre permission, l'entrevue sera enregistrée pour faciliter la collecte d'informations, puis transcrite pour analyse. Les données collectées seront conservées

dans un endroit sécurisé et éliminées dans un délai de 2 ans. Toutes les informations que vous fournissez seront considérées comme confidentielles.

Je tiens à vous assurer que cette étude a été examinée par le Comité d'éthique de la recherche de l'Université baptiste de Californie pour s'assurer qu'elle est conforme aux directives fédérales pour la recherche humaine. Si vous avez des questions sur vos droits en tant que participant à la recherche ou pour obtenir des renseignements supplémentaires sur la participation, veuillez me le faire savoir ou communiquer avec mon superviseur à xxxxx@xxxxx.xxx. La décision finale concernant la participation vous appartient.

APPENDIXE

## Questionnaire du Guide D'Entrevue

Je m'appelle [Arit Asamudo] et je suis doctorante au département d'administration publique de la California Baptist University. Je mène actuellement des recherches sous la supervision du Dr O. McKinney sous le titre de Partage des risques et gouvernance par le biais de partenariats public-privé en Afrique : évaluation de l'expérience du secteur de la santé publique en Afrique de l'Ouest. Dans le cadre de ma recherche de thèse, je cherche à découvrir vos points de vue sur l'efficacité / inefficacité de la prestation des soins de santé publique en Afrique de l'Ouest, à travers une interview. L'entrevue devrait durer environ 30 minutes au total.

Le questionnaire est un guide de l'entrevue et vous prend environ 15 minutes à lire et vous aide à prendre une décision éclairée concernant votre participation. La participation à ce processus est entièrement volontaire et il n'y a aucun risque connu ou prévu pour la participation à cette étude. Les questions sont assez générales et vous pouvez refuser de répondre à toutes les questions auxquelles vous ne souhaitez pas répondre. Aux fins de cette entrevue, les hôpitaux universitaires et les hôpitaux généraux sont appelés hôpitaux gérés par le gouvernement.

Toutes les informations que vous fournissez seront considérées comme confidentielles et un numéro aléatoire vous sera attribué pour dissimuler votre identité. Les données collectées seront conservées dans un endroit sécurisé et éliminées dans un délai de 2 ans. Si vous avez des questions concernant cette étude ou si vous souhaitez obtenir des renseignements supplémentaires pour vous aider à prendre une décision concernant la participation, n'hésitez pas à communiquer avec le Dr McKinney par

courriel à xxxxx@xxxxx.xxx. La décision finale concernant la participation vous appartient.

Je tiens à vous assurer que cette étude a été examinée par le Comité d'éthique de la recherche de l'Université baptiste de Californie pour s'assurer qu'elle est conforme aux directives fédérales pour la recherche humaine.

Une fois toutes les données analysées, vous recevrez un résumé des résultats de la recherche.

1. Vous identifiez-vous comme homme ou femme ?
2. Quel est votre âge ?
3. Allez-vous principalement dans un hôpital géré par le gouvernement ou privé pour vos besoins en matière de soins de santé ? Veuillez indiquer la raison de votre choix.
4. Dans l'ensemble, les services des hôpitaux gérés par le gouvernement sont-ils meilleurs et opportuns par rapport aux hôpitaux privés ? Pourquoi pensez-vous que c'est le cas ?
5. Avez-vous été référé par un hôpital privé à un hôpital géré par le gouvernement ou vice versa ?
6. Avez-vous été référé en raison de l'absence d'équipement médical (appareils d'IRM / balayage) ou du manque de professionnel de la santé pour le type de soins nécessaires ?
7. Direz-vous que les hôpitaux gérés par le gouvernement sont mieux équipés avec des équipements médicaux à jour et des professionnels de la santé fiables que les hôpitaux privés ? Pourquoi dites-vous cela ?

8. Allez-vous dans un hôpital public ou privé pour des soins spécialisés ? Veuillez fournir votre réponse et pourquoi.
9. Sur la base de vos visites dans des hôpitaux gérés par le gouvernement et privés, comment vos données personnelles sont-elles stockées / récupérées ?
10. Habitez-vous en milieu rural ou urbain ?
11. Pensez-vous que votre localité affecte la qualité des services de santé que vous recevez ? Pourquoi dites-vous cela ?
12. Les services de soins de santé, y compris les soins spécialisés, ont-ils été accessibles, abordables et efficaces ? Veuillez donner les raisons de vos réponses.
13. Comment payez-vous vos besoins médicaux ou êtes-vous couvert par une assurance ?
14. Vous a-t-on déjà refusé des services médicaux ? Dans l'affirmative, veuillez fournir de brefs détails sur les raisons.
15. Votre assurance maladie couvre-t-elle tous vos besoins en matière de soins de santé, y compris les soins spécialisés (oncologue, gynécologue, cardiologue, néphrologue) ?
16. Pensez-vous que la provision et la prestation des services de soins de santé peuvent être améliorées ? Si « oui », quelles seraient ces améliorations ?

APPENDIXF

**Entrevues**

Je m'appelle [Arit Asamudo] et je suis doctorante au département d'administration publique de la California Baptist Université. Je mène actuellement des recherches sous la supervision du Dr O. McKinney sous le titre de Partage des risques et gouvernance par le biais de partenariats public-privé en Afrique : évaluation de l'expérience du secteur de la santé publique en Afrique de l'Ouest. Dans le cadre de ma recherche de thèse, je mène des entretiens avec des résidents et des professionnels tels que des médecins, des professionnels de l'assurance et des décideurs politiques pour découvrir leurs points de vue sur l'efficacité et l'efficience ou l'absence d'efficacité de la prestation des soins de santé publique en Afrique de l'Ouest.

L'entrevue durerait environ 45 minutes et la participation à cette entrevue est entièrement volontaire et il n'y a aucun risque connu ou prévu pour la participation à cette étude.

Les questions sont assez générales (par exemple, quelle expérience avez-vous du service de santé publique ?) et vous pouvez refuser de répondre à toutes les questions d'entrevue auxquelles vous ne souhaitez pas répondre et peut mettre fin à l'entrevue à tout moment.

Avec votre permission, l'entrevue sera enregistrée pour faciliter la collecte d'informations, puis transcrite pour analyse. Les données collectées seront conservées dans un endroit sécurisé et éliminées dans un délai de 2 ans. Toutes les informations que vous fournissez seront considérées comme confidentielles.

Je tiens à vous assurer que cette étude a été examinée par le Comité d'éthique de la recherche de l'Université baptiste de Californie pour s'assurer qu'elle est conforme aux directives fédérales pour la recherche humaine. Si vous avez des questions sur vos droits

en tant que participant à la recherche, veuillez me le faire savoir ou communiquer avec mon superviseur à xxxxx@xxxxx.xxx. La décision finale concernant la participation vous appartient.

APPENDIXG

## Questions D'Entrevue

**Médecins**

1. Travaillez-vous strictement dans les hôpitaux publics / privés ou les deux ?
2. Quelles différences notables y a-t-il entre la façon dont les services de soins de santé sont fournis dans les hôpitaux privés et publics ?
3. Selon vous, lequel est le mieux équipé en termes d'équipement médical à jour ?
4. Diriez-vous que les hôpitaux gérés par le gouvernement manquent d'une bonne gestion ? Si oui, pourquoi le pensez-vous ?
5. Pensez-vous que les partenariats entre des organisations internationales, par exemple l'Agence des États-Unis pour le développement international (USAID), ont conduit à des changements institutionnels et à des pratiques innovantes dans le secteur de la santé publique ? Veuillez fournir quelques explications/exemples basés sur votre réponse.
6. Les partenariats comme ceux mentionnés ci-dessus ont-ils favorisé ou brouillé la responsabilisation dans le secteur de la santé publique ?
7. Compte tenu de la volonté du gouvernement d'offrir des soins de santé universels, diriez-vous que le partenariat entre le gouvernement, les fournisseurs d'assurance-maladie et les médecins a atteint son objectif ? Veuillez fournir les raisons de vos réponses.
8. Les politiques gouvernementales en matière de soins de santé en matière de prestation de services ont-elles été efficaces ou efficientes ?

9. Quelles améliorations aimeriez-vous voir qui seraient bénéfiques pour toutes les personnes concernées, y compris celles qui consultent un médecin ?

**Décideurs**

1. Compte tenu du plan stratégique de gestion de la santé (2018-2022) trouvé sur le site Web du ministère de la Santé du pays, diriez-vous que les objectifs du plan ont été atteints / sont en train d'être atteints ?
2. Si non, quels sont, selon vous, les obstacles ?
3. Des partenariats entre des organisations internationales comme celle-ci et l'Agence des États-Unis pour le développement international ont-ils mené à des changements institutionnels et à des pratiques novatrices dans le secteur de la santé publique ? Veuillez fournir les raisons de vos réponses.
4. Compte tenu de la volonté du gouvernement d'offrir des soins de santé universels, diriez-vous que le partenariat entre le gouvernement, les fournisseurs d'assurance-maladie et les médecins a atteint son objectif ? Veuillez fournir les raisons de vos réponses.
5. Pensez-vous que les politiques sur les méthodes actuelles de partage des risques, en particulier les partenariats public-privé, doivent être revues ?
6. À quelle fréquence les politiques en matière d'éthique dans le secteur de la santé publique sont-elles révisées ?
7. À votre avis, le rôle de la gouvernance des risques dans la prestation de la santé publique a-t-il été efficient et efficace ?

8. La contribution de tous les intervenants est-elle sollicitée lors de la formulation des politiques de soins de santé ?
9. À votre avis, ces intrants sont-ils reflétés dans les politiques de gestion de la santé élaborées ?
10. Compte tenu du régime national d'assurance maladie actuel, y a-t-il un encouragement à ce que les hôpitaux gérés par le gouvernement soient utilisés dans la fourniture de services de soins de santé assurés ?

**Professionnels de l'assurance maladie**

1. Compte tenu de la volonté du gouvernement d'offrir des soins de santé universels, diriez-vous que le partenariat entre le gouvernement, les fournisseurs d'assurance-maladie et les médecins a été efficace ? Veuillez fournir les raisons de vos réponses.
2. Quel a été (le cas échéant) le plus grand obstacle à la fourniture d'une couverture d'assurance maladie ?
3. Avez-vous dû refuser des services de soins de santé aux bénéficiaires ? Si oui, pourquoi ?
4. Les politiques gouvernementales actuelles sur la prestation et la prestation des soins de santé ont-elles été utiles pour la prestation d'une couverture d'assurance maladie ?
5. Des pratiques novatrices (amélioration de la gestion des dossiers, amélioration du calendrier de déclaration et base de données unique pour les professionnels de la santé) permettront-elles d'offrir plus rapidement une couverture d'assurance et de réduire la bureaucratie imminente au sein du partenariat public-privé ?