PUBLIC PRIVATE PARTNERSHIP (PPP) IN THE ETHIOPIAN HEALTH SECTOR: THE CASE OF ADDIS ABABA CITY

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Declaration

I, the undersigned, declare that the work contained in this dissertation is my own original work and that I have not previously in its entirety or in part submitted at any university for a degree.

Signature …… Date ……

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Abstract

This dissertation investigates the context within which PPP programs are taking place in the Ethiopian heath sector and examines the extent to which the theoretically appealing principles of PPPs, in general, and health service PPPs, in particular, are implemented in Ethiopia by taking the health sector of Addis Ababa as a particular case. The current status and constraints of the public health sector in terms of effectively addressing the health needs of citizens are investigated with the view of involving the private health sector in addressing the challenges of the public health sector. Within the framework of New Public Management, the study attempts to critically assess the policy and regulatory environment of health sector PPPs in Addis Ababa. Institutional capacity for managing health sector PPPs and the extent of risk sharing and mutual support in the existing public private collaborations in Addis Ababa's health sector are also evaluated using the governance approach to PPPs as a conceptual framework.

Mixed concurrent triangulation methods with qualitative emphasis were applied as a methodology to address the research questions. Primary data was collected through detailed structured questionnaire distributed to 242 purposively selected respondents in the health sector of the city. In addition to the 24 key informant interviews conducted one-to-one with health sector leaders, experts and experienced resource persons, secondary data was collected from various sources including FMoH, AAHB, USAID-PHSP, statistical reports and many other sources. The Data collected from multiple sources was analyzed using both qualitative and quantitative approaches giving due emphasis to the qualitative approach owing to the nature of the research questions under study.

The study generally indicated that the status and realities in the existing health system in Ethiopia calls for collaboration with the private health sector which should be informed by appropriately designed PPP model. It was found out that while the public health sector in Ethiopia as well as Addis Ababa is severely resource-constrained, which calls for active involvement of non-state actors, the private health sector is not properly incorporated into the health system. This dissertation argues that the policies, legal and regulatory frameworks of the incumbent government and the Addis Ababa City Government in particular do not provide adequate room for the development of PPPs in the health service delivery. The study also discovered that the existing institutional framework and capacity of the public sector is not adequate and appropriate to manage both the existing and future PPP initiatives in the health

sector of Addis Ababa. Although the existence of different types and levels of risks in PPP initiatives theoretically calls for fair risk sharing and government support to encourage the private partner, no meaningful support is currently provided by the government to the private sector in Addis Ababa. The government offers little or no practical support to the private health sector in the areas of subsidy, access to finance, tax relief and duty-free privileges and creation of demand for PPP delivered health services.

Finally, the study recommends that the health sector of the city should be considered as a total system that effectively involves the role and contribution of the private health sector. The policy and regulatory environment of health sector PPPs should be formally established which, this dissertation argues, will in turn address the issues of institutional capacity, risk sharing and mutual support in PPP initiatives. As the body of knowledge in PPPs in general and health sector PPPs in particular is developing rapidly, this study also suggests further scholarly research to be conducted in the area of applying PPPs within the developmental state political context, promoting public interest goals in health sector PPPs.

Dedication

This dissertation is dedicated to my beloved wife, Beri, and our daughter, Raey, for strongly inspiring me throughout my study. Beri is very far beyond just wife as she relentlessly offered me all the help I needed to successfully complete my PhD. Our little Raey, let this PhD dissertation and my achievement be your source of inspiration in all your future endeavors and a reminder that strong commitment and purpose-driven life pay off.

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Acronyms

AABOFED: *Addis Ababa Bureau of Finance and Economic Development*
AACCSA: *Addis Ababa Chamber of Commerce and Sectoral Associations*
AACHB: *Addis Ababa City Health Bureau*
AAFMHACA: *Addis Ababa Food, Medicine and Healthcare Administration and Control Authority*
AAHAPCO: *Addis Ababa HIV/AIDS Prevention and Control Office*
AAHB: *Addis Ababa Health Bureau*
ADB: *African Development Bank*
AIDS: *Acquired Immunodeficiency Syndrome*
AMREF: *African Medical and Research Foundation*
ANC: *Antenatal Care*
ARM: *Annual Review Meeting*
ART: *Antiretroviral Therapy*
BOT: *Build-Operate-Transfer*
BPR: *Business Process Reengineering*
CBHI: *Community Based Health Insurance*
CDC: *Center for Disease Control*
CGAA: *City Government of Addis Ababa*
COICA: *Korean International Cooperation Agency*
DOTS: *Directly Observed Therapy Short-course*
ECA: *Economic Commission for Africa*
EDHS: *Ethiopian Demographic and Health Survey*
EFY: *Ethiopian Fiscal Year*
EHNRI: *Ethiopian Health and Nutrition Research Institute*
EPI: *Expanded Program on Immunization*
EPRDF: *Ethiopian People's Revolutionary Democratic Front*
EQA: *External Quality Assurance*
FDI: *Foreign Direct Investment*
FDRE: *Federal Democratic Republic of Ethiopia*
FMHACA: *Food, Medicine and Healthcare Administration and Control Authority*
FMoH: *Federal Ministry of Health*
GAVI: *Global Alliance for Vaccines and Immunization*
GDP: *Gross Domestic Product*
HCFR: *Health Care Financing Reform*
HEP*:* *Health Extension Package*
HF: *Financing Agent*
HIV: *Human Immunodeficiency Virus*
HMIS: *Health Management Information System*
HPHEIA: *Higher Public Health Education Institutions Association*
HSDP: *Health Sector Development Program*
IFC*:* *International Finance Corporation*
IHP: *International Health Partnership*
IMF: *International Monetary Fund*

IRS*:* *Indoor residual spraying*
ITNs*:* *Insecticide Treated Nets*
JHU: *John Hopkins University*
MAPPP-E: *Medical Association of Physicians in Private Practice-Ethiopia*
MCH: *Maternal and Child Health*
MDG*:* *Millennium Development Goals*
MDR: *Multidrug Resistant*
MoFED: *Ministry of Finance and Economic Development*
MOU: *Memorandum of Understanding*
NGOs: *Non-Governmental Organizations*
NHA: *National Health Account*
NPM: *New Public Management*
OAU: *Organization of African Unity*
PASDEP: *Plan for Accelerated and Sustained Development to End Poverty*
PBS: *Protection of Basic Services*
PFSA: *Pharmaceutical Fund and Supply Agency*
PHCU: *Primary Healthcare Unit*
PhD: *Doctor of Philosophy*
PHSP: *Private Health Sector Program*
PPD: *Public Private Dialogue*
PPM: *Public Private Mix*
PPP: *Public Private Partnership*
QC: *Quality Circles*
RHB: *Regional Health Bureau*
SHI: *Social Health Insurance*
SNNPR: *Southern Nations, Nationalities and People's Region*
SPSS: *Statistical Package for Social Sciences*
STDs: *Sexually Transmitted Diseases*
TB: *Tuberculosis*
TGE: *Transitional Government of Ethiopia*
TQM: *Total Quality Management*
UNFPA: *United Nations Fund for Population Activities*
USD: *United States Dollar*
UK: *United Kingdom*
UNDP: *United Nations Development Program*
UNECA: *United Nations Economic Commission for Arica*
UNECE: *United Nations Economic Commission for Europe*
USAID: *Unites States Aid for International Development*
WB: *World Bank*
WFP: *World Food Program*
WHO: *World Health Bank*
WorHO: *Woreda Health Office*
WTO: *World Trade Organization*

Chapter 1: Introduction

1.1 Background of the Study

The role of the government in public service delivery has become an important issue of research and policy debate in recent years. New Public Management as a new paradigm strongly argues that the traditional organizational form of the public sector and hierarchical bureaucracy are inherently inefficient and that the introduction of market mechanisms is believed to have meaningfully enhanced the efficiency of public service delivery (Broomerg and Mills, 1998). As the size of government increases, its inefficiency increases while the demand from citizens to get access to efficient and cost effective services is ever-growing. This reality has urged governments in both developed and developing countries to look for better systems and institutional arrangements particularly in the past three decades. Hughes (2003) argues that this transformation in the management of the public sector since the early 1980s is an attempt to fundamentally reform the traditional administration which predominated for most of the 20th century and introduce a more flexible, efficient and market based form of public management.

The reform programs that are prompted by the weaknesses and failures of the traditional administration and ever increasing expectations from citizens have called for the inclusion of multiple actors and more collaborative arrangements in public service delivery. According to Cassels (1995), reform programs generally aim at improving performance by moving away from integrated conventional hierarchy towards a network of public and private providers in which interactions are dependent more on contractual and less on bureaucratic controls. One of the promising reform approaches to improve public service delivery has been the enhanced engagement of the private sector. In such arrangements, it is argued that problems associated with public service delivery in general and efficiency, economy and equity in particular can be effectively addressed.

Though there are theoretical arguments for the distinct existence and clear dichotomy between public and private institutions, new governance thinking has come up with empirical findings that question the actual dichotomy between the two sectors in real-life service delivery environments. According to Jooste (2008), the blurring nature of boundaries between public and private sectors is calling for mechanisms which allow both sectors to work together by sharing

benefits, risks and responsibilities. In the practical world of public service delivery, problems have become more and more complex for public agencies to handle on their own (Stun, 2006).

In spite of the fact that the birth of New Public Management and alternative service delivery mechanisms, by involving the private sector actors, is attached with economically advanced western countries, its importance is considerably growing in recent years in developing low-income countries. In developing countries, the public sector is intrinsically weak and resource-constrained, while the private sector is generally believed to be profit-oriented and relatively efficient. These beliefs, some of which are informed by empirical studies have opened new rooms in international financial institutions and development agencies to think of involving the private sector in the public sector reform programs designed under the umbrella of new public management (Richer, 2004).

Because of the fact that many governments in developing countries believed in extensive governments, growing expectations and demands of citizens added to the incompetent, resource constrained and corrupt governments has led to the search for more private sector involvement. The fact that the private sector is growing in terms of both scope and size in almost all aspects of social services (World Bank 2011), has made governments and development partners to augment this sector in implementing development programs and providing public services by addressing the inefficiency and quality problems that are arguably the typical characteristics of the public sector service delivery. Staab (2003) strongly argues that countries that have worked in collaboration with the private sector in public service delivery have responded more positively to policy reforms in improving the service delivery quality and efficiency.

Health service is one of the most socially and politically sensitive public services for all types of governments. In advanced countries, public health needs of citizens which exceeded the capacity of governments to handle have prompted governments to invite the active participation of and collaboration with the private sector. Such active engagements of the private sector were also supported by appropriate public policy frameworks. The New Public Management approach which was started in the UK in the early 1980s and subsequently spread to other advanced countries has already brought about relatively better improvements in the quality, accessibility and efficiency of health services in such countries (Hughes, 2003; McLaughlin and Osmorne 2002; Polidano 1999). In developing countries, however, as Ellias (2005) argues, the dwindling

of resources in the health sector combined with the increasing demands in the sector has, in recent years, required policy makers to see the involvement of the private sector as one mechanism to tap resources that have moved away from the public sector. The preconditions that are necessary to work with the private sector were also important issues for governments.

Everywhere in the world, Stein et al. (1997) argues, the role of the public health system is evolving, moving away from the direct provision of services to the formation of partnerships in order to advance health services. A wide range of literature is emerging with strong arguments for some form of public-private collaboration in the health sector. According to Mckee et al. (2006), there is nothing as such exclusively public provision regarding health services. Even when the health services are provided by the public sector, some forms of arrangement with the private sector is unavoidable at some stage of the service delivery. Conducive legal and institutional arrangements are considered to be important factors that need to be addressed before embarking upon collaborative working approaches (World Bank, 2011).

Marek et al. (2005) see that there are visible paradoxes in the service delivery mechanism in the health sector. They argue that while the private sector is actually playing a strong role in health service delivery, governments in many countries continue to provide health services using their own bureaucratic structures. Although countries in mixed health systems are lately recognizing the importance of working in collaboration with the private sector by establishing suitable roles for the two sectors in health service delivery, developing countries have not yet fully tested the appropriateness of the partnership approach and its actual benefits in improving health service delivery.

According to Domberger and Fernandez (1999) partnership and collaboration with the private health sector includes contractual relationships for the provision of public services where actual ownership remains with the government. Continuous interaction and dialogue between public and private institutions is highly required for service delivery collaboration to bring about the desired results.

Although there are several challenges in identifying and implementing alternative service delivery mechanisms in the health sector, opportunities for collaboration will continue to grow in the future in response to the difficulties that developing countries are facing in addressing the health service needs of their citizens (Brooberg and Mills, 1998; Loevinsohn, 2008). Domberger

and Fernandez (1999) stress that the future of service delivery carries with it various benefits to both public and private actors which will facilitate the willingness to collaborate by creating convergence of objectives to both actors.

It was strongly argued on the World Economic Forum (2005) that challenges of governments in the health service delivery can be resolved by bringing the private sector on board. It is also continuously stressed that the public sector and its institutions are in charge for initiating partnerships and develop the interest and confidence of the private sector. The justification was that productive, competitive, diversified and responsible private sector can play a key role not only in curative health services but also in preventive health services.

The opportunities for public private collaboration and partnership for better health service delivery require not only state willingness but also strong institutional capacity from the government side. According to World Bank (2011), Jutting (1999) and Marek et. (2005), strong and effective governments and public institutions which are able to harness the competencies and contribution of the two sectors including the resources, innovation and the productivity of the private sector are required in order to harvest the benefits of public private collaboration in the health sector.

Scholars, policy makers and politicians generally agree on the importance of public private partnership and collaboration in the health sector in developing countries. According to Batley and Larbi (2004) and Lagomarsino et al. (2009), public private collaboration in the health sector needs appropriate policies and legal frameworks that enable the private sector to collaborate with the public health systems and play a positive role towards achieving the health sector goals of the government. Even after suitable public private health service collaboration policies are established, World Bank (2011) argues, in developing countries, there is still a need to identify and create workable public private arrangements and institutional structures including plausible procurement and risk sharing systems that facilitate the effective implementation of partnerships.

As the health policies and systems of developing countries are, at least in principle, believed to target the health needs of the poor, the best mechanisms of addressing the poor through the public private partnership structures is a serious issue to be worked out in a country specific manner. The arguments above clearly show that the potential for public and private health sectors to work in partnership can only be utilized to the benefits of the citizens when the

policies and legal environments are appropriately established and institutional arrangements are structured to ease the implementation of partnership initiatives.

In Ethiopia in general and in Addis Ababa City in particular, the ever growing health expenditure coupled with the rapidly increasing population has put a strong and visible pressure in the public health sector. According to USAID (2012), the national goals in the health sector are highly ambitious and hence present a serious challenge to the government unless alternative mechanisms of health service delivery are developed. Despite the fact that delivering health services through PPP arrangements is officially considered as an alternative in the Ethiopian health sector, the policies governing these partnerships, the way the partnerships are exercised and the challenges facing the process are not adequately studied so far as indicated in the problem statements discussed below.

1.2 Statement of the Problem

The main research problem that this dissertation tries to address is the policy, legal and institutional environment of public private partnership in the health sector of Addis Ababa. In public services that essentially require the active engagement of non-state actors, the extent to which the private health sector is involved in service delivery needs to be empirically investigated by taking critical cases from the health sector.

The government of Ethiopia holds that health is a basic human rights and quality health care should be accessible regardless of income. Despite a lot of gains in the Ethiopian health sector the health system still faces some serious challenges including shortage of qualified human resources and lack of sustainable financing (FMoH, 2012).

In Ethiopia, there are significant challenges in meeting the health care needs of the population where there is a moderate to heavy disease burden. In a country where one physician serves about 37,000 people (USAID, 2012), which is significantly below sub-Saharan standard and nearly 70% of health care is out of pocket (USAID, 2013), ensuring equity and accessibility in health services will remain the biggest challenge for the public sector working alone. As, HIV/AIDS, TB, malaria, maternal and child health, and nutrition are the national urgent health issues of the health sector in Ethiopia as well as Addis Ababa (FMoH, 2010), it will be difficult or at least will take a long time for the public health sector to meet these health needs. In Addis

Ababa, the focus of this study, post abortion care coverage was only 28% in 2014/15 while contraceptive acceptance rate was only 33% in the same year. Child health services were also limited in that only 37% of children who need vitamin A supplements were served and 145,410 children who needed de-worming did not get the service in 2014/15.

The public health sector in Addis Ababa is generally characterized by overcrowded health facilities, high professional turnover, old and nonfunctional equipment and inadequate bureaucratic capacity (FMoH, 2014a). On the other hand, the private health sector in Addis Ababa is growing rapidly over the last years. For instance, 75% of the hospitals in Addis Ababa are private. More importantly, private health facilities have relatively better quality equipment and technology and impliedly provide better quality health services (USAID, 2012). Despite this, the practice of considering the public and private health sectors as a total system and pooling resources and capabilities towards common goal is not so far properly studied.

One of the major obstacles to PPP in the health sector is that, by its very nature, the public sector is not as such very interested in the private sector (USAID, 2012). Though this argument reflects that there is mistrust between the two sectors, the health policy and strategies of the Ethiopian government indicate the opportunities for working with the private health sector in general and some visible practices of PPP in particular. It is clearly articulated in the Ethiopian health policy that partnership and collaboration with the private sector will be encouraged to deliver health services to citizens and achieve the health policy goals (TGE, 1993). All the subsequent health sector development plans which are also implemented by Addis Ababa's health sector similarly indicate the need for PPP and collaboration to achieve the program objectives (FMoH, 2000; FMoH, 2005; FMoH, 2010). Though there are declared intentions of the government to involve the private sector in health service delivery through PPP, the policy framework that should govern the partnership arrangements in the city's health sector is not empirically studied. A research conducted by Peterson (2011) contends that in the absence of sound and conducive policy environment, embarking upon PPP practices will do more harm than benefit. However, Peterson's study did not comprehensively address the elements of the policy frameworks that are said to be sound and conducive from the perspectives of both the public and private sectors engaged in PPP in health.

Public services in general and health services in particular should be fundamentally based on and to effectively meet public interest goals (Reich, 2002). More specifically, UNECE (2012) stipulates that the design and application of PPP initiatives should sustainably promote the public interest goals that can positively contribute to good governance in service delivery. The controversy that remains unresolved in the body of literature is that what constitutes public interests in the design and application of PPP in health service delivery is not thoroughly studied. Moreover, while the public health sector is largely concerned with promoting public interest and good governance in service delivery, the question how the private health sector, which is mainly profit-oriented, can promote and ensure public interest goals remains unanswered.

The principles and practices of PPP should be guided by clearly stipulated duties and rights of the partnering entities (Smith & Brook, 2001). If left unregulated, as Peterson (2011) argues, PPP practices may lead to greater harm than good. However, the type of legal and regulatory framework that yields mutual benefit to both parties in the health service delivery needs to be further studied taking the interest and objectives of the parties into account. On the other hand, the argument by Chang (2002) that health PPPs lead to greater efficiency remains unresolved until the institutional capacity of the public health sector, which has simultaneous responsibilities of partnering and regulation, is empirically studied. Previous researches on the potential and challenges of PPP in Ethiopia (e.g. Asubonteng, 2011; USAID, 2014), strongly argue for adequate institutional capacity for successful PPP practices. However, none of these studies specifically address what constitutes adequate institutional capacity in general and how institutional capacity affects PPP in the health sector. Moreover, the studies were conducted at national level and did not address the contextual peculiarities of the health sector of Addis Ababa.

Public private partnership practices are not entirely new to the health sector of Addis Ababa. Currently high impact public health services such as HIV/AIDS, TB/DOTs, malaria, immunization and reproductive health services as well as non-clinical services are provided in partnership with the private health sector (FMoH, 2012; USAID, 2013). Though these practices signal the initiatives to introduce full-scale PPP in the health sector, the practices and challenges in selecting, negotiating with and entering into contract with the private partner is not adequately researched.

According to Jutting (1999), the question of whether the government is an efficient and capable purchaser of services within the PPP framework needs a country specific empirical study. Particularly when the government is a purchaser, provider and regulator (Spiering and Dewulf, 2006), how these triple roles may pose a critical challenge to a smooth operation of PPP practices is not so far adequately studied in the context of Addis Ababa's health sector. Unlike traditional procurement, the process and context in which the private partner is selected will definitely have not only short term impacts on the specific service but also determine the overall success or failure of the PPP initiative (WHO, 2004). How the PPP practices in health services in Addis Ababa are affecting the outcome of the programs is not studied well. Though a report by Asubonteng, (2011) highlights that the PPP procurement in Ethiopia is not governed by appropriate frameworks, the report neither indicates which services are provided through PPP approach nor what procurement frameworks are missing.

Risk sharing is a fundamental requirement for PPP initiatives. When PPP proposals are perceived risky due to lack of careful identification, analysis and negotiation to share risks, as Urio (2009) argues, potential partners will prefer to refrain from or at least remain indifferent in considering PPPs as appropriate option. In this regard, a preliminary review of health sector PPP practices in Addis Ababa reveals that the extent to which risks are identified and allocated to the partner that can effectively and efficiently handle them is not clear. Neither the perception about the prevalence of risks in health service PPPs nor the attitude towards sharing risks with the partner is so far studied.

As PPPs are alternative public service delivery approaches (Smith and Brook, 2001; Peterson, 2011, WHO, 2006), at the early stage of the scheme, both the national government and the concerned public agencies should nurture the initiatives by providing support to the PPP program in general and to the private partner in particular (UNECE, 2012). However, the body of literature is not clear about the types of supports that the government can provide to the health sector PPPs. Referring to the Ethiopian private sector in general, (ADB, 2013) it is argued that this sector is highly disorganized, short-term profit-oriented and lacks sufficient institutional capacity. In the health sector of Addis Ababa, where the private sector is at its infant stage (Asubonteng, 2011), neither the types nor the levels of support that the government is providing to the private partners in the health sector PPP programs is empirically studied and documented.

Studies that are so far conducted in the areas of PPP in general and health service PPPs in Ethiopia in particular are either limited in number or lack methodological rigor. As most of the studies are conducted and/or sponsored by government organizations directly working on health (e.g. FMoH, FMHACA, AACHB) and bilateral and multilateral development partners (e.g. USAID, IMF, WB, ADB), rigorous scientific studies are not so far conducted using scholarly methodology that can contribute to the existing body of knowledge in PPP. This gap in the body of literature in health sector PPP is the most important research problem that this study will resolve based on empirical study.

In response to the above research problem, the purpose of this research is, therefore, to study the context within which PPP programs are taking place in the heath sector of Addis Ababa and identify the extent to which the theoretically appealing principles of PPPs in general and health service PPPs in particular are implemented in Ethiopia by taking the health sector of Addis Ababa as a particular reference.

1.3 Research Questions

As stated under section 1.2 above, the body of knowledge in the health sector PPP has a lot of unanswered questions and hence needs further research. This study posed the following four questions and tried to empirically answer them with a distinct methodology discussed in chapter three.

1. What are the challenges in the existing health sector that imply the need for public-private partnership in Addis Ababa?
2. To what extent do the policies, legal and regulatory frameworks of the incumbent government and the City Administration give room for PPP in the health service delivery in Addis Ababa?
3. How does the current institutional capacity of the public sector influence the effective implementation of PPP initiatives in the health sector of Addis Ababa?
4. To what extent are risks shared and do the partners mutually support each other in the existing PPP programs in the health sector of Addis Ababa?

1.4 Research Objectives

This study essentially addresses the problems stipulated under section 1.2 and the research questions outlined under sections 1.3 above. It has the following general and specific objectives.

1.4.1 General Objective

The general objective of this dissertation is to explore the public policy environment of Ethiopia in terms of encouraging or discouraging PPP in health service delivery in Addis Ababa. Through a mixed concurrent triangulation strategy giving emphasis to qualitative aspects, the study attempts to identify the current practices and challenges in implementing public private collaborations in the areas of HIV/AIDs, TB, reproductive health and non-clinical services in the health sector of Addis Ababa.

1.4.2 Specific Objectives

The specific objectives of this research are:

- to assess the challenges in Addis Ababa's health sector and discuss their implications for public private partnership,
- to investigate the policies, legal and regulatory frameworks of the incumbent government and find out the extent to which they allow PPP for health service delivery in Addis Ababa,
- to elucidate the current institutional capacity of the public sector and analyze how it influences the effective implementation of PPP initiatives in the areas of HIV/AIDS, TB, reproductive health and non-clinical services in the health sector of Addis Ababa City, and
- to find out the practices of risk sharing and mutual support in the existing PPP programs (HIV/AIDS, TB, reproductive health and non-clinical services) in the health sector of Addis Ababa and analyze how this affects the success or failure of the PPP initiatives.

1.5 Research Hypotheses

This study investigates the policy and legal environments, institutional capacity and risk sharing and mutual support practices in PPP initiatives by focusing on the four PPP programs namely: HIV/AIDS, TB, reproductive health and non-clinical services. The general hypothesis of this study is that responses provided by respondents from the four PPP programs do not significantly

vary at the 0.05 level of significance. Specifically, the following hypotheses are formulated in relation to Policy and legal environment, institutional capacity and risk sharing and mutual support.

Hypothesis 1: Ho: For all the variables under policy and legal framework, responses provided by respondents from the four PPP programs do not significantly vary at the 0.05 level of significance.

HA: For all the variables under policy and legal framework, responses provided by respondents from the four PPP programs significantly vary at the 0.05 level of significance.

Hypothesis 2: Ho: For all the variables under institutional capacity for PPP, responses provided by respondents from the four PPP programs do not significantly vary at the 0.05 level of significance.

HA: For all the variables under institutional capacity for PPP, responses provided by respondents from the four PPP programs significantly vary at the 0.05 level of significance.

Hypothesis 3: Ho: For all the variables under risk sharing and mutual support, responses provided by respondents from the four PPP programs do not significantly vary at the 0.05 level of significance.

HA: For all the variables under risk sharing and mutual support, responses provided by respondents from the four PPP programs significantly vary at the 0.05 level of significance.

NB: Though hypotheses are formulated by combining different variables for technical convenience, they are separately tested in the data presentation and analysis sections.

1.6 Significance of the Study

Over the last two decades, in Ethiopia, following the change in government from more centralist oriented to more market oriented system, the role of the private sector in social sector development has been gaining relatively better acceptance at least in principle. The researcher

strongly believes that studying the policies, practices and challenges of public private partnership in the health sector of Addis Ababa can have a remarkable contribution to the larger body of knowledge, public policy making and practice in the health sector in general.

Public sector reforms undergoing within the framework of new public management are still theoretically and conceptually shallow and opening up a wide range of debates in the field of Public Administration. The existing literature on the New Public Management and its applicability in developing countries has several unanswered questions and unresolved debates. Even more importantly, the theoretically appealing public private partnership concepts which were developed and tried in economically advanced western societies are still conceptually and theoretically less matured with regard to their applicability in developing countries in general and Ethiopia's health sector in particular. This empirical research, which is embedded in New Public Management concepts and theoretical frameworks, can contribute to the existing literature on public private partnership and its applicability in the health sector. The findings of this research will also initiate further academic discourses and additional studies which will pave the way for the advancement of contemporary knowledge on public management.

Acknowledging the role of the private sector in the Ethiopian health sector, policy makers need to clarify and carefully work out on how the potential of the private sector can be tapped in the process of addressing the health needs of the society. The findings of this research can provide policy makers with first-hand empirical information on the windows of opportunities for partnering with the private health sector. It can also provide mechanisms of establishing institutionalized public private collaboration that will benefit the government, the private sector and ultimately the citizens at large. Future policy reforms and revisions in the Addis Ababa's health sector can also make use of the findings from this research.

The operational practices of the current partnership between the public and private health sector can also benefit from the outcome of this research. The practices and challenges of public private partnership in the health sector was investigated and revealed by this research. Practitioners who are playing regulatory and service delivery roles in the health sector of Ethiopia as well as Addis Ababa can use the findings of this research in the process of improving their public private partnerships and addressing the challenges that may arise in their partnership practices.

1.7 Scope of the Study

As Cresswell (2009) strongly argues delimiting a research project using specific time frame, location, population or issue to be investigated helps the researcher to focus the center of attention and address the research problem in a resource and time efficient manner. Accordingly, the scope of this dissertation is framed as follows:

1. The study is confined only to the health sector of Addis Ababa. Addis Ababa is selected for the study due to its relatively better experience of PPP in the health sector. This justification will be discussed further in chapter 3.
2. Health sector PPP programs that are already in practice in the city were selected. PPP initiatives that are in the pipeline were not included in the study. This is mainly because, in addition to studying the policy, legal and institutional frameworks, the study aims at investigating the risk sharing and mutual support practices and this can only be made by taking functional PPP practices that can be used for assessment.
3. Health services that are said to have high health impacts (HIV/AIDS, TB and reproductive health) and outsourced non-clinical health services were included in the study. Other public-private collaborations such as immunization, partnerships in the pharmaceutical sector…etc was not included in this study due to time and resource constraint.
4. The study provides the perspectives of respondents from the public and private sector and excludes the opinions of patients and health service users (beneficiaries) due to methodological inconvenience as this study focuses more on policy issues.
5. Respondents who are currently employed in public, private or non-governmental institutions directly related to the issues of PPP were selected to fill the questionnaire or participate in key informant interviews.

1.8 Limitations of the Study

This study had certain limitations that include the following:

- Because the role and participation of the private sector in the Ethiopian health sector has a brief history (Asubonteng, 2011), shortage of relevant and sufficient secondary data about PPP in the sector was a serious challenge. Specifically in the health sector of

Ethiopia as well as Addis Ababa, relevant data regarding the status of PPP were very limited and, hence, the author opted for extensive primary data to substantiate his argument.

- As this study takes the health sector of Addis Ababa as a particular reference, the uniqueness of this research within specific city context makes it difficult to replicate exactly in other contexts (Creswell, 2009).
- Respondents who participated in the study were busy with their institutional matters and did not have sufficient time to provide detailed information as particularly required by the key informant interviews. This might have compromised the depth of information that could have been collected from these sources.
- Though respondents were selected using two stages sampling method, the inability to ensure normality of distribution and limiting the data analysis to descriptive statistics and non-parametric tests might have compromised the statistical power of the quantitative component of this study (Collis & Hussey, 2003). Justification for these methods will be further discussed in chapter 3.
- Due to the nature of qualitative research, the data obtained from interviews with key informants and the analysis of these data may run the risk of different interpretations by different readers (McNabb, 2008).
- In parallel with this study, the researcher carried additional academic responsibilities such as teaching and student advising as a faculty member. Though this might have created serious time constraint for data collection, analysis and writing the dissertation, utmost effort was made to maintain the required rigor throughout the research process.

1.9 Organization of the Dissertation Report

This dissertation constitutes eight chapters. The first chapter deals with introductory issues. The research background, the problem statement, research questions and objectives, significance of the study, scope of the research and limitations are discussed in chapter one. In the second chapter, relevant literature related to the theoretical and empirical issues of public private partnership are discussed and carefully linked to this dissertation. The third chapter deals with research methodology and procedure. The philosophical underpinnings of this dissertation, the research approach and methods of data collection, analysis and interpretation are discussed with

scientific justifications of the methods employed in this research. Data presentation, discussions, analyses and interpretations are included in chapter four to chapter seven. The author chose to devote full fledged chapter to each research objective for the purpose of technical convenience for readers. Accordingly, answers to the research objectives stated under sub-section 1.4.2 of chapter one are addressed separately between chapter four to chapter seven. The fourth chapter gives specific attention to the status and challenges of the health sector of Addis Ababa and their implications for PPP. The fifth chapter presents the findings and analysis of the policies, legal and regulatory environment of the Addis Ababa's health sector. The sixth chapter focuses on the analysis of the institutional capacity of the health sector in terms of managing PPP programs. In chapter seven, the status of risk sharing and mutual support between the public and private health sector are analyzed and discussed. Finally, in chapter eight, the conclusions and knowledge contributions, directions of future research and policy recommendations which are informed by the analyses and interpretations made in the preceding chapters are presented.

Chapter 2: Public-Private Partnership: Review of Related Literature

2.1 Chapter Overview

The development of public private partnership was not completed overnight. Its genesis is strongly related to the history of public administration. The roles and responsibilities given to the public sector and its various institutions were increasingly demanding. On the other hand, despite its late emergence in the arena of service provision, the private sector was perceived as superior in terms of efficiency, economy and service orientation. It, therefore, makes a logical sense that development of the concept of public private partnership can be best understood by looking into backgrounds and characteristics of the public sector and the private sector.

The overall purpose of this chapter is to intensively review and analyze the conceptual and theoretical underpinnings of public private partnership and link the existing body of knowledge to the research questions discussed in chapter one. By reviewing the theories, principles and backgrounds of PPP, the researcher establishes his particular study within the existing body of literature. This review has also helped in the development of conceptual framework established towards the end of this chapter, which was used as a guide in the development of data collection instruments.

2.2. Theoretical Review

2.2.1. Public Service Delivery: Philosophical Foundations

As stated earlier in chapter one, the concept of public service delivery is highly related to the development of the public sector and its administrative machineries. The questions of both what services are referred to as "public services" and who should deliver the services is a long time agenda for academicians and policy makers (Hood and Lodge, 2006). As any research issue should be established within certain philosophical underpinning (Guba and Lincoln 1994), this dissertation also tries to establish its theoretical and conceptual discourses within two philosophies of public service delivery: the theory of welfare state and the theory of private markets and competition (Eagle, 2005). These philosophical backgrounds are important to establish the discussion of public private partnership in service delivery in general and Addis Ababa's health sector in particular.

2.2.1.1. Public Service Delivery: Philosophy of Welfare State

The philosophical argument of the welfare state helps to understand how public services are designed, financed and provided (Batley and Larbi, 2004). According to Lane (2000), the redistributive state essentially gives prominence to the promotion of equality in income and wealth by addressing the recognized needs of the relatively needy members of the society. The redistributive state that mainly uses different policy instruments focuses on ensuring relative equity in both social and economic aspects. However, as Hughes (2003) and Pacek and Freeman (2005) argue, welfare states, at least in principle, work towards promoting service affordability and accessibility. Though established on the fundamental ideas of relocation and despite the fact that welfare functions are extensions of redistribution (Fisher, 1998), the specific concept of welfare state is essentially different. Welfare state is generally defined as a political economy in which the state plays relatively stronger role in the economy, which signifies a mixed economic structure instead of full deregulation of the economy and free market system (Flynn, 2008). According to Osborne (2010), welfare state is based on the philosophy of equality of opportunity, fair distribution of resources, and deliberate government intervention to ensure provision of opportunities for those who may not have access and capability. From the perspective of public service delivery, as Mclaughlin et al. (2002) argue, the public sector plays a dominant role throughout the process of planning, provision and evaluation of public services.

Giving the public sector relatively broader role, the welfare state philosophy argues that the state should vigorously allocate resources adopting policies that promote effective resource utilization (Lynn, 2006; Brooks and Manza, 2006). In the welfare state concept, which is usually implicitly or explicitly expressed in the policy documents of the government; non-state sectors are either deliberately neglected or given secondary role. The historical foundation of the welfare state, which was based on the objective of improving the well-being of the poor and those with low income by providing them with specific goods and services, gave the state and its institutions a dominant role in public policy making, implementation and resource allocation.

According to Brooks and Manza (2006), the operational boundary of the welfare state was not exclusively limited to the poor and underprivileged segment of the society. Through time, the activities and interventions of the state expanded to those who were external to the scope of its coverage. Today, the welfare states and their footprints are available all over the world including

the developed countries. For instance, as Mills (2007) argues social services such as health and education are provided through government subsidies in European countries. Welfare philosophies are also guiding the process of policy making and implementation in many ways (Lane, 2000; Veenhoven, 2000). In its contemporary sense, as Walle and Hammerschmid (2011) argue, the intervention areas of the welfare state include health, education, housing, income generation and other social services.

In both developing and developed countries that pursue state functions based on welfare philosophies, the above services are provided to citizens either free of charge or at a nominal price. Though the specific financing mechanisms may vary among different states, the government plays a key role in the provision of socials services such as health. According to Flynn (2008), the service charges that are collected from service users are used to subsidize the services for relatively poor citizens. This approach, which is referred to as cross subsidization is common in public service delivery including health services in which relatively capable segments of the society are charged higher prices and in order to subsidize services for the poor. This implies that profit generation, at least in principle, is not the objective of a welfare state. Under the strict application of the welfare state concept, market forces in general and profit maximizing private sector in particular play secondary role regarding public service delivery.

An important logical issue that needs to be addressed here is the relationship between the welfare objectives of the state and the role of non-state actors including the private sector. According to Standing and Bloom (2000), the minimal role of non-state sector in public service delivery does not necessarily mean that the private sector has no role at all. It can be argued that even in a stringently welfare oriented states, non-state actors such as the civil society and the private sector can be utilized as strategic partners in achieving objectives of the government. In its actual practice, following the development of modern public sector management, several arrangements that give remarkable room for the involvement of the private sector and non-governmental organizations are introduced. The assumption that it is only the government that can effectively and efficiently address the objective of welfare is being challenged recently. However, the body of literature is still shallow in the areas of addressing the welfare needs of citizens by actively involving non-state actors. Public private partnership, which is the focus of this study, still has a lot of unanswered questions with regard to simultaneously addressing the welfare objective of the government and the profit making objective of the private partner.

Delivering public service within welfare state framework has its own challenges. According to Ehsan and Naz (2003), the administration of welfare services is not technically and bureaucratically easy. Among other things, financing public services through revenues collected by the government and attaining citizen satisfaction; ensuring the operational efficiency of the state machinery in terms of utilizing scarce public resources; and the equitable and adequate provision of public services with limited involvement of the users and non-state actors is an evident challenge for governments. These challenges are motivating governments to plan and implement reforms in different ways. On the one hand, policy makers are triggered to find alternative policy provisions, institutional arrangements and legal frameworks to overcome the challenges and simultaneously promote the welfare objectives. On the other hand, scholars as well as policy makers are coming up with the recommendations of fundamental policy changes that question the feasibility of the welfare concept.

One of the on-going debates is the political environment within which welfare oriented states operate. It can be argued that public service delivery, at least in principle requires democratic environments and inclusive governance. This is mainly because, in addition to the core services (e.g. health), citizens are equally interested in the service delivery process and the application of democratic principles in the process of providing public services.

The public sector and its institutions have wide ranging roles and intervention areas in welfare oriented states. Lane (2000) affirms that governments in welfare oriented states shoulder the responsibility to provide basic economic and social services to the citizens which makes them bureaucratically and functionally complex (Mloka, 2013). This argument, however, is based on the assumption that the welfare state exclusively uses its own machineries in the process of service delivery. The ongoing research question and policy agenda is how to make the government remain smaller while effectively discharging its welfare responsibilities. For Ramani et al. (2008), the size of the public sector and the magnitude of its responsibilities for providing the ever expanding public services is questioned with recommendations to introduce public private partnership. As the growing influence and capacity of non-state actors in service delivery such as health is considered as untapped potential by researchers and policy makers (Seldon 2005; Wang, 2000; Windrum and Koch, 2004), interests are growing to institutionalize the contribution of these actors in service delivery. Realities over the last three decades imply that

mechanisms of collaborating with non-state actors in general and the private sector in particular need to be worked out by addressing policy, legal and regulatory issues to accommodate the mutual interest of the state and non-state actors.

The option of looking for collaborative arrangement with non-state actors is also justified from the sustainability perspective of the welfare state. According to Jakutyte (2012), Harding and Preker (2003) and Finlayson (2002), in terms of sustainably financing public services, the welfare state with its machineries alone cannot ensure public services available and accessible without interruption. Though welfare approach is politically and socially appealing to the citizens, it directly or indirectly exerts financial pressure on the public sector and its agencies (Haque, 2004).

According to Quaye (2010), the welfare state primarily focuses on ensuring equity in public service delivery by financing them through its own means including taxes and other methods such as insurance and revenues from public enterprises. The common challenges of the welfare state and its approach to service delivery can be resolved by looking for other approaches. The idea of introducing market concepts in public service delivery, as discussed in the next section, is attracting the attention of governments.

Based on the above philosophical underpinnings of welfare oriented state, the policy of the incumbent government towards the involvement of the private sector in service delivery is analyzed in the later chapters of this dissertation. The extent to which the private sector is encouraged by the government to play meaningful roles in health service delivery is empirically studied.

2.2.1.2. Developmental State and Welfare Orientations

The whole idea of public service delivery within welfare state context is also embedded in developmental states. As this study is conducted within the politico-economic context of developmental states, it is important at this juncture to highlight the conceptual background of developmental state and explore the rooms for private sector involvement.

Developmental state refers to an ideology as well as a development approach positioned between liberal open model and central planning model of a unitary state (Bolseta, 2007). Bolseta also asserts that developmental states are neither capitalist nor socialist in ideology as they

pragmatically utilize the advantages of both the public and private sector roles in the development endeavors of the state. However, the welfare orientation of a developmental state is evidenced in their peculiar nature of deliberate intervention in the economic development as well as service delivery processes. Particularly, developmental states have explicitly defined socio-economic objectives of correcting inequality in public service delivery (Edigiheji, 2005). They also claim to ensure steady growth, poverty reduction and provision of affordable and accessible public services in a sustainable manner. According to Marwala (2009), developmental states emphasize policy and institutional intervention to bring socio-economic development by effectively playing leadership roles in planning, implementation and evaluation of development programs. In this ideology, which Fritz & Menocal (2007) calls "re-recognition of the state role", states are responsible not only to regulate other actors but also to provide essential services including health and education.

Though theoretical and empirical literature about developmental states is scanty, the following are identified as the requirements for effective developmental states and their capacity to effectively and efficiently deliver public services such as health (Bolseta, 2007; Marwala, 2009; Edigiheji, 2005), Fritz & Menocal, 2006; Gumeda, 2009; Hayashi, 2010).

- Developmental vision developed and shared to all levels of the state including to citizens.
- Strong political commitment at different levels of the government.
- Creation of autonomous, merit based and motivated bureaucracy.
- Institutional capacities to initiate, develop, negotiate and agree on development interventions.
- Maintenance of strategic relations with all stakeholders
- Efficient and effective planning and coordinating center to align and harmonize development interventions.

The above statements generally imply that developmental states are not necessarily authoritarian states. Interestingly, the theoretical arguments about developmental states heavily emphasize the active role of non-state actors in general and the private sector in particular. For instance, Bolseta (2007) argues that regardless of the fact that developmental states exhibit a clear departure from neo-liberal ideology, cooperation between the government and the private sector is an essential

requirement. Similarly, Edigiheji (2005) also stresses that the development intervention and correction of inequality in public service delivery under developmental state context should give due emphasis to the organizational configuration that includes the private sector as a key partner. As developmental states aim at utilizing the positive potential of the private sector, (Bolseta, 2007), they put planned efforts to create enabling environments for private investors by issuing favorable policies and strategies. Strengthening Bolseta's argument, Marwala (2009) also asserts that developmental states are not extremely far from capitalist states in terms of the room for private sector involvement. Scholars such as Edigiheji (2005), Fritz & Menocal (2006), Maphunye (2009), Radice (2008), Jayasuriya (2005) strongly argue that developmental states should closely work in partnership with the private sector in order to effectively address the development needs of their citizens. However, these studies emphasize that the state is responsible to issue policies in which the private sector can involve in pro-poor projects and programs including employment creation, poverty reduction and provision of affordable and accessible health and education services.

The concepts and features of developmental state and the room for private sector involvement stated above have several implications for public private partnership in the health sector. Firstly, the literature implies that welfare oriented states in general and developmental states in particular have rooms for private sector involvement. Secondly, at least in principle, partnership with the private sector is considered as an important potential for developmental states to effectively address the development needs of their citizens. Thirdly, in their objectives of creating conducive environment for socio-economic development, states are required not only to regulate but also to nurture and develop the private sector within the context of the development objectives of the government. The extent to which the incumbent government operating under developmental state ideology provides room for the private sector involvement in general and PPP in health in particular will be empirically investigated in chapter 5.

2.2.1.3. Public Service Delivery: The Philosophy of Market and Competition

The paradigm shift in public administration and the introduction of New Public Management initiated the concept of market and competition in service delivery in the 1980s (Akintoye, Beck and Hardcastle, 2003; Hughes, 2003; Mclaughlin, Osborne and Ferlie, 2002). Following the public sector reforms, the concept of market and competition is gaining popularity in public

service delivery. Directly or indirectly, most countries and their citizens depend on market principles and philosophies in service delivery including health and education services. The most important issue, however, is balancing the market principles with citizens' interest, which are a long time unresolved challenges for governments. England (2004) and Geus (2001) strongly argue, goods and services that can be objectively measured and priced are relatively appropriate to delivery through market mechanisms. This argument did not, however, consider goods that are essential for the collective good of the society regardless of their ability to be delivered through the market principles. Jamali (2004), Hodge and Greve (2005) and Gwatjin (2001) clearly indicate that leaving socially important merit good such as health and education entirely to the market forces will have adverse political and social consequences.

There are several theoretically appealing arguments that private markets are very effective in the allocation of various products through the price mechanism. In this regard, Geus (2001) argues that there are several goods and services that can be effectively and efficiently delivered through the market principles involving competitive processes. This argument does not specifically address the types of goods and services where the market can be efficient. In the argument for market principles in service delivery, it has to be always clear that all goods and services are not similar. Arguments for market philosophies in public service delivery are very wide. Ayee (2005), for instance, puts that if the delivery of goods and services is left to the state, it creates government dependability which involves high transaction costs but also inefficiency of the services. Despite the above arguments, service delivery through the market and completion cannot be panacea. It has been practically observed that even the market fails on several grounds to effectively and efficiently deliver goods and services that are considered to be pure private goods (Buse and Harmer, 2004; Bjorkman, 2003; Greenwood, Pyper and Wilson, 2002). Moreover, as indicated above, the delivery of some goods and services (e.g. health) cannot be entirely left to the private sector due to their social and political impacts (Hywood, 2000).

The discussion of welfare philosophy under the above section culminated in the justifiable argument that providing public services through the welfare principles is not strategically sustainable as it usually puts unbearable pressure on the government. Similarly, the idea of exclusively using market forces and principles of competitive service delivery falls short of addressing the peculiar characteristics of certain services and also fails to recognize the social and political implications of certain goods and services such as health and education. The

fundamental thesis of this research is clearly embedded in this line of thought. Public-private partnership in public service delivery, which will be discussed in detail in this chapter, is justified by the theoretically established and practically proven facts of public failure and market failure (Hughes, 2003; Musgrove, 1996).

Theoretically, the public sector is generally considered to be lethargic usually rigid (Peterson, 2011) while markets are perceived to be more flexible and are easily able to fiddle with changing situations (Spiering and Dewulf, 2006; Wale, 2011). Market advocates also argue that due to its energy and flexibility, the market provides greater incentives for novelty and growth and hence promotes private economic prosperity (Boyne, 2002; Manning, 2001). From the perspective of public service delivery, these theoretical justifications for market forces and competitive principles need to be empirically tested through country specific studies. As the ultimate goals of the private sector and public sector are not entirely identical, there is a need to look for symmetry where public sector goals can be achieved through market principles.

According to Klijn and Teisman (2002), the public sector has the tendency to rely on hierarchical structure, authority and organizational power to deliver public services. The private sector, on the other hand, operates based on economic principles of demand and supply and voluntary interactions of service providers and receivers (Reich, 2002; Prowle, 2000). This argument seems to undermine the paradigm shifts in public sector management and the dynamism of new public management that many developed and developing countries have already incorporated as an important approach to public service delivery. Discussing about cooperative public management, Domberger and Fernandez (1999) strongly argue that in the era of globalization, cooperative working arrangements and bringing partners on board is equally important in today's public sector governance and service delivery.

Walle and Hammerschmid (2011) argue that markets are forms of synchronization in which separate self-governing organizations achieve equilibrium through economic principles while public bureaucracy focuses on rules, regulations, hierarchy and control. Similarly, Oflynn (2007) underscores that coordination in the private sector is generally self directed, while the public sector is usually associated with government agencies that coordinate through bureaucratic rules and regulations. The peculiar nature of coordination, profit motive and the environment of competition make the private sector organizations more flexible and receptive to citizens' needs

as compared to public sector organization in general (Walle and Hammerschmid, 2011). Putting water tight compartments between the public and private sector organizations, the above arguments fail to consider the possibility of making the public sector as efficient and flexible as the private sector.

As an integral element of market principles, the theory of private markets promotes competitive process for public service delivery. The theory of competition does not make any peculiarity between public and private sector organizations with regard to delivering goods and services. According to Torchia et al. (2013), public service delivery is not the sole mandate of public organizations as both public and private sectors can compete for the delivery of the services. However, the theoretically sound concept that when services are delivered through competitive process, yield better efficiency and effectiveness, does not necessarily hold true under all circumstances. More importantly, it is often practically unproved that some services (e.g. health) delivered through competitive means necessarily lead to the satisfaction of the citizens. Public interest goals such as participation, accessibility, affordability, transparency and inclusiveness which citizens require in addition to and as part of the service may not be necessarily ensured through mere competition.

Some scholars argue that the competition for public service delivery can be left to private businesses so that good performing private organizations can work in collaboration with public organizations (Soderlund, Arena and Goudge, 2003). Under the framework of new public management where partnership with the private sector is encouraged, the scope of government intervention is reduced with limited functions. The ongoing argument is that the involvement of the private sector leads to the reduction in the size of the public sector and the growth of the private sector. However, as Yescombe (2007) and Staab (2003) put it rightly, the reduction in the scope of the government does not necessarily mean the complete reduction in its role. It is rather the change in its role from direct delivery of services to facilitating service delivery.

The practical vigor in public administration is both internally and externally forcing governments to reform. In response to the developments in public administration principles and new approaches to governance, leaders are obligated to adopt the good features of management approaches or administrative philosophies in order to achieve public interest goals (Akintoye and Beck, 2009). As an important requirement and in response to the traditionally inflexible system

of public sector governance, as African Development Bank (2013) and Cassels (1995) argue, states need to introduce and adopt flexibility in governance to ensure the most favorable realization of several public sector objectives. The approach to public service delivery should be based on the peculiar characteristics of the services and taking the political and social implications of services into account. According to Cartlidge (2006), organizations that function based on free market principles should involve in the provision of goods and services that meet the characteristics of pure private good while social welfare approach should be introduced for other services of public interest. For public services with high social impact, leaving everything to the private sector and competitive market cannot effectively address the public interest goals (Fessel and Beresford, 2009).

It can be argued that the free market system can provide an opportunity for public-private partnership provided that the preconditions for private sector development and PPP are adequately fulfilled. Hodge (2006) underscores that the low performance of the state and its failure to achieve its developmental goals shed serious reservation on its effectiveness to lead the service delivery responsibilities which call for other service delivery approaches such as PPP. According to Gruening (2001), Jutting (1999) and Miller and Fox (2007), the paradigm shift in public sector governance as a field of activity with emphasis on promoting the private sector and working in collaboration in order to improve the economic and social objectives of the people is the foundation for the introduction of market concepts as well as PPP in public service delivery.

As conferred earlier in this section, public service delivery through the dominant intervention of the public sector and public administration principles and practices is being questioned because of its inherent weaknesses. Discussions on the limitations and challenges of the public sector will escort us towards finding alternative approaches to public service delivery in general and relevance of PPP in particular. New Public Management paradigm, which is the basic framework for this dissertation, promotes management of the public sector in a manner that is similar, to a large extent, to the management of the private sector. Considering the inherent weaknesses of both the public and private sector, the conditions under which NPM in general and PPP in particular works better is an important research question and policy issue.

In the study of policies, practices and challenges of public private partnership in the health sector of Addis Ababa, the above discussions about the elements of market and competition is

analyzed. The profit motive of the private health sector in PPP initiatives, issues of open and competitive environment for service delivery and negotiation and dialogue, risk sharing and mutual support as important features of market-oriented service delivery will be investigated.

2.2.1.4. Limitations of the Public Sector in Service Delivery

The development of alternative approaches to public service delivery is mainly due to the constraints in the public sector. These constraints are either due to the inherent characteristics of the traditional public administration or the way leaders manage public services (Law Commission of Canada, 2003). Theoretically, public organizations are generally structured with the assumptions of bureaucracy in its ideal sense, which characterizes the traditional public administration. This Weberian model of public bureaucracy was adopted with undue prominence to rules, regulations, procedures and external control (Osborne, 2010; Nuwagaba, 2013). Osborne argues that, in practice, these types of traditional public organizations prevail even today in most countries and are affecting public service delivery due to their natural structural deficiencies and longstanding traditional leadership attitudes. Moreover, coordination of public sector organizations and their services under traditional bureaucratic systems is one of the key challenges today (Bouckaert, Peters and Verhoest, 2010).

An argument by Nwowi (2006) also testifies that most institutions are still organized around the Weberian model with excessive attention to hierarchy and bureaucratic structures. As the most common and grave limitation of the public sector, an unwarranted reliance on rules, regulations and control may lead public sector agencies to overregulation (Kumaranayake, 1997). He also argues that overregulation may ultimately leads to negative outcomes in that it has the tendency to demoralize public sector employees and negatively affect their efficiency. For instance, health service delivery, which is entirely implemented based on strict rules, regulations and institutional control, will neither address the efficiency and effectiveness nor the public interest goals discussed above (Michell, 2008; Lowvinsohn, 2008).

Theoretically, excessive reliance on rules and regulations constrains efficient and effective service delivery (Nisar, 2007). Practically as well, according to Lane (2000), the introduction of unduly rigid and highly bureaucratic systems have upset effective workers, secluded unproductive ones, and have affected the effectiveness of public sector management. It can be argued that the inability to effectively manage public sector employees directly or indirectly

affects the quality of public service delivery (Peterson 2011; Palmer, 2000). Performance based reward systems that typify the operation of service delivery in the private sector are usually nonexistent in the public sector. This clearly suggests that civil servants with initiative can be frustrated because the structural arrangement and the functioning of public organizations can suffocate creativity and initiative which can result in high turnover of employees in the public sector (Lane, 2000).

It can be argued that rules and regulations are not bad in themselves as long as they are able to promote public interests and good governance in managing public organizations. As Vigoda (2002) underscores, it will be catastrophic to run formally established organizations, whether public or private, without rules and regulations that establish their smooth and predictable operation. The limitation of the public sector is not attributed to the prevalence of rules and regulations per se; it is the inflexibility of these rules and regulations and lack of room for change that makes them weak in terms of effectively and efficiently providing services. Even in the most contemporary concepts and practices of public administration and service delivery, the value of rules and regulations cannot be fully neglected or underestimated. According to Greenwood et al (2002), rules and regulations are indispensable and can be effectively utilized in promoting equity in the provision of public services.

Principles of good governance, which are essential requirements of public service delivery (Grimsey and Lewis, 2007) can only be enhanced under the prevalence of clear, equitable and predictable rules and regulations. Lim (2003) also stresses that rules and regulations can serve as courses of action for solving routine problems and are effective tools of coordination to control routine and operational activities in an organization. Excessive regulation, which is the peculiar feature of the Weberian style of public sector management, does not permit government organizations to apply innovative techniques and seek latest approaches to enhance the delivery of the public service (Flynn, 2008). This weakness not only hampers the government's ability to motivate its own employees but also affects the environment of partnership with non-state actors including the private sector. When rules and regulations and strict adherence to them are a mere requirement regardless of whether services are delivered or not, it momentously paralyzes the public sector and its objectives.

Another considerable limitation of the public sector is lack of inducement for the public servants and their motivation to work. Service delivery in the public sector is generally slow and inefficient because of the lack of enthusiasm of government employees. On one hand, as Urio (2010) and Sarmento (2010) argue, employment in the public sector is permanent and guarantees security of tenure to the public servants. Permanent employment that does not relate employee performance with resultant remuneration has a counterproductive tendency of affecting the incentive to work. In the traditional public administration systems, the hierarchically structured organizations are filled with permanent employees who are paid regardless of their performance (Sheeran, 1993; Reynaers, 2010). On the other hand, compensation systems in the public sector are generally perceived to be lower than the private counterparts. These perceptions of low reward, some of which are experientially tested in many developing countries (Calabrese, 2008), negatively affect the morale and motivation of public sector employees to perform in the best interest of the citizens. In developing countries, the low enthusiasm coupled with low remuneration systems is also a significant push factor triggering high turnover of qualified public servants to the private sector and NGOs (Besley and Ghatak, 2007). It can, therefore, be argued that the public sector in developing countries in particular, suffers from acute shortage of competent workers, on one hand, and highly de-motivated existing staff, on the other hand.

The public sector has also another limitation attributed to its responsibility of making services accessible to citizens regardless of the service qualities. According to IFC (2011), as service accessibility for many governments gets more precedence than service quality, public services provided by government agencies are perceived by citizens as inferior quality. Although variations in service quality between the public and private sector need to be empirically studied in a service specific manner, public services whether provided by the government or the private sector, should be delivered within a certain quality standard (Simmons, Powell and Greener, 2009). More importantly, the existing perception that services provided by the government agencies are of low quality should be changed. Bhat (2000) argues that leaders in the contemporary public management era should make sure that public service delivery is user-driven with a deliberate effort to continuously satisfy citizens, which are referred to as "customers" under the new public management context. The limitation of the service delivery in the public sector as Munhurrun et al. (2010) stress can be resolved by making planned intervention to advance the service standards. It can be argued that the public sector services

should be driven by goals and values of the public and not regulations. An important research issue here is looking for appropriate legal and institutional arrangements that can improve service delivery in the public sector. The attempt by the public sector to improve its weaknesses and deliver services that meet the ever growing demands and quality requirements of the citizens,' needs planned and sustainable reform in the public sector. It can be strongly argued that simple incremental changes within the existing structure, organizational system and resources will have less value in terms of improving service delivery in the public sector.

The limitation of the public health system in Addis Ababa and the call for alternative service delivery approaches is not empirically studied so far. The fourth chapter of this dissertation briefly addresses the status of the public health system of Addis Ababa based on the theoretically argued limitations of public sector service delivery. The extent to which the public sector is addressing the health needs of the citizens and some observed gaps in the health system are analyzed to establish the need for alternative health service delivery arrangement in general and public private partnership in health in particular.

2.2.2. New Public Management: Concept and Background

The emergence of the concept of new public management (NPM) is directly related to the limitations of the public sector discussed above. As Dasante and Bzwi (2007) argue, the political and organizational deficiencies of the traditional model of public service delivery gave birth to the concept of new public management. The emergence and development of NPM concept was based on the growing reality of government failure in efficient delivery of public service and the enhancement of a suitable environment for sustainable development (Hughes, 2003; Haque, 2004, Harding, 2009).

According to Lane (2000), NPM is essentially concerned with cost reduction and generally enhancing public sector performance through different approaches that are essentially aimed at enlightening efficiency and effectiveness in the public sector. The justification behind the introduction of NPM was to introduce private sector efficiency and effectiveness in the public sector by adopting principles and practices of private sector management (Finlayson 2002; Hess and Adams, 2007). The concept of NPM is mainly embedded in the theory of managerialism and microeconomic theory that will be discussed later in this chapter. NPM essentially emphasizes the reconsideration of the role and purpose of the government and, in parallel, the growing

importance of market principles and private sector values in public sector governance and service delivery.

In response to the long time discontent of citizens due to the limitation of the traditional public administration in addressing citizen's needs, Osborne (2010) underscores, NPM came up with a new dimensions of politics, economics and public sector management in which market principles are given due consideration. The supposition behind this is that a blend of market incentives and political processes will do better in enhancing efficiency and quality in delivering public services. When properly applied, the NPM tools ultimately lead to the reduction of the public sector by detaching those activities which are not part of its main objectives (Gruening, 2001; Lynn, 2006).

NPM as a new governance approach constitutes a set of public sector reform strategies from which governments can opt for some issues and disregard others under specific circumstances (Fatemi and Behmanesh, 2012). This implies the availability of diverse varieties of NPM tools that a particular government can use for specific services. The positive outcome of any particular NPM tool fundamentally depends on the government's capability to contextualize the NPM concepts in terms of specific circumstances of a given country. According to Mclaughlin and Osborne (2002), the principles and ideological aspects of NPM have been captured differently by different authors.

It can be argued from the above descriptions that NPM with the principles of managerialism mainly focuses on productivity of organizations. Unlike the customary public administration that focuses on rules, regulations and managerial control, the NPM concept explained by Hood (1991) promotes the role that flexible management can play in enhancing efficiency.

The expression about NPM provided by Hood in Hughes (2003) is more comprehensive in terms of adequately covering its inherent characteristics. Hood's description of NPM includes:

i. Practical professional management in the public sector based on true decentralization of powers to lower level public managers so that they can effectively manage their departments. True devolution of power makes managers responsible for the results of their departments and leads to individual accountability for their actions.
ii. Result based performance management which mainly emphases outcomes instead of outputs. To ensure this, work units are expected to develop performance indicators to

track progress and compare against plans. Result oriented performance measurement can also be used as an objective decision making tool to motivate and reward employees.

iii. Performance planning followed by program budgeting that facilitates output controls. In performance and program based budgeting, budget is allocated on the basis of specific programs of departments. This new approach to planning and budgeting ultimately helps for better alignment of operational activities to achievement of strategic objectives of organizations.

iv. Effective decentralization supported by true devolution of power in which large government departments are split into smaller policy departments in order to enhance efficiency through autonomous planning, resource utilization and problem solving at their respective levels .

v. Market and competition based delivery of public services through open tendering which adds value to cost reduction and quality improvement.

vi. Management practices based on private sector styles that focus on pragmatic and flexible approach to human resource acquisition, development and utilization.

vii. Efficient resource utilization by effectively applying cost reduction strategies that aim at minimizing wastage and maximizing resource productivity.

The different reform programs that are planned and implemented drive the ideas of the reforms from the above classifications and characterizations of NPM. The explanations given by Hood, by and large, advocate the relocation of private sector forms of governance and organization to the public sector. In short, the argument is that the management principles should be universal in the sense that they should be applied to both private and public sector in a fairly similar manner (Flynn, 2008). According to Barzelay (2001), by structurally and conceptually changing the traditional public sector to private sector styles, advocates of NPM theoretically argue that efficiency and effectiveness of the public sector can be improved. The assumption behind this argument is that the private sector is generally more efficient and effective in service delivery.

From the perspectives of political and social objectives, the body of literature is still shallow in terms of the NPM's ability to effectively address the equity, affordability and good governance in service delivery. Challenging the traditional bureaucratic system of administration NPM

scholars argue for the introduction of market forces in the delivery of public services (Hughes, 2003; Mclaughlin and Osborne, 2002). This theoretically sound argument is, however, challenged in different ways. On one hand, the application of the concept in developing countries is not empirically tested with adequate research and delivering public services using the market mechanisms have several practical challenges in poor countries. On the other hand, critics argue that NPM seems to be obsessed with the private sector and its management styles. As Lane (2000) argues, the assumption that the private sector is an efficient allocator of resources and hence making use of all its approaches of management should be questioned given the recent economic crisis in countries which overwhelmingly relied on the private sector. Limitations of the private sector will be further discussed later in this chapter.

The preference for the private sector styles of management clearly entails greater prominence on competition within the scope of the public sector. According to Kalimullah et al. (2012), the NPM movement advocates that public services should be delivered within the framework of productivity and efficiency by doing more with less. It can be implied from this argument that whatever specific list of options is selected from the NPM package, productivity and efficiency should be important criteria to measure their feasibility and success.

The interest in the private style of management in the public sector is that within the NPM framework organizations with better performance higher emphasis on quality, value, customer satisfaction, and results instead of excessive reliance on rules (Gruening, 2001; Larbi, 1999). The purpose of this argument is not to entirely disregard the importance of rules and regulations in an organization. As indicated in the previous section, it is not the prevalence of rules and regulations that matters in public sector management; it is rather the way they are used in managing the day-to-day affairs of organizations. In this regard Walle and Hammerschmid (2011) underscore that rules and regulations are helpful but the fundamental concern of NPM theory is that, placing undue prominence on rules and regulations by remarkably compromising quality and swift service provision to citizens. When applied to the management of public services, as Andrews and Walle (2012) argue, rules and regulations should augment, and not pin down, equity and the enhancement of public service accessibility.

More importantly, the justification behind NPM is a shift from inflexible control-oriented to relatively easier and approachable service-oriented public organizations (Mclaughlin, Osborne

and Ferlie, 2002). According to Lynn (2006), NPM approach is followed by a strong argument for the introduction of competitive contracting in public service delivery instead of the traditional procurement. This clearly implies that the key market principles of competition, negotiation and contract management that are highly performance-oriented should lead public service delivery. As Hughes (2003) puts it correctly, the fact that governments were faced with diminishing real income but with politically demanding responsibility of maintaining services at the same level has pushed governments to opt for NPM as an important alternative approach. While the capacity of the public sector to effectively address citizens' needs was being challenged mainly due to resource pressure (Fetresco et al, 2010), there was an endlessly growing demand to augment productivity and continuous quality improvement in the delivery of public services, which led to the birth of NPM.

According to Hood and Loudge (2006), the enhancement in the performance of public organizations and the greater use of the private sector in the delivery of public services is possible and realistic to overcome the challenges of the public sector. When public services are delivered using one of the appropriate NPM arrangements, Grimsey and Lewis (2004) underscores, reliable, efficient, competitive and open public procurement system should be in place for contracting out and contracting in some goods and services from the private sector. This approach should also avoid monopolistic tendencies in the delivery of public services.

The assumption behind this argument should be tested carefully. On one hand, dependable, efficient and competitive procurement system requires the prevalence of developed and well functioning private sector and this should be practically proven. On the other hand, working within the NPM environment not only required the prevalence of dependable market system, but also strong public sector capacity to effectively plan, implement and regulate NPM approaches.

The arguments by Jamali (2004) and Hughes (2003) are also prominent in the sense that the prevalence of suitable public policy environment and appropriate legal backing are essential requirements to introduce market-oriented style in the delivery of public services. Though NPM advocates contractual relationships that are mainly based on performance, the important foundations for such approach should be given priority and worked out for dependable service delivery in the public sector. The application of market principles and business practices in public institutions has its limitations. In line with this, the argument by Graut (2008) highlights

that in some cases; the introduction of NPM and the involvement of the private sector may complicate public sector governance. Though this argument is put forward from the perspective of the profit orientation tendency of the private sector and the obsession to control this tendency by the public sector, a well functioning NPM as Hess and Adams (2007) stress is essentially based on mutually beneficial cooperation and trust based relationships.

The above discussions clearly imply that the application of New Public Management and its derivative menus can be safely used as a public sector management approach regardless of the political ideology. The utilization of public private partnership models and the concept of managerialism in the delivery of health services in Addis Ababa can be studied within the context of the political ideologies of the incumbent government. However, how governments can contextualize the application of PPPs within their political and economic policies is an issue for research, which is addressed in this study.

2.2.3. The Private Sector and Public Service Delivery

The discussions about NPM point towards the need to move away from the traditional model of public administration and look for private style of management which will be incomplete without further discussing the general background and characteristics of the private sector. For the purpose of this study, the private sector is defined as a set of formally or informally established institutions with the purpose of generating profit by delivering goods and services (Lane, 2000; Broadbent and Laughlin, 2003). It should, therefore, be noted that non-state actors such as voluntary organizations, NGOs and all other civic and professional associations are outside the scope of this research. The following sections of this chapter discuss the overview of the private sector, its backgrounds, management styles and inherent weaknesses. These discussions will lead us later to the conceptualization of PPP, which is the focus of this study.

The term private sector covers wide ranging set of institutions that operate under profit objective. According to Osborne (2010), the basic objective of the private sector is profit generation through the delivery of goods and services demanded by citizens. In a free market environment, the private sector usually faces competition and the inherent risks which in turn serve as a source of motivation to enhance productivity, efficiency and effectiveness in order to ensure reasonable profit from its operation.

Theoretically, as Oflynn (2007) argues, the competitive atmosphere provides the motivation for higher productivity and encourages overall innovation of the private sector. The assumption that competitive service delivery, ultimately leads to low cost and high quality services should be proved through empirical research. Though Arnold and Kehl (2010) argue that competition yields benefits to consumers and, therefore, should be encouraged, how high impact social service such as health can be delivered is still open for research.

One of the key limitations related to the private sector arises from its inbuilt profit objective. The private sector may involve in legally and morally unacceptable practices for the purpose of maximizing its short term profit (Bel, Fageda and Warner, 2010). The private sector's misbehaviors are largely associated with its unregulated profit objective. For instance, Graut (2008) and Oxfam (2009) argue, quality of services in the private sector may not be necessarily better than that of the public sector in circumstances where the private sector is gratuitously obsessed with short term profits that may even compromise the citizen's wellbeing. Similarly, as Logomarsino (2009) emphasizes, unregulated private sector is often worse than the public sector service delivery. It is also strongly argued that issues of equity, accessibility, transparency, inclusiveness and other public interest goals are less emphasized in the private sector.

In management approaches where partnership with the private sector is opted for, governments and citizens are usually skeptical of the private sector. This is because there are several evidences in which the private sector interest conflicts with the public sector interest. In the study of public private partnership in the health sector, the actual and perceived limitations of the private sector will be discussed by looking at the extent to which this sector is oriented towards public interest goals and is ready to take risks in the health sector of Addis Ababa City.

As public private partnership in the health sector involves the private sector as an integral element, the analysis of the private health sector in Addis Ababa will provide an important foundation to establish the study of policies, practices and challenges in PPP. Part of chapter four of this study addresses the features and status of private health sector and its service delivery and links the findings to the analysis of PPP in health sector of Addis Ababa.

2.2.4. Public Private Partnership and Service Delivery: Concept and Background

2.2.4.1. Introduction

Public Private Partnership is one of the approaches to public sector reform programs initiated as a result of the weaknesses in the traditional public administration. It is to be recalled that the past few years have testified several reforms in public sector governance and such reforms have been motivated by different internal and external factors. As the result of the weaknesses in the traditional public administration, Hughes (2003) underscores, low employee motivation in the public sector followed by low public sector efficiency and the citizen's lack of confidence in public service delivery, NPM emerged as an important alternative in public sector governance. The challenges in the public sector in terms of responding to the needs of the citizens have generally convinced government officials to look for service delivery approaches that are more market-friendly and efficient. As will be discussed in detail in the next sections, PPP is one of the most prominent NPM approaches is getting popularity in the areas of infrastructure and service delivery.

2.2.4.2. Defining Public Private Partnership

As any concept in public administration, public private partnership does not have universally accepted single definition. However, despite the variations in the perspectives and the scope of the issues covered in the definition, they all fundamentally mean the participation of the private sector in public sector issues. According to Akintoye and Beck (2009), public private partnership is defined as a continuous relationship between public and private organizations which involves a commitment for relatively longer time period, and a mutual sharing of the risks and rewards of the interaction. The definition given by Michell (2008) appears to be wider in scope. He defines PPP as collaboration among business, non-profit organizations and governments in which risks, resources, and skills are shared in initiatives that benefit each partner and the society at large. On the other hand, Akintoye et al. (2003) and Khanon (2010) define PPP as a supportive arrangement between the public and private sectors based on the capability of each partner that best meets clearly specified public needs through the careful distribution of resources, risks and benefits. The above definitions seem to have different perspectives on the concept of the private sector in the PPP definition. Inclusion or exclusion of the not-for-profit sector in the definition of PPP is always an issue of debate among authors.

Despite slight variations, however, it can be inferred from the definitions, that PPP arrangements are based on the willingness of the two parties. More importantly, the willingness on the part of government to involve the private sector in a contractual arrangement based on something more fundamental than short term and ad hoc interactions is an important requirement. As will be discussed later in this chapter, the willingness and commitment of the government to involve the private sector should be explicitly expressed in its national policy documents, which in certain ways reflect the political ideologies of working with the private sector. This is clearly evident even in developing African courtiers such as Nigeria, South Africa, Ghana that have clearly articulated and explicitly defined national PPP policies that show the political and public policy space for partnership with the private sector (Government of Nigeria, 2005; Government of South Africa, 2004; Government of Ghana, 2011).

Referring to the above definitions, several conceptual issues can be driven and clarified. It can be inferred from the definitions that PPP is different method of public service procurement by combining the best of the public and the private sector with an emphasis on value for money and delivery of quality services to the public. The procurement approach is mainly different from the traditional approach in the sense that it gives due attention to mutual benefits and long-term sustainable relationships. Another inference that can be made from the definitions is that PPP is a formal partnership between public sector organizations and the private sector. This does not, however, necessarily mean that PPPs cannot be informal at the initial stage. There are empirical evidences that the early stage of PPP can take the form of informal partnerships (IFC, 2011). The term formal in the PPP definitions refers to the partnership between the two parties established through agreed and signed contracts that govern their entire relationship. Procurement and risk sharing arrangements are also conducted based on clearly articulated formal contractual documents.

As the definitions imply, cooperation between the public and private sector involves a joint definition of measurable performance targets and a clear allocation of responsibilities as well as careful identification of areas of competence between the public and private sector organizations. It can be understood that the cooperation is a lasting and unwavering relationship between the partners. Throughout the partnership term, the partners share the risks and rewards of the partnership in proportion to their level of investment in the project being undertaken by the

partnership. It can also be inferred that PPPs involve shared responsibility and, to some extent, authority in activities and outcomes emerging from the interactions.

The most important concept of PPP is that it is a sustainable and long-term relationship. As Grimsey and Lewis (2007) indicate, single and ad hoc agreements to supply goods and services do not qualify PPP. Though the duration of PPP arrangements may vary among different projects or different types of services, most PPP projects have long-term durations of more than five years. In these contractual arrangements, resources from the public and private organizations are pooled and the responsibilities shared so that the efforts of the partners complement each other in the provision of public services (Akintoye et. al, 2003).

It can be inferred from the definitions also that PPPs should carefully address the mutual benefits of the partnering institutions. As Nikolic and Maikisch (2006) and Shaw (2004) underscore, the two parties should recognize that their involvement in the partnership will make them better off as compared to operating independently. This idea is further elaborated by Yescombe (2007) that PPPs are collaborative arrangements that are designed to facilitate the leveraging of any strengths or competitive advantage that may exist between partnering organizations so that they can obtain an increased amount of return for a given level of risk taken in the context of these partnerships. The benefits to the parties may be financial or non-financial reward. An argument by Calabrese (2008) emphasizes that the return on investment to the private sector that is engaged in PPP should be clearly expressed as financial gain. However, Dasante and Bzwi (2007) and Brainard (2006), taking a wider perspective of reward to the private sector, argue that rewards that are non-monetary at least in the short run, may attract the private sector to engage in PPPs even more than direct monetary incentives. Akintoye et al. (2003) also add value to the above argument that PPPs can be viewed as a form of a relationship based on mutual trust in which each partner is, to a large extent, a principal in its own right and, therefore, does not necessarily rely heavily on the other partner. Whatever type of reward the partners gain from the interaction, as African Development Bank (2013) and Barrows and David (2012) emphasize, the partnership should be supported by means of a contract which specifies the rules which govern the relationship and provide the partners with some assurance of the basic outcomes.

The definitions explained above clearly indicate that PPPs in their real sense require the understanding to the political, economic, financial and technical aspects of the partnerships and

developing the PPP contracts within the frameworks of these contracts. This implies that both public and private sector partners need to have sufficient institutional and professional capacity for the successful implementation of PPP programs. It is particularly important to note that the public sector needs to have appropriate capacity and required institutional infrastructure before engaging in PPP programs. As pointed out, it is usually the responsibility of the government to motivate, nurture and develop the interest of the private sector in such a way that it can have trust, confidence and willingness to work with the public sector. At the early stage of the PPP development, empirical evidence also shows that the public sector goes far to the extent of supporting the private sector through subsidies, tax reliefs and other schemes (Robinson et. al. (2010).

2.2.5. Policies, Legal and Regulatory Frameworks for Public Private Partnerships

The introduction and application of PPP programs should be imbedded in the national policies and strategies of the government. PPP programs may not be effectively aligned to the national development programs in the absence of appropriate public policies that give room for the private sector collaboration and constructive regulation. The theoretical discussions of the policies, legal and regulatory frameworks governing PPP programs are discussed below.

2.2.5.1. Public Policy Environment for PPPs

Public policy is an attempt by a government to address a public issue by instituting laws, regulations, decisions, or actions pertinent to the problem at hand (Denhardt and Denhardt, 2009). More importantly, public policy indicates the intentions of the government to address public problems in certain ways. Akintoye and Beck (2009) argue that explicit policy should be issued by the government to set the direction for implementation of PPP programs. In the absence of clear public policies, government ministries will not have the mechanism to enable PPP ideas to materialize into concrete projects. According to Cheung (2009), PPP policies that align the PPP programs with the national development objectives are required. Adding to this, Musgrove (1996) also indicates that whether a given service should remain in the hands of the state, or be turned over to other private organizations is an important public policy issue that implies the room for PPP projects. It can be inferred from the above argument that the more government gives room for the private sector participation in solving public problems, the more PPP programs can be considered as alternative delivery mechanisms and vice versa.

Public policies that allow for PPP initiatives, as Jakutyte (2012) underscores, should be thoroughly analyzed and researched. His argument is that as public services such as health and education are not commercial products, they tend to be heavily dependent on taxpayers money. Thus, clear social, economic and political objectives should be identified and clarified. From this, it can be argued that mere economic efficiency should not drive the whole direction of PPP policies. In a similar line, Reynaers (2010) emphasizes that public interest goals such as social equity, inclusiveness, accessibility, transparency and accountability should be carefully considered when the participation of the private sector in service delivery in general and PPP projects in particular are considered. Specifically in developing countries, these social and political goals should be given due attention when public policies are designed to introduce PPPs in service delivery and infrastructure development.

The values and principles of the government should also be considered when PPP is opted for. According to UNECE (2008), in addition to the political ideologies of the incumbent party, the values that the government wants to promote in the country should also be given due consideration. An important question here is whether or not PPPs can be accommodated in any political system regardless of the political ideology that the incumbent government is advancing. Given that the concept of PPP initially originated from the NPM movements (Hughes, 2003), which was more of a neo-liberal thought, the feasibility of the concept to be utilized in political systems outside neo-liberal framework needs to be researched.

Public policy about PPPs is a national issue rather than a specific department or government ministry. In this regard, Jamali (2004) highlights that PPP policies should involve all relevant public institutions and their specific units in such a way that the potentials for PPP initiatives in all the public sector entities of the government can be effectively accommodated in the PPP policy. Before a consolidated national PPP policy is developed, public private dialogue that establishes trust and confidence among potential partners is important. By creating a forum in which government officials and stakeholders can discuss their concerns openly, conflicts can be resolved and problems of the different parties can be reduced before more serious problems emerge (Akintoye & Beck, 2009). Similarly, Oflynn (2007) underscores that coordination and cooperation within the government is a good basis for effective policy implementation. The practice of dialogue, cooperation and coordination will have an essential value in reducing or

eliminating contradictions and conflicts between the PPP policy and other pre-existing policies (Harding, 2009). Elaborating this argument, UNECE (2008) indicates that it is essential that stakeholders affected by the new policy be given the opportunity to be involved in the PPP policy preparation.

Scholars argue that getting into PPP programs as a public policy should be a learning process rather than a radical decision. Broadbent and Laughlin (2003) argue that governments should prioritize and identify realistic objectives for their PPP policy based on practical contexts and practices in the specific country and sector. This implies that starting PPP initiatives with projects that are most likely to succeed, which are relatively simple and straightforward, will give lessons to get into more advanced and complicates PPP initiatives.

National PPP policies should as much as possible be attractive to the private sector. In this regard, Cheung (2009) underscores that PPP policy frameworks must provide procedures and confidence to the private partner in such a way that the investor can see working with the public sector as a potential area of investment. For instance, there should be a sufficient number of projects in order to attract the investment interests of the private sector and motivate investors by providing the potential for sustainability. As discussed earlier, the adequate accommodation and ensuring public interest into PPP policies is an essential element that should not be neglected. The arguments for public interest goals in PPP policy is briefly discussed below.

2.2.5.2. Ensuring Public Interest Goals in PPPs

As clearly indicated in the earlier sections, PPPs are alternatives to public service delivery and hence have goals that are essentially beyond commercial goals. Akintoye and Beck (2009) argue that PPPs were initially proposed as a financial mechanism to place government expenditure off the balance sheet. This mere financial strategy was generally unable to create confidence in both private sector investors and even the beneficiaries. Empirically, as Wang (2000) argues, there were concerns that the government sector was losing control over the delivery of essential services such as health, water and education when PPPs were used. These facts ultimately pushed governments to seriously consider a number of public interest goals instead of excessively focusing on the criteria of economic efficiency.

Issues of addressing public interest are even more serious when it comes to public services such as health and education. According to Cohen and Eimicke (2008), governments are expected to design mechanisms to ensure the public that they are the main beneficiaries of projects by defining how PPPs can promote the public interest through PPPs. For instance, public policies may explicitly indicate that there are certain core services which should not be delivered at any price by the private sector. However, the government should adequately justify that the public interest goals of social equity, inclusiveness, accessibility, transparency and accountability will not be compromised when a given public service is delivered by the private sector. Moreover, Dasante and Bzwi (2007) argue that getting to PPP as an alternative approach should simultaneously ensure these public interest goals in addition to the traditional financial efficiency criteria. According to UNECE (2008), services performed by doctors and nurses within public hospitals, teachers within government educational facilities and judges within courts, are regarded as core services which is the function of government to provide while support services such as logistics and general services can be delivered by the private sector. The argument by Reynaers (2010), however, emphasizes that public interest goals can be promoted in both core and support services and should not be undermined in any PPP policy framework.

Continuous formal and informal consultation with the relevant stakeholders will have a remarkable value in addressing the concerns of dealing with public interest goals. In this regard, Hodge (2006) argues that an early and consistent involvement can establish confidence in the private sector. It can also be argued that bringing end-users and those involved in providing the service, their objectives, needs, and concerns can be identified and addressed in the PPP. The more citizens, who are the direct recipients of the services are involved in the PPP policy process, the more public interest goals can be strategically incorporated into the PPP programs.

PPP policies should be based on sufficient knowledge of their benefits and potential drawbacks. Arguments by Jakutyte (2012) and UNECE (2008) stress the importance of undertaking a comprehensive cost/benefit analysis of potential projects. Similarly, Fussel and Beresford (2009) argue when the government approves the project where it needs to involve the private sector through a PPP, there should be a careful comparison of financial and non financial costs and benefits. Although national PPP policies may not necessarily contain an in-depth analysis of costs and benefits (as this is done at individual project level), the policies should stipulate the

detailed study of costs and benefits as a pre-requisite for considering PPP as an alternative to the delivery of specific public services.

Accountability and transparency as essential elements of good governance in PPP programs should be integral parts of PPP policies to ensure public interest. According to Nwowi (2006), issues of accountability and transparency are relatively challenging to the private partners due to the commercially confidential nature of some aspects of their activities. This puts limitations on accountability, which could present a challenge to local authorities and national governments which consider transparency and accountability as essential requirements for democracy and good governance. As a solution to this dilemma, Sciulli (2009) recommends that national PPP policies and specific PPP contracts to clearly address issues of accountability and transparency throughout the PPP process including partner selection, contract management and private sector operations.

To ensure accountability of PPP initiatives, UNECE (2008) emphasizes, there needs to be good performance assessment and measurement in the public services and this work is best accomplished by autonomous bodies, set-up to supervise performance in specific sectors. According to Wallarta (2002), concerns for accountability can be better addressed when the needs and interests of the beneficiaries are carefully taken into account. It is often argued that the citizens need more and more access to different alternatives of services. In this regard, Standing and Bloom (2002) underscore that by increasing choice, governments can create incentives to providers to improve services and performance as funding largely depends of the preferences and demands of beneficiaries.

The argument that the transfer of public service delivery to the private sector may lead to an increased service charge is another concern, which potentially exclude the socially and economically disadvantaged segment of the society. It is often argued that governments are generally expected to regulate undue increase in service charges to protect those who are at risk from higher charges (Lane, 2000).

As will be discussed later in this chapter, to ensure public interests, governments can increase the support to the project in order to ensure the sustainability of existing and new services that are believed to be socially essential. It can be argued that health services that have significant social impact can be delivered through PPP approach only as long as the government gives closer

attention to the issues of social equity, inclusiveness and accessibility. The legal and regulatory frameworks that should guide the initiation and implementation of PPP programs are discussed below.

2.2.5.3. Legal and Regulatory Frameworks for PPPs

Once governments issue clear public policies that stipulate the intention and willingness of the public sector to work in collaboration with the private sector, the legal and regulatory environment should be specifically designed and communicated. According to Cheung (2009), secure, predictable, stable, consistent and commercially-oriented legal and regulatory framework is essential prerequisites for the successful implementation of PPP projects. In a similar line, instead of promulgating excessively detailed and prescriptive procedures, national PPP legal frameworks should be as proactive and flexible as possible to accommodate the likely changes that may occur in sector specific PPP initiatives (Grimsey and Lewis, 2002). The implication of the argument is that the legal and regulatory frameworks should be more of enablers than constraints to the PPP initiatives. For instance, PPP laws should not place heavy legal constraints on investors. This clearly implies that the removal and streamlining of non value adding approval procedures throughout the PPP process and the lifting of legal restrictions on the investors' rights to use the benefits of their investment should be considered carefully (UNECE, 2008).

PPP laws, as Grimsey and Lewis (2007) argue, are not those laws with undue control mechanisms. Similarly UNECE (2008) indicates that better laws are those that are knowable and secure, allowing the private partners to plan investment decisions and to adopt longer term as opposed to short-term perspectives when entering a market. Predictability of PPP laws is an important quality as both the public and private partners identify, analyze and take PPP risks based on the predictability of the law governing the PPP in general. This implies that private investors particularly consider unpredictability and instability of the legal framework as a risk area for their investment in PPPs. The requirement for predictability and reliability is not merely limited to laws specific to PPPs. According to Domberger and Fernandez (1999), other legal frameworks that are promulgated to govern and regulate functions such as investment, tax and customs, security, and contracts should also be predictable. Not only the private partners but also financial institutions look mainly to the legal and contractual framework for protection and want to make sure that the legal environment is fairly predictable. PPP legal frameworks should

include legislations that clarify rights and obligations in PPP processes. Generic PPP laws are important in establishing strong foundation for sector specific PPP contracts. Elaborating on this, Wallarta (2002) and UNECE (2008) argue that private investors prefer common legislation as opposed to sector-specific rules. The justification is that generic laws that are issued at the national level involve numerous lenders and investors while specific legislation on sectors has a smaller constituency and is perceived as more vulnerable to change at the hand of the host government. However, it can be argued that sector specific PPP guidelines are also equally important in terms of regulating and standardizing PPP contracts and specific issues that may arise in the PPP projects.

National PPP legislations promote a common understanding of the main risks and allow consistency of approach. Elaborating this, Akintoye and Beck (2009) argue that approving national PPP laws before embarking on sector specific guidelines reduces the time and costs of negotiation by enabling all parties concerned to agree on a standard approach without extended negotiations. Moreover, national PPP legislations facilitate the dispute handling process in case some conflicts arise between the public and private partners. According to Buse and Harmer (2004) as litigations arising from PPP projects may be expensive and burdensome; the public sector can improve the framework in which commercial disputes are solved. In this regard, the commercial code alone may not effectively address the specific issues of PPP projects and hence calls for national PPP laws to provide legal solution to these disputes. It can also be argued that in the presence of well established PPP legislation, the private partners will be less skeptical towards PPP initiatives and will have more confidence that the judiciary will enforce the laws and enforce contracts if they invest in PPP projects.

As disputes and conflicts throughout the PPP process are expected, initial remedies are usually recommended based on mutual understanding and agreement particularly at the early stage of the disagreement. According to African Development Bank (2013), the prevalence of national PPP legislation will also pave the way for the public and private partners to negotiate and resolve problems within themselves before resorting to the formal courts for solution.

The prevalence of PPP legislation alone is not sufficient for good governance in PPPs. Elaborating on this argument, Hodge and Greve (2005) emphasize that, whatever legal frameworks are in place, the mechanisms of enforcement and how the laws are used is as

important as the legal documents. UNECE (2008) also adds that the public sector which usually takes the leadership role in the PPP process should make the implementation of the PPP legislation friendlier to the private sector by putting emphasis on helping business to comply with rules and become real partners. This argument implies that a uni-directional and strict application of the laws without due consideration of the practical contexts in the PPP environment will jeopardize the sustainability and strategic relationships between the partners.

The development of both national PPP legislation and sector specific PPP guidelines requires adequate consultation with and participation of stakeholders. Cartlidge (2006) argues that right from the beginning of designing rules on PPPs as well as on reviewing the existing rules public consultation and dialogue with key stakeholders should be utilized as much as possible. Values and principles of good governance should be clearly reflected in the legal and regulatory frameworks for PPPs. Explaining this, Urio (2010) highlights that the practice of extending the rule of law to people who do not have access to laws to protect their rights should be given due attention in the implementation process. This, generally, implies that the socially and economically disadvantaged people, who need to improve their access to basic services, should be adequately empowered when PPP laws are enforced. As high social impact services, such as health and education, need to be inclusive and accessible to the poor and socially neglected people, the PPP laws should provide adequate room to accommodate the needs and concerns of these people. The relatively heavy profit orientation of the private sector can be regulated by establishing carefully articulated legal provisions that promote the need for equity, inclusiveness and affordability (Sciulli, 2008). Public services can be more accessible and affordable to the wider constituency, if the legal and regulatory framework formally recognizes and gives room for people who may be potentially deserted due to their economic and social circumstances. Health sector PPPs for instance should clearly indicate the mechanisms for making health services accessible and affordable to the poor who may not afford the service charges levied by the private partners.

The application of PPP laws should mainly follow an adequate public communication and awareness building. According to Akintoye and Beck (2009) and UNECE (2008), creating common understanding about PPP legal environments will help in empowering the public in general and those who may be directly affected by the PPP projects in particular. In this regard, Peterson (2011) recommends that informing and educating the public about their rights to access

good services and to enable them to participate in decision-making, preferably while the project is still at the planning stage should be part of implementing the PPP laws. It can be argued that the public as ultimate beneficiary of services should have the mechanism to monitor, evaluate and correct how the services are delivered through PPPs. To effectively do so and pave the way for citizens involvement, the legal and regulatory framework should clearly indicate how and to what extent the public will actively participate in the governance of PPP initiatives. Institutional capacity, which is another important requirement for the successful implementation of PPP programs, is discussed in the following section?

2.2.6. Institutional Capacity and Public Private Partnerships

Having appropriate policy and legal framework is not a sufficient condition for the effective implementation of PPP in public service delivery. Practically, institutional capacity plays a significant role in determining the success and failure of PPP programs. Requirements of institutional capacity and procurement system, which will guide the data collection and analysis in the later chapters, are briefly discussed below in separate sub-topics.

2.2.6.1. Issues of Institutional Capacity in the Public Sector

A decision to deliver public services through a PPP approach is a shift to new model of public sector governance. As Pasha and Nasar (2003) argue, new skills that fit into this new governance must be developed for PPPs to be effectively implemented. Broadbent and Laughlin (2003) also emphasize that PPP projects involve a number of negotiations, contractual management and financial issues that are clearly diverse from the usual business transactions. For instance, as PPPs require skills that can identify the outputs of projects, institutional capacity should be developed to initiate, plan, implement and evaluate PPP projects with the end result to the citizens in mind.

As clearly presented in the previous section, PPP models are largely embedded in NPM concepts and hence are result-oriented. According to UNECE (2008), result orientation, among other things, involves setting specifications and targets that the private partner has to accomplish in order for the payment to be made and to monitor the performance of the partner and predict any risks that threaten the delivery of the project. The public sector's capacity to identify and nurture private partners from different industries is also essential to the success of PPP initiatives. In this regard, IFC (2011) indicates that governments may not have the capacity and skills to introduce

and implement PPP approaches particularly at the early stage. It, therefore, recommends governments to look for outside technical support at the introduction stage of the PPP approach.

The introduction of PPP should be made in parallel with continuous capacity building activities. Explaining this, Ismail (2013) indicates that it is practically difficult for a government department to change overnight from the status quo, where it has acquired an asset through traditional procurement, to managing the delivery of goods and services using PPP models that involve technically different approach. This argument implies that as an attempt to radically change the traditional approach into a PPP approach requires a learning process that would assist public sector managers to make an informed and well thought decisions at every stage of the PPP process.

As a key institutional capacity for PPP programs, public sector organizations should have PPP units. According to Robinson et al. (2010), the main role of the PPP unit is to facilitate the development and management of the project preparation process as most government organizations do not practically have sufficient expertise in this area. As PPPs generally involve projects with long-term duration, the analysis and preparation of the projects needs careful attention and hence requires PPP units that can help planners and decision makers with the technical and strategic implications of each PPP project (African Development Bank, 2013).

Some countries have PPP units at national, local and specific organization levels. The national PPP units do not usually conduct the projects but provide the policy, technical, legal and other support mechanisms to local authorities and government institutions that have the dependability of initiating the projects (Link, 2006). Having PPP units within the public sector is essential in terms of enhancing the capacity of government institutions and helps them effectively manage the whole PPP process from the development of the initial project initiation to the bid evaluation process and signing of contracts. Spiering and Dewulf (2006) point out that in some countries PPP units are staffed with highly experienced PPP professionals who actively consult managers on the technical aspects of PPP projects such as financial and legal issues.

Delivering public services through PPP may have relatively higher transaction costs. To effectively manage the transaction costs involved in the PPP procurement process, Urio (2010) highlights the role of national PPP unit in reducing lead time and unnecessary costs in order to improve the quality of the PPP procurement process with standardized contracts and procedures.

Moreover, national PPP units ensure the consistency of PPP procurement within the country regardless of the sector and specific project being considered. Furthermore, Spiering and Dewulf (2006) argue that national PPP units can advise the private sector partners as well as government organizations on legal and institutional bottlenecks to the implementation of PPP projects.

National PPP units generally play a leadership role at the early stages of the PPP introduction. In order to discharge their responsibilities effectively, national PPP units need to be well structured and organized with the required staff, materials and other institutional requirements. It can also be argued that the unit should be mandated with clear duties and responsibilities which are augmented by sufficient authority. This argument implies that the role of national PPP units should not necessarily be limited to consultative activities (UNECE, 2013). It can therefore be argued that at least in the due course of discharging their duties, the units should be provided with fairly adequate decision making capacity, which in part, is reflected in their autonomy. According to Wang (2000), the leadership role of the PPP units can only be effectively played if the units are staffed with properly qualified PPP experts and these experts are fully motivated. In other words, attracting, retaining and effectively utilizing highly qualified experts is a key challenge for the public sector. The institutional capacity building process of the public sector should, therefore, essentially include human capital management strategies to develop and utilize key experts who are usually obtained from the competitive labor market. Further stressing this an argument by Wallatra (2002) implies that the failure to have highly qualified staff in the PPP units will ultimately lead to poorly designed and managed PPP projects in individual government ministries.

To build the culture of communication and mutual understanding, PPP units should promote a strong dialogue with all players in the market (Nuwagaba, 2013). This should finally end up in mutual trust and confidence about both the technical issues of the PPPs and the reliability to the public and private sectors to work in collaboration. In some countries, PPP units with sufficient institutional capacity go to the extent of conducting action researches and identify potential areas where PPP approach can be considered (Torchia, Calabro and Morner, 2013). Doing so, the units provide informed professional consultation to both the relevant line ministries and the potential private investors who may wish to provide services through PPP models.

The prevalence of PPP units plays a significant role for capacity building for countries who wish to introduce PPP programs. According to Petersen (2011), PPP advisers who are positioned within the PPP units also play a remarkable role and they can facilitate dialogue between the public and private partners based on government policies and technical guidance. Because of their professional expertise, PPP advisors can arrange different training and consultancy services to the relevant public organizations. It can be inferred from the above discussions that PPP units (both national and sector specific) will consistently invite relevant stakeholders and create conditions to reach consensus on the objectives and strategies of utilizing PPP models for mutually beneficial outcomes.

An argument by Wang (2000) indicates that the key role of the PPP units in establishing strategic relationships with the private sector should not be overwhelmed by conflict of interest and bias towards either the public or the private sector. This argument implies the importance of the PPP unit's impartiality and independence from the private sector to guarantee that PPP processes and outcomes promote the public interest and operates according to the principles of the public sector. In other words, PPPs as public sector governance approach require bodies that can independently scrutinize projects after they have been signed in order to determine whether or not policy objectives have been met. In the prevalence of conflict of interest and deliberate bias, however, the PPP units and the individual PPP experts will be tempted to promote other purposes and ultimately compromise the public interests which are reflected in the positive outcomes of the PPP projects.

In collaboration with the sector based PPP units, the national PPP units need to establish national PPP capacity building programs to build the expertise of government officials (UNECE, 2008). The PPP capacity building program as Farlam (2005) argues should begin from the top level leaders within the government in order to establish both leadership and technical competencies regarding PPP approaches. When the capacity building programs are cascaded down to the operational levels, more emphasis should be given to the practical skills such as PPP planning, project management, PPP accounting and financial management, PPP contact administration, monitoring and evaluation and other essential skills (ADB, 2013, UNECE, 2008).

Capacity building for PPPs should not be limited to a single sector. Since PPP as service delivery approach is a national issue, cooperation among different sectors is required in PPP training

programs because it saves resources and avoids reinventing the wheel each time a country launches a PPP program (UNECE, 2008). National PPP units should technically assist government institutions to establish their own units and build their capacity in the above technical and leadership areas. More importantly, capacity building efforts of the government at both national and sector levels requires technical assistance from other countries that are known to have best practices with regard to PPP approach in public service delivery. Stressing this idea Grimsey and Lewis (2004) underscore that, to the extent possible, outside expertise should be utilized in order to establish favorable foundation to initiate PPP programs in a given sector or country. It can also be argued that the need for external assistance and professional support is imperative particularly at the early stage of the PPP initiatives. For countries that are initiating PPPs, Nikolic and Maikisch (2006) argue the key requisite is to give the necessary skills, usually by recruiting external PPP advisers.

While it is advisable to have PPP experts hired as consultants or technical advisors at ministry levels, UNECE (2008) underscores the care that should be taken in the process of hiring the experts. It is argued that only credible advisors with appropriate experience are recruited, while setting clear and binding rules of project governance, putting sufficient control mechanisms in place, and developing standard contract guidelines in order to maintain a seamless integration of the external advisers within the relevant government department. The capacity to identify, negotiate and enter into contract with the right partner is considered as a PPP procurement system. This system as an important component of institutional capacity is briefly discussed below.

2.2.6.2. Procurement Systems in PPPs

Right from the beginning, the elementary concept of PPP is an approach to the procurement of public services and infrastructure (Akintoye, Beck and Hardcastle, 2003). Good procurement system adds value to the institutional capacity, if it fulfills some aspects of good governance that will be discussed under this section.

Procurement in a fairly functioning system is based on the principles of competition and merit. According to Shaw (2004), transparency in PPP procurement means ensuring that information about the PPP procurement and contract management regime and individual PPP opportunities are made available to all interested parties. PPP procurement system is said to be transparent, if

all the relevant stakeholders and particularly the private sector partners have relatively open access to information related to the PPP process. Pasha and Nasar (2003) also add that transparency calls for procurement policies and practices that are seen to be fair in all respects, with full information available and openly accessible. It can be fairly argued that transparent PPP procurement system promotes competitive procurement process in which governments select private partners based on their relative competence and economic benefits for the public at large. Further stressing the need for transparency, UNECE (2008) underlines that in the PPP procurement process, partner evaluation and contract award criteria should be made known to all interested competitors in advance for each individual project.

Information regarding the PPP contract statement, bid appraisal and selection procedure should all be retained in safe custody and made available for those who may need them. Similar argument by Cohen and Eimicke (2008) indicates that the content of the PPP contract should be made clear to parties who require information at any time. Good procurement system that makes information available and accessible enhances the sense of ownership of the stakeholders and facilitates their involvement in the monitoring and evaluation of the PPP projects including the outcomes of such projects to the community (Grimsey and Lewis, 2007; Hodge, 2006).

Despite the fact that the essential guiding principle of PPP procurement system is to make sure transparent and open procurement process, the need to guarantee secrecy of the PPP bid should not be undermined. According to UNECE (2008), in cases where the procurement involves the protection of patents and copyrights, or for national security reasons, the PPP procurement should reasonably maintain the secrecy without significantly compromising the transparency which is the essential requirement of PPP system.

The procurement system of PPP projects should also be governed by certain principles that are reflections of good governance framework. These principles may include the following. On one hand, the PPP procurement manual should clearly allow the private partners the right to complain to the extent of appealing to the formal justice system in case the party perceives that the PPP procurement and partner selection process are inappropriately handled (Grimsey and Lewis, 2004). It can be implied from this argument that both the bureaucratic and formal court systems should invariably promote justice and respect the rule of law throughout the PPP

process. The public administration in particular should be committed to provide prompt corrective measures with the principles of fairness to both parties.

On the other hand, Nisar (2007) indicates that an independent monitoring authority with powers to self-initiate investigations into the PPP procurement practices can play an important role in monitoring the implementation of the rules by individual procuring entities. As clearly indicated in the NPM guiding principles, PPP procurement system should separate the provision and regulation (Lynn, 2006; Hughes, 2003). This implies that public organizations which directly participate in the bid processing and partner selection process should not also conduct the monitoring and evaluation of the process. As a recommendation to resolve the provider-regulator controversy, UNECE (2008) recommends the establishment of a separate agency, which has responsibility for overall procurement policy formulation in the PPPs and the authority to exercise outright oversight regarding the proper application of the procurement rules and regulations.

One of the challenges of ensuring good governance in PPPs is avoiding or at least reducing conflict of interest in the procurement process. Grimsey and Lewis (2004) argue that the contracting authority should be completely independent of the projects and the companies involved in the bidding in order to avoid a conflict of interest. This argument implies that conflict of interest that may arise at any stage, particularly during PPP negotiations and contract offering should be carefully watched and loopholes for corrupt practices be effectively addressed.

Equality of access to competition and the right to be treated equally throughout the bidding and partner selection process should also be given serious attention. Related to this argument, UNECE (2008) underlines that non-discrimination during the PPP procurement process is usually achieved through the creation of rules specific to this issue, as well as more general requirements not to act in a way which could diminish fair competition. An argument by Cartlidge (2006) also indicates that equality of opportunities is measured based on the extent to which private partners are given chances to bid for PPP projects regardless of their origin, type of ownership and an industry to which they belong. However, it can be argued that governments which are highly oriented towards the public sector delivery, as discussed in the earlier section, may sometimes be more interested to select partners which are affiliated to public enterprises at

the expense of competency. As this tendency clearly compromises equality of opportunity for the pure private partners to participate in PPP project competition, the government should explicitly indicate that the opportunity is equally open to all bidders and no discriminatory actions should take place at any stage of the process. PPPs fundamentally require risk identification and efficient allocation with the spirit of mutual support. Issues of risk sharing and mutual support are briefly discussed in the following section.

2.2.7. Risk Sharing and Mutual Support in PPPs

The actual practices of PPPs involve various types and levels of risks for both public and private partners. The inherent feature of PPPs involves effective risk identification, analysis and proper allocation. As this thesis tries to investigate, the mechanisms and challenges of risk sharing and mutual support in the PPPs of the Ethiopian health sector, the theoretical foundations of risk identification, allocation and mutual support in PPPs in general are discussed in the sub-sections below.

2.2.7.1. Risk Identification and Allocation in PPPs

Any business commonly involves some level of risk. Akintoye et al. (2003) define risk as a probability or threat of damage, injury, liability, loss, or any other negative incidence that is caused by external or internal susceptibilities, and that may be avoided through anticipatory action. The assumption in PPP approach to service delivery is that, whatever risks are involved in the due course of the PPP projects, the risks can be identified, analyzed and properly allocated to the private or public partner which is best capable of managing them (Grimsey and Lewis, 2002). However, Jakutyte (2012) argues that the shift and the degree to which the private sector is ready to take the risks sometimes affect the viability of projects. The controversy over identifying and allocating risks in PPP projects arises from the highly risk averting characteristics of the private sector. In line with this argument, Wang (2000) underlines that though most public services are socially essential to the community; lenders tend to be highly risk averse and will disregard even the most socially essential project if they perceive it to have high risk.

This tendency of the private investors to be highly sensitive to risks is a serious challenge for the public sector organizations which are highly interested to work with the private sector. Illustrating this argument, a study by Bojovic (2006) indicates that repeated invitations made by

public organizations in some public service delivery projects may fail to attract sufficient number of interested private partners, which ultimately frustrates the public sector.

The skill to identify, analyze and properly allocate risks should be available within the public sector institutions. According to Domberger and Fernandez (1999), during the initial stages of the PPP project identification and preparation, it is mandatory to list all the pertinent project risks and their possible allocation. It can also be argued that risk identification and allocation should be a continuous process. For instance, Joyner (2007) and Nisar (2007) argue that having a inclusive list of possible risks will help the partners to exhaustively address each risk during negotiations and incorporate which risks are handled by which party. This will also be clearly stipulated in the PPP contract document, which will facilitate risk monitoring, evaluation, reporting and learning.

The PPP partners can use different mechanisms to mitigate or manage PPP risks. According to UNECE (2008), the public sector for instance can use a number of tools such as insurance to mitigate the risk of a force majeure event, which could damage a state-owned property essential to the private component of the project. However, scholars argue that the public sector organization which is planning to engage in PPP should thoroughly study the possible risks and maintain up-to-date information about the properties that need to be insured. In the due course of the PPP project implementation as Akintoye, Beck and Hardcastle (2003) argue, the concerned government institution should establish a risk monitoring system to ensure that services are delivered according to contracted performance specifications. This requirement implies that risk monitoring and evaluation should be part of the project performance that will determine not only the immediate decisions for service payments and other administrative measures but also for future and long term relationships with the partner under consideration.

Risk identification, analysis and allocation should focus on several types of risks. For instance , Klijn and Teisman (2002) argues that at macro level, governments are supposed to address political risk, including the fear that governments will come in unilaterally and change the rules that may have immediate adverse effect on the private sector in general and PPP approach in particular. It can, therefore, be argued that during the negotiation and allocation of PPP risks, the government should be willing and committed to take risks associated to the political factors of the system. Bureaucratic risks which are generally related to the structures and systems of the

public sector are also key areas of concern for the private investor. Bureaucratic risks pose a challenge to the private sector by delaying important decisions and unduly increasing transaction costs of PPP projects. According to UNECE (2008), like the political risks, bureaucratic risks can also be analyzed and allocated to the public sector. The argument is that the government can make some adjustments to the bureaucratic structures and systems in such a way that the bottlenecks to important activities are resolved.

According to Nisar (2007), the government can provide different types of support to mitigate the risk to the private sector. Discussing about the possible approach to reduce PPP risks Robinson et al. (2010), for instance, argues that governments can use guarantees as an appropriate form of government intervention, in particular to shield the private sector from risks that it cannot anticipate or control. Similarly UNECE (2008) indicates that the public sector organization can set a minimum revenue guarantees that bound the private sector's exposure to demand risk. The public sector guarantee clearly implies that governments take on liabilities which have important fiscal implications once the risk analysis proves that the government is the appropriate body to assume the risk. The above arguments imply that the more the public sector is ready to take risks under its jurisdiction, the more private partners will be willing to engage in collaborative ventures. To realize mutually supportive risk sharing environment, governments must stay focused on the fact that the whole point of the PPP is to improve performance of the project and this requires flexible negotiations with respect to risk sharing (UNECE, 2008)

PPP risks are not similar throughout the project process. According to Akintoye et al. (2003), most of the PPP risks are usually higher at the early stage of the project and gradually diminish once the project goes operational. This indicates that for projects in which the risks are properly managed, the monitoring of risks and effectively learning from each stage of the projects helps to mitigate the risks before they actually occur. It is, however, strongly recommended that both the public and private partners collaborate in monitoring the risks as the project progresses and make sure that each risk element is being efficiently handled by the appropriate body.

2.2.7.2. Government Support for PPPs

It was discussed earlier; PPP is an approach to deliver public services in mutually collaborative and beneficial relationships. However, as Reynaers (2010) argues, particularly at the introduction level, the public sector should go half way and encourage the private sector to take part in the

partnerships. In line with this, Calabrese (2008) underscores that the decision to support the implementation of a PPP project should be based on an assessment by the government of the economic and social value of the project with clearly convincing justification that the government should provide some sort of support to nurture the partnership. Exemplifying the justifications for government support, Akintoye and Beck (2009) highlight that, some PPP projects may not be financed by the private sector alone due to unbearable financial requirements at the building stage of the projects. This implies the need for government intervention in the form of facilitating access to loan and other mechanisms of financing the project.

Generally, UNECE (2008) argues that the existence of uninsurable political risks is a clearly evident justification for the government to provide guarantee for PPP projects in which the private partner is so doubtful to the extent of refraining from such projects regardless of their return on investment. Sometimes the government may also decide to deliver public services at low cost due to their high impact to the public at large. According to IFC (2011), provision of subsidy to the private provider is acceptable if there is a credible reason that the services should be provided at lower cost without significantly affecting the profit margin to the private service provider. Governments are generally considered to have greater risk bearing capacity as compared to their private counterparts. As Akintoye et al. (2003) argue political, legal, bureaucratic, economic and financial risks can be better managed by the public sector due to the inherent mandates of the government to regulate these issues.

Financial support from the government to the PPP can be provided in different ways including the provision of subsidy, financial instruments and guarantees (UNECE, 2008). However, it can be argued that financial support provided to the PPP initiatives should ultimately benefit the end-users by enhancing affordability of public services to more and more people. Moreover, public support to PPP projects can be provided in all or some of the following ways.

Firstly, the government can facilitate conditions for the private investor to gain access to investment capital through loans (Hodge and Greve, 2005). The arguments for government support for PPP projects imply that in order to encourage the private partner by resolving its financial constraints, the government can facilitate interest free or low interest loans from financial institutions. However, access to investment capital for PPP projects should be an integral part of the national policy issue and should not be decided on an ad hoc basis. Secondly,

the government can provide support to PPP initiatives in the form of guarantee for the repayment of loans. According to Akintoye and Beck (2009), when the government provides public guarantee, financial institutions will be encouraged to provide loan to the private investor wishing to engage in PPP projects. Thirdly, the government can also support PPP programs by providing tax and customs related benefits. Dasante and Bzwi (2007) argue that some governments provide tax relief for private partners engaged in PPP projects. It can be argued that the tax relief should not only encourage more private partners to PPP projects but also should be reflected in the amount of user charges levied on end-users. Some governments also provide duty-free and other customs privileges to encourage private investors in PPP projects. Finally, at the early stages of the introduction of PPP, governments conduct communication and education programs to raise public awareness about services provided through PPP models (UNECE, 2008).

It can be further argued that awareness raising programs which are best conducted by the public sector are used to create more demand for services in such a way that demand related risks for the private partner are reduced.

2.2.8. Theoretical Framework for Analyzing Public Private Partnership

The concepts and backgrounds of NPM discussed above generally advocate market-oriented public service delivery and the application of private sector style of management. However, it is worth noting that the NPM approach in general and PPP in particular is embedded within certain theoretical foundations, which is also utilized in this research. As Lynn (2006) argues, several theories provide the philosophical underpinnings and justification for the changing role of government in general and market-oriented private sector involvement in public service delivery. These include Institutional Theory, Systems Theory, Rational Choice Theory and Principal Agent Theory, which have important roles in analyzing the individual research questions stated in chapter one. The four theories discussed under this section are used as a framework to understand the policies, legal and regulatory environments, institutional issues and capacities, risk sharing tendencies, commercial orientation in PPPs, mutual support and cooperation, PPP procurement system and other important issues raised in this research.

2.2.8.1. Institutional Theory

In any discussion on issues related to public-private partnership, there are two important entities involved: the public sector and the private sector. The interactions, interfaces and collaborations between these entities can be explained using institutional theory. Institutional theory focuses on the deeper and more pliant aspects of social structure. According to Scott (2001), institutional theory explains the processes by which structures, policies, rules, norms, and routines become established as authoritative processes that govern social behavior in all aspects. Providing an important framework as an analytical tool, institutional theory explains how policies, rules, norms and other elements are created, diffused, adopted, and adapted over space and time; and how they fall into decline and disuse (Scott, 1987).

Tolbert and Zucker (1999) describe institutions as social structures that have attained a high degree of flexibility and adaptability. Institutions are composed of cultural-cognitive, normative, and regulative elements that, together with associated activities and resources, provide stability and meaning to social life. The most fundamental analytical framework of institutional theory is embedded in the inherent characteristics of institutions. This is well explained by Hodgson (2006) that institutions are transmitted by various types of carriers, including symbolic systems, relational systems, routines, and artifacts. Though institutions by definition imply stability and ongoing operation they are generally subject to change processes, both incremental and radical in some way.

Another important analytical relevance of the institutional theory to the study of public private partnerships is given by Scott (2001). He argues that in order to survive, organizations must conform to the rules and belief systems prevailing in the environment because “institutional isomorphism”, both structural and procedural, will earn the organization legitimacy. This implies that not only the establishment of organizations but also their day-to-day operations should be based on set of policies, rules and regulations that give the organization and its activities acceptable legitimacy. It can also be argued that institutions are not collections of individual actions; they are rather structures and standards that guide individual actions within organizations.

Although organizations in different types of environment react differently to similar challenges (Ebner and Beck, 2008; Furubotn and Richter, 2008), these different challenges are mainly attributed to the set of rules and regulations governing the institutions. In this regard, Scott (2001) underscores that, social, economic, and political factors, constitute an institutional structure of a particular environment which provides organizations with advantages for engaging in specific types of activities within the system. The argument here goes that these social, economic and political factors should be captured and adapted to the policy environment. Institutional theory strongly argues that organizations perform efficiently and effectively in attaining their mission, if they receive adequate institutional support (Najeeb, 2014; Meyer and Roman, 2006). Based on the essential idea of institutional theory, it can be argued that flexibility and sustainability of activities of organizations will be seriously endangered in the absence of legal and institutional framework that gives organizations not only legitimacy but also a roadmap for processes and results.

The theory of "institutional deficiencies" clearly elaborates that organizational activity in the absence and careful implementation of policies, rules, regulations and other institutional frameworks (Scott, 2001). It is argued that relationship-based transactions will prevail where rule-based markets cannot flourish due to institutional deficiencies. The theory of institutional deficiency provides a powerful analytical framework in the sense that absence of clearly established and exhaustively implemented institutional tools (policies, rules, regulations etc…) may adversely affect organizational performance. For instance, Scott illustrates that personal connections, informal information, and blurred business-government relations (which also encourage corruption) will constrain the development and transformation of organizations. The study of public private partnership in the health sector of Addis Ababa utilizes the arguments of institutional theory to analyze the policies, legal and regulatory frameworks, institutional capacity and other relevant elements in PPP practices and challenges.

2.2.8.2. Systems Theory

Systems theory provides another important theoretical foundation for the study of inter-organizational collaboration and partnership. In his description about systems theory, Amagoh (2008) defines systems as a set of interrelated and organized parts working together in a coordinated manner in order to attain some common purpose. These elements continually affect

one another, directly or indirectly, in order to survive as a coordinated entity, and attain the objective of the system (Laszlo and Krippner, 1998). Systems theory also highlights that the behavior of each element in a system has an effect on the behavior of the whole; the behavior of the elements and their effects on the whole are interdependent; and while subgroups of the elements all have an effect on the behavior of the whole, none has an independent effect on it (Schnider and Somers, 2006). Systems theory explains that systems have sub-system and the interrelationship and interaction among the elements moves towards equilibrium of the whole system.

The above explanations of systems theory provide an essential analytical framework for the study of public and private sector organizations. The following are additional characteristics of systems, which are used to analyze how the components and sub-systems are interrelated and interact with each other (Zokaei, Seddon and Omonovan, 2011). Firstly, all systems have inputs, outputs and feedback mechanisms which help them attain their goals in a self correcting manner. Secondly, systems generally maintain an internal behavioral consistency regardless of changes in the external environment. Systems maintain their equilibrium and survive in the environment internally by regulating and correcting themselves and externally by adjusting to environmental changes. Practically, almost all systems are open systems in the sense that the input-process-output interactions take place with other systems in the external environment. Thirdly, systems exhibit peculiar features that are different from the whole but are not possessed by any of the elements of the system at an individual level (Caldwell, 2012). Finally, systems have boundaries that are usually defined by the system observer. Systems seize to function when an element is removed or significantly altered. Together, they allow understanding and interpretation of the universe as a meta-system of integrated wholes, and organize our thoughts about the world (Amagoh, 2008).

Systems theory as an analytical framework for the study of public private partnership is applied to conceptualize the health sector of Addis Ababa and analyze the policies, practices and challenges of PPP in the health sector. The legal and regulatory environments within which the public and private health systems interact are analyzed using the theoretical features of systems. Moreover, the risk sharing mechanisms, the mutual support and cooperation among the different

systems and the procurement policies and practices are studied using concepts from systems theory.

2.2.8.3. Rational Choice Theory

The research problem and individual research questions stated in chapter one can be analyzed using the concepts from rational choice theory as a framework. According to Oppenheimer (2008), rational choice theory is a framework for conceptualizing social-economic behaviors. He describes rationality as purposeful, well thought decision to optimize ones benefits. Rationality, according to Vos and Abraham (2002), also refers to well thought decision and action of an individual that such decisions and actions are taken if costs of doing something balance with the benefits that would be derived from the action. Man as benefit maximizing animal acts in a very rational manner to engage behaviors and deliberate decisions that ensures his utility. Rational choice theory, which is being applied in the study of economics, political science, public administration, sociology and other disciplines, explains the inherent behavior of human beings of looking for the most efficient decision in achieving goals (Feiock, 2007). Individuals choose the best action according to identifiable functions, and constraints facing them. Oppenheimer (2008) underscores that the fundamental idea of rational choice theory is that patterns of behavior in organizations and societies reflect the choice made by individuals as they try to maximize their benefits and minimize their costs.

Rational choice theory, though conceptually appealing, is constrained by what scholars call “bounded rationality”. Bounded rationality, here, refers to the constraining factors that limit the absolute rationality of decision makers. Shortage of time, lack of sufficient information and knowledge, information asymmetry and other factors affect the ability of a person to make the most rational decision (Hodgson, 2012; Feiock, 2007).

The application of rational choice theory in the analysis of decision making and implementation in organizations is based on the concepts of “rational choice” and factors that constrain rational choice (bounded rationality). The policies and practices of public private partnership in the health sector are full of negotiations and decisions that can be theoretically explained using the concepts of rational choice and bounded rationality. Practices and problems of risk identification,

analysis and sharing, mutual support between the public and private health sector and procurement decisions are studied using the concepts from rational choice theory.

2.2.8.4. Principal-Agent Theory

Principal-agent theory assumes that actors anywhere are governed by economic self-interest (Kassim and Menon, 2003). The question is then how principals can manage the self-interest of those empowered to act on their behalf, their agents, so that it is aligned with the purposes that the principals wish to achieve. Both conflicts of interests and the agents' inherent access to key information are usually the sources of information asymmetry (Gailmard, 2012).

In public policy, 'principals' are ultimately citizens and 'agents' are politicians and bureaucrats, but the whole structure of a public bureau can be seen as being governed by chains of principal-agent relationships (Kassim and Menon, 2003). However, it can be argued that principal-agent relationships can also be contextualized to government entries as principals and any other party acting on behalf of the government as agents. More importantly, Miller and Whitford (2002) point out that the effectiveness of the principal in terms of controlling the agent depends on:

a. How much information the principal has about the performance of the agent, and
b. How far the principal can structure the relationship so as to control the agent or give incentives so as to make the agent's interests correspond to the principal's.

Practical challenges of managing public services within the context of the principal-agent theory emanate from the complexity of its application. According to Gailmard (2012), there are general problems of control by principals in the public sector, resulting from the multiplicity of principals with diverse objectives, the difficulty of constructing incentives where profits do not accrue to agents, procedural constraints, and the meagerness of democratic accountability as a mechanism of regulating the behavior of the agent. It can clearly be inferred from these arguments that even in the most contemporary approaches to public sector management, the problems of principal agent relationship cannot be easily solved. As Shavell (1979) and Miller and Whitford (2002) emphasize, solving the incentive problems in the principal agent relationship needs a continuous learning and reform process. The relationship between principal and agent, according to Lane (2000), can be structured in different ways, in an attempt to overcome these problems and to motivate the agent to act in the interest of the principal. The

principal-agent problem is particularly severe in the classical bureaucratic form of administration due to the inherent nature of bureaucratic complexity, monopolistic nature of agents and usually ambiguous contractual relationships (Gailmard, 2012).

According to Sciulli (2009), the traditional approach to controlling the agents is by separating the sphere of policy-making by politicians from administration by public servants or other agents, and establishing merit based, neutral and professional bureaucracy. This argument, however, does not consider the limitations of the traditional hierarchies and the rigid rules and regulations that, on one hand, constrain effective service delivery and, on the other hand, de-motivate public sector employees to perform in the best interest of the citizens.

New approaches to public management in general and NPM approach in particular aim to further clarify the relationship between policy-makers and service providers, for example, through performance contracts (Hughes, 2003; Cohen and Eimicke, 2008). This implies two important things. Firstly, public service delivery is governed by the principal-agent relationship between the government and its employees. This essentially motivates public servants due to the performance-oriented contractual relationship and the reward that is attached to specific performance. Secondly, principal-agent relationship in the NPM context takes service delivery away from the public sector to the non-state actors such as the private sector based on negotiated and mutually beneficial contracts. As Lane (2000) points out, such arrangements seek to enhance the accountability of agents to policy-makers, give managers greater autonomy in day-to-day operations, and strengthen their incentives to respond to clients' demands. This clearly shows that there is a remarkable shift from bureaucratic chains of command to contract based market relationships.

According to Gailmard (2012), transparent contractual relationships within the public sector or between the public and private sectors are ways of making the principal's demands clearer and giving the agent incentives to fulfill rather than frustrate the principal's policy. Doing so, the agent's interests can be fairly addressed as in incentive and reward in the process of discharging its responsibilities as specified in the contracts. In this line, Osborne (2010) underscores that organizational arrangement for service provision should be appropriate in such a way that the demands of both the principal and the agent can be adequately attended to. Despite the fact that efficient contractual arrangements usually develop through competitive pressures under market

conditions, public sector organizations do not have such habits. According to Lane (2000), the principles of agency theory have prompted reforms in public sector management with emphasis on performance measurement and incentives in public service delivery.

As clearly indicated above, both within the government and between the government and non-state actors, relationships are governed by performance-based contractual relationships that mutually benefit both the principal and the agent. In line with this, Horton et al. (2002) underscore that contractual relationships are advantageous in that they specify the basis on which performance will be monitored and offer powerful incentives of profit and loss. From the perspective of agency relationships with the private sector which is largely profit-oriented, such contractual arrangements will fairly address the interest of the private partner and hence motivates it to perform. As Miller and Whitford (2002) accentuate, range of different types of contractual arrangements can be made based on the peculiar nature of the services which may include duties and rights of the principal and the agent, duration of the contract and risks accrued to both parties in the contractual relationships.

As a visible challenge to the contractual relationship under the agency model, Vos and Abraham (2002) argue that there are challenges in the contractual relationships which may arise from the limited information (bounded rationality) available to the negotiating parties. The information scarcity may include the terms and contingencies, the self-interested opportunism of the parties, and the uncertainty of the environment which involves some risks. Cohen and Eimicke (2008) also add that under some circumstances, performance requirements are difficult to specify, monitor and enforce, especially for the more qualitative services such as education, which are characteristic of government. This limitation in the application of the model, as Akintoye and Beck (2009) argue, leads to high transaction costs incurred in the process of negotiating and managing contracts. For Hywood (2000), some organizations may justify the internal delivery of some services due to high transaction costs. It, therefore, implies that the question of whether to deliver the service through own institution or to contract out depends on a careful working out of the transaction costs. In this line, Lane (2000) indicates that institutions such as private organization or government bureau are generally established with the main purpose and effect of optimizing transaction costs. Though new management approaches favor contractual arrangements, a pragmatic and well thought decisions should be made by contextualizing and balancing service delivery through contracts and vertical integration (England, 2004; Mclaughlin

and Osborne, 2002). A very important contextual requirement for contractual relationship provided by Miller and Whitford (2002) is that it is less costly to make contracts where there are trust, legal system, information and skills to do so in both the public and private sectors.

Principal agent model is an essential framework to analyze public private partnership in the health sector of Addis Ababa. This study conceptualizes the government as a principal having two agents: the public sector employees and the private health sector. The issues of capacity building, dialogue, negotiation, contracting out, risk sharing and mutual support, contract management and conflict resolution are all important issues involved in PPPs that can be analyzed using the principal-agent model discussed above.

2.3. Empirical Review

2.3.1. Introduction

The theoretical issues discussed in the preceding sections, highlighted the characteristics of the public and private sectors in service delivery. It has also been identified that the weaknesses in the public sector led governments to look for alternative service delivery approaches under the NPM framework. Though PPP as one of the NPM tools is theoretically argued to be effective in improving public services, the contexts within which it is applied to specific public services are important success and failure factors. The following section reviews the empirical literature on the policies, practices and challenges of implementing PPP projects in the health sector. The review will also help in identifying the key factors that contribute to the success or failure of PPP initiatives in the health sector.

2.3.2. Overview of Health Service Delivery in Developing Countries: Implications for PPP

The inherent weakness of the public sector is reflected in the low level of health service delivery in developing countries. According to Cornia and Mwabu (1997), developing countries in general and sub-Saharan countries in particular suffer from high burden of diseases. Despite the fact that health services are predominantly delivered by the public sector in developing countries, these countries fall behind by many of the health and health related indicators. Although public sector investments and effective interventions on burden of diseases are receiving emphasis in developing countries in general and in Africa in particular, people in these countries still face a

huge burden of preventable and treatable health problems (Osewee, 2006). Discussing the impact of poor health, Quaye (2010) points out that the high burden of communicable and non-communicable diseases and injury and trauma, including the social impact of these, has adversely affected development in Africa.

Despite the fact that individual countries are on different levels of performance, the practical evidences reveal that Africa is still not on track to meet the health Millennium Declaration targets and the prevailing population trends could undermine progress made (African Union, 2007). It can be argued that the health system in Africa, which Lewis (2006) pointed out as highly bureaucratic and public sector oriented, might have contributed to the low level of performance and health status. For instance, African Union (2007) indicates that maternal mortality rate in Africa is between 500 and 1500 per 100000 mothers which is significantly high. Although this figure is targeted to be reduced to 228 at the end of the MDG, many African countries are still far behind this figure. Similarly, meeting the target of 61 per 1000 under 5 mortality from the current 171 per 1000 at the end of the MDG period in Africa, is a serious challenge. Low level of health in developing countries is also reflected in the low life expectancy. In Africa for instance, life expectancy has been reduced further to an average of 52 years by many factors including HIV/AIDS and other epidemics (African Union, 2007).

Efforts are being made by the respective governments and the donor community to improve health status in developing countries. In many African countries, for instance, as Kaseje (2006) and African Union (2007) argue, economic growth, decline in conflicts and important efforts towards democracy and good governance are all contributing to health. However, it can be argued that government policies heavily focus on traditional bureaucratic structures for health service interventions. An argument by Chang (2002) that wide ranging interventions are being implemented and important progress is being made in addressing the root causes of the disease burden in Africa, falls short of admitting the fact that the interventions are either by the traditional public sector or by external financial assistance. It can also be argued that both undue reliance on the public bureaucracy and donor community for public health care cannot effectively address the ever increasing health care demands. According to African Union (2007), in Africa, for instance, unlike developed countries, people suffer from high disease burden due to the reasons discussed below.

Firstly, health systems in Africa are too weak and services are highly under-resourced to support targeted reduction in disease burden and achieve universal access. As a result, health interventions by the government and external assistance often do not match the scale of the problem. The low capacity of the public health sector in Africa is reflected in the weak health infrastructure and finance. Health care in Africa is mainly financed by the donor community or out-of pocket, which are clearly challenging in terms of sustainability and affordability. As a result, health facility to population ratio on average is generally low in these countries (Lewis, 2006).

Secondly, in most African countries, the benefits of health services do not equitably reach those with the greatest disease burden. As Lewis (2006) underlines, this is particularly attributed to the governance of the African health system which is characterized by low equity, accessibility, transparency and accountability. It can, therefore, be argued that the high disease burden in Africa is attributed not only to low capacity of the public sector but also to lack of good governance and maladministration in the health service delivery through the traditional bureaucracy.

Thirdly, lack of appropriately planned and implemented collaboration and partnership with non-state actors has significantly affected the health system. Quaye (2010) emphasizes that in Africa, despite the fact that the private health sector plays a remarkable role; its contribution is not strategically aligned to the national health goals. It is evident that the health system highly emphasizes the bureaucratic structure of the public sector and does not have clearly designed mechanisms to work with other sectors (Lewis, 2006). It can be argued that lack of inter-sectoral collaboration and well designed collaboration adversely affects coordination among the state and non-state actors in health, health sector information system and efficient allocation of scarce health sector resources including health professionals.

Finally, acute shortage of appropriately trained and motivated health workers is a critical problem. It can be argued that the African public health sector generally suffers from workforce crisis. On the one hand, the already very few trained health professionals are highly demotivated due to low level of remuneration and mismanagement, which are reflected in low quality of health service delivery. On the other hand, triggered by both push and pull factors, health professionals in the public health system migrate to either the private health sector within their

countries or to foreign countries adding fuel to the already existing shortage of health workforce (Naicker et.al, 2009, Shattuk et.al. 2008). According to Makasa (2010), migration of health workers to rich nations is draining human resources for health in poor countries, which is exacerbated by insufficient training of adequate number of health workers. While Africa has 10% of the world population, it bears 25% of the global disease burden and has only 3% of the global health work force. Of the four million estimated global shortage of health workers one million are immediately required in Africa (African Union, 2007).

In summary, the above discussions reveal the realities and challenging conditions in the health system of developing countries. The low capacity of the public health sector, weak health system governance characterized by traditional bureaucratic structure and severe shortage of health professionals has led to high disease burden and poor health services. It can be safely argued that the reform movements in the health sector in developing countries should seriously consider well structured and institutionalized partnership and collaboration with the private health sector which is already serving large number of people (both poor and rich) in these countries. The practices and challenges in the existing public private partnership in the health sector in developing countries are discussed below.

2.3.3. Policies, Practices and Challenges of PPPs in the Health Sector in Developing Countries

As clearly indicated in the preceding section, the health system in developing countries in general and sub-Saharan Africa in particular is known for its poor quality and inaccessible services. Recognizing this problem, the World Bank, (2011) strongly argues that the health system in developing countries needs urgent improvement. Adding to these facts, the World Bank study indicates that in Sub-Saharan Africa, the poorest 20% benefit from only 13% of public money for health care compared to almost 29% percent of public money benefiting the richest 20% (World Bank, 2011). Bloom et al. (2009) point out that there are both market failures and state failures in low-income countries in delivering health services to the citizens' expectations. In these countries, the growth of the private sector in health services delivery is not augmented by appropriate regulation and alignment to the national health policy objectives.

Though the public sector is generally responsible for health outcome of the people, more than 50% of health care spending in sub-Saharan Africa comes from private practices and private

providers are responsible to deliver 50% of the services (World Bank, 2011). This implies two important facts. Firstly, the public sector is unable to cover the health needs of the whole population and needs the involvement of other actors. Secondly, the private sector is already playing key roles in the health coverage of sub-Saharan countries. The need for the involvement of the private sector in health service delivery is clearly visible in Africa when one is able to see the health sector as a system. Highlighting the above argument, Nishtar (2004), underlines that many health professionals migrate between the public and private health sectors extending their professional services to augment their personal income. This practically blurred demarcation between the two sectors indicates the high potential for them to collaborate and work towards the same goal. However, an argument by Harding (2007) underlines that finding ways on how to collaborate is important for both the public and private sector to yield the expected results in health service delivery in developing countries.

In Africa, for instance, some countries already recognize the key role of the private health sector in addressing the health gap of their countries. These countries officially declared their commitments to work with the private sector by promulgating different policies and strategies that give favorable environment for the participation of the private sector. The national policy of the government in South Africa, for instance, provides sufficient room for the private sector to involve in public service delivery in general and health service provision in particular (Government of South Africa, 2005). In countries such as Ghana, Tanzania and Nigeria, the belief is that the private sector must be the integral part of any solution in providing more equitable health care to all people (Government of Ghana, 2011; United Republic of Tanzania, 2009). It can be argued that the government policy towards the role of the private sector in the economy should be clearly articulated and stipulated in the national policies and strategies to have meaningful contribution of the private sector in the service industries. The above countries, for instance, have officially and formally allowed public private partnership that attracts the private sector in health service delivery.

The partnership with the private health sector in developing countries, as Broomberg and Mills (1998) argue, needs careful attention due to the peculiar nature of health services. Explaining this, Musgrove (1996) indicates that the health sector is neither just like any other economic sector nor totally distinct from it. However, health services in developing countries are both poor and inaccessible due to both government failure and market failure and hence call for deliberate

policy intervention. He strongly argues that failure in the health sector is generally worse than failure elsewhere in the economy. On the other hand, state intervention in the health service should neither lead to government failure nor to market failure (Bjorkman, 2003). This implies that the public policies that are issued and implemented with regard to health services should correct both inefficiencies of the government and the opportunistic and monopolistic nature of the private sector. Osewee (2006) also adds that the low trust of the government towards the private sector in developing countries is a source of inability to engage this sector.

The PPP policy of the government of Nigeria, for instance, right at the beginning, acknowledges the key roles that the private health sector can play in addressing the health needs of the Nigerian population (Government of Nigeria, 2005). This has two important implications for the health sector in Ethiopia. On one hand, the PPP policy is just the derivative of the overall government policy towards the private sector in that country, that provides it sufficient room in public service delivery. On the other hand, the PPP policy in health shows that the private sector can be trusted and is able to positively contribute to the health outcomes of the country.

It should be noted, however, that the positive contribution of the private health sector can only be attained under appropriate legal and regulatory environments. Jamali (2004) underlines that in the absence of clear and well thought national and sector specific policies and legal frameworks, PPPs in health will not deliver the expected outcomes. In this regard, a study by Nishtar (2004) also points out that in developing countries there is a general failure to have overarching policies and sector specific legislations to guide PPPs in health service delivery. She further argues that the already existing interfaces are based on ad hoc and opportunistic relationships. This raises questions of credibility, sustainability and lack of sufficient participation of the stakeholders and particularly the citizens.

The PPP practices in developing countries, as Harding (2009) and Nishtar (2004) argue, are, therefore, characterized by ill-defined governance mechanisms, confused responsibilities of public and private health sectors, unfair risk sharing, less transparent procurement systems and generally less credible collaborations. Almost all literatures consulted for the purpose of this research strongly argue for the active involvement of and partnership with the private health sector in developing countries due to the poor and inaccessible health services (e.g. Bazoli, 2009; Abrahamson, 1999; Cassesls, 1995; IFC, 2011; Lim, 2003; Jefferys, 2004). Even though

collaboration is unavoidable and imperative, it does not necessarily mean that all types of collaborations are productive and efficient. On one hand, partnership with the private sector should be established on deliberate national policies and legal frameworks. In some developing countries, PPP initiatives were found to be counterproductive and even worse that the public delivery of health services due to policy and regulatory deficiencies (Bwana, 2014). The study indicates that the obsession with the involvement of the private sector without addressing the legal and regulatory issues is responsible for such unintended outcomes.

In a similar line, underlining the caution that should be taken before embarking on PPP in developing countries, Madaleine (2013) argues, partnerships should be based on empirical research that would enable detailed assessment of the specific issues in individual PPP projects and particular sectors. He also strongly recommends the policy and regulatory frameworks to carefully address the issues of accountability in PPP projects. The commitment needs to come from the public sector in that governments in developing countries should see their national and sectoral policies in order to create conducive policy and regulatory environment that promotes cooperative, mutually beneficial and effective joint working arrangement (Ansell and Gash, 2007; Mills, 2007).

Stressing the need to engage the private sector in health, Farlam (2005) indicates that many African countries are trying to increase the role of the private sector in health service delivery. It is, however, made clear in several studies (e.g. Nwagaba, 2013; Marek et. al, 2005; Standing and Bloom, 2002) that the policies, legal frameworks, institutional issues and the overall governance of the partnership with the private sector are not designed in detail.

Well designed and policy supported PPPs empower both the public and private health sectors in Sub-Saharan Africa (IFC, 2011). In this region of Africa, in spite of billions of dollars of international aid channeled to the health sector, 50% of total expenditure is financed by out of pocket from its largely impoverished population. Surprisingly, in situations where health services are provided in partnership with the private sector, if the opportunistic and rent-seeking behavior of private providers is not well regulated, it leaves the citizens to undue exploitation and substandard health services (Lagomarsino, 2009). Attributing this problem to the lack of appropriate policy and legal framework as well as some institutional deficiencies, the study strongly argues that carefully planned and implemented contracts will not only give value for

money for the public sector but also help in regulating the behavior of the private health sector. In a similar line, Cheung (2009) stresses that in countries where public policies are not in favor of the private sector involvement; policy changes are required so that governments can enable the private sector play a more meaningful role in health service delivery.

Another study by Nishtar (2004) indicates that the private health sector in developing countries is highly fragmented, diverse and lacks institutional capacity and operational consistency. These characteristics raise serious concerns regarding the possibility of PPPs and their role in addressing the health needs of the poor. However, it can be argued that the public sector (government) is generally responsible to nurture and develop the private health sector in such a way that it is institutionally empowered to deliver health services to the poor. It can be argued that the government's role in public health delivery does not necessarily mean that it has to produce and deliver health services; its role in contemporary governance should be enabling non-state sectors to make sure that services are delivered.

In Africa, for instance, TB, malaria, HIV/AIDS, which are recognized by governments as the worst health issues are more preventive than curative issues. The provision of these services through the active engagement of the private health sector requires an immediate policy attention of the national governments (Jefferys, 2004). As the private health sector is primarily interested in profit making, commercial orientation of these services is what attracts the interest of private service providers. It is, however, found out that it is not only the legal and regulatory frameworks, but also the risk sharing, support schemes and procurement mechanisms that are not attractive to the private health sector (Mills, 2007).

Harding (2009) points out that in developing countries it may be easier to work with private service providers on public health related activities such as immunization, STDs, family planning, nutrition and other services. For him, the delivery of higher level clinical services through PPP should follow the provision of simpler health services. The assumption is that though these services are relatively difficult to make them commercially oriented, at the early stage of PPPs, the trust and mutual understanding can be established through cooperative and collaborative working relationships. The trust established between the two sectors should, however, develop into full scale PPPs later.

Abramson (1999) argues that governments from the Latin American and Caribbean countries contract out primary health services to the private sector without strong regulatory framework for PPPs. It is, therefore, strongly argued that many of these partnerships either end up in unresolved conflicts or fail to deliver the desired outcomes. Recalling these problems, Abrahamson stresses that it should not be taken for granted that all types of PPPs will necessarily yield positive outcomes in all situations. The implication is that, the policy environment, the legal and regulatory framework, institutional capacity, the risk sharing and mutual support and the overall governance played a strong role in determining the success or failure of PPP initiatives in the health sector.

Another study by Center for Global Development (2009) also indicates the challenges of partnering with the private sector in the health sector. In developing countries, though interest is growing within the donor community and governments in developing countries on ways to work with private sector to accelerate progress towards high priority health objectives, there are several challenges that make partnerships very difficult (Center for Global Development, 2009). These include:

- lack of clearly defined role of the private and public health sectors;
- lack of trust and positive attitude towards each other,
- inability to effectively communicate and solve common problems in the health sector through constrictive dialogue,
- perception of un-affordability in inaccessibility of the private health sector for poor people,
- diverse and fragmented private health sector that lacks common goals and focus, and
- lack of public sector skills in designing and managing partnerships.

The above challenges of partnership in the health sector in developing countries imply that the interest of the respective governments and the pressing need for PPP are not enough by themselves. It can be argued, therefore, that the preconditions required from both the public and private sectors should be fulfilled. As Buse and Harmer (2004) argue, appropriate policy environments and regulatory frameworks as well as adequate institutional capacity can solve the above problems. When the environment is appropriate, Buse and Harmer argue, high impact public health services such as HIV/AIDS, TB and Malaria services can be provided in

partnership with the commercial health sector. They strongly stress that good governance in health service delivery should fairly involve the active participation of the private sector by pluralizing decision making and simultaneously shaping the relations of power, authority and legitimacy between the public and private sectors. This argument clearly indicates the need for formally established relationships in which the private health sector can equally negotiate with the public health sector on issues related to risk and reward, sharing duties and responsibilities, support and cooperative relationships, accountability and transparency in decision making in health and all other issues of common interest.

Nishtar (2004) points out that by strengthening the role and participating of the private sector in health in Pakistan through PPPs, collaboration between public and private sectors includes not only treatment but also prevention and control of diseases. World Economic Forum (2005) indicates the problems of effective PPP governance in the health sector as the multiple purposes involved in partnerships sometimes come up with contrasting motives presenting new set of challenges for the government. In delivering high impact public health services, it is stressed that good governance, access to sustainable funding and optimization of public sector and private sector interests and objectives are the key challenges in developing countries.

Recognizing the health sector as a system is one of the key challenges in Africa. In this regard, Cassels (1995) underscores that, the preventive and curative health services cannot be separated in the health system of a country. In a similar line, an argument by Marek et al. (2005) emphasizes that linking single issue health partnerships to improvements in the wider health care system should be the objective of PPPs in the health sector. The partnership in developing countries misses the interface between different diseases such as TB, Malaria, HIV/AIDS, Material Health, sanitation, reproductive health as well as health promotion and communication issues that would contribute to the preventive aspects of health services (World Bank, 2010). This implies that the public and private health sectors are not working towards the common goal of improving the health system of the country as a whole. Issues of sharing health sector vision and working towards that vision is one of the challenges making partnerships difficult in Developing countries.

Cassels (1995) indicates that since health service delivery under the PPP arrangement is based more on contracts than bureaucratic controls, effective PPP contracts, standards of performance,

monitoring outputs and outcomes and tracking the use of resources should be carefully conducted. These, however, are not common in the health sector PPPs of developing countries, compromising the expected results from such arrangements. Despite the fast growth of the private health sector and the subsequent complexity of the health system as a whole in developing countries, these developments are not followed by appropriate policies, legal frameworks and institutional arrangements.

2.3.4. Improving PPP Policies and Practices in the Health Sector in Developing Countries

Despite the above challenges in engaging the private sector in health service delivery in developing countries, pursuing this approach is inevitable due to the deteriorating capacity of governments to address the health needs of the public through its own resources. More importantly, the growth of the private health sector in developing countries over the last two decades is a promising untapped potential for addressing accessibility and equity issues of health services for the poor (Mitchell, 2008; IFC, 2011; Palmer, 2000). The need to improve PPP in the health sector in developing countries is stressed by several writers. It can be argued that the current PPPs in the health sector should be regulated properly. Regulation of the private sector in general and that of the private sector in particular should be based on legal and regulatory frameworks that address the strategic issues of both the private and public sectors. Studies also emphasize the need to conduct a thorough assessment of the health services and the identification of possible PPP areas in the health sector (e.g. Nishtar, 2004)

In line with the argument above, Mitchell (2008) underscores that considerable work needs to be done to develop the accountability and transparency through a well established legal and regulatory framework that helps not only to regulate the venture but also to build trust and confidence between the two sectors. Loevinsohn (2008) highlights that public private partnership in the health sector in developing countries can be improved by working out the policy, legal and institutional frameworks that facilitate partnerships and establish performance oriented collaboration between the two sectors. He says “performance based contracting” in which relationships are based on clear definition of series of objectives and indicators by which to measure contractor performance collection of data on the performance indicators and consequences for the contractor should be worked out carefully for successful PPP in the health sector”. He recommends the following issues to be given serious attention by the government.

- Conducting series of dialogues with stakeholders to build trust and confidence to work together,
- Define the services and identify the potential areas of collaboration and contracting,
- Design monitoring and evaluation mechanisms to trace successes and failures and take corrective actions,
- Develop transparent and acceptable procurement system to guide the selection of the private partner,
- Build strong institutional framework for implementation and management of the contract, and
- Develop contract documents and implement a transparent bidding procedure in selecting and engaging the private sector in health service delivery.

The discussions about the practices of PPP in the health sector in developing countries indicate the existence of various types of collaboration between the two sectors. While some of these countries have done a very good job of establishing the PPP initiatives on favorable policies, regulatory environments and institutional frameworks, most countries that are already practicing PPPs in their health systems do not have the required policy, legal and institutional backing to facilitate the partnerships. As the collaborative practices are largely based on ad hoc and opportunistic relationships, it can be argued that the sustainability of the PPPs and their potential in addressing the health sector needs are at stake.

The implication of these evidences for this particular study is analyzed and interpreted in the upcoming chapters using a distinct methodology discussed separately in chapter three.

2.4. Public Private Partnership in the Context of the Ethiopian Health Sector

The context of PPP in developing countries in general is discussed in the above sub-sections. This section focuses on the context for defining PPP in the Ethiopian health sector and existing experiences of partnership.

2.4.1. Defining the Private Health Sector in Ethiopia

In the context of the Ethiopian health sector, the private health sector is divided mainly into private for-profit and private not-for-profit organizations involved in different activities related

to health service delivery (FMoH, 2014c). For the purpose of this dissertation, only the private for-profit institutions are considered to analyze public private partnership. The private for-profit can be subdivided into the formal health service and products providers and the informal providers. The informal providers are also outside the scope of this dissertation; only the formal sector is considered.

According to FMoH (2014c), the formal private health service and product providers include the following.

- Health care providers operating in hospitals and clinics
- Diagnostic laboratories and diagnostic imaging facilities
- Pharmacies, drugstores and rural drug vendors
- Manufacturers of pharmaceutical health commodities and technologies
- Importers and distributers of health related commodities
- Biomedical equipment maintenance service providers and
- Health professionals training institutions

The operational definition of PPP for this dissertation takes into account the above categories of formal private health service and products providers.

2.4.2. Defining PPP in the Context of the Ethiopian Health Sector

The operational definition of PPP for this dissertation is established based on the definition given by the Ethiopian FMoH. According to FMoH (2014c), public private partnership in the health sector is defined as bringing actors in the health sector together based on mutually agreed roles, responsibilities, risk sharing modalities and partnership principles. For the Ethiopian health sector, PPP refers to a wide gamut of possible relationships between the public and private health sectors for integrated planning, service delivery and monitoring of services. The following are clearly recognized as PPP models for the Ethiopian health sector which also apply for Addis Ababa.

a. *Social Franchising:* This encompasses a network of private health practitioners linked through contracts to provide socially beneficial services under a common brand. It is one of the innovative ways that we leverage the reach of private health providers for the

delivery of high impact health services such as HIV/AIDS treatment, TB, malaria, reproductive health and immunization.

b. *Concession:* Refers to the granting of a right to a private sector to finance, build, renovate, manage and deliver a service using a public health care facility for a specific period of time in exchange for a fee paid directly by the government, by the end user of the infrastructure or by both.
c. *Contracting out:* refers to the outsourcing of the delivery of services which had traditionally been provided by the government. In the context of the health sector, this may refer to transferring the delivery of clinical and/non-clinical hospital services to the private sector based on mutually agreed contracts.

The study of policies, practices and challenges of PPP in the health sector of Addis Ababa is fundamentally based on the above operational definition of PPP and models that are contextualized for the Ethiopian health sector.

2.4.3. Existing PPPs in the Ethiopian Health Sector

Contrary to the conventional belief that PPPs are non-existent in the Ethiopian Health sector, there are several collaborative practices that can be considered as PPP within the framework given by FMoH to define PPP in the health sector. The following are few of the existing PPPs in the Ethiopian health sector which are also being actively practiced in the Health sector of Addis Ababa.

a. Social Franchising Models

- ***PPM-DOTs:*** This refers to the delivery of TB services through an arrangement called public private mix directly observed treatment short course. Under this arrangement the public sector provides drugs, reagents and other logistic services while the private health institution (hospital or clinic) delivers the service using its own facility and generates revenue through consultation fee and affordable laboratory charges. PPM-DOTs is being practiced in selected private hospitals and clinics in Addis Ababa, Amhara, Diredawa, Harari, Oromia, SNNPR and Tigray regions.
- ***HCT:*** This is the delivery of HIV counseling and testing service through public private collaboration. The public sector delivers test kits, reagents, supportive supervision and capacity building training to the private health institution while in

return, the private health institution delivers the service free of charge. Combined with other health services, HCT service is being delivered in selected private hospitals and clinics in Addis Ababa, Amhara, Diredawa, Harari, Oromia, SNNPR and Tigray regions.

- ***HIV/AIDS ART:*** This is the delivery of antiretroviral therapy to people living with HIV and HIV/AIDS patients where the drugs and other important logistics are supplied by the government and the service is delivered to the beneficiaries using the private health facility. The private health institution benefits from this arrangement by establishing continuous linkage to the patients and charging for consultation fees and laboratory services. The delivery of ART services using public private collaboration arrangement is actively practiced in private hospitals in Addis Ababa, Amhara and Tigray regions.
- ***HIV/AIDS PMTCT:*** This refers to the delivery of prevention of mother to child transmission of HIV/AIDS services using an already established private health facility. Under this arrangement, the public sector provides drugs, reagents and training services to the private facility while the private health institution provides the service and harvests more clients and generates revenue through consultation fee and laboratory charges. Combined with at least one of the above services, PMTCT service is being actively delivered using PPP in private hospitals in Addis Ababa, Amhara, Diredawa, Harari, Oromia, SNNPR and Tigray regions.
- ***Malaria Diagnosis and Treatment:*** Using social franchising PPP, the private health institution is involved in the delivery of malaria diagnosis and treatment services using its facility with the drug and logistics support from the public sector. Malaria diagnosis and treatment service using PPP is actively practiced in Amhara and SNNP regions.
- ***Reproductive Health and Family Planning:*** This is another social franchising PPP model under which private health institutions are involved in the delivery of family planning and reproductive health services with the support from the government. Combined with at least one of the above PPP services, reproductive health and family planning services are being delivered in private health facilities in Addis Ababa, Amhara, Diredawa, Harari, Oromia, SNNPR and Tigray regions.

b. Concession Models

- ***The Indian Eye Care Center:*** The Indian Ophthalmology Center (IOC) located in the premises of Zewditu Hospital (Addis Ababa), is a well recognized PPP arrangement under the concession model. It is an eye treatment and care center in which the government provides land, human resources, utility services and other logistics while the private institution delivers the eye care services including high level surgical services with affordable agreed service charge.
- ***Ayder Hospital Dialysis Center:*** This is a PPP arrangement in Ayder Hospital (Mekele, Ethiopia) under which the government granted the right to a private investor to establish a dialysis center within the premises of the Hospital, use land and facilities of the hospital and deliver the dialysis service with an affordable service charge agreed between the government and the private institution.
- ***Private Wing within Public Hospitals:*** As an important component of the health care financing reform program of the Ethiopian health sector, the private wing within public hospitals is the delivery of health services outside the normal working hours using the already existing public health facility. Based on an agreement between the public hospital and medical practitioners (in this case private), health services are delivered at a relatively higher service charge outside the conventional working hours to citizens who can afford to pay for a relatively better health services. The private wing as a PPP model is being practiced in public hospitals in Addis Ababa, Amhara, Oromia and other regions.

c. Contracting-Out Models

- ***Outsourcing of Non-clinical services in Public Hospitals:*** This PPP model also follows the implementation of the Ethiopian health care financing reform. With the objective of improving the quality and efficiency of health service delivery by creating conducive environment for professionals to focus on clinical services, many of the non-clinical hospital services are contracted out to private providers. These services generally include cleaning services, laundry services, food preparation and provision services, security services and others. As this is a strategic decision of the public health sector to work with the private sector for the delivery of health services

in general, this dissertation operationally considers the contracting-out as a distinct model of public private partnership.

The above facts generally indicate that PPPs in the health sector, at least as an entry point to the more sophisticated PPP models, are being actively practiced in Ethiopia in general and in Addis Ababa in particular. In the health sector of Addis Ababa, almost all of the PPP models contextually defined for the Ethiopian health sector are being practiced except for malaria diagnosis and treatment service. However, despite the practices, the unanswered questions that prompted this study are policy environments, the legal frameworks and institutional arrangements within which these PPP initiatives are being practiced in Addis Ababa city. The conceptual model that will be used as a framework for analyzing PPP in the health sector of Addis Ababa City is developed by the researcher based on the theoretical and empirical literature reviewed in the earlier sections of this chapter.

2.5. Conceptual Model for Analyzing PPP in the Health Sector of Addis Ababa

The review of theoretical and empirical literature about PPPs in the preceding sections has revealed that the PPP practices have a lot of antecedents for successful performance. The theoretically attractive justifications for PPPs have set off factors that determine their success or failure at different levels. The following factors are identified from the review of the literature for the study of public-private partnership in the health sector which will guide instrument development, data collection and analysis to answer the research questions outlined in chapter one. The brief operational definition of the factors is given below followed by their interrelationship using a conceptual model.

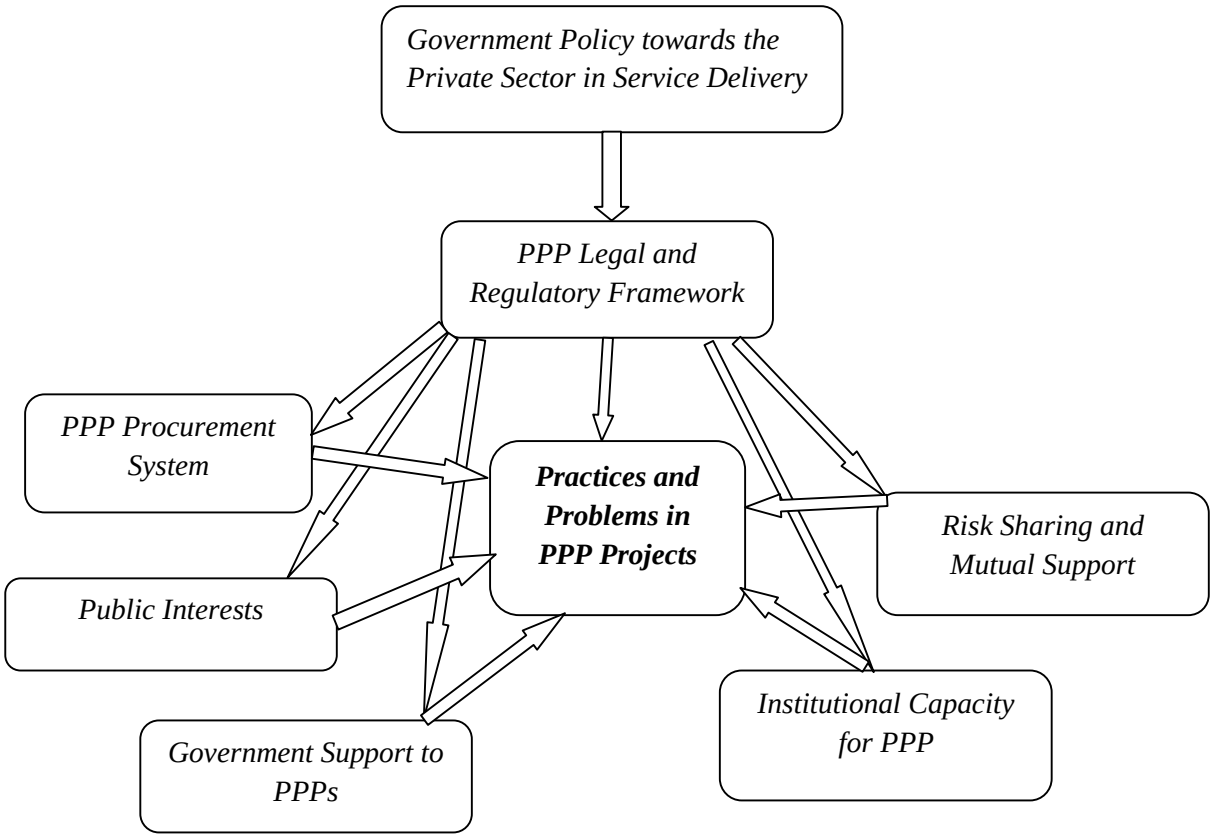
i. *Government Policy Environment:* refers to the political, economic and social policies of the government towards the private sector.
ii. *Public Interest Goals:* are defined as set of activities conducted by the PPP stakeholders to identify and accommodate the interests of the general public into the PPP initiatives.
iii. *Legal and Regulatory Framework:* refers to the set of formally established rules and regulations that govern PPP initiatives and projects.
iv. *Institutional Capacity:* is defined as set of structures, resources and human capabilities available for the implementation of PPP.

v. *Risk Sharing and Mutual Support:* Refers to the mechanisms and practices of risk identification, analysis, allocation and monitoring between public and private sector actors.

vi. *Government Support to PPPs:* Refers to the set of incentives provided to the private sector partner in the forms of economic, financial, technical and other support schemes.

vii. *PPP procurement system:* refers to the mechanisms and procedures through which the private partner is selected for PPP projects.

Fig. 2.1: Conceptual Model for Public Private Partnership in Public Service Delivery



Source: Developed by the Author from the review of the literature, 2014

Chapter 3: Research Methodology and Procedure

3.1 Research Paradigms and the Choice of this Dissertation

This section briefly highlights the main research paradigms that guide methodological approaches to social research. The main purpose of the section is not to introduce the details of research paradigms available in the body of literature, but, by succinctly highlighting the philosophical underpinnings, to establish the paradigm within which the study of public private partnership in the health sector of Addis Ababa is embedded.

The approach to answering the research questions is essentiality embedded in the research paradigm followed by the study (Collis & Hussey, 2003). A paradigm is a worldview that presents a definition of the social world linked to related sources of information (data) and appropriate ways (methods) to tap these sources (Guba and Lincoln 1994). The broad theoretical frameworks, also called paradigms, provide researchers with a unified set of concepts, principles, and rules for conducting research (Ulin, Robinson and Tolley, 2005). Paradigms or perspectives can vary a great deal among researchers who see the world through different cultural, philosophical, or professional lenses. There are two overarching paradigms (world-views) shaping research: Positivism and Constructivism.

For social researchers who adopt positivist paradigm, things can be studied as hard facts and the relationship between these facts can be established as scientific laws. According to Crano and Brewer (2002), Crossan (2003) and Collis and Hussey (2003), positivist researchers essentially employ quantitative approach and attempt to identify causal explanation and fundamental laws to explain human behavior. Rejecting the importance of human beliefs and interests, positivists advocate value-free research and independence of the researcher from the subject under investigation. Constructivist researchers, on the other hand, strongly believe that reality is not a rigid thing that exists in a vacuum (Crossan, 2003). As reality and its composition is influenced by its context, constructivists argue that the intricate relationship between individual behavior, attitudes, external structures and socio-cultural issues are important in the construction of reality (Ulin, Robinson and Tolly, 2005; Berg, 2001; Crossan, 2003). Constructivist researchers are, therefore, more interested in qualitative approach in addressing research problems by collecting in-depth information from people who are directly immersed in the phenomenon.

The two paradigms discussed above may guide the research methods that individual researchers may choose. However, due to the complex nature of research problems in the social world, the two paradigms alone and limiting oneself to single paradigm has been challenged over the last decades. The paradigm wars commenced with a challenge to the dominance of the mono method era during the 1960s resulted in the emergence of a mixed method and later in the 1990's of mixed model eras (Tashakkori and Teddlie 2003). There are two contending theories regarding the application of positivist and constructivist paradigms in conducting research. On one hand, incompatibility theory argues that positivist and constructivist worldviews are incompatible and hence cannot be simultaneously used in a single research study (Cameron, 2011). This line of argument clearly undermines the value of mixed methods in social research. On the other hand, compatibility theory argues that positivism and constructivism are not mutually exclusive and are actually overlapping. Arguing for the possibility of accommodating the two paradigms in a given research, this line of thought introduces a third set of belief called pragmatic paradigm which laid the foundation for mixed method research (Creswell, 2009).

The third set of beliefs called pragmatic paradigm in its simplest sense is a practical approach to a problem and has strong associations with mixed methods research. Pragmatism can be considered a bridge between paradigm and methodology and it is considered as a stance at the interface between philosophy and methodology (Greene and Caracelli, 2003). According to Patton (2002), using pragmatist world view is believed to sensitize researchers and evaluators to methodological biases that accumulate from their own socialization experiences within their respective discipline areas. Pragmatic approach is used by social researchers as a means of promoting methodological appropriateness to enable them to increase their methodological flexibility and adaptability (Creswell, 2009).

This study on Public-Private Partnership in the Health Sector of Addis Ababa is fundamentally based on the pragmatist belief discussed above. As Creswell (2003) argues, pragmatists link the choice of approach and methods directly to the purpose and nature of the research questions posed. The research problems and questions stated in chapter one lend themselves to a pragmatist approach as they can be best addressed by essentially mixing the approaches and methods in the research process. The researcher strongly believes that "what works better" method will allow him to address questions that do not sit comfortably within a wholly quantitative or qualitative approach and procedure. This study follows a pragmatist approach as

the researcher subscribes to the argument by Tashakkori and Teddlie (2008) and Creswell (2003) that pragmatist approach advances an intuitive appeal, permission to study areas that are of interest, embracing methods that are appropriate and using findings in a positive manner in harmony with the value system held by the researcher. Research problems in public administration in general and public private partnership in particular can be scientifically studied based on a pragmatist approach that can address research questions by utilizing both quantitative and qualitative data and developing arguments from multiple perspectives (McNabb, 2008).

3.2 Mixed Methods

This study used mixed research design to answer the research questions stipulated in chapter 1. Mixed methods research is a research design with philosophical assumptions as well as methods of inquiry. As a methodology, Dornyei (2007) argues, it involves philosophical assumptions that guide the direction of the collection and analysis of data and the mixture of qualitative and quantitative data in a single study or series of studies. Its central premise is that the use of quantitative and qualitative approaches in combination provides a better understanding of research problems than either approach alone (Leech and Onwuegbuzie, 2009).

This dissertation used mixed methods which Creswell (2009) defines as a procedure for collecting, analyzing and "mixing" both quantitative and qualitative data at some stage of the research process within a single study to understand a research problem more completely (Creswell, 2009). The rationale for mixing is that neither quantitative nor qualitative methods are sufficient by themselves to understand in detail the policies, practices and challenges that are prevalent in the public-private partnership environment of the health sector of Addis Ababa. As Tashakkori and Teddlie (2008) and Creswell and Plano Clark (2007) argue when used in combination, quantitative and qualitative methods complement each other and allow for more complete analysis and interpretation.

A mixed method research essentially has quantitative and qualitative components. Quantitative research, which mainly relies on numerical data, uses positivist claims for developing knowledge, such as cause and effect thinking, reduction to specific variables, hypotheses and questions, use of measurement and observation, and the test of theories (Collis and Hussey, 2008). A researcher who chooses quantitative approach isolates variables and causally relates them to determine the magnitude and frequency of relationships. Moreover, the researcher

identifies and determines the variables to investigate and design a distinct and predetermined methodology to study the variables (Khotari, 2004). In doing so, as Zoltan (2007) puts it rightly, the researcher isolates himself/herself from the phenomenon being investigated and maintains a "neutral" role in the research design, data collection, analysis, and interpretation process.

Qualitative research, on the other hand, is an inquiry process of understanding where the researcher develops a complex, holistic picture, analyzes words, reports detailed views of informants, and conducts the study in a natural setting (McNabb, 2008). According to Ulin et al. (2005), the qualitative researcher makes knowledge claims based on the constructivist worldview (Guba & Lincoln, 1994). As a result, a qualitative research is conducted by collecting data from those who are immersed in everyday life of the setting in which the study is framed. As argued by Ritchie (2003), a qualitative researcher believes that people who are part of the phenomenon under study understand the issue much better than any other people who are external to the process. Data analysis is also based on the values that these participants perceive for their world. Knowledge claims that are based on multiple contextual factors are generated as outcome of a qualitative research process (Miller, 2000).

Combining quantitative and qualitative methods, a researcher applying mixed methods builds the knowledge on pragmatic grounds (Creswell 2009) and bases the research approach on the techniques that can best address the problems and research questions at hand. As an unfolding research (Creswell 2009), unlike the quantitative research, the choice of variables is determined based on what works best in terms of effectively answering the research questions. Teddlie and Tashakkori (2009) also strongly argue that research approaches, as well as variables and units of analysis, which are most appropriate for finding an answer to the specific research question are selected based on the nature of the research and the practical problem to be solved.

Essentially quantitative and qualitative data are combined and integrated at some stage of the research process to add value to the arguments and answer research questions in a more meticulous manner. Onwuegbuzie et al. (2009) argue that mixed methods research is based on the major tenet of pragmatism that quantitative and qualitative methods are compatible and can be utilized in a single research. This study, which advances the above line of arguments, is conducted based on both numerical and text data collected concurrently and merged at the analysis stage to better understand the research problem.

The design of mixed methods, as Creswell (2009) argues, should give due consideration to the issues of priority, implementation and integration. For Creswell, priority in mixed research refers to which method, either quantitative or qualitative, is given more emphasis in the study while implementation refers to whether the quantitative and qualitative data collection and analysis comes in sequence or in chronological stages, one following the other, or in parallel or concurrently. Integration on the other hand refers to the phase in the research process where the mixing or connecting of quantitative and qualitative data occurs.

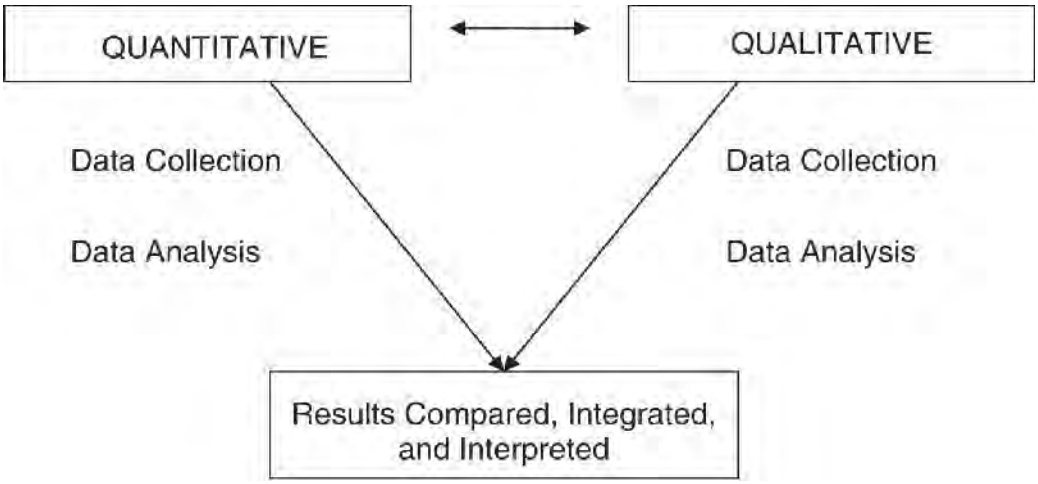
This study used a mixed concurrent triangulation strategy with qualitative priority and emphasis, which the researcher believed can effectively answer the research questions stated under section 1.3 of chapter 1. Creswell (2009) describes mixed concurrent triangulation strategy as a strategy with two concurrent data collection phases and priority is usually equally given to quantitative and qualitative components of the research. Priority can also be given to either quantitative or qualitative aspect of the study (Morse, 1991). The primary purpose of concurrent triangulation strategy is confirmation, corroboration or cross-validation within a single study (Morgan, 1998). As Teddlie and Tashakkori (2009) put it rightly, this strategy integrates the quantitative and qualitative data at the analysis and/or interpretation stage to look for convergence or divergence of data and/or arguments to strengthen knowledge claims.

For the purpose of answering the research questions, quantitative and largely ordinal data were collected from relevant respondents using a self-developed questionnaire based on the variables identified by the researcher. Relevant quantitative data were also collected from published and unpublished documents in the health sector. The goal of the quantitative data in this research was to identify the important variables related to the policies, practices and challenges in the health sector PPP and systematically investigate the attitudes of the respondents on how these variables contribute to the PPP environment in the health sector of Addis Ababa.

Concurrently with the quantitative data collection, qualitative data was collected from key informants who have an in-depth knowledge and experience of PPP and its contexts in the Ethiopian health sector in general and Addis Ababa in particular. Qualitative text data was collected using a self-developed semi-structured interview protocol administrated to purposely selected respondents. In addition to the in-depth interviews, relevant documents were also exhaustively consulted to help explain why and how the variables identified determine the

success or failure of PPP practices in the health sector. The rationale for this approach is that, as a new area of research in Ethiopia, the qualitative data and results provide a general picture of the research problem, i.e., how and under what contexts are PPP initiatives practiced in the Addis Ababa's health sector. The mixed concurrent triangulation strategy that this research used is indicated in the following visual model.

Fig.3.1. Visual Model of Mixed Concurrent Triangulation Strategy



Source: Adapted from Creswell, 2009

This study gives priority to qualitative method, based on what Morse (1991) abbreviated as "QUAL + quan" model to indicate the emphasis given to qualitative component with the block letters (QUAL) and secondary role given to the quantitative aspects using the small letters (qual). This method is selected mainly because the qualitative research represents the major aspect of data collection and analysis in the study, focusing on in-depth understanding of the policies governing PPPs, the practices currently in place and the challenges that may pose threat to the future of PPP programs in the health sector of Addis Ababa.

More priority and focus is given to the qualitative component in this study due to the following reasons. Firstly, public private partnership as an important component of new public management is a recent development in low income countries and the practice is at an infant stage (IFC, 2011), calling for an in-depth understanding of the issues related to its application. More importantly, as the emergence of the private sector in Ethiopia as well as Addis Ababa is a recent phenomenon (Asubonteng, 2011), public private partnership in general and collaboration in the health sector in particular is not much researched. The author strongly believes that PPP in

the health sector of Addis Ababa is at an exploratory level. Therefore, to understand the public private collaboration in the health sector of Addis Ababa where little is so far known, the researcher believes qualitative emphasis will help to explore the phenomenon and pave the way for future research. Secondly, public private partnership in the health sector is a complex process (Buse and Walt, 2000) that needs understanding the phenomenon, the context and multiple actors in the process. Such complexities can best be studied using mixed methods with emphasis on qualitative (Creswell, 2009). Thirdly, the different perspectives of the actors in the health sector of the country as well as the city need to be systematically studied to enhance the depth and breadth of understanding of public private collaboration in the health sector. Finally, the theories pertaining to public private partnership and collaboration in general and health sector partnerships in particular can be expanded by applying qualitative priority approach to specific studies.

As the study heavily utilizes qualitative methods and gives priority to this method, the purpose of the quantitative component, though conducted concurrently, is to supplement the qualitative analysis and interpretation in answering the research questions. As the context of PPP in the health sector is not yet adequately explored, advanced quantitative analysis and statistical tests will have less value in this less developed area of research.

Quantitative and qualitative results were integrated at the third stage of the qualitative analysis and at this stage the results of the quantitative data, which were displayed first for the sake of convenience, is used as an input for the data integration to triangulate, find convergences and develop interpretations.

3.3 Variables in the Study

The general research objective stipulated in chapter, “to explore the policies, practices and challenges surrounding the PPPs in the health sector,” requires identifying and determining the set of variables to be studied. The participation in one of the PPP programs in the health sector (HIV/AIDS, TB-DOTs, Reproductive Health and Non-clinical service outsourcing) as a practitioner was the criteria to select the respondents who filled in the questionnaire.

The factors that are believed to contribute to the success or failure of the PPP initiatives were indentified from the review of the literature and selected by the researcher. These factors, which

are discussed in the literature review and depicted in the conceptual model in chapter 2, are the most important factors that are empirically studied and tested in PPP programs in other sectors (infrastructure, education, water services, solid waste management) and proved to influence the outcomes of PPP practices (UNECE, 2008). The factors and variables that are related to the policies and practices of PPP identified by the researcher for the purpose of this study are indicated in the table below.

Table 3.1: Variables Predetermined for the Study

No	Factors	Variables within the Factors
1	Policy environment	10 items measured on a 5 point Likert scale
2	Legal and regulatory framework	10 items measured on a 5 point Likert scale
3	Institutional capacity	7 items measured on a 5 point Likert scale
4	Risk sharing and mutual support	7 items measured on a 5 point Likert scale
5	Government's support scheme	6 items measured on a 5 point Likert scale
6	Procurement system	10 items measured on a 5 point Likert scale

Source: Developed by the Author, 2014

The factors and variables determined and laid down in the table above were used to develop a detailed structured questionnaire (annex 1) that was administered to the selected respondents. These factors and variables were also used as a guide in developing the semi-structured interview protocol that was administered to selected key informants to collect qualitative data.

3.4 Justification to Study the PPP in Addis Ababa

As indicated above, the study on policies, practices and challenges of public private partnership in the Ethiopian health sector will focus on the case of Addis Ababa. Addis Ababa, the capital city of Ethiopia, is selected for this study based on critical case selection criteria. Patton (2001) indicates that critical case sampling looks at cases that will produce sufficient information in addressing the research purpose and answering the research questions. Selecting cases based on critical information criteria permits logical generalization and maximum application of information to other cases because if it is true of this one case, it is likely to be true of other similar cases as well.

Addis Ababa meets the critical information criteria and is, therefore, selected for this dissertation due to the following reasons. Firstly, Addis Ababa as the seat of both the federal government and the city government is a nucleus of complex health sector interactions in general and a concentration area of private health institutions in particular. This will provide the researcher in-depth information about public private partnership and the challenges surrounding the partnerships. Secondly, the physical proximity of the federal government, city government and the private health sector institutions in the city leads to frequent functional relationships and provides the researcher with critical information about public private interface in health service provision and regulation. Thirdly, as indicated under section 12.3.3 of chapter 2, almost all of the PPP initiatives, except malaria diagnosis and treatment are being actively practiced in the health sector of Addis Ababa. Finally, the preliminary field visit by the researcher and his previous study in Addis Ababa has revealed that there are attempts to introduce public private partnership in the Ethiopian health sector (Bikila, 2007). Though the researcher had investigated PPP in the health sector of Addis Ababa in 2007, this study, on the one hand, tries to incorporate new developments over the last 9 years and on the other hand, broadens the scope of the research by incorporating additional PPP programs such as reproductive health. This makes the city rich with information regarding public private partnership in the health sector.

3.5 Target Population and Sample

3.5.1 Population of the Study

The population for this study is the employees who are working in the four PPP programs in public hospitals, private hospitals, private clinics and private outsourcing agencies. The health facilities in Addis Ababa that are currently implementing PPPs and number of employees working in the PPP programs in each health facility are indicated in the table below.

Table 3.2: Health Facilities and Target Population in Each Facility

No	Institutions	HIV/AIDS	TB	RH	Non-Clinical Services	Population
1	Public Hospital	-	-	-	10	120
2	Private Hospital	18	24	-	-	228
3	Private Clinic	-	32	56	-	320
4	Private Contracting Agency	-	-	-	35	105
Total number of employees who are eligible to fill the questionnaire						**773**

Source: Addis Ababa City Government Health Bureau, 2014

Employees who were participating in at least one of the PPP programs in the institutions during data collection refers to the population from which sample respondents are selected to fill in the structured questionnaire. As indicated in table 3.2 above, a total of 773 employees and managers were providing services in the four PPP programs. The fact that employees who participate in and are familiar with the PPP programs also deliver other services in the same institution has been a challenge for the researcher to determine the population size. Moreover, most institutions did not have updated information about their employees and their specific assignments. As a result, the target population for this study was simply identified as the employees and managers in the above institutions, who were providing services in HIV/AIDS, TB, reproductive health and non-clinical services. For the purpose of identifying the target population, the researcher was assisted by the leaders of the respective institutions during the preliminary visits of the institutions. Nurses, public health officers, physicians, program coordinators, team leaders and administrative heads who were engaged in the PPP programs as direct providers or coordinators of the services were considered as the population for the study.

3.5.2 Sampling

The purpose of the quantitative component of this research as discussed above is to supplement the qualitative data and analysis. For the purpose of collecting quantitative data, sampling of organizations was conducted using stratified sampling of organizations. Initially, organizations that implement at least one PPP program were grouped into six strata as follows:

- Public hospitals outsourcing non-clinical services,
- Private hospital delivering HIV/AIDS related services,
- Private hospitals delivering TB related services,

- Private clinics delivering TB related services,
- Private clinics delivering reproductive health services, and
- Private contracting agencies delivering non-clinical services to public hospitals.

The researcher developed the above six strata based on the list of institutions obtained from Addis Ababa Health Bureau (AAHB). The number of institutions that fall under each stratum is indicated in table 3.2 above. However, it is important to note that two of the above strata are not mutually exclusive as some of the private hospitals that deliver HIV/AIDS related services also deliver TB related services. Stratified sampling was used to ensure representativeness across the different organizations and PPP programs. The sample size of organizations from each stratum was then determined by the researcher and random selection of organizations from each stratum was conducted as indicated in table 3.3. The author strongly believes that as organizations are randomly selected from each stratum, organizations and their respective PPP programs are fairly represented in the quantitative part of data collection.

At the second stage, purposive sampling was used to select employees and managers who are very familiar with the policies, practices and challenges of PPP programs in their respective organizations. The author was assisted by concerned officials of the respective institutions, to develop the list of employees who understand the policy environment, legal and institutional frameworks as well as the risk sharing and mutual support practices. In other words, employees and managers who filled the questionnaire were those who were familiar with the PPP policies, practices and challenges in public hospitals, private hospitals, private clinics and private outsourcing agencies. The author strongly believes that purposive sampling of employees is justifiable from the perspectives of enhancing the in-depth understanding of policies practices and challenges of PPP in the health sector of Addis Ababa City.

Therefore, the researcher has used two strategies to enhance the representativeness of the quantitative data. Firstly, the stratified sampling of organizations was random and hence institutions and the various PPP programs are fairly representative. Secondly, relevant employees and managers were selected from the sampled organization; fairly large sample size was generated to increase the degree of representativeness (Levistik and Tyson, 2008). Accordingly, adding up the number of respondents from each stratum, total sample size of 284 was generated which incorporated about 37% of the population as indicated in table 3.3 below. The researcher

strongly believes that selection of respondents using stratified sampling of organizations and purposive sampling of individual respondents has enhanced representativeness.

3.6 Data Collection

As a mixed concurrent triangulation strategy, quantitative and qualitative data were collected in parallel. This has significantly helped the researcher to identify the challenges in the data collection process and take corrective actions on the spot.

3.6.1 Quantitative Data Collection

Quantitative data was collected from respondents, i.e., employees and managers who are familiar with and participated in the currently active PPP programs. Based on the conceptual model and literature review in chapter 2, a detailed questionnaire was developed and pilot tested on 8% of the sampled respondents to check for validity. The main body of the questionnaire contained a 5 point Likert scale that constitutes numerous items under each category. As indicated in table 3.1 above, the individual Likert items are organized under 6 major factors that determine the environment of PPP in the health sector. Responses to these Likert items ranged from strongly agree to strongly disagree in some of the factors and from very high to very low in other factors. The responses to the individual questions were coded from 5 to 1, which along the continuum indicate the most favorable and the least favorable measurements.

Questionnaires developed and pilot tested were distributed to 284 purposively selected respondents and 242 fully completed questionnaires were obtained with a response rate of 85%. The composition of the PPP programs and organizations from which quantitative date was collected is indicated in the table below.

Table 3.3: PPP Programs, Organizations and Number of Respondents

No	PPP Program	Type of Organization	No of Organizations	No of Questionnaires Distributed	No of Questionnaires Returned
1	HIV/AIDS	Private Hospital	10	50	42
2	TB Care	Private Hospital	10	50	44
3	TB Care	Private Clinic	12	60	52
4	RH	Private Clinic	10	40	34
5	Non-Clinical Services	Public Hospital	6	48	41
6	Non-Clinical Services	Contracting Agency	6	36	29
			Total	**284**	**242**

Source: Developed by the Author, 2014

For the purpose of convenience, ART, HCT and PMTCT services are categorized under HIV/AIDS related PPPs. Therefore, the respondents who filled in the questionnaire under the HIV/AIDs category are those who deliver services or coordinate the services in one of the specific PPP areas. Contracting agency in this study refers to the private companies that provide non-clinical services (cleaning, laundry, food preparation and provision, security etc.), services to public hospitals based on the outsourcing of these services following the implementation of the health care financing reform of the City. The brief background of the respondents is indicated in the tables below.

Table 3.4a: Brief Background of the Respondents

Organization of the Respondents			Position of the Respondents						Total
			Nurse	HO	Physician	Program Crdntr.	Team Leader	Admin Head	
Public Hospital	PPP type	Non-Clinical		3		2	28	8	41
	Total			3		2	28	8	41
Private Hospital	PPP type	HIV/AIDS	3	5	5	5	17	7	42
		TB	5	0	8	5	22	4	44
	Total		8	5	13	10	39	11	86
Private Clinic	PPP type	TB	23		4	6		19	52
		RH	27		0	0		7	34
	Total		50		4	6		26	86
Contracting Agency	PPP type	Non-Clinical					12	17	29
	Total						12	17	29
Total	PPP type	HIV/AIDS	3	5	5	5	17	7	42
		TB	28	0	12	11	22	23	96
		RH	27	0	0	0	0	7	34
		Non-Clinical	0	3	0	2	40	25	70
Total			58	8	17	18	79	62	**242**

Source: Author's Survey, 2014

Table 3.4a above indicates organization of the respondents, specific PPP programs from which the respondents were selected and position of the respondents. Regarding their organization, 41 (17%) of the respondents who filled in the questionnaire work in public hospitals while 86 (35.5%) of them are in private hospitals. 86 (35.5%) of the respondents work in private clinics in Addis Ababa city while 29 (12%) of them are selected from private contracting agencies delivering services such as cleaning, laundry, security and other outsourced services. Therefore, given the research objectives to be addressed, it can be argued that the selection of respondents is organizationally representative.

Regarding the specific PPP program of the respondents, 42 (17%) of the respondents work in HIV/AIDS services while 96 (40%) of them are from TB services. While 34 (14%) of the respondents are selected from RH services, 70 (30%) of them are from outsourced non-clinical services working either in public hospitals or private contracting agencies. It can also be argued that selection of respondents is fairly representative across the different PPP programs being practiced in the health sector of Addis Ababa. Respondents were also selected from different positions in their respective institutions. As indicated in table 3.4a above, majority of the respondents, 79 (33%) are team leaders in their respective organizations, while 62 (25%) are head of administration followed by 58 (24%) nurses from different health facilities. Health officers, medical doctors and program coordinators together account for 43 (18%) of the respondents. Given the fact that these respondents were selected based on their current experience in at least one of the active PPP practices, the author strongly believes that the position of the respondents is adequately representative in terms of obtaining reliable information regarding the issues under investigation. The education levels of the respondents and their experience in the health sector, as shown in table 1.4b are also sufficient and appropriate to provide relevant and reliable data for the study as depicted in the table below.

Table 3.4b: Background of the Respondents

Position of the Respondents			Level of Education			Total
			Diploma and TVET	First Degree	Second Degree and Above	
Nurse	Experience in the health Sector	5 years & below	7	5	1	13
		6 to 10 years	5	14	2	21
		11 to 15 years	8	12	2	22
		16 to 20 years	0	0	2	2
	Total		20	31	7	58
Public Health Officer	Experience in the health Sector	6 to 10 years		3	3	6
		11 to 15 years		1	0	1
		21 years & above		0	1	1
	Total			4	4	8
Physician (Medical Doctor)	Experience in the health Sector	5 years & below		3	0	3
		6 to 10 years		5	1	6
		11 to 15 years		7	1	8
	Total			15	2	17
Program Coordinator	Experience in the health Sector	5 years & below	0	3		3
		6 to 10 years	1	5		6
		11 to 15 years	3	4		7
		16 to 20 years	0	1		1
		21 years & above	0	1		1
	Total		4	14		18
Team Leader	Experience in the health Sector	5 years & below	1	4	0	5
		6 to 10 years	5	21	3	29
		11 to 15 years	5	21	5	31
		16 to 20 years	0	10	2	12
		21 years & above	1	1	0	2
	Total		12	57	10	79
Administration Head	Experience in the health Sector	5 years & below	7	3	0	10
		6 to 10 years	2	12	5	19
		11 to 15 years	5	18	4	27
		16 to 20 years	2	4	0	6
	Total		16	37	9	62
Total	Experience in the health Sector	5 years & below	15	18	1	34
		6 to 10 years	13	60	14	87
		11 to 15 years	21	63	12	96
		16 to 20 years	2	15	4	21
		21 years & above	1	2	1	4
	Total		**52**	**158**	**32**	**242**

Source: Author's Survey, 2014

The above table indicates the educational level and experience of the 242 respondents, who filled in the questionnaire. Majority of the respondents, 158 (65%), have first degree in different fields of study, while 52 (21%) have attained diploma and TVET levels. Relatively smaller number of the respondents, 32 (13%), have second degree and above. Therefore, it can be argued that as quite a large number of the respondents, 190 (78.5%), have first degree and above, the author

strongly believes that they can understand the policies, practices and challenges surrounding the PPPs in the health sector of Addis Ababa. Regarding their experiences in the health sector, majority of the respondents, 208 (86%), have served in the health sector for more than 5 years and can better understand the context of the health sector in general and the practices of PPP in the health sector in particular.

3.6.2 Qualitative Data Collection (Key Informant Interview)

The key features of the in-depth key informant interview are: its intention to combine structure with flexibility, its natural instructiveness, its strength to use a range of probes and other techniques to achieve depth of answer in terms of penetration, exploration and explanation, opportunity to create new knowledge or thoughts at some stage and interview data needs to be captured in its natural form (Lewis and Ritchie, 2003). As this study gives more emphasis and priority to qualitative data, detailed information was collected from those who are involved in the health sector PPP programs as policy makers, health service planners, leaders, implementers, monitoring and evaluation experts and other highly experienced professionals.

Following the research approach and philosophy adopted in this study, respondents for key informant interview were selected from the Ministry of Finance and Economic Development (MoFED), Federal Ministry of Health (FMoH), Ethiopian Food, Medicine and Healthcare Administration and Control Authority (FMHACA), Addis Ababa Health Bureau, Addis Ababa Food, Medicine and Health Care Administration and Control Authority (AAFMHACA), Health Offices of 5 Sub-Cities, the Private Health Sector Program (PHSP) of the USAID which is currently working on PPP in the health sector, Ethiopian Public Health Association, Addis Ababa Chamber of Commerce and Sectoral Associations, Private Clinic Owners Association, 5 major public hospitals and 5 major private hospitals in Addis Ababa. The organizations and number of respondents selected from each organization as a key informant interview is presented in the table below.

Table 3.5: Short Description of Respondents for Key Informant Interview

No	Organization	Number of Respondents	Respondent's Position and relevance for Key Informant Interview
1	MoFED	1	Team leader and PPP focal person and is currently leading the national PPP initiative.
2	FMoH	1	Team Leader and PPP focal person and is coordinating the health sector PPP taskforce.
3	FMHACA	1	Experienced in private health sector regulation
4	AAHB	1	Team leader and Legal expert. Experienced in legal issues related to PPP.
5	AAFMHACA	1	Team Leader and well experienced in the private health sector operation in Addis Ababa.
6	Health Offices of 5 sub-cities	5	Senior experts and Team leaders. Mandated with collaboration with and regulation of private clinics.
7	PHSP-USAID	1	Team leader and PPP specialist. Actively working on technical support for the on-going PPP practices in Ethiopia.
8	Ethiopian Public Health Association	1	Experienced in health system of Ethiopia as well as Addis Ababa.
9	AACCSA	1	Team leader and working on the promotion of public private dialogue in Addis Ababa City.
10	Private Clinic Owners Association	1	Member and Clinic Owner. Experienced in public private collaboration in Addis Ababa.
11	5 Public Hospitals	5	Senior experts and team leaders. Familiar with policies and practices of PPP in Addis Ababa.
12	5 Private Hospitals	5	Directors and Administrators. Experienced in the currently on-going PPP initiatives.

Source: Developed by the Author, 2014

The selection of these institutions was based on critical sampling method which Patton (2001) describes as the selection of institutions based on the important information such institutions contain in relation to the research questions under investigation. As indicated in table 3.5 above,

individual key respondents were also selected based on their practical knowledge and experience of the health sector governance and particularly the PPP practices at national as well as city levels. The identification of the individual key respondents was facilitated by a snowball approach in which key respondents from FMoH and AAHB, initially identified by the researcher were requested to recommend other reliable and experienced key informants in other institutions. The researcher has tried to verify their relevance for key informant interview by closely looking at their role and position in their respective organizations and experience in the health sector. As indicated in table 3.5 above, almost all of the respondents have active roles in at least one of the planning, implementation, evaluation and/or regulation of health service management and governance.

Semi-structured interview protocol developed by the researcher based on issues extracted from the literature and conceptual model was administered with purposely selected officials and senior experts in each of the above institutions. One respondent from each of the institutions was selected based on his/her in-depth knowledge of the policies, practices and challenges of public private partnership in the health sector. As indicated in table 3.5 above, the selection of key informants was strongly based on their expedience and familiarity with PPP policies and practices in Ethiopia as well as Addis Ababa. Guided by the semi-structured interview protocol, 24 in-depth one-to-one interviews were conducted to collect data that can intensively describe the policies, practices and challenges of PPP in the health sector of Addis Ababa. All the interviews were individual face-to-face interviews which consumed 80 to 110 minutes each. The interview responses were carefully recorded on an interview data matrix developed based on and in parallel with the semi-structured interview protocol. Though the actual names of the respondents were used on the data matrix for the purpose of recording the interview responses, the names are deliberately changed into nicknames for data presentation and analysis to comply with ethical requirements in social research as discussed under section 3.10 of this chapter.

3.6.3 Secondary Data Collection

Published and unpublished data sources related to the policies, practices and challenges of public private partnership were utilized to gather data that can effectively address the individual research questions posed in this study. Health policies and subsequent directives and regulations issued by the federal, regional and local governments were carefully studied to gain relevant

information. The strategic and operational plans of institutions involved in the health sector were also consulted to collect relevant data to address the research questions. Performance reports of health sector institutions and research findings related to the issue under investigation were also utilized. Through desk reviews, important internal and external institutional documents pertaining to the research questions were systematically investigated.

Collection of data from secondary sources was mainly facilitated by personal interaction during the interviews. Particularly, key informants played an important role in identifying and locating relevant documents for the study as documents mentioned during the interviews were requested from the appropriate unit or department. The researcher acknowledges that as organizational documents are prepared for specific administrative, political, economic or social purposes, there may be chances of manipulation of facts to meet those purposes. However, a strong effort was made at least to make sure that the documents are official documents generated by that particular organization.

3.7 Data Analysis

3.7.1 Quantitative Data Analysis

Data analysis refers to the process of evaluating data using analytical and logical reasoning to examine each component of the data provided (McNabb, 2008). Collis and Hussey (2003) argue that data analysis approach is guided by and depends on the epistemological perspective followed in the research, approach to the problem and particular research questions. The quantitative data analysis in this mixed concurrent triangulations research with qualitative emphasis was used to supplement the qualitative analysis and interpretation. The 242 complete and returned questionnaires, which were checked and cleaned, were entered into SPSS version 20 for analysis. Descriptive statistics and limited non-parametric tests were used to analyze the quantitative data. As the research issue in general, i.e., “Policies, Practices and Challenges” and the individual research questions under section 1.3 do not lend themselves to advanced statistical analysis, the utilization of simple statistical tools was believed to effectively play the role of the quantitative data in this study. It was stated earlier in chapter one that the overall intention of this dissertation is to explore and describe the environment and status of PPP in the health sector of Addis Ababa.

The quantitative data were, therefore, analyzed using one of the approaches to Likert type data analysis. Data analysis was mainly organized under the PPP factors indicated in table 3.1 above. The coded responses for each specific variable under each factor were used to measure the attitude of respondents to each factor. These measurement responses were counted and merged together to provide combined results that can best measure the given factor. The extent to which the factor under consideration is available in the PPP program was, therefore, measured by merging and integrating the responses of all the respondents under each Likert item.

One of the common non-parametric statistical tools called "Kruskal Wallis test" was applied to test the implied null hypothesis (proposition). For all the individual variables included in the questionnaire, the implied null hypothesis is that responses do not significantly vary across the four PPP programs namely: HIV/AIDS, TB, reproductive health and non-clinical services. The null hypothesis is rejected at the 0.05 level of significance inferring that responses significantly vary across the different PPP programs. Not rejecting the null hypothesis at the specified level of significance (0.05) infers homogeneity of responses across the four PPP programs. It is important to note that the purpose of this research is not strictly hypothesis testing. Kruskal Wallis tests are used to check how respondents from the different sample groups responded to the individual questions and prove consistency of response across sample groups. A non-parametric test in general and Kruskal Wallis test in particular were used in this study based on the following justifications (Dowdy, Wearden and Chilko; 2004).

i. Though organizations were randomly selected using stratified method, and all relevant employees from the sampled organization were selected, normality of distribution, which is the criteria for parametric tests, couldn't be ensured.
ii. The Likert item variables are measured on an ordinal level using a 5 point scale and hence violate one of the parametric assumptions.
iii. The independent groups, i.e., HIV/AIDS, TB, RH and Non-clinical services are more than two and hence call for Kruskal Wallis test instead of Mann Whitney U test.
iv. The samples in the study are independent of each other, i.e., there is no individual respondent who belonged to more than one categorical group.

The results of the combined Likert scale responses under each factor and the outputs of the Kruskal Wallis test were used as an important input for the concurrent triangulation to comprehensively answer the research questions.

3.7.2 Qualitative Data Analysis

According to Creswell (2009), qualitative data analysis is generally iterative in the sense that data collection, analysis and interpretation can be done in parallel and simultaneously. This was practically applied in the qualitative component of this research. The perspectives chosen in this research and the individual research questions stated lend themselves to qualitative approach to data analysis with relevant quantitative evidences to triangulate the findings.

The qualitative data analysis and mixing of qualitative and quantitative results for this study was conducted in three stages. At the first stage, the data collected using different methods was organized and displayed to create order and sensible structure. This was achieved by initially refining and reducing the data and then coding the reduced data in order to establish meaningful tags to the different categories of raw data.

At the second stage, the analysis proceeded with the generation of key themes that emerged from the interview responses. The generation of the key themes was essentially guided by the purpose of the study and research questions stated in Chapter 1. As the interview protocol was developed based on conceptual and theoretical models within which the research problem is addressed, the generation of key themes from the interview responses was also based on this framework.

On the third stage of the data analysis, where the mixing of the qualitative and quantitative data is done to concurrently triangulate the results, the empirical qualitative information collected, coded and displayed was carefully connected to the results from the quantitative analysis. At this stage, the outputs from the quantitative data analysis are compared, integrated and interpreted with the results from the qualitative analysis. Using divergence-convergence analysis, the quantitative and qualitative results as well as information from secondary sources were triangulated in such a way that the research questions are effectively answered.

The analysis from the triangulated results was then carefully connected to the theoretical propositions and the larger body of knowledge addressing the research problem. Connecting the meanings from qualitative and quantitative information, logical interpretation was made to

separately answer the research questions stated in chapter 1. The patterns, trends and interconnections of the results were analyzed and interpreted in light of the research questions and the theoretical and empirical literature that was reviewed in chapter 2. The concurrent mixed triangulation of results at this stage and the connection to the larger body of knowledge in PPP areas was used to identify the implication for policy, practice and academics which is the ultimate purpose of this dissertation.

3.8 Reliability and Validity of the Quantitative Component

Though emphasis and priority was given to the qualitative component, an attempt was made to enhance the reliability and validity of the quantitative data and results. Zoltan (2007) argues that reliability and validity of the instrument are very important to decrease errors that might arise from measurement problems in the research study in quantitative study. Reliability according to Lewis and Ritchie (2003) refers to the accuracy and precision of a measurement procedure. To ensure the reliability of the questionnaire, the instrument was pilot tested on 8% of the respondents before distributing the 284 questionnaires. Doing so, it was ensured that the same results were obtained with repeated administration of the same survey to the similar respondents. Internal consistency of the items measured on the Likert-type scale was also checked on the results of the pilot study. How well the various items in a measure appear to reflect each of the variables being measured was assessed.

Creswell (2009) describes validity as the degree to which a study accurately reflects or assesses the specific concept or construct that the researcher is attempting to measure. In this study, content validity was established to show the extent to which the items in the questionnaire and the scores from these questions exhaustively represent all the possible questions about policies, practices and challenges in the PPP environment. The items in the questionnaire under each PPP factor were assessed and commented by experienced colleagues from the Department of Public Administration and Development Management and PPP professionals who helped in the development of the final questionnaire. Utmost effort was made to ensure that questions under each factor are relevant to the subject it has aimed to measure. Doing so, the researcher believed that the questionnaire is adequate in both content and design in terms of collecting sufficient and good quality data from the relevant respondents.

The criterion-related validity is used to demonstrate the accuracy of a measure or procedure by comparing it with another measure or procedure, which has been demonstrated to be valid. The researcher could not get any previously developed instrument in this topic of research. Though continuous efforts are made before the questionnaire was approved and distributed for full scale data collection, no similar or even relevant instrument was identified to compare with the self-developed questionnaire to check for criterion-related validity. As clearly stated in chapter one, this is conceded as one of the limitations of this study.

3.9 Establishing Credibility in the Qualitative Component

As a mixed method research, the quality of the whole research depends not only on the validity and reliability of the quantitative component, but also on the credibility of the qualitative component. According to Lincoln and Guba (1994), the researcher seeks believability based on coherence, insight, and instrumental utility through a process of verification rather than through traditional validity and reliability measures. Although the results of a qualitative study within a given specific context cannot be exactly generalized to other contexts (Berg 2001), statements about the researcher's positions-the central assumptions, the selection of informants, the biases and values of the researcher enhance the study's chances of being replicated in another setting (Creswell, 2009).

The credibility of the qualitative component in this research was established in the following ways as recommended by Creswell (2009) and Creswell and Miller (2000).

i. The interview results were compared and triangulated with other sources of information such as secondary sources.
ii. Feedback was obtained from key informants about the accuracy and relevance of the major thematic categories identified. This was done by requesting the national PPP focal person from MoFED, the team leader and PPP focal person of the FMoH, and the key informant from AAHB to comment on the thematic categories developed by the researcher before data analysis and interpretation was done.
iii. Thick and rich description was made to ensure that the factors under consideration are addressed in a greater depth. Rather than simply describing the content of what the respondents said, the researcher tried to investigate and understand the contexts and implications of the information obtained from the respondents.

3.10 Research Permission and Ethical Considerations

As social science researches in general and mixed method researches in particular primarily focus on human beings as a source of information (Tashakkori and Teddlie, 2003), this study was fully governed by the ethical principles of social research. To this effect, during data collection through questionnaire and semi-structured interviews, utmost care was made to protect every respondent thereby building confidence with participants of the research. The research problem, the research purposes and questions as well as the instruments designed to collect data carefully considered ethical issues related to public administration research, the health sector ethics and preferences of individual respondents.

More specifically, this study promoted and maintained ethical values of social research in the following ways. Permission from the individual institutions and informed consent of the sampled respondents were obtained before distributing questionnaires and conducting interviews. The researcher did pledge to the respondents that no information supplied to him in the course of the study will be disclosed to any third party nor will it be used for other purpose than this study. To keep the anonymity of the participants, no respondent in this study is mentioned by name in any place in the research report except on the interview data matrix which will not be disclosed to third party. All the names used in the presentation and analysis of interview responses are nicknames generated by the researcher for the purpose of this dissertation. The institutions to which individual respondents belong are not also mentioned in the research report. All sources of information are duly acknowledged and carefully utilized with no distortion and unwarranted manipulation. The data are maintained, updated, accurate and secured to comply with the national laws of Ethiopia. The final dissertation report will be made accessible to the institutions and individuals who have participated in the research process.

3.11 The Role of the Researcher

The role that the researcher plays at different phases of the study has epistemological and axiological implications for the process as well as the outcome of the research (Collis and Hussey, 2003). Though this study used a mixed concurrent triangulation strategy, the researcher played different roles in the quantitative and qualitative components of the study. In the quantitative component, data collection was conducted using structured and detailed questionnaire and the researcher played minimal role and had very limited relationship with the

respondents. The researcher, therefore, did not have the room to influence the data collection process and its outcome. As the data analysis was conducted using statistical tools from SPSS version 20 and the results were interpreted based on the established statistical results before they were connected to the results from the qualitative analysis, the personal values of the researcher did not influence the analysis and interpretation.

Qualitative research, on the other hand, is characterized by the room for interaction of the researcher and the respondents (McNabb, 2008; Creswell, 2009). During the data collection through key informant interviews, the researcher played a more participatory role due to the nature of the issues being addressed. Moreover, the researcher has participated in the capacity building program of some of the organizations as a training facilitator and has in the process established relationships with some of the participants in the key informant interviews. As five of the respondents were the former students of the researcher at undergraduate level and known to him very well, the interview process was not as formal as the quantitative data collection. The relationship with the other respondents in the interview was also more informal and interactive due to the constructivist nature of the questions and the long time the researcher had with each respondent during the interviews. All these practical realities at the qualitative study level posed the possibility of bias to the interview process and its outcomes.

Despite the above risks for bias, utmost effort was made to eliminate the possible bias and make the study as value-neutral as possible. Except the personal familiarity of the researcher with the interviewees, which happened by coincidence and the relationship that was developed on the interview tables, the researcher did not have any personal and professional interest that tempted him to bias the process and the outcome of the study. More importantly, extensive verification procedures, including triangulation of data sources, member checking, and thick and rich descriptions of the issues under consideration was used to make the role of the researcher negligible in terms of influencing the direction of the findings.

Chapter 4: An Overview of Addis Ababa's Health Sector: Implications for Public Private Partnership

4.1 Introduction

The methodology and procedure for the study was presented in chapter three. It was discussed in chapter two that the argument for PPP in the health sector should be based on clear evidences of need that takes in to account the actual contexts of the health system under consideration. The purpose of this chapter is to briefly discuss the status of the health sector of Addis Ababa and identify the major challenges that are cited as justifications of reform in general and public private partnership in particular. This chapter briefly introduces the country and city background, the status of the health services, the governance and stewardship in the health system, health service delivery, health infrastructure, resources, financing and the different challenges that are calling the attention of policy makers and researchers to look for public private partnership as alternative mechanism to address the challenges. Data for this chapter was collected from relevant secondary sources. Performance reports and published documents from the Federal Ministry of Health and Addis Ababa City Government and information from different journal articles and working papers were also used. The data from the secondary sources were substantiated and triangulated by information obtained from key informant interviews.

4.2 Background of the Ethiopian Health Sector

Ethiopia is a land locked country in East Africa with the population of 90,076,012 (FMoH, 2015). The government is organized as a federal structure with the central government and nine regional states and two city administrations. The nine regional states that have autonomous administration and parallel administrative structure are Afar, Amhara, Benishangul-Gumuz Gambella, Harari, Oromia, Somali, Southern Nations Nationalities and People's Region and Tigray. The two city administrations that report to the federal government are Addis Ababa and Dire Dawa. In this form of constitutionally established federal arrangement (FDRE, 1995) the health sector is also governed by powers, duties and responsibilities shared between the federal government and the regional states.

The land area of the country, which is estimated at about 1.1 million square kilometers, has all varieties of climates which imply different living styles and disease prevalence (Keller, 2009).

The proportions of male and female residents are almost equal. Around 23.4 percent of women are of reproductive age (15-49 years) and 45 percent of the population is younger than 15 years (FMOH, 2012). It can be argued that the close male-female ratio implies the strategic and operational attention that should be given to health services of the country from the perspectives of sex and gender.

Ethiopia is a growing but a poor country in sub-Saharan Africa. Its gross domestic product (GDP) in 2010/11 was estimated at Birr 511.16 billion (US$31.7 billion) and per capita income at US$392. The government report over the last couple of years indicates a fast growing Economy with a double digit GDP growth rate. For instance, the Economic growth (GDP at constant basic price) in 2010/11 was estimated to be 11.4 percent (FMoH, 2014a). It should be noted, however, that international financial institutions like the World Bank and IMF reported slightly lower Economic Growth rates. The service sector in the Ethiopian Economy is reported to be among the fast growing sectors. For instance, in 2014/15, the Ethiopian Service sector grew at 12.5% while agriculture and industry grew at 9.0% and 15.0% respectively. The fast growth in the service sector of the Economy in general and the service sector in particular directly or indirectly imply the growth in the health sector. The share of the service sector from the total GDP was 45.6% followed by agriculture and industry which were 41.0% and 13.4% respectively. Government reports generally indicate that the economy has grown in real GDP terms at a rate of 11 percent per annum for the past five years (MOFED, 2012; National Bank, 2010).

The growth in the economy which is argued by the government as an outcome of the poverty reduction strategies has several implications for the Ethiopian health sector. Firstly, as poverty is closely related to the health condition of a society, poverty reduction efforts will have an impact in improving the health status of citizens by improving their living conditions, enhancing their health seeking behavior and improving their affordability to better health services. Secondly, as health is generally a cross-sectoral issue, the development and change in other sectors such as agriculture, industry and other social services like education and utilities will affect how health services should be delivered and governed. This calls for inter-sectoral collaboration and partnership in governing public services in general and health services in particular (FMoH, 2010). Thirdly, economic development is often followed by life style changes of the society. The 15.0% growth in the industry sector for instance implies fast industrialization which will

eventually lead to rapid urbanization and consequential life style changes. Both the disease burdens and governance strategies for health services will be influenced by these developments and life style changes. Finally, the growth in the Ethiopian economy, very clearly, involves the participation and contribution of the private sector. As will be discussed later in this chapter, the growth in the Ethiopian health sector is followed by concomitant growth of private health facilities and services. It can be argued that the growth of the private sector should positively contribute to the efforts in addressing the health sector gaps of the country.

Several reports and research findings indicate efforts and achievements of the public sector in addressing health and health related issues of the country. For instance, FMoH (2015) indicates that 55 percent of the total population had access to safe drinking water in the year 2014/15. Access to primary health care services and coverage of the Expanded Program on Immunization (EPI) were 92.1 percent and 74.5 percent, respectively. Estimated life expectancy at birth is 54 for males and 57 for females (FMoH, 2012; FMoH, 2014b). Though the figures seem to indicate that Ethiopia's health sector has registered remarkable achievements, the government clearly admits that the health services are still lagging far behind WHO standards and the planned HSDP targets of the government. Despite the achievements, Ethiopia's health sector is far from delivering what is required and the health status of the population is still poor (Tesfamichael, et al, 2013; FMoH, 2014b). This problem is mainly attributed to the limited capacity of the public sector to finance, and regulate the health sector. According to Tesfamichael (2013) and Eskender (2014), the low level of health service delivery is partly due to the low level of health sector financing. Since health care in Ethiopian is mainly financed by the public sector, out of pocket payments and donors contribution (FMoH, 2014a; FMoH, 2013) the ever growing health service needs of the citizens could not be satisfied with limited and yet less sustainable financing.

The investment in the health sector and health expenditure in Ethiopia has remarkably grown over the last few years. Attesting this, the fourth round of National Health Accounts (NHA) showed that between 2004/05 and 2010/11, health expenditure from all sources increased at an annual rate of about 43 percent and per capita health expenditure increased from US$7.14 to US$16.1 (FMOH 2010). It can be safely argued that the growth in health expenditure per se cannot guarantee access, equity, affordability and quality of health services unless appropriate stakeholders are brought on board and innovative health system governance approaches are established. This argument can further be illustrated with the data from FMoH (2010) and FMoH

(2014a). The data testifies that Ethiopia's health sector remains underfinanced when compared with the World Health Organization (WHO)-recommended minimum spending of US$34 per person per year to provide basic health care services in developing countries (WHO, 2001), which later was updated to US$54 and more recently to US$60. Health sector reforms and the introduction of new approaches to health service delivery aim at not only increasing per capita health expenditure but also ensure that citizens are getting access to better quality services at affordable prices. The need to involve the private sector and utilize its untapped potential is justified from these perspectives. It was discussed in chapter two that the theoretical underpinning of the argument for public service reform in general and the involvement of the private sector in public service delivery including the health service in particular is well established in New Public Management paradigm.

Several research findings and government reports (e.g. Degu et.al, 2012; Eskender, 2014; Samuel et. al, 2007, FMoH, 2010) indicate the government's efforts and planned interventions to improve the status of the Ethiopian health services. The health policy promulgated by the transitional government of Ethiopia in 1993 mainly focused on democratization and decentralization of the health care system (TGE, 1993). Seen from the perspective of contemporary public sector management, the intention to democratize and decentralize the health system implies the room for participation and active role of multiple stakeholders including the society and the private sector. The Ethiopian health policy, which declares the government's commitment to develop the preventive and curative components of the health care, indicates that the government will work towards ensuring accessibility of health care for all segments of the population. To achieve these policy goals the need for the development of the private sector, inter-sectoral collaboration and the participation of non-governmental organizations is stipulated in the policy document. However, the approaches to involve and work with the private sector are highlighted neither in the policy nor in the subsequent HSDPs. As the derivatives of the national health policy, four Health Sector Development Plans (HSDPs) of 5 years each were developed and implemented since the coming of EPRDF to power (FMoH, 2014a). The latest Health Sector Development Plan (HSDP IV) which is implemented between 2010/11 and 2014/15, is a comprehensive health sector plan that constitutes ten main strategic objectives namely:

- Improving access to health services
- Improving community ownership of the health system and services

- Maximizing resource mobilization and utilization
- Improving quality of health services
- Improving public health emergency preparedness and responses
- Improving pharmaceuticals supply and services
- Improving regulatory system of the health sector
- Improving evidence-based decision making by harmonization and alignment
- Improving health infrastructure and,
- Improving human capital and leadership in the health sector.

The above health sector development plans and strategic objectives, which are designed in response to the existing gaps and challenges in the Ethiopian health sector, infer the heavy burden on the public health sector and imply the need for the involvement and active participation of non-state actors in general and the private health sector in particular. Each of the ten strategic objectives mentioned above involves not only adequate resources but also innovative governance system and structures where the private sector can be considered as key stakeholder and partner given its growth over the last couple of years.

From the perspectives of the new public management, the above strategic goals call for more innovative and flexible public sector management style in general and private sector involvement in particular. The following implications can be drawn in this regard. Firstly, achieving the above goals requires professional management style in which managers are autonomous and confident in decision making on issues that are under their jurisdiction. Secondly, explicit standards of measure and output control as well as efficiency in resource utilization are attained when the management style of the private sector is introduced into health service delivery. Finally, the principles and practices of inter- and intra-organizational competition in service delivery, which is often available in the private sector, are argued to add value to the requirements of efficiency and effectiveness in public service delivery.

The Ethiopian health sector gives due emphasis to health services that are said to be high impact public health issues. In this regard, the major priorities of the HSDP-IV are improving maternal and child health, and reducing and reversing the impact of major communicable diseases such as HIV/AIDS, tuberculosis (TB), and malaria (FMoH, 2010). As suitably justified in chapter three, this study focused on selected high impact public health issues in order to conform to the

governments focus areas, on the one hand, and to emphasize the need for alternative health service delivery approaches in these areas of health, on the other hand.

The public sector in Ethiopia adopted several mechanisms to address the health sector objectives. For instance, The Health Extension Program (HEP), the Accelerated Expansion of Health Centers, and the accelerated training of health officers and doctors, all of which are also being actively practiced in Addis Ababa are considered as vehicles for improving service delivery to the community at large (FMoH, 2014a). It can be argued, however, that the attempts that are made by the government and the specific strategies developed to achieve the health sector goals (FMoH, 2005; FMoH, 2010) are characterized by traditional public administration and welfare state values. The argument by Mclaughlin et al. (2002), in welfare state, the public sector plays dominant roles in the process of planning, provision and evaluation. The use of traditional bureaucracy in public service delivery also heavily relies on structures, rules, regulations and administrative control than using innovative and flexible management approaches (Osborne, 2010; Nuwagaba, 2013; Lane 2000). Empirical literature also reveals that heavy reliance on traditional public bureaucracy for health service delivery in sub-Saharan Africa has serious limitations in terms of effectively addressing the health service needs of citizens. It can, however, be argued that the specific strategies to achieve HSDP IV have the opportunity to tap the potential of the private sector through partnership arrangements. In this regard, the health care financing, harmonization, and alignment "One Plan, One Budget and One Report", the health commodity supply system and comprehensive human resource development which are referred to as system issues (FMoH, 2013; FMoH, 2014a) all signal the imperatives for the involvement of the private sector as an essential component of the health system.

The above facts and arguments about the health system of Ethiopia also work for Addis Ababa. The rest of the subsequent sections specifically focus on the health system of Addis Ababa and the findings justifying the need for public private partnership in the city.

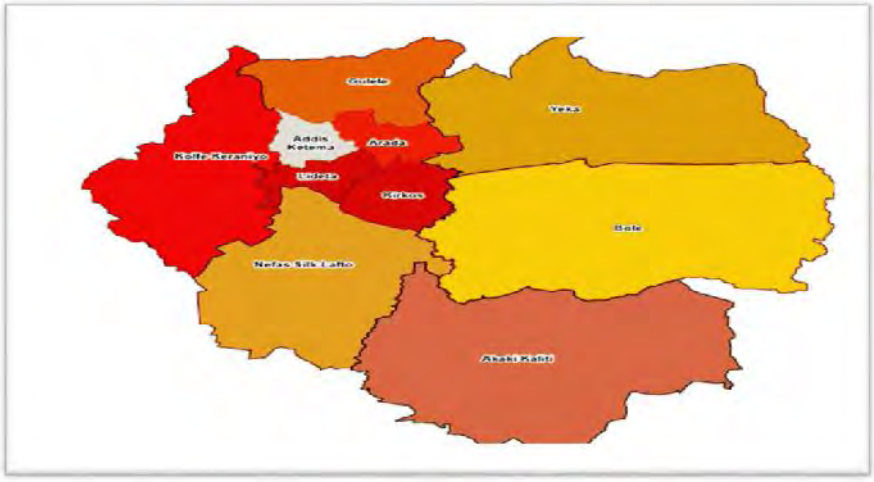
4.3 Brief Overview of Addis Ababa City Government

This study, for methodologically justified reasons, is conducted in Addis Ababa. The deeper understanding of the policies, practices and challenges of PPP in the context of the city is the focus of this research, which will have theoretical and analytical implications for the health sector of other areas of the country. Addis Ababa is the capital city of Ethiopia, which is one of

the biggest primate capital cities in Africa. Located at the center of the country, the city lies 9°1′48″N latitude and 38°44′24″E longitude at an altitude ranging from 2,100 meters at Akaki in the south to 3,000(9,800 ft) meters at Entoto Hill in the North. This makes Addis Ababa the third highest city in the world, after La Paz and Quito in Latin America (AABoFED, 2014). While the city occupies a total land area of 540 square kilometers, its time zone is categorized in East Africa Time (UTC+3).

Addis Ababa is one of the oldest cities in Ethiopia and was established by Emperor Menilik in the process of State formation in 1887. The city, as the largest and dominant political, economic, cultural and historical city of the country, has passed through different socio-economic and political development processes (AABoFED, 2014). The current administrative map of the city is presented below.

Map 1: Administrative Map of Addis Ababa City



Source: Atlas of Addis Ababa City, 2014

Having a status of a city and a state, present Addis Ababa is the capital of the federal government and a chartered city. It is also the seat of several international organizations and diplomatic institutions. For instance, the African Union and its predecessor the OAU, the United Nations Economic Commission for Africa (UNECA) and numerous other regional and international organizations have their head quarters in Addis Ababa. In its current political and administrative context, the city is divided into ten sub-cities which are the second administrative units next to city administration. The ten sub-cities and their population are presented in the table below.

Table 4.1: Population of Addis Ababa City disaggregated by Sub-cities and Sex

No	Sub-city	Population		
		Male	Female	Total
1	Addis Ketema	146, 517	158,728	305,245
2	Akaki Kality	105,109	113,869	218,978
3	Arada	122,175	132,358	254,533
4	Bole	177,243	192,015	369,258
5	Gulele	153,045	165,800	318,845
6	Kirkos	129,102	139,862	268,964
7	Kolfe Keranio	245,946	266,443	512,389
8	Lideta	115,814	125,467	241,281
9	Nefas Silk Lafto	179,160	194,091	373,251
10	Yeka	196,923	213,334	410,257
Addis Ababa		**1,571,040**	**1,701,961**	**3,273,001**

Source: Addis Ababa City Government Finance and Economic Development Bureau, 2014/15

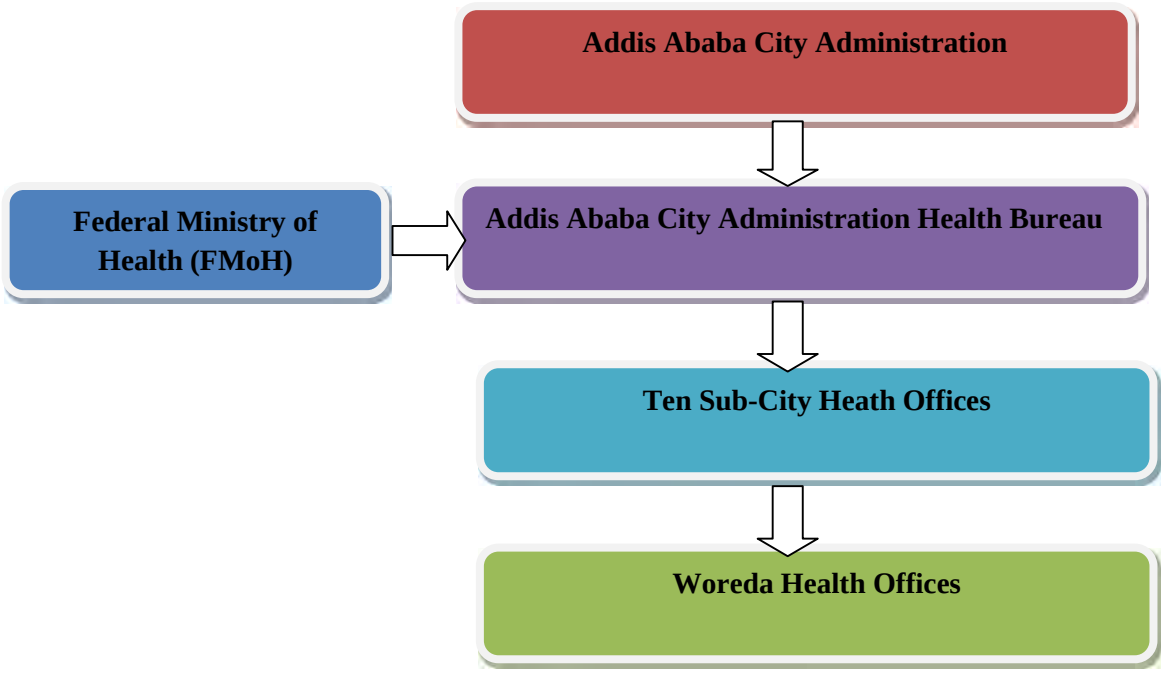
As a reflection of the political and administrative decentralization, the sub-cities are further divided into Woredas, which are the smallest administrative units of the city. Under the current arrangement, the ten sub-cities are locally organized into 116 smaller administrative units called 'Woredas' in which each sub-city constitutes varying number of Woredas based on its relative population size and geographic coverage (AAHB, 2015; AABoFED, 2014). At the city level, mayor-council model is adopted with an appointed mayor and elected council, while at the sub-city level, appointed chief executive officers are ultimately in charge of implementing the different sectoral policies and strategies including the health sector. The structure of the health service administration of the city government subscribes to the decentralized governance approach stipulated in the health policy of the federal government, subsequent HSDPs and the structure of the City Government. From conceptual point of view, it can be argued that fully decentralized health system, at least in principle, gives autonomy to lower level units not only to plan and implement health services within their own jurisdiction, but also to exercise the freedom to choose appropriate governance and management approach including the option of public private partnership. The governance and regulatory system of the health sector of Addis Ababa is discussed below.

4.4 Governance and Regulation of Addis Ababa's Health System

The governance and stewardship issues of the health sector of Addis Ababa are fundamentally based on the 1995 FDRE constitution, the health policy of the Transitional Government of Ethiopia and the governance structure of the City. Accordingly, the decentralized governance and the sharing of power and duties between the federal and the regional governments is the primary basis of the health sector governance of Addis Ababa (FDRE, 1995). Responsibility of health policy, regulation, and service delivery is shared among the Federal Ministry of Health (FMOH), Health Bureau of the City Government, and Woreda health offices (WorHOs). Policy development as well as development of standards and operational protocols is the responsibility of the FMOH (FMoH, 2014). The implementation of policies, standards, and protocols as well as the responsibility for service delivery at the city level is mandated to Addis Ababa Health Bureau (AAHB). Structurally, AAHB is also responsible for owning, financing, and supervising the service delivery of the hospitals owned by the city government. Woreda health offices manage and coordinate the operation of the primary health care units (PHCUs) such as health centers and clinics. They are responsible for planning and budgeting of health programs and health care services as well as negotiating budgets with finance offices and cabinets/councils at the woreda level.

As clearly stipulated in the 1995 FDRE constitution, the relationship between the federal government and regional state institutions including the City Government of Addis Ababa does not reflect direct accountability to one another. This decentralized structure and parallel governance is also reflected in the health sector of the City. Accordingly, in the decentralized context of the City Government, while both Addis Ababa Health Bureau and the Woreda Health Offices, as parts of the health system, are not directly accountable to the FMOH. Addis Ababa Health Bureau is accountable to the city government, while the 116 Woreda Health Offices directly report to their respective local governments called Woreda Administrations. However, functionally, the lower-level health entities are technically accountable to their higher counterparts and they are supposed to submit regular reports. The governance structure of the health sector of the City Government is depicted in the diagram below.

Figure 4.1: The Governance Structure of the Health Sector of Addis Ababa City



Source: AAHB, 2014

The administrative structure of the public health sector in Addis Ababa reveals that administratively the City Government is autonomous to govern its health system. While policies, standards and operational protocols are developed by FMoH, the health bureau of the city government handles health service delivery and regulation within its own jurisdiction (FMoH, 2005; FMoH, 2010). The decentralization of the health system indicates not only the sharing of administrative responsibilities within the different levels of the government but also the responsibilities of partnering with and regulating the private health sector at their respective levels. The strategic framework for public-private partnership which was prepared in 2013 by FMoH indicates that the specific governance for collaborating with the private health sector should be aligned with the decentralized structure of the health care system of the country. The government of Ethiopia has endorsed this structure of governance in order to simplify both the collaboration with and regulation of the private health sector at regional and local levels (FMoH, 2013b).

Though the relationship between the FMoH and the health system of the city government do not structurally reflect strict accountability relationships, collaboration and mutual support between

FMoH and AAHB are common practices. In this regard, FMoH (2014a) reveals that the FMOH supports regional health bureaus in system development/revision, design of health sector programs, and setting of targets in line with the national plans and targets, resource mobilization, and allocation and harmonization of efforts with partners as well as in creating platforms for reviewing progress against HSDP targets and for sharing of experiences. To strengthen information flow and effective resource mobilization and use the FMOH and RHBs including AAHB introduced a woreda-based national planning system in 2007/08 (FMoH, 2014b). The main purpose of this planning system is to ensure that health plans at the grassroot level are evidence-based, result-oriented, and contributing toward country-level health sector targets, while at the same time helping higher-level plans (of the FMOH and RHBs) to be more realistic, gap filling, and supportive of the lower-level plans. The FMOH and RHBs use the Woreda-based plans to identify financial and nonfinancial resource requirements and gaps at local levels. According to FMoH (2013), this evidence-based planning process is improving value for money and health authorities at different levels are negotiating with their counterparts in finance.

The practice of bottom-up planning in the health sector of Addis Ababa has key implications for partnership with the private sector. Firstly, it can be argued that the health gaps at local levels can be filled using locally identified solutions including locally established PPPs that can be integrated into the national health sector plans. It was theoretically discussed in chapter two that locally contextualized PPPs will have the power of effectively assessing actual gaps and solve those problems using locally appropriate means. Secondly, local level health structures are better equipped with realistic and evidence based information about the potential and feasibility of partnering with the private sector. Thirdly, bottom-up planning provides the room for the local government health structures to recruit develop and utilize the untapped potential of the private sector. The challenge identified by USAID (2008) and FMOH (2014b) that the efforts to collaborate with the private sector at local levels was constrained by the lack of capable and qualified private operators can be solved by empowering local governments to identify and develop the private sector at local levels.

Recognizing its cross-cutting and multi-sectoral nature and its multiple impacts, the national as well as the city health system governance and stewardship gives particular attention to HIV/AIDS issues. To illustrate this, for instance, the National HIV/AIDS Council coordinates and leads HIV/AIDS prevention and control activities with broader stakeholder participation. At

Addis Ababa levels, the HIV/AIDS coordination offices, which are accountable for the council is mandated with coordinating interventions against the epidemic. The Country Coordinating Mechanism and the National and City Level Review Boards are also important governance structures that allow decisions in a participatory manner (FMoH, 2014a; FMoH, 2014b; FMoH, 2013a). As the above facts imply, the need to involve the private sector in the fight against HIV/AIDS, the practices and challenges of involving private health facilities in a coordinated manner in the governance of this multi-sectoral issue will be discussed in chapter five.

As discussed earlier in this section, the decentralized approach to the health system governance is operationalized by making public health facilities accountable to the local authorities that are closer to the community. More importantly, FMoH (2013a) and FMoH (2014b) reveal that health institutions in Addis Ababa are legally autonomous and allowed to retain and use the revenue they are generating. They are also allowed to establish their own governing bodies in which the community and local administrations are represented. This is an important component of the health care financing reform of the Ethiopian health sector which Addis Ababa Health Bureau is also actively implementing. It can be argued that the health sector reform program in general and the health care financing reform in particular, which are the derivatives of the health policy of the government, promote democratization and decentralization of the health system. At least in principle, the decision making autonomy at the local level implies the opportunity for local authorities to identify the potential and feasibility of working with the private sector at their jurisdictions.

4.5 Health Service Delivery

Over the last two decades, the health sector of Addis Ababa has been in a continuous reform processes. Aligned with the public sector reform programs that aimed at improving the efficiency and effectiveness of public service delivery in Ethiopia, various reform tools have been designed and implemented in the public health sector of the city. It can be argued from the elements and ultimate objectives of the reform programs in the health sector that some essential values and principles of new public management are reflected in the reform initiatives. As a public sector reform component, Addis Ababa Health Bureau has been implementing various activities, including the Business Process Re-engineering (BPR), to improve health service delivery in the city. Moreover, the health sector reforms in general and the health care financing reform in

particular aim at making health services accessible, of better quality, sustainable, affordable to citizens (FMoH, 2014a; AAHB, 2015). In the efforts to reform the health sector shifting the responsibilities and risks of health service delivery away from the public sector to non-state actors, particularly to the private sector, is an important policy agenda. However, service delivery in Addis Ababa seems to excessively focus on the public sector structure. To illustrate this, health service delivery in the public sector is organized into a three-tier structure of specialized hospitals, general hospitals, and PHCUs.

The emphasis on the health service delivery through the public sector structure is also reflected in the health extension package (HEP), which is being implemented by AAHB. Subscribing to the strategies of FMoH, The city government has been implementing the HEP delivering 24 packages of services at community and household levels. Though the initial objective of HEP was to improve primary health care coverage of the rural population, it has contributed to the efforts of achieving the primary health coverage of the City (AAHB, 2015). HEPs primarily focus on the promotive and preventive aspects of health services as well as the delivery of primary health services at the community levels. The policy and practice of HEP, which is considered to be Ethiopia's health sector flagship (FMoH, 2014a), has important implications. On one hand, the policy and practice reflects the welfare orientation of the government towards health services which signals strong government intervention which involves high demand for human and financial resource to be deployed in this area of services. On the other hand, the policy and practice opens up a new research area on the possibility and feasibility of involving the private sector in the delivery of some of the packages in health extension program.

Regardless of the heavy intervention of the government in the health system governance and service delivery in Addis Ababa, the health sector of the city still undergoes several challenges in terms of meeting the health needs of citizens as well as the health service standards. Some of the health related facts of the city are presented in the subsequent tables below.

4.5.1 Maternal and Child Health

The health policy of the federal government and the subsequent health sector development plans as well as the different plans of the city government emphasize maternal and child health (MCH) issues as one of the priority areas. In line with this, the urban health extension program which is being implemented by Addis Ababa Health Bureau considers MCH as one of its key pillars.

Several external supports from different donors are also channeled to this segment of the health services. This section discusses about the facts and challenges in the delivery of MCH services by giving specific attention to some aspects of the services.

Table 4.2: Trends in Contraceptive Acceptance Rate in Addis Ababa City

Year (G.C)	Women Aged 15-49	New and Repeat Acceptor	Performance (%)
2010/11	959,634	272, 867	28.4%
2011/12	980,723	248,827	25.4%
2012/13	1,007,469	227,993	22.6%
2013/14	1,121,212	214,341	19.1%
2014/15	1,056,843	349,566	33.1%

Source: Source: FMoH, 2011; FMoH, 2012; FMoH, 2013; FMoH, 2014, FMoH, 2015

As illustrated in the table above, contraceptive acceptance rate is still significantly low in Addis Ababa. Contraceptive acceptance rate declined between 2010/11 and 2013/14 and increased to 33.1% in the year 2014/15. However, this rate is one of the lowest in the country and far lower than the national CAR of 70% in the same year.

Table 4.3: Trends in ANC, Delivery by Skilled Attendants and Post Natal Care Coverage in Addis Ababa City

Year (G.C)	Total Number of Expected Pregnancy	ANC Coverage		Deliveries by Skilled Attendants		Post Natal Care Coverage	
		Number	Coverage	Number	Coverage	Number	Coverage
2010/11	70,819	82,756	116.9%	47,762	67.4%	26,373	37.2%
2011/12	72,376	100,644	139.1%	48,034	66.4%	30,285	41.8%
2012/13	72,743	71,218	97.9%	53,048	72.9%	34,756	47.8%
2013/14	72,317	71,067	98.2%	53,219	73.5%	34, 841	48.1%
2014/15	76,308	76,308	100 %	76,308	100%	76,308	100%

Source: FMoH, 2011; FMoH, 2012; FMoH, 2013; FMoH, 2014, FMoH, 2015

Table 4.3 above indicates that all the three indicators of maternal health namely ANC coverage, delivery by skilled birth attendants and postnatal care coverage have steadily improved over the last 5 years and attained full coverage by the year 2014/15. Most of the key informants from the public institutions attribute this achievement in maternal health services to the proliferation of health extension package in the city. On the other hand, Gebreyohannes who is a PPP specialist in PHSP strongly argues that the participation of private health facilities in maternal health services should not be undermined (Gebreyonannes, March 3, 2015). His argument is also supported by key informants from private hospitals.

Table 4.4: Tends in Abortion Care Rate in Addis Ababa City

Year (G.C)	Number of Expected Pregnancy	Abortion Care	Percent
2010/11	70,819	7,091	10 %
2011/12	72,376	6,730	8.8
2012/13	72,743	6,933	9.5%
2013/14	72,317	7, 068	9.7%
2014/15	76,308	21,494	28.17

Source: FMoH, 2011; FMoH, 2012; FMoH, 2013; FMoH, 2014, FMoH, 2015

Abortion care in Addis Ababa did not improve between the years 2010/11 and 2013/14. Though abortion care dramatically increased from 9.7% in 2013/14 to 28% in 2014/15, it is considered the lowest by all standards given the relative position of Addis Ababa's health system. For instance, the 2014/15 abortion care rate of 28% is even less than that of Harari (32.1%) and Diredawa (34%) in the same year. Almost all the key informants confirmed that abortion care rate in Addis Ababa is very low. Key informants cite the following challenges for the delivery of maternal and reproductive health services in Addis Ababa.

- Absence of 24 hours a day and 7 days a week service in most health facilities, especially in HCs;
- Lack of a separate newborn corner and absence of a neonatal unit in some health facilities;
- Lack of regular supply of inputs to health facilities;
- High turnover of trained staff delivering maternal and reproductive health services;

It can be argued that despite heavy intervention of the government and enacted commitment to improve maternal health conditions in Addis Ababa, evidences indicate that the health needs of citizens are not still fulfilled. Most of the key informants unanimously believe that the challenges which are affecting the delivery of maternal health services call for greater involvement of the private sector in the health service delivery of Addis Ababa. As clearly depicted in the analytical model presented in chapter two, well designed and properly managed partnership arrangements can resolve many of the limitations of the government in addressing the health gaps identified above.

Table 4.5: Under 5 Children Receiving Vitamin A Supplementation in Addis Ababa City

Year (G.C)	Total Number of Children 6 to 59 Months of Age who Need Vitamin A	Number of Children Who Received Vitamin A	Coverage
2010/11	321,663	195,265	60.7%
2011/12	328,732	36,261	11.0%
2012/13	337,488	132,206	39.2%
2013/14	343, 327	184, 867	53.8%
2014/15	354,028	131,553	37%

Source: FMoH, 2011; FMoH, 2012; FMoH, 2013; FMoH, 2014, FMoH, 2015

Vitamin A supplementation as an important component of child health showed varying results over the last 5 years. It can be generally argued that vitamin A supplementation coverage declined from 60.7% in 2010/11 to 37% in 2014/15. Despite the heavy emphasis given by the government and development partners to promote child health, coverage of some of the child health services including vitamin A supplementation is among the lowest as compared to the national average of 81%.

Table 4.6: Children 2--5 Years of Age De-wormed in Addis Ababa City

Year (G.C)	Number of Children who need de-worming	Number of Children De-wormed	Coverage
2010/11	132,117	126,432	95.7%
2011/12	135,020	0	0%
2012/13	138,617	27,917	20%
2013/14	141, 326	21, 415	15.1%
2014/15	145,410	0	0%

Source: FMoH, 2011; FMoH, 2012; FMoH, 2013; FMoH, 2014, FMoH, 2015

As the table above indicates, coverage of eligible and needy children who were de-wormed in 2010/11 was 95.7% in Addis Ababa. However, this rate declined to 20% in 2012/13 and to 15.1% in 2013/14. Coverage of child de-worming was 0% in 2014/15 indicating significant gap in child health services.

Table 4.7: Immunization Coverage by Different Antigen in Addis Ababa City

Year (G.C)	Surviving Infants	Penta-3	%	PCV-3	%	Measles	%	Fully Immunized	%
2010/11	65,791	59,369	90.2%	NA	NA	56,904	86.5%	55,516	84.4%
2011/12	67,237	57,684	85.8%	57344	85.3%	55,161	82%	50,583	75.2%
2012/13	69,833	62,002	88.8%	36,976	52.9%	62,474	89.5%	60,671	86.9%
2013/14	70, 054	63, 815	91.0%	36, 876	52.6%	64, 371	91.8%	61, 210	87.3%
2014/15	73255	73,255	100%	73,255	100 %	73,255	100%	74,866	100%

Source: FMoH, 2011; FMoH, 2012; FMoH, 2013; FMoH, 2014b, FMoH, 2015

Immunization coverage has been achieved much better in Addis Ababa over the last 5 years. As table 4.7 above indicates, all eligible children were fully immunized (100%) by the year 2014/15. Key informants attribute the success of full immunization to the participation of private health facilities, hospitals and clinics in the delivery of immunization services being implemented based on agreement between the government and the private health sector. Reflecting the early stage of the development of PPP, the collaboration of the private health sector with the public sector in the delivery of immunization services highlights the potential for full scale PPP in the health sector of the city.

Regardless of the numerical percentage achievements in the immunization coverage in Addis Ababa, key informants from FMoH, AAHB and public hospitals have unanimously identified the following challenges in the delivery of child health services in general.

- Shortage of spare parts and accessories for refrigerators at HP level, and lack of proper concern for the cold chain system
- High number of unvaccinated children and high dropout rate
- Lack of automatic generator in areas with frequent power interruptions
- Sub-optimal integrated supportive supervision at all levels
- High turnover of experienced health workers
- Delay in implementation of newborn corners in public health facilities
- Inadequate space availed to NICU in some hospitals with limited equipment and material

In spite of the fact that child health is among the focus areas of the government as well as global development goals such as the MDG, it can be argued that child health services are not fully covered in the health sector of Addis Ababa. One would also argue that service coverage does

not necessarily mean quality, equity and sustainability in health services. Key respondents indicated that issues of accessibility, efficiency and effectiveness in health service delivery are complex issues that go beyond the capacity of the public sector alone. Based on the above challenges facing the immunization services of the City's health sector, it can be argued that most of the capacity gaps in the public health sector can be resolved by opting for the greater involvement of the private health sector. As clearly discussed in chapter two, the private sector is more endowed with resources as compared to the public sector such as the Ethiopian health sector that shoulders multiple responsibilities with limited and often unsustainable financial resources. This argument is confirmed by Ato Mecha from FMoH and Ato Kelifa from a private hospital who strongly argued that with appropriate structures and benefit sharing arrangements, the private sector can come up with adequate resources to finance and deliver essential health services including child health (Ato Mecha, August 4, 2014; Ato Kelifa, September 3, 2014).

4.5.2 TB and HIV/AIDS Services

TB and HIV/AIDS related services are given special attention by both the Federal government and city government. This is because, on the one hand, TB and HIV/AIDS mutually reinforce each other and interventions to fight the diseases are usually comprehensive. On the other hand, TB and HIV/AIDS have high socioeconomic impact and hence call for special attention. This section analyzes the facts and challenges related to TB and HIV/AIDS service delivery in Addis Ababa and interpret the implications for PPP in the delivery of these services.

Table 4.8: TB Case Detection Rate in Addis Ababa City

Year (G.C)	Estimated Number of New TB Cases 258/100000 Population	Number of New TB Cases Detected	Case Detection Rate
2010/11	2,380	2,291	47.2%
2011/12	7,298	12,079	165.5%
2012/13	8,055	7,298	90.6%
2013/14	8,312	7,529	90.5%
2014/15	7,336	7,336	100 %

Source: FMoH, 2011; FMoH, 2012; FMoH, 2013; FMoH, 2014b, FMoH, 2015

TB case detection rate steadily increased over the last five years. In the year 2014/15, TB case detection rate of the city has already attained 100%. Key informants unanimously revealed that TB diagnosis and treatment services are available in almost all public health facilities in Addis Ababa. Moreover, Private clinics and hospitals in the city are involved in TB diagnosis and

treatment services through PPP arrangement signed between AAHB and individual health institutions. However, the delivery of TB related health services is constrained by different challenges. Almost all key informants from the public sector and different documents from AAHB and FMoH identified the following challenges which are affecting the quality and sustainability in the delivery of TB diagnosis and treatment in public health facilities.

- Irregular supply of reagents
- Underutilization of TB culture diagnostic services due to insufficient sample transportation mechanism
- Low ownership of MDR TB management at all levels stalling the expansion of MDR TB treatment sites
- Inadequate implementation of daily observed treatment at facility level

The above challenges directly or indirectly imply several issues. On one hand, the public health facilities are already constrained by capacity limitations to effectively deliver TB diagnosis and treatment services. On the other hand, arguably, most of the challenges identified can be overcome by systematically involving non-state actors including the private sector at a greater depth and scope.

Table 4.9: HIV Counseling and Testing in Addis Ababa City

Year (G.C)	Number of Individuals Tested for HIV	Number of Individuals Tested Positive for HIV	Percentage of HIV Positive Individuals
2010/11	326,910	19,067	5.83%
2011/12	352,445	19,939	5.7%
2012/13	503,930	19,149	3.8%
2013/14	611,416	18, 931	3.1%
2014/15	687,311	19,261	2.8%

Source: FMoH, 2011; FMoH, 2012; FMoH, 2013; FMoH, 2014b, FMoH, 2015

Table 4.9 above indicates a steady decline in the percentage of HIV positive individuals between 2010/11 and 2014/15 in Addis Ababa. The HIV prevalence rate of 2.8% is considered to be high compared to the national 1.3% rate. As discussed in chapter two, the delivery of HIV/AIDS related services including HCT, ART provision and PMTCT are the key focus areas of the government due to their high burden and cross-cutting nature. However, the delivery of these services through the public health facilities faces sectoral constraints. Almost all the key

respondents unanimously observed the following limitations of the public health system in terms of effectively delivering HIV/AIDS services.

- Shortage of rapid diagnostic kits
- Delay in maintenance of CD4 count machines
- Shortage of budget to secure HIV test kits
- Poor coordination and information gap among agencies and AAHB

The inherent weakness of the public sector in public service delivery was theoretically established in chapter two. The above facts also generally reveal that the public health sector in Addis Ababa is not sufficient in itself to effectively deliver HIV/AIDS services. Almost all of the respondents unanimously revealed that HIV/AIDS related services such as HCT, ART, PMTCT and other services cannot be effectively delivered by the public health structure alone. They are testified that the involvement of the private health facilities has meaningfully contributed in improving accessibility and equity in delivering the services. Therefore, it can be argued that the constraints in the public health system in effectively addressing HIV/AIDS services prompt the active participation of non-state actors and PPP in particular.

4.6 Health Facility

Effective delivery of health services generally depends on the adequacy and quality of the health facilities. This section presents the evidences related to the status and challenges regarding the health facilities in the health sector of Addis Ababa and analyzes the implications for the introduction of PPP in the health sector. The table below indicates growth in the number of hospitals and health centers in all the regional governments.

Table 4:10: Trends in health facility between 2010/11 and 2014/15

Region	Year									
	2010/11		2011/12		2012/13		2013/14		2014/15	
	H	HC	H	HC	H	HC	H	HC	H	HC
Tigray	13	162	13	170	14	183	14	212	15	214
Afar	3	28	3	28	3	50	5	61	5	62
Amhara	18	512	18	520	19	724	19	796	74	805
Oromia	23	818	42	825	42	991	42	1085	97	1215
Somali	6	35	7	35	8	85	8	113	9	140
Ben-Gumuz	2	22	2	29	2	30	2	31	2	32
SNNPR	22	463	22	463	22	513	22	599	79	663
Gambella	1	23	1	23	1	24	1	28	1	28
Harari	2	8	2	8	2	8	2	8	2	8
Addis Ababa	10	26	11	26	11	37	11	50	11	62
Diredawa	1	15	1	15	1	15	1	16	1	16
National	**101**	**2112**	**122**	**2142**	**124**	**2660**	**127**	**2999**	**296**	**3245**

Source: FMoH, 2011; FMoH, 2012; FMoH, 2013; FMoH, 2014b, FMoH, 2015

Growth in health facility in Addis Ababa is relatively lower as compared to the bigger and relatively developed regions. For instance, between 2010/11 and 2014/15, the number of hospitals increased from 18 to 74 (311%) in Amhara, from 23 to 97 (321%) in Oromia, from 22 to 79 (259%) in SNNPR while it increased from 10 to 11 (10%) in Addis Ababa City. As shown in table 4:10 above, Afar and Somali regions, which are considered as less developed regions in Ethiopia have shown better rate of change in the number of hospitals between 2010/11 and 2014/15 (66.6% and 50% respectively). Given the fact that 3 of the 11 hospitals in the city are owned and operated by military and police institutions, the remaining hospitals appear to be overburdened. However, the growth in the number of health centers is relatively higher as compared to other regions. Between 2010/11 and 2014/15, the number of health centers grew from 26 to 62 (138%). However, it was found out that the expansion and rehabilitation of health centers in Addis Ababa is conducted with no support from the Federal Ministry of Health while other regions obtain financial support from the Ministry. Most of the key informants argued that the health facility construction, rehabilitation and expansion efforts of the Ethiopian public sector are more skewed towards the regional governments with very minimal attention to Addis Ababa City Government. However, Ato Mengistu from AAHB and Ato Mecha from FMoH pointed out

that both the City government and the Federal government are showing commitments to expand the construction of new hospitals in Addis Ababa. Mengistu's expression is worth quoting:

> *"FMoH is planning to construct complex tertiary level hospital in Addis Ababa and this will be a big breakthrough in the curative health service delivery in Addis Ababa City and beyond"*

Table 4.11: Health Facility to Population Ratio in Addis Ababa City

Year	Population	Hospital		Health Center		Health Post		PHC Coverage
		Number	Ratio	Number	Ratio	Number	Ratio	
2010/11	2,975,608	10	1:297561	37	1:80422	0	0	00
2011/12	3,041,002	11	1:276455	50	1:60820	0	0	00
2012/13	3,041,002	11	1:276455	50	1:60820	0	0	0.0
2013/14	3, 212, 327	11	1:292029	80	1:40154	0	0	0.0
2014/15	3,273,001	11	1:297,546	88	1:37193	0	0	0.0

Source: FMoH, 2011; FMoH, 2012; FMoH, 2013; FMoH, 2014b, FMoH, 2015

As can be seen in the above table, in the year 2010/11, Addis Ababa had a hospital to population ratio of 1:297,561 which did not show any meaningful improvement until 2014/15. For instance the hospital to population ratio of 1:297, 546 in the year 2014/15 is not significantly different from the ratio in the year 2010/11. Moreover, even this ratio does not reflect the actual coverage of hospitals in the city due to the following facts. Firstly, Addis Ababa as a melting pot of the country is argued to be the ultimate destination for most rural-urban migrations and this distorts the actual relevance of the ratio. Secondly, the public hospitals in Addis Ababa provide services not only to the city dwellers and the hinterlands but also to other neighboring regions and towns. Finally, the role and contribution of private hospitals in the city and the collaboration with these institutions should be taken into account in understanding the actual coverage and density of hospital as one cannot put a water tight compartment between the public and private health system of the city. It can, therefore, be argued that the hospital to population ratio with all its limitations in reflecting the true status of the health infrastructure is still low, which calls for the participation and collaboration with the private health sector.

Health center to population ratio in the year 2010/11 was 1:80,422 which gradually improved over the five years and reached 1:37,193 in the year 2014/15. As compared to the hospital to

population ratio, health center to population ratio significantly improved in the last five years. As table 4.11 clearly shows, this improvement is attributed to the steady growth of health centers from 37 in 2010/11 to 88 in 2014/15. However, it can be argued that, regardless of significant improvement in the health center coverage in the city, the fact that health posts are not available in the city clearly reflects the high burden of the public health facilities in Addis Ababa. It can, therefore, argued that regardless of the limitation of using health facility to population ratio as an indicator of coverage and accessibility, public health facilities are not sufficient in terms of addressing the health needs of the people in general.

It can also be argued that the head counting of health facilities per se is not a good indicator of efficiency, effectiveness, quality and affordability of public health services. As Samuel et al. (2007) and FMoH (2007b) point out, public health facilities are generally known to suffer from acute shortage of medical supplies and important equipments. Attesting this argument, almost all key informants from public hospitals unanimously indicated that highly outdated equipments that are not properly and regularly maintained are constraining the efforts of delivering health services with the requirements of efficiency, effectiveness and quality. On the other hand, PPP strategic framework prepared by FMoH argues that private health facilities are relatively better in terms of delivering quality health services (FMoH, 2013). It also appears that private health facilities are more accessible to users particularly in urban areas. To illustrate this, the distribution of health facilities by type and ownership is depicted in the table below.

Table 4.12: Distribution of Health Facilities by Type and Ownership in Addis Ababa City

Year	Hospital				Private Clinics			
	Public	Private	NGO	OGA	Lower	Medium	Higher	Total
2010/11	10	34	1	2	143	226	204	573
2011/12	11	34	1	2	143	226	204	573
2012/13	11	34	2	2	148	238	213	599
2013/14	11	34	2	2	157	276	224	657
2014/15	11	35	2	2	183	337	257	777

Source: FMoH, 2011; FMoH, 2012; FMoH, 2013; FMoH, 2014, FMoH, 2015

The above table indicates the distribution of private health facilities in relation to public health facilities. The 2014/15 data indicates that relatively large number of private hospitals (35)

operate in Addis Ababa. However, table 4.12 indicates that there was no significant improvement in the growth of private hospitals in Addis Ababa City over the last five years indicating relatively low private investment in the health sector. The table also reveals that the number of private hospitals in the city is three times the public hospitals. The distribution of private clinics is also significant in Addis Ababa. While the large number of private clinics in other regional governments is medium and lower clinics, in Addis Ababa, in 2014/15, large number, 594 (76%), of the total private clinics are medium or higher clinics. For instance, while higher clinics were only 3.5% in Amhara, 3% in Oromia, 1% in SNNPR, in Addis Ababa, 36% of private clinics had higher clinic standard in 2014/15. This implies that private hospitals and higher level clinics are more skewed towards Addis Ababa.

The growth of private health facilities in Addis Ababa clearly implies the following. Firstly, it indicates the involvement of the private health sector in health service delivery and reveals that large number of people receives health services from private facilities. Illustrating this fact, World Bank (2006) points out that 42% of Ethiopians living in urban areas get health services from the private sector. Secondly, the increasing involvement of the private health sector implies the need for regulation. The excessive profit orientation of the private sector as discussed in chapter two may tempt the private health sector to compromise quality and ethical standards in health service delivery. Finally and more importantly, the increase in the private health facilities implies the prevalence of untapped potential in terms of establishing public private partnership to utilize the capabilities of this sector through mutually beneficial and collaborative governance arrangements.

4.7 Human Resources for Health

Acute scarcity of qualified health professionals is a key challenge in the health sector of the country as well as the city (FMoH, 2007b; Samuel et. al, 2007, FMoH, 2014b). The achievement of health sector goals in Addis Ababa is seriously challenged by the shortage of relevant professionals. The distribution of health professionals in the public sector of the four major regions is depicted in the table below for the purpose of comparison.

Table 4.13: Distribution of Health Professionals in the Public Sector of Addis Ababa and four Major Regions

No	Profession	Addis Ababa		Tigray		Amhara		Oromia		SNNPR	
		No	Ratio	No	Ratio	No	Ratio	No	Ratio	No	Ratio
1	Specialist (All type)	314	1:10423	97	1:50165	151	1:129973	211	1:151412	43	1:404720
2	General Practitioner	201	1:16283	93	1:52322	286	1:68622	353	1:90504	262	1:66423
3	Health Officer	651	1:5027	439	1:11084	963	1:20380	1647	1:19397	1343	1:12958
4	Pharmacist	195	1:16784	91	1:53472	239	1:82117	535	1:59715	136	1:127963
5	Pharmacy technician	472	1:6934	679	1:7166	1125	1:17445	1397	1:22869	948	1:18357
6	Nurse BSC	1,227	1:2667	593	1:8205	547	1:35879	1419	1:22514	634	1:27449
7	Clinical Nurse(Dip)	1,907	1:1716	3207	1:1517	6313	1:3108	10560	1:3025	7837	1:2220
8	Midwives (Dip+BSc)	409	1:8002	762	1:6385	587	1:33434	1894	1:16868	1284	1:13553
9	All Nurses	3,276	1:999	4562	1:1066	7447	1:2635	13873	1:2302	9755	1:1784
10	Lab Technologist	221	1:14809	139	1:35007	363	1:54066	680	1:46982	200	1:87015
11	Lab Technicians	271	1:12077	476	1:10222	933	1:21035	1259	1:25375	1091	1:15951
12	Radiographer	84	1:38964	9	1:540666	12	1:1.63mil	22	1:1.45mil	16	1:1.08mil
13	Radiology technician (X-ray)	38	1:86131	36	1:135166	43	1:456418	44	1:726090	24	1:725125
14	Environmental Health (Dip+BSc)	171	1:19140	262	1:18572	25	1:785040	1069	1:29885	584	1:29799
	Total	9437	-	11445	-	19034	-	34963	-	24157	-

Source: Calculated from FMoH, 2015

For the purpose of comparison, the researcher used for bigger and relatively developed regions in terms of health, education and other social services and the health sector of these regions is generally comparable to Addis Ababa. Table 4:13 above clearly indicates that health professional coverage in Addis Ababa is relatively better than even the major regions of the country. In almost all professions, the health professional to population ration is significantly better in Addis Ababa as compared to the regions. Particularly, for relatively scarce professional categories such as specialists, radiographer and radiology technology, professional to population ratios are significantly lower (indicating better coverage) compared to the major regions. It can also be argued that health professional distribution is more skewed towards the major urban areas due to

socio-economic factors that serve as push and pull factors instigating rural-urban and urban-urban migration (WHO, 2009). It can be argued that the relatively better coverage of health professionals in the city does not necessarily indicate better quality of health service delivery due to several reasons. Firstly, the public health sector both at national level and in Addis Ababa is known to suffer from high attrition rate of health professionals. In this regard, Kiros et al. (2013) reveal that the high attrition rate of professionals with low replacement rate leads to further shortages in the public health institutions which ultimately aggravate service quality and coverage in the public sector.

Secondly, the existing professionals' level of motivation and commitment to provide quality services with the expected professional standards can be questioned. As clearly discussed in chapter two, the public sector is generally characterized by low incentive and rewards system as well as low motivation to deliver services in an innovative manner. This leads not only to the low quality of health services but also serves as a push factor for health professionals to resign from public health institutions and join either the private health sector within the country or migrate abroad for search of better jobs. The concept of rational choice theory can effectively explain the facts that health professionals in the public sector of the city act as rational decision makers who need to optimally utilize their knowledge, skill and available time to get fair returns from their competency. As the principal agent theory underscores, ability of the leadership in the public health sector (the principal) to acquire, develop, retain and utilize competent health professionals (the agents) through mutually agreed and contractually bound beneficial relationships is an essential requirement. Illustrating this, Getachew and Vita (2014) argue that the high turnover of health professionals from public health institutions is partly attributed to the lack of competent leadership and failure to motivate and retain the professionals.

Finally, most health professionals in Addis Ababa provide services in both the public and private health facilities. FMoH (2013a) points out that majority of health professionals in Addis Ababa for instance switch between public and private health facilities as either regular or part-time service providers. It can, therefore, be argued that the health professional to population ratio discussed above does not necessarily reflect the extent to which the professionals' time and skills are utilized within the public health system. As explained by systems theory, conceiving the health sector of the country as a system working towards the same goal, utilizing the knowledge

and skills of the existing health professionals in both public and private health facilities will add value to the accessibility and quality of health services.

In line with the above discussions, interviews with key informants and analysis of different relevant documents from AAHB reveal several human resources related challenges that are facing the public health sector. These challenges generally include the following.

- Low capacity of the public bureaucracy in the management of health professionals
- Critical shortage of teaching staff in teaching hospitals
- Inability to standardize health professionals motivation and retention packages and,
- Weak coordination among the partners, private health sectors and other institutions

The above discussions about health professionals have important implications for public private partnership. On one hand, the high turnover, low motivation and commitment of the existing professionals and the switching between public and private health facilities highlights new areas of partnership with the private health sector. This may include mechanisms on how the public and private sectors can acquire, develop and utilize health professionals in such a way that their knowledge and skills can be optimally utilized in both sectors. On the other hand, PPP areas on how to jointly train and develop new professionals can be solicited. In this regard, FMoH (2013) indicates the potential of utilizing both public and private health facilities and institutions for training health professionals through mutually agreed and formally established PPP arrangements.

4.8 Pharmaceutical Supplies and Distribution

The procurement and distribution of safe and sufficient pharmaceutical supplies and medical equipment are key requirements in achieving health sector goals. The health sector reform in general and business process reengineering (BPR) implemented by the FMoH and AAHB in particular aim at improving the supply of pharmaceuticals on a sustainable basis. FMoH (2014a) points out that the government of Ethiopia recently reorganized the procurement of pharmaceuticals, medical equipment, and supplies as part of the reform initiatives cascaded to other regions including Addis Ababa City Government. The previous practice of conducting procurement of pharmaceuticals in a fragmented and disorganized manner by various FMOH units and independent agencies was not only inefficient but also led to lack of sustainable supply.

FMoH (2014a) and FMoH (2014b) also reveal that duplication of effort at every level of the supply chain, mismanagement and frequent stock-outs of pharmaceuticals, and lack of affordability and irrational use of drugs were some of the problems that existed in the public health sector in particular. These challenges are theoretically well established in the recent paradigms of public administration. For instance, Hughes (2003) argues that public sector reforms within the NPM framework aim at separating the purchaser, provider and regulator. The incumbent government, in line with the theoretically recommended purchaser-provider-regulator dichotomy, established a Pharmaceuticals Fund and Supply Agency (PFSA), which is accountable to the FMOH and responsible for timely procurement and distribution of pharmaceuticals to health facilities. The public health facilities of Addis Ababa get pharmaceutical supplies from PFSA which is autonomous Para-public enterprise mandated with the procurement and distribution of pharmaceutical supplies to public health institutions throughout Ethiopia.

PFSA applies need based procurement system in coordination with its regional branch offices (FMoH, 2014a). The regional branch offices check and transfer the requests of health centers and hospitals to the head office for procurement. Receiving the requests of the public health institutions, PFSA conducts the procurement of pharmaceuticals from local manufacturers and foreign suppliers and distributes them to the health institutions using its own regional branches which serve health institutions within 160 kilometers radius (FMoH, 2010; FMoH, 2014a). PFSA is not strictly profit-making public agency. According to FMOH (2010) and FMoH (2014a) PFSA conducts the procurement and distribution of pharmaceuticals using the support from different donors. Primarily, the agency uses a Revolving Drug Fund to strengthen its working capital through the financial support from the GAVI Alliance, the Global Fund to Fight AIDS, Tuberculosis and Malaria, and the Protection of Basic Services (PBS).

It can be argued from the above facts that the delivery of health services using the public sector facilities heavily relies on PFSA for the procurement and distribution of pharmaceuticals. Given the theoretically argued inherent weaknesses of the public sector discussed in chapter two, the efficiency, effectiveness, quality and accessibility of the procurement and distribution of pharmaceuticals through this agency can be questioned from several perspectives. As a result, the pharmaceuticals supply in the Ethiopian as well as Addis Ababa's public health sector suffers

from the following challenges as identified by FMoH (2014) and confirmed by most of the key informants interviewed.

- Weak coordination with stakeholders in forecasting, financing and purchasing;
- Weak internal audit system and delay of audit reports, which questions the transparency in decision making and fund utilization;
- Poor infrastructure for supply chain management such as trucks, cold chain, warehouses and connectivity
- Gap in inventory management and quantification skill along the supply chain;
- High turnover rate of qualified staff ;
- Inadequate handling of pharmaceuticals at airport warehouses;
- Delay in procurement and distribution of pharmaceuticals and medical supplies;
- Delay in procurement and assembly of medical equipment;
- Delay in construction, hand over and use of new warehouses and offices; and
- Robbery of pharmaceuticals and medical equipment along the supply chain and forged procurement requests from health facilities.

As indicated above, heavy reliance on the public bureaucracy which is characterized by strict adherence to rules, regulations and procedures has led to delay in decision making and associated adverse consequences in pharmaceutical procurement and distribution in the public health sector of Addis Ababa. In practice, however, the role of the private sector in the production and supply of pharmaceuticals as an important aspect of health service delivery requires due attention. It can be argued that production and distribution of pharmaceutical supplies through public private collaboration arrangements can be considered as a potential candidate for PPP projects in Addis Ababa. The distribution of pharmaceuticals production and supply institutions in Addis Ababa is depicted in the table below.

Table 4.14: Trends in the Distribution of Pharmaceuticals Production and Supply in Addis Ababa

Year	Pharmacy	Drug Store	Rural Drug Vendor	Drug and Medical Supplies	
				Importers and Distributers	Manufacturers
2010/11	189	232	1	163	8
2011/12	189	232	1	163	9
2012/13	189	232	1	163	9
2013/14	335	273	1	163	10
2014/15	378	273	1	163	10

Source: FMoH, 2011; FMoH, 2012; FMoH, 2013; FMoH, 2014b, FMoH, 2015

As shown in table 4.14, the number of pharmacies grew from 189 to 378 between 2010/11 and 2014/15 which indicates a growth by 100% in five years. The number of drug and medical supplies manufacturers grew from 8 to only 10 in five years (25%) while the number of drug stores, rural drug vendors and importers and distributers of drug and medical supplies did not show any improvement over the five years. However, Addis Ababa has relatively better number and distribution of pharmaceuticals production and supply as compared to other regions as indicated in the table below.

Table 4.15: Distribution of Pharmaceuticals Production and Supply in all Regions in 2014/15

Regions	Pharmacy	Drug Store	Rural Drug Vendor	Drug and Medical Supplies	
				Importer	Manufacturer
Tigray	7	129	113	9	2
Afar	0	30	25	0	0
Amhara	179	579	494	17	0
Oromia	86	545	134	18	2
Somali	10	175	618	0	0
Ben-Gumuz	2	7	205	0	0
SNNPR	19	139	28	8	0
Gambela	2	6	244	0	0
Harari	6	25	21	3	0
Addis Ababa	378	273	1	163	10
Diredawa	11	21	1	6	0
National	**700**	**1929**	**1884**	**224**	**14**

Source: FMoH, 2015

Table 4:15 above reveals that Addis Ababa had large number of pharmacies (378) in the year 2014/15 while in the same year, Amhara, Oromia and SNNPR had 179, 86 and 19 pharmacies respectively. The highest number of pharmaceuticals importers are also located in Addis Ababa with 163 importers followed by Oromia (18) and Amhara (17). Data from FMoH clearly indicates that 73% of the pharmaceuticals importers and 69% of the manufacturers operate in Addis Ababa (FMoH, 2014a; FMoH, 2015). The ownership of pharmaceuticals production and supply in Addis Ababa is generally more skewed towards the private sector. Illustrating this, CGAA (2012) indicates that more than 98% of the pharmaceuticals business is owned and operated by the private sector.

The weaknesses of the public health sector in addressing the pharmaceuticals needs of the health sector and the parallel growth in the involvement of the private sector in the pharmaceuticals industry have clear implications for public private partnerships. Firstly, working with the private sector is argued to resolve the challenges in the procurement and supply of pharmaceuticals in the public health sector. Secondly, partnership with importers, distributors and manufacturers is believed to ensure efficiency, timeliness and sustainability of pharmaceutical supplies to both the private and public health sectors, which will add value in achieving health sector goals of accessibility, affordability, quality, equity. Finally, the increasing involvement of the private sector in the pharmaceutical industry entails inclusive and collaborative approach to regulation. As discussed in chapter two, the traditional and coercive approach to regulation using strict rules and regulations, which is the characteristic of the classical public administration, will not have an effective and sustainable outcome in terms of regulating the behavior of the private pharmaceutical sector. Regulation through partnership based on principles of mutual support, as Lagomarsino (2009) strongly argues, will lead to commonly beneficial outcomes to both the public and private sectors and ultimately to the citizens at large.

4.9 Health Information System

Policy making and planning in the health sector strongly require the generation, management and utilization of up-to-date health and health related information (FMoF, 2014a; FMoH, 2014b). The quality of information for planning, monitoring, and evaluation of health sector activities is also critical. Health and health related information is consolidated, analyzed and reported at the national level by the FMoH through the Policy Planning Directorate of the Ministry. However,

effective collection and reporting of information from the health facilities and the city health bureau are crucial for successful documentation and utilization of health related information.

Recognizing the critical importance of health information system, FMoH emphasizes the practice of routine health management information system including better patient record documentation/registration and reporting on sector-wide indicators that have been developed with stakeholders' engagement. The 2015 performance report of Addis Ababa Health Bureau indicates that performance monitoring and quality improvement measures are being institutionalized, and facility-level data are being analyzed and used to improve service delivery at facility level. The practice of collecting and compiling health information at the facility and local government levels not only adds value to the quality of information system at national level but also facilitates bottom-up planning and decision making at the lower level in the context on the decentralized health governance that Addis Ababa claims to practice (FMoH, 2014b; FMoH, 2015; AAHB, 2015).

Within the public sector, complying to the national practice, the health system of Addis Ababa practices Integrated Supportive Supervision, which is used to provide on-the-spot policy, managerial, and technical support and guidance to health facilities and lower-level health authorities as well as to help the flow of the health information and feedback process. However, regardless of the fact that both the public and private health sector can be conceived as a system in terms of their ultimate goals, both the health information management and integrated supportive supervision does not adequately incorporate the private health sector (Ato Mecha, August 4, 2014). Moreover, information from key informants and review of AAHB documents reveal that the existing health information system faces the following challenges.

- Inadequate use of data quality assurance mechanisms at district and facility levels;
- Lack of integration of HMIS with pharmaceutical, regulatory, human resource, and other information systems;
- Inadequate coordination with the private sector and other stakeholders at regional level;
- Gap in the establishment and functioning of performance review teams;
- Poor documentation and dissemination of monitoring and evaluation, routine information, surveys, surveillance and operational research findings; and
- Limited practice of experience sharing and documenting, and scale up of best practices.

The above facts about health information system in Addis Ababa's health sector have key implications for collaboration and partnership with the private sector. On one hand, policy making, planning and decision making in the health sector can adequately accommodate the interests, developments and constraints in the private sector only if this sector is systematically empowered to generate, compile, analyze and forward valuable information for decision making at various levels of the health system governance. It can be argued that adequately incorporating the private health sector into the health information system of the country demands efforts beyond administrative requirements and the strict application of rules and regulations. Collaboration and mutually agreed partnership that motivates the private sector will add value to the commitment of this sector in collecting, compiling, analyzing and documenting valuable health information for planning and decision making at various levels.

4.10 Health Care Financing

In was theoretically discussed in chapter two that sufficient and sustainable financing is one of the key issues in public service delivery. The Ethiopian health sector in general and that of Addis Ababa in particular is financed from different sources including the government treasury (federal, regional, and woreda/district levels), bilateral and multilateral donors, household out-of-pocket expenditures, international and local non-governmental organizations (NGOs), private and public enterprise employers, and insurance companies. The public health sector is highly underfinanced even by sub-Saharan standard (Eskender, 2014; FMoH, 2013b; FMoH, 2014a). The poor quality and inaccessibility of health services is generally attributed to the under-financing of the sector.

Table 4.16: Share of Health Budget of Addis Ababa City as compared to other Regions

Region	Population	Allocated Budget (ETB)	Allocated Budget Percapita	Share from Total Budget
Tigray	5,055,000	631,797,333	125	**7.2%**
Afar	1,723,000	226,079,381	131	**8.1%**
Amhara	20,399,000	2,956,474,467	145	**11.9%**
Oromia	33,692,000	4,253,924,571	126	**12.0%**
Somali	5,452,000	572,629,000	105	**8.1%**
Benishangul-Gumuz	1,005,000	286,341,386	285	**13.1%**
SNNPR	18,276,000	3,178,591,512	174	**15.7%**
Gambella	409,000	215,166,318	526	**13.4%**
Harrari	232,000	56,641,000	244	**5.1%**
Addis Ababa	3,273,001	1,384,600,000	423	**5.3%**
Dire Dawa	440,000	177,317,000	403	**11.1%**
National	**90,140,000***	**11,067,474,968**	**123**	**11.1%**

Source: FMoH, 2015

The budget allocated from the government treasury to the health sector of Addis Ababa reflects the under-financing of the sector. The health budget per-capita of Birr 423 (USD equivalent of 20), is among the lowest compared to even most sub-Saharan countries (World Bank, 2014). Though significantly higher than the national health budget per-capita of Birr 123 (USD equivalent of 6.15), Addis Ababa's health budget per-capita is about three times lower than the USD 64 recently recommended by World Health Organization. Moreover, share of the total budget from the total budget of the city (5.3%) is also the lowest as compared to all other regional governments except Harari (5.1%). Therefore, it can be argued that the health sector of Addis Ababa is severely underfinanced. This implies that given the ever growing health service needs of the citizens in response to the increasing complexities in both preventive and curative health, the public sector alone cannot adequately finance the health sector of Addis Ababa.

In response to this challenge, the government approved a health care financing strategy in 1998 which aimed at increasing availability of health care resources in a way that would improve equity and sustainability and lead to improved quality of care (Eskender, 2014, USAID, 2008; FMoH, 2014a).

The Ethiopian health care financing reform, which is also being implemented by Addis Ababa City Government, has important strategies including user fee revision, revenue retention and utilization to improve quality, rules for rationalizing and systematizing fee waivers, health facilities governance, establishment of private wings in public hospitals, and outsourcing of nonclinical health services. The strategy also identifies health insurance as a mechanism to generate additional sources of revenue, and a way to increase the country's low level of health service utilization. The Ethiopian health insurance program as an integral part of the health care financing reform has two components: Social Health Insurance (SHI) for the formal sector and Community Based Health Insurance (CBHI) for the informal sector (Eskinder, 2014). According to FMoH (2014a), CBHI, which is envisaged to cover more than 83 percent of the population, has completed its pilot implementation and is due for full-scale implementation including Addis Ababa. However, both SHI and CBHI are not progressing as per the expectation of the government and the key stakeholders (FMoH, 2014b; Enkender, 2014). The annual performance report of the FMoH for the year 2013/14 and information from key informants reveals the following as serious challenges in the realization of SHI and CBHI.

- Delay in finalization of preparatory works for the implementation of SHI,
- Lack of adequate human resources in CBHI scheme,
- Limited commitment by higher officials on the sensitization and mobilization of beneficiaries,
- Limited understanding on the scheme by employers and employees,
- Limited political leadership at some levels and ownership in some Woreda administrations, and
- Low quality of health care services (i.e., caused by unavailability of drugs, medical supplies, and adequate staff) and low commitment of health providers which in turn affect client satisfaction.

In addition to the health care financing reform programs discussed above, which are believed to ensure sustainable and predictable financing of the Ethiopian health sector, the government is working with health sector partners on securing more resources for the sector and on harmonizing interventions with the broader HSDP framework and with annual operational plans at different levels (FMoH, 2013; FMoH, 2014b; AAHB, 2015). In order to institutionalize the practices of mobilizing financial resources from the donor community, the FMOH, in

consultation with partners developed the HSDP Harmonization Manual (HHM) and signed a Code of Conduct and the International Health Partnership (IHP) Compact with key health sector partners (FMoH, 2014a). By signing IHP as resource mobilization framework, the government strongly believes that the country will be able to mobilize and channel more resources to the health sector as well as enhance effective utilization of these resources. Most key informants believe that the health sector of Addis Ababa will remarkably benefit from the resource mobilization initiatives implemented by government units at different levels. In recent years, a significant amount of resources has been mobilized from several bilateral and multilateral partners. Financial support to the health sector of Addis Ababa from different donors in the year 2014/15 is presented in the table below.

Table 4.17: Financial Support from Donors and Utilization in Addis Ababa in the Year 2014/15

No	FUND Source	BBF from 2013/14	Income of the 2014/15	Total	Utilized	Utilization Rate %
1	UNFPA	78,543	1015446	1,093,989	1,093,989	100.00
2	UNICEF	347,356	1,690,887	2,038,243	2,038,243	100.00
3	MoH GLOBAL	4,524,830	4,273,808	8,798,638	8,231,503	93.55
4	MoH GAVI	1,692,230	27,952,397	29,644,627	25,918,656	87.43
5	AAHAPCO GLOBAL	123,378	0	123,378	105,012	85.11
6	WHO & OTHERS	220,554	4,894,411	5,114,965	3,316,349	64.84
7	JHU	159,657	0	159,657	129,050	80.83
8	EHNRI	1,002,713	0	1,002,713	626,804	62.51
9	KOICA PROJECT	279,848	350,980	630,828	630,530	99.95
10	CDC	0	102,724,381	102,724,381	18,900,279	18.40
11	AMREF	73104	6,200	79,304	79,304	100.00
12	WFP	264,524		264,524	190,920	72.17
	TOTAL	**8,481,702**	**58,334,360**	**66,287,012**	**42,631,575**	64.31

Source: AAHB, 2015

The above table indicates the different sources of financial support provided to the health sector of Addis Ababa. In the year 2014/15 a total of 66,287,012 was obtained from 12 international sources and only 64.31% of the total amount was utilized. Key informants interviewed attributed the low fund utilization rate of Addis Ababa's health sector to the following constraints.

- Poor planning of health services
- Weak and often bureaucratic procurement system

- Less coordination between health facilities and AAHB as well as between AAHB and the development partners.
- Low institutional capacity including lack of sufficient number of employees with required skills.

Therefore, it can be argued that despite financial flow from several development partners, the health sector of Addis Ababa is not institutionally capable of effectively utilizing the support that would have somehow improved public health service delivery. It was also discussed in chapter two that the involvement of the private sector in public service delivery not only adds value to the efficiency and quality of public services but also contributes to achieving value for money in the delivery of public services.

The above facts generally reveal that health care financing in the Ethiopian public sector is constrained by several challenges which call for the strategic and mutually beneficial partnership with the private sector. Firstly, the health budget allocated from the government treasury is significantly low to effectively address the health needs of the City. Secondly, the health care financing reform in general and the two insurance schemes in particular faced technical and leadership problems at their implementation phases, falling short of achieving the desired outcomes within the planned schedule. Thirdly, the health sector of the city government is not institutionally capable of effectively utilizing the already low and arguably less sustainable financial support from development partners. Fourthly, out-of pocket health expenditure is still significantly high implying that patients are vulnerable to unexpected expenditures. For instance, in 2013/14, out-of pocket health expenditure was 37% of the total health expenditure of Addis Ababa City Government. Between 2004/05 and 2013/14, out-of pocket health expenditure increased by 116% (FMoH, 2014a, AAHB, 2015).

Given the fact that 88% of the Ethiopian people are multi-dimensionally poor (UNDP, 2014), good quality health services would be unaffordable to the majority of the people including the poor in Addis Ababa. Fifthly, the health sector financing in general is heavily dependent on donor support. Ironically, at national level, donor support from bilateral and multilateral sources was 37% in 2004/05, 39% in 2007/08, 50% in 2010/11 and 52% in 2013 (FMoH, 2014a) testifying significant increase over years. As WHO (2012) rightly explains, donor dependent

health care financing makes the health system vulnerable to health care crisis due to its inherent characteristics of unpredictability and less sustainability.

In response to the challenges in the existing practices and approaches in health care financing, the involvement of and partnership with the private sector can be considered. As theoretically argued in chapter two, properly designed and implemented PPP can enhance the financing of health care. Given the acute shortage of financial resources in the public sector, health sector projects that require large investments can be implemented by the private sector finance through suitable PPP model such as BOT.

4.11 Summary of Findings

The facts and discussions in this chapter reveal that the health sector of Addis Ababa still undergoes several challenges despite all the efforts made by the public sector and development partners conforming to the empirical literature on the public health sector of sun-Saharan Africa. Though the growth in investment in the health sector has remarkably improved the health status of the city in many aspects, majority of the health indicators are still at low level when compared with other developing countries. The HSDPs implemented so far and the MDGs in general and HSDP IV in particular have ambitious health sector goals to improve the health status of the country as well as the city with particular emphasis on diseases such as HIV/AIDS, TB, malaria, and maternal and child health which are known to have high socio-economic and public health impacts. Following the rapid urbanization and associated life style changes, prevalence and impact of non-communicable diseases is also recognized as the focus area of the health sector demanding attention in Addis Ababa. Practically, though both the public and private health sectors are involved in the treatment and management of the above diseases and health concerns, the role and contribution of the private health sector is not boldly recognized and integrated into the health system. On the contrary, empirical studies on other African health systems such as South Africa, Tanzania, Ghana and Nigeria indicate that their respective governments have clearly stipulated the role of the private sector in the health sector.

The health sector governance appears to give heavy emphasis to the public sector and its bureaucratic structures which implies the strong welfare orientation of the government. The position and role of the private health sector is not clearly visible in the governance structure of the health sector of Addis Ababa.

The growth of health sector assets such as health facilities and human resources indicates that the involvement of the private sector is also remarkably involved in health sector investments particularly in urban areas. In Addis Ababa, for instance, the private sector owns and operates the largest number of private hospitals and pharmaceutical businesses. While the high turnover of health professionals from public health facilities implies migration to the health facilities in urban areas, the knowledge, skills and time of the health professionals is practically utilized by both the public and private health facilities. The health information system of Addis Ababa's health sector appears to focus strongly on the public sector structure while in practice information from the private health sector adds value in health sector planning and decision making.

Health care financing appears to be heavily dependent on foreign assistance from bilateral and multilateral sources and out-of pocket payments due to the under-financing from the government treasury. While the former is clearly unpredictable and less sustainable in terms of achieving the long-term goals of the health sector, the later is generally unaffordable for people who live under multidimensional poverty. This fact is also true for most countries in Sun-Saharan region in which the public health system is unduly donor dependent. Partnership with the private sector can be considered as a potential area of financing the health sector through well designed and mutually agreed arrangements.

Chapter 5: Policy, Legal and Regulatory Frameworks of PPP in the Health Sector of Addis Ababa

5.1 Introduction

The status of Addis Ababa's health sector and the challenges in addressing the health care needs of the people were discussed in chapter 4. It is also revealed in chapter 4 that the practical realities in the existing health system call for governance approaches in which the private health sector can take greater roles through public private partnerships. Based on the arguments for the enhanced role of the private sector in general and PPPs in particular, this chapter assesses the policies, laws and regulations that are in place and analyzes the extent to which these frameworks allow the application of PPPs as alternative health care delivery approaches.

This chapter, which answers research question number 2 of this thesis, analyzes the data collected through in-depth interviews, relevant documents and structured questionnaire distributed to 242 respondents from public and private health institutions. Though the analysis gives greater priority and emphasis to the qualitative information, responses from the questionnaire are also quantitatively analyzed using descriptive statistics and kruskal-Wallis test to triangulate results and find out convergence of arguments to effectively answer the research question related to policies, legal and regulatory framework governing PPPs in the health sector of Addis Ababa.

5.2 Government Policy towards PPP in the Health Sector

The public policy environment towards the participation of the private sector in social services is largely embedded in the philosophy of the incumbent government. As clearly indicated in chapter 2, the political philosophy of the welfare state gives the government to play an active role in economic development as well as service delivery. The philosophy of market and competition, however, strongly argues that greater efficiency, innovation and dynamism can be attained when public services are delivered through the active role of the private sector which is based on market principles and competition. The fundamental research issue here is that, given the social importance of health services, what types of public policies should be in place to accommodate both governments' responsibility to make health accessible to citizens and doing this through enhanced efficiency and effectiveness. The analysis and discussion about the policy

of the incumbent government towards the PPP in the health sector are discussed below. The author argues that discussions about PPP in the health sector of Addis Ababa are embedded in the macro level policies determined at the national level. The following table also shows the results of the respondents who filled in the questionnaire about this issue.

Table 5.1(a): Government Policy towards PPP in the Health Sector (N=242)

PPP Programs		Strongly Disagree		Disagree		Neutral		Agree		Strongly Agree		Total		Kruskal-Wallis Test	
		N	%	N	%	N	%	N	%	N	%	N	%	Mean Rank	KW Values
Pol_Ideology	1	3	7.1%	3	7.1%	2	4.8%	20	47.6%	14	33.3%	42	100.0%	140.05	H= 23.60 df= 3 P= 0.000
	2	3	3.1%	16	16.7%	12	12.5%	34	35.4%	31	32.3%	96	100.0%	131.12	
	3	9	26.5%	10	29.4%	5	14.7%	7	20.6%	3	8.8%	34	100.0%	71.96	
	4	6	8.6%	12	17.1%	6	8.6%	28	40.0%	18	25.7%	70	100.0%	121.24	
Total		21	8.7%	41	16.9%	25	10.3%	89	36.8%	66	27.3%	242	100.0%		
Econ_Policy	1	4	9.5%	8	19.0%	5	11.9%	15	35.7%	10	23.8%	42	100.0%	114.51	H= 5.05 df= 3 P= 0.168
	2	3	3.1%	12	12.5%	9	9.4%	48	50.0%	24	25.0%	96	100.0%	131.70	
	3	4	11.8%	5	14.7%	5	14.7%	16	47.1%	4	11.8%	34	100.0%	104.37	
	4	4	5.7%	14	20.0%	7	10.0%	28	40.0%	17	24.3%	70	100.0%	120.02	
Total		15	6.2%	39	16.1%	26	10.7%	107	44.2%	55	22.7%	242	100.0%		
Private Role	1	14	33.3%	18	42.9%	3	7.1%	3	7.1%	4	9.5%	42	100.0%	115.85	H= 4.10 df= 3 P= 0.251
	2	31	32.3%	42	43.8%	12	12.5%	9	9.4%	2	2.1%	96	100.0%	114.04	
	3	9	26.5%	15	44.1%	5	14.7%	4	11.8%	1	2.9%	34	100.0%	123.90	
	4	14	20.0%	34	48.6%	6	8.6%	11	15.7%	5	7.1%	70	100.0%	133.96	
Total		68	28.1%	109	45.0%	26	10.7%	27	11.2%	12	5.0%	242	100.0%		
PPPH_adequat	1	19	45.2%	17	40.5%	1	2.4%	1	2.4%	4	9.5%	42	100.0%	104.87	H= 8.17 df= 3 P= 0.043
	2	30	31.3%	51	53.1%	9	9.4%	5	5.2%	1	1.0%	96	100.0%	116.27	
	3	8	23.5%	12	35.3%	6	17.6%	7	20.6%	1	2.9%	34	100.0%	144.74	
	4	22	31.4%	28	40.0%	9	12.9%	8	11.4%	3	4.3%	70	100.0%	127.37	
Total		79	32.6%	108	44.6%	25	10.3%	21	8.7%	9	3.7%	242	100.0%		
Coherent_Pol	1	15	35.7%	21	50.0%	1	2.4%	3	7.1%	2	4.8%	42	100.0%	111.50	H= 2.06 df= 3 P= 0.561
	2	30	31.3%	40	41.7%	11	11.5%	11	11.5%	4	4.2%	96	100.0%	124.58	
	3	10	29.4%	13	38.2%	4	11.8%	5	14.7%	2	5.9%	34	100.0%	131.15	
	4	23	32.9%	32	45.7%	6	8.6%	7	10.0%	2	2.9%	70	100.0%	118.59	
Total		78	32.2%	106	43.8%	22	9.1%	26	10.7%	10	4.1%	242	100.0%		
Pol_Contribution	1	1	2.4%	8	19.0%	6	14.3%	13	31.0%	14	33.3%	42	100.0%	130.27	H= 3.76 df= 3 P= 0.289
	2	8	8.3%	13	13.5%	9	9.4%	38	39.6%	28	29.2%	96	100.0%	127.58	
	3	2	5.9%	6	17.6%	6	17.6%	12	35.3%	8	23.5%	34	100.0%	117.79	
	4	9	12.9%	16	22.9%	4	5.7%	26	37.1%	15	21.4%	70	100.0%	109.69	
Total		20	8.3%	43	17.8%	25	10.3%	89	36.8%	65	26.9%	242	100.0%		

Source: Author's Survey, 2014

5.2.1 Political Ideology of the Government and the Room for Private Sector Participation

The incumbent government openly declared that it adopts developmental state ideology, which, as discussed in chapter two, applies strong, deliberate and strategic state intervention in the socio-economic development endeavors of the country. The political ideology of the Ethiopian government, which is mainly reflected in its policies and strategies, reveals the extent to which it is willing to involve the private health sector in service delivery. As indicated in chapter two, the extent to which the political ideology of the government gives room for the participation of the private sector in public service delivery is an important foundation for the success of PPPs in the health sector.

The result from respondents who filled in the structured questionnaire (table 5.1a) above indicates that 36.8% and 27.3% of the respondents agree and strongly agree respectively, which shows that 64.1% of the respondents generally believe that the political ideology of the incumbent government does not prevent private sector participation. However, Kruskal Wallis P value of 0.001 (H=23.60, df= 3), indicates that the level of agreement among the different PPP types (HIV/AIDS, TB, reproductive health and family planning and non-clinical services) is significantly different from each other. This significant difference in responses is because of the difference is opinions which is explained by the mean ranks of the responses. As indicated above, the fact that respondents from reproductive health groups tend to agree less (mean rank= 71.96) while respondents from the HIV/AIDs group show the highest level of agreement (mean rank= 140.05) has created statistically significant variation of responses across the four PPP program. However, this discrepancy is resolved by using information from key informant interviews.

The above result is triangulated with information obtained from key informant interviews. An interview with Ato Mecha form FMoH reveals that the EPRDF led government right from the beginning declared a market led economy abolishing the command economy which gave the government unrestricted right in every sphere of its activities (Ato Mecha, August 4, 2014). Ato Tadesse from MoFED also argues that working with the private sector is not merely about political ideology, but also the practical realities on the ground makes engaging the private sector inevitable. Understanding this, the current Ethiopian government has openly declared its commitment to enhance the involvement of the private sector in the economy in general and

service delivery in particular (Ato Tadesse, August 5, 2015). An argument by Ato Mengistu from AAHB also stresses that the Ethiopian government introduced a free market economy following the 1991 victory of EPRDF, which is a clear indicator of its intention to give room for the participation of the private sector (Ato Mengistu, August 4, 2014). Similarly, a statement by Ato Bayisa from FMHACA can be quoted as follows:

> *As one of the pillars of the democratization and decentralization efforts of the Ethiopian government is introducing market and competition in the Economy, the political ideology of the government clearly captures this reality and is governed by the fact that the limitations of the government in the economy is resolved by involving the private sector (Ato Bayisa, August 8, 2014)*

Ato Kiros from private hospital also argues that though the political ideology of the current Ethiopian government appears to heavily emphasize state intervention in service delivery, it does not totally undermine or eliminate the role of the private sector (Ato Kiros, August 5, 2014).

Therefore, it can be inferred from the above analysis that at least in principle, the political ideology of the incumbent government has rooms for the participation of the private sector in service delivery. Responses and arguments from both questionnaire and key informants clearly indicate that there is no barrier to the private sector participation in service delivery that can be openly attributed to the political ideology of the EPRDF government. This implies that, at least ideologically, the health sector of Addis Ababa does not have political barrier to involve the private sector in health service delivery.

The economic policy of the Ethiopian government and the space for the private sector involvement, which is a reflection of the political ideology, was also analyzed. Economic policies that boldly state the active role of the private sector generally tend to have favorable conditions for PPPs to flourish. In light of this argument, analysis was made to find out whether the economic policy of the incumbent government gives adequate room for the active participation of the private sector.

In this regard, responses of the respondents who filled in the structured questionnaire reveal the following results. A total of 66.9% of the respondents (table 5.1a) argue that the economic policy of the incumbent government gives sufficient room for the participation of the private sector in

service delivery. Respondents from TB category have the highest level of agreement (mean rank= 131.70) and respondents from reproductive health category less favorable responded (mean rank= 104.37). However, Kruskal Wallis P value of 0.168 (H= 5.05, df= 3), indicates that the responses among the different PPP types (HIV/AIDS, TB, reproductive health and non-clinical services) do not significantly vary at the 0.05 level of significance. This implies that respondents from all categories almost similarly believe that the economic policy of the government gives adequate room for the participation of the private sector in public service delivery.

Results obtained for the interviews with key respondents also converge with the above facts. Regarding the room for private sector participation in service delivery, Ato Tadesse from MoFED strongly argues that most of the policies and strategies of the Ethiopian government clearly stipulate the active role that the private sector should play in the economy (Ato Tadesse, August 5, 2014). Ato Petros from AACCSA also argues that the economic policy of the government is generally favorable for the private sector participation. Ato Mecha from FMoH similarly argues as follows:

> *The free market economy declared by the Ethiopian government is more or less reflected in the policy documents and the commitment of the government to involve the private sector is clearly established in these documents. The problem is that the economic policies are general statements which do not outline the details of how and in which specific sectors the private sector is strongly encouraged (Ato Mecha, August 4, 2014).*

With slight variations in the depth of arguments, the responses of almost all the participants in key informant interviews indicate that the economic policy of the incumbent government is generally favorable for private sector participation.

The economic policy of the government was assessed by referring to various policy documents. The investment policy of FDRE government, for instance, clearly indicates that the private sector is the engine of the Ethiopian economy. The policy also stipulates the different incentives that the government will provide to encourage the private sector investment (FDRE, 2011). However, it can be argued that the investment policy is more inclined towards foreign direct investment (FDI) and the manufacturing sector. Though the private sector is clearly welcomed in the

investment policy, the specific attention to service delivery in general and health care delivery in particular are not explicitly stated. On the other hand, the government policy has restrictions on private sector investments in some selected sectors. As Zenebe and Abdissa (2014) strongly argue in the areas of telecom business and electric power, for instance, that the economic policy is not still deregulated implying that the private sector is not given meaningful role in these sectors.

The arguments above generally imply that the economic policy of the government except some selected sectors gives sufficient room for the participation of the private sector in service delivery including health. The empirical literature shows that countries such as Ghana explicitly indicate where and how the private sector can involve in the socio-economic development of the state. Based on the above evidences, it can also be argued that as the private sector is not prohibited from public service delivery in the economic policy, the room is not closed for the private health sector to participate in health care delivery in Addis Ababa.

The role that the private sector can play in public service delivery should be clearly stipulated in different policy and strategy documents of the government. In this regard, views of respondents who filled in the questionnaire are described as follows. Responses from the questionnaire (table 5.1a) point out that 73.1% (28.1% strongly disagree and 45% disagree) of the respondents believe that the government policy and strategy documents do not sufficiently outline the role that the private sector can play. Only 16.2% of the respondents believe that private sector role is adequately stipulated in the government strategy documents. Though the respondents from non-clinical service category have the highest level of disagreement (mean rank=133.96), at the 0.05 level of significance, Kruskal Wallis P value of 0.251(H= 4.10, df= 3) confirms that the responses of all the PPP types (HIV/AIDS, TB, reproductive health and non-clinical services) are almost similar. This implies that respondents from all the four categories, almost unanimously believe that the government policies and strategies do not adequately and clearly stipulate the specific roles that the private sector can play.

Information obtained from interviews with key informants also converges with the above results. Discussing about the policy and strategy documents of the Ethiopian government, Ato Bayisa from FMHACA argues that as a reflection of the ideology of the government following the abolition of the Derg regime, the policies and strategies of the government, at least in some way,

indicate the role of the private sector (Ato Bayisa, August 8, 2014). Ato Kelifa from a private hospital also shares this view citing the role of the private sector in HSDP IV (Ato Kelifa, September 3, 2014). However, Ato Ahmed from public health association argues differently as follows:

> *The policy and strategy documents only have some paragraphs talking about the role of the private sector. However, my reservation is that the roles are not clearly specified in such a way that the public and private sectors can understand the expectations of each other. Moreover, the crude statements of private sector roles are not detailed into specific projects and programs in some sectors such as health" (Ato Ahmed, September 3, 2014).*

W/ro Meselech from private hospital, sharing the above view, understands the statements written about the private sector in the HSDPs in a different way. Though the HSDP documents as government strategy documents have clauses about the private sector involvement and PPP, no specific role is detailed out in the documents. Interviews conducted in public hospitals almost unanimously reveal that the policy and strategy documents of the government indicates that the private sector will have key roles but fails to specifically indicate the roles, duties and responsibilities of the private sector in each segment of service delivery (W/ro Meselech, August 7, 2014).

The above arguments can be confirmed by looking at some of the government policy and strategy documents which are uniformly applied in all regions including Addis Ababa. The health policy of TGE, for instance, openly declares the intention of the government to work with the private sector through PPP and other collaborative arrangements (TGE, 1993). The four HSDPs (HSDP I, HSDP II, HSDP III and HSDP IV) have all almost similar statements about the role of the private sector. HSDP IV, for instance, indicates that the private sector will have active roles through collaborative endeavors on selected health sector priority programs and health system issues. It also indicates that the government will collaborate with private sector on the expansion of health infrastructure, local production of pharmaceuticals, provision of health services, training of health professionals and mobilization of resources for the health sector. It also asserts that it will closely work with professional associations on improving quality of health services and reducing professional malpractices (FMoH, 2010). However, neither the health

policy nor the specific HSDPs clearly and specifically stipulate the roles that the private sector can play in the health sector. They are just crude declarations that are nowhere translated into division of labor between the public and private sector in general and the role to be played by the private health sector in particular. On the contrary, empirical studies indicate that African countries such as South African and Nigeria clearly stipulate the role of the private sector by issuing PPP policy.

Other government strategy documents, such as the PASDEP, GTP, FMoH strategic plan on HIV/AIDS, FMoH family planning guideline, FMoH on malaria, HCFR documents, CBHI proclamation and directives, SHI proclamation and directives, do not adequately stipulate the role that the private sector can play. These policy and strategy documents either have very simple phrases that "the private sector will be involved" or do not talk about the role of the private sector at all.

It can be argued from the above facts that despite the declaration of the government that market and competition is the rule of the game, the government policy and strategy documents do not adequately reflect the specific roles that the private sector can play in service delivery in general and health service provision in particular. This clearly implies that in the absence of clearly and adequately stipulated roles of the private sector, both developing PPP frameworks and implementing them will be a challenging task for the government. As stated in chapter two, PPPs refer to the sharing of responsibilities, benefits and risks, which right from the beginning require clearly articulated roles of both the public and private sectors in service delivery. Moreover, it was reflected in the review of literature in chapter two that the extent to which the public sector is interested in the role of the private sector should be clearly reflected in the policy and strategy documents.

5.2.2 Working together as a Foundation for the Development of PPP Policy

It is theoretically argued that full scale PPPs gradually develop as the public and private sectors closely work together on common issues. This implies that the policy on PPPs can be an outcome of pre-existing relationship between the public and private sectors. In the health sector, at the early stage of partnerships, the practice of closely working together on issues of common concern and mutual benefits gradually develops into formal PPP arrangements which are often

supported by policy. Whether the public health sector is adequately working with the private health sector was investigated in this research.

Responses from the questionnaire, (table 5.1a), reveal that a total of 77.2% of the respondents do not believe that the public sector is adequately working with the private health sector while only 12.4% responded favorably. Kruskal Wallis P value of 0.043 (H= 8.17, df= 3), indicates that the responses from the four respondent groups (HIV/AIDS, TB, reproductive health and non-clinical services) are significantly different from each other at 0.05 level of significance. This significant variation in responses is because of the highest level of unfavorable response from HIV/AIDS respondents (mean rank=104.87) and the lowest level of unfavorable response from reproductive health respondents (mean rank=144.74). Despite the variation in responses, the total results indicate that the majority of the respondents believe that the government is not adequately working with the private health sector.

Conforming to the results from the structured questionnaire, responses from in-depth interview with relevant experts and leaders generally reveal that though gradually emerging, the practice of closely working together on common matters is at a very infant stage. Ato Mecha from FMoH strongly argues that because of the inherent characteristics and the divergent objectives of the public and private health sectors in Addis Ababa, the public sector is not closely working with the private health sector (Ato Mecha, August 4, 2014). Ato Kiros from a private hospital shares the above view but attributes the problem to the strong regulatory intervention of the government. He is quoted as saying:

> *The working relationship between the government and the private health sector of the city largely focuses on regulatory relationship than collaborative relationships. As the private health sector is required to comply with the standards set by the public sector, we usually work together on how to meet the standards and comply with government regulatory requirements. Surprisingly, these regulatory relationships are not often based on mutual understanding and cooperation. They are rather based on rules and regulations which we perceive are generally inflexible to accommodate the practical problems of our institutions (Ato Kiros, August 5, 2014)*

A response provided by Ato Hailu from a public hospital reveals that the public and private health sectors are not currently working together due to low level of trust from the public sector towards the private sector. He argues that current relationship is inadequate and full of suspicion due to the unduly excessive profit motive of the private health sector which tempts them to commit administratively, legally and professionally unacceptable practices (Ato Hailu, September 9, 2014).

Similarly, Ato Mengistu from AAHB strongly argues that the public sector is very suspicious of the private health sector due to the tendency of the later to abuse healthy relationships. He expresses his argument as follows:

> *Even with the most elementary and introductory levels of collaboration in health services of the city that we start with the private sector, we observe repeated mal-practices and professionally unethical behaviors that impair out motivation to look for further partnerships(Ato Mengistu, August 4, 2014)*

The informants from sub-city health departments provide almost similar responses. Though the public sector is willing to engage the private health sector, the relationships so far are limited to regulation, participation on meetings as stakeholders and the emerging collaborations in the areas of HIV/AIDS, TB and reproductive health.

Ato Bulti from a public hospital in Addis Ababa also agrees that the public health sector and the private health sector are not adequately working together. He attributes the problem to lack of policy framework for collaboration, divergence of objectives and the mistrust between the public and private sectors (Ato Bulti, September 5, 2014).

The arguments about the low level of collaboration between the public and private health sectors are also highlighted in several documents. The PHSP evaluation report, for instance, indicates that because of the initial low interest of the public sector towards the private health sector, the initiatives taken by USAID did not progress as expected (USAID, 2012). The low level of interest of the government to closely work with the private health sector implies either the lack of convergence of interests between the two sectors or inadequacy of relationship building that would have been done through various mechanisms including open and formal public private dialogue. A preliminary PPP framework developed by FMoH also indicates that the public sector

is not so far effectively utilizing the untapped potential of the private health sector. The document strongly argues that though there are several potentially promising areas of cooperation and partnership, currently the public and private health sectors are not effectively working together (FMoH, 2013).

The above arguments and analysis can be explained by systems theory and principal agent theory discussed in chapter two. The inability to consider the health sector of Addis Ababa as a total system has probably made adequate collaborations difficult. It can be argued that Addis Ababa's health sector is a total system which essentially constitutes both the public and private health sectors as important components. It can also be argued that, when properly shared, both the public and private health sectors of the city work towards the same ultimate goal. More importantly, the two sectors naturally need each other and one can provide key inputs to the other in the progress towards their goals.

On the other hand, principal agent theory provides the framework for these relationships. The question of why does the public sector work with the private health sector needs to be analyzed from the perspective of motivation and incentive for both sectors. Both the principal (in this case the public health sector) and the agent (the private health sector) should have clear motivation and reward mechanisms that also constitute punishments in case one fails. This relationship should also be governed by predictable set of rules and regulations that are discussed under institutional theory in chapter two.

In summary, the public sector is not adequately working with the private health sector due to mistrust, inability to find out common goals and absence of policy and legal framework that facilitates the relationships.

5.2.3 PPP Policy as a Requirement for Successful PPP Projects

Partnerships should be governed by coherent policies and principles. Whether the current PPP practices in Addis Ababa's health sector are governed by coherent policies that lay down clear objectives and principles of partnership was investigated. The responses from the question about the existence of coherent PPP policies in the health sector reveal the following results. Majority of the respondents (76%) who filled in the structured questionnaire (table 5.1a) believe that existing partnerships in the health sector of the city are not governed by coherent policies that

clarify principles of partnership. Only 14.8% of the respondents argue for the prevalence of coherent policies governing partnership in the health sector. Respondents from HIV/AIDS group have the highest level of disagreement (mean rank= 111.5) while respondents from reproductive health category have the highest level of agreement (mean rank=131.15). This implies that the highest number of respondents sampled from HIV/AIDS category believe that there is no coherent policy to govern partnership between the public and private health sectors in Addis Ababa. However, at the 0.05 level of significance, Kruskal Wallis P value of 0.561(H= 2.06, df= 3) indicates that responses from all the respondent categories is not significantly different from each other implying that responses are almost similar across the respondent groups.

The above results obtained from questionnaire responses are also triangulated with information from key informant interviews. In this regard, Ato Abatneh from a private hospital strongly argues that the partnerships for HIV/AIDS, for instance, are guided by simple memorandum of understanding (MoU) which is mainly based on voluntary interactions (Ato Abatneh, August 7, 2014). Ato Belete, a respondent from the health department of one sub-city has a similar view. Arguing about the lack of unified and coherent policy, he says:

> *Whatever we work together, we do it through common understanding and informal norms. If we call them for a meeting they come and attend in good faith. If we request them for cooperation, they co-operate regardless availability of governing policies and principles of cooperation (Ato Belete, August 11, 2014)*

W/ro Almaz, the head and owner of a private clinic, who participated in the interview, has a slightly different argument. She stresses that the PPP to provide TB-DOTS for instance has a guideline which is also supported by MoU (W/ro Almaz, September 5, 2014). The argument by Ato Mecha from FMoH emphasizes on the lack of coherent policy to guide health sector partnerships and cooperation. This view is also shared by Ato Mengistu from AAHB and Ato Seid from a public hospital. Using the statements of Ato Seid:

> *Partnerships and cooperation based on ad-hoc arrangements in the absence of coherent policy are common practices which are even sometimes affecting the healthy relationships that we have with our stakeholders. Had the partnerships been governed by clear policies, it would have clearly established the benefits, risks and rewards for both parties. In the current partnership environment we do*

not know who is being benefited from the partnership and who is being adversely affected (Ato Seid, August 12, 2014)

It can be inferred from the above responses and arguments that the existing partnerships between the public and private health sectors of Addis Ababa are governed by ad hoc and informal relationships rather than coherent policies and PPP principles. Based on the arguments of the institutional theory, relationships that are not established based on a set of governing rules, regulations and procedures will face critical challenges in the due course of their practices. In the theory of the principal agent relationships, the principal (in this case the public sector) and the agent (the private health sector) working together in the absence of coherent policies may ultimately end up in conflicts related to role ambiguity, role conflicts, and interest divergence. Above all, borrowing the arguments of the rational choice theory, both the public and private health sectors are rational decision makers who believe that the principles of partnership should add value to the partnering entities. The issues related to the principles of NPM and PPP are all based on the argument that there should be the rule of the game and the rule should fairly treat the players. In the absence of these principles and policies, partnerships will run the risk of sustainability and ultimate failure.

PPPs as alternative approach to the health sector governance bring together the public and private sectors to work together in such a way that both benefits and risks are fairly allocated and shared. The level of awareness of the respondents about the relationship between the prevalence of PPP policies and success of PPP programs was investigated. Analysis of response from the structured questionnaire (table 5.1a) indicates that the majority of the respondents (63.7%) generally agree that the prevalence of PPP policy contributes to the success of PPP initiatives while only 26.1% of the respondents have unfavorable response to the statement. Moreover, while the respondents from the HIV/AIDS PPPs indicated the highest level of agreement (mean rank= 130.27), at the significance level of 0.05, Kruskal Wallis P value of 0.289 (H= 3.76, df= 3) indicates that the level of agreement among the four PPP types is not significantly different. This implies that respondents from all the categories of HIV/AIDS, TB, reproductive health and non-clinical services almost uniformly believe that the prevalence of PPP policy contributes to the success of PPP initiatives in the health sector.

Converging with results from the questionnaire responses, almost all the participants in the key informant interviews strongly argue that PPP policy is not only an important factor but also a prerequisite for the success of PPP programs. Ato Tadesse from MoFED expressed his views as follows:

> *The success of PPP initiatives heavily depends on not only the prevalence of sectoral PPP policy such as health sector PPP but also on national PPP policy that addresses intersectoral issues. I argue that a ministry, agency or any government entity who wishes to implement PPP should first do its home work in developing PPP policy framework (Ato Tadesse, August 5, 2014).*

The above facts generally imply that the key players in both the public and private health sector have good awareness about the contribution of PPP policy to the success of PPP programs in the health sector. As a result, they can attribute the success or failures of PPP initiatives to the policy environment and make efforts in developing new policies or improving existing ones. Table 5.1 (b) below bears the continuation of variables from table 5.1 (a) for government policy towards PPP. Issues related to incorporating core values of the government, public private dialogue and importance of identifying potential PPP areas are summarized in the table below.

Table 5.1(b): Government Policy towards PPP in the Health Sector (N=242)… (Continued)

PPP Programs		Strongly Disagree		Disagree		Neutral		Agree		Strongly Agree		Total		Kruskal-Wallis Test	
		N	%	N	%	N	%	N	%	N	%	N	%	Mean Rank	KW Values
Core Values	1	2	4.8%	6	14.3%	12	28.6%	14	33.3%	8	19.0%	42	100.0%	124.48	H= 3.79 df= 3 P= 0.284
	2	11	11.5%	17	17.7%	23	24.0%	21	21.9%	24	25.0%	96	100.0%	117.99	
	3	1	2.9%	2	5.9%	7	20.6%	18	52.9%	6	17.6%	34	100.0%	141.06	
	4	9	12.9%	11	15.7%	13	18.6%	27	38.6%	10	14.3%	70	100.0%	115.03	
Total		23	9.5%	36	14.9%	55	22.7%	80	33.1%	48	19.8%	242	100.0%		
Dialogue	1	12	28.6%	14	33.3%	7	16.7%	7	16.7%	2	4.8%	42	100.0%	133.23	H= 2.31 df= 3 P= 0.510
	2	33	34.4%	39	40.6%	11	11.5%	6	6.3%	7	7.3%	96	100.0%	117.52	
	3	9	26.5%	14	41.2%	7	20.6%	4	11.8%	0	0.0%	34	100.0%	127.78	
	4	21	30.0%	34	48.6%	9	12.9%	4	5.7%	2	2.9%	70	100.0%	116.88	
Total		75	31.0%	101	41.7%	34	14.0%	21	8.7%	11	4.5%	242	100.0%		
PPP_areas	1	16	38.1%	13	31.0%	5	11.9%	5	11.9%	3	7.1%	42	100.0%	121.68	H= 0.21 df= 3 P= 0.976
	2	35	36.5%	36	37.5%	9	9.4%	11	11.5%	5	5.2%	96	100.0%	119.27	
	3	11	32.4%	14	41.2%	4	11.8%	3	8.8%	2	5.9%	34	100.0%	122.68	
	4	25	35.7%	23	32.9%	9	12.9%	8	11.4%	5	7.1%	70	100.0%	123.88	
Total		87	36.0%	86	35.5%	27	11.2%	27	11.2%	15	6.2%	242	100.0%		
PPP_clarity	1	4	9.5%	7	16.7%	1	2.4%	13	31.0%	17	40.5%	42	100.0%	140.93	H= 4.85 df= 3 P= 0.183
	2	13	13.5%	14	14.6%	15	15.6%	28	29.2%	26	27.1%	96	100.0%	121.03	
	3	3	8.8%	5	14.7%	8	23.5%	11	32.4%	7	20.6%	34	100.0%	117.96	
	4	8	11.4%	16	22.9%	7	10.0%	27	38.6%	12	17.1%	70	100.0%	112.21	
Total		28	11.6%	42	17.4%	31	12.8%	79	32.6%	62	25.6%	242	100.0%		

Source: Author's Survey, 2014

5.2.4 Political Ideology and PPP Policies

One of the key challenges of introducing PPP in a given public sector is incorporating the core values of the political ideology of the incumbent government into the PPP policies. The incumbent government of Ethiopia promotes the political ideology of developmental state with the core values of selective government intervention, strategic leadership, promoting equity and inclusiveness in public services. These values have clear implications and effects on how PPPs in the health sector of the city can balance the market principles with developmental state values. Respondents' views about the accommodation of developmental state values in PPP policies were analyzed as follows.

The majority of the respondents (52.9%) who filled in the structured questionnaire (table 5.1b) believe that the core values of developmental state can be fairly accommodated in the PPP

policies in the health sector. On the other hand, 24.4% of the respondents argue against the possibility of incorporating developmental state values into PPP policies that are inherently embedded in NPM concepts. While the respondents from the reproductive health category have the highest level of agreement about the possibility of accommodating developmental state values within PPP policies (man rank= 141.06), respondents from TB-DOTS category agree less with the statement (mean rank= 117.99). However, the overall result of respondents does not significantly vary across the four respondent groups. Kruskal Wallis P value of 0.284 (H= 3.79, df= 3) clearly infers that the null hypothesis cannot be rejected as responses across the four PPP types are almost similar at the 0.05 level of significance.

Data obtained from key informant interviews generally converges with the above results. For instance, Ato Tadesse from MoFED strongly argues that the PPP policy can adequately accommodate the core values that the incumbent EPRDF led government are promoting under the umbrella of developmental state (Ato Tadesse, August 5, 2014). Similarly, Ato Mengistu from AAHB points out that the values and principles of developmental state focus on making citizens the center of attention and this can be incorporated into the PPP policy (Ato Mengistu, August 4, 2014). His argument, however, does not address the issue of profit motive which the private sector brings to the negotiation table. An important policy issue is how to reconcile the core values of developmental state with the profit motive of the private sector. Ato Mecha from FMoH is quoted as follows:

> *Right from the beginning, if the PPP policy development process involves all the key stakeholders in general and the private sector in particular, the core values and the interests of the government which is a reflection of the ruling party can be fairly negotiated and accommodated. As the values of developmental state are simple values that can attract attention, they can easily be accepted by stakeholders and incorporated into PPP policies (Ato Mecha, August 4, 2014)*

Most of the respondents from private hospitals have slightly different argument about the possibility of promoting developmental state values in PPP policies. Ato Hailu, for instance, emphasizes that in developmental states, there is a tendency to determine policies from above and implement authoritatively (Ato Hailu, September 9, 2014). As PPP processes are governed by the values and principles of NPM discussed in chapter two, flexibility, open dialogue,

negotiation and result orientation are the essential requirements. However, Ato Yimer from Addis Ababa FMHACA strongly argues that regardless of operating under developmental state or NPM framework, PPP policies can incorporate what the government ultimately needs to achieve in the health sector (Ato Yimer, August 8, 2014). His argument is that within the developmental state framework, what the Ethiopian government aspires to attain in the health sector as stipulated in the HSDP documents is what everybody including the private health sector wishes to see. Majority of the responses from other participants (public health association, private hospitals, Chamber of Commerce and Sectoral Associations) generally indicate the difficulty of incorporating the core values of developmental states into PPP policies in the health sector.

It can be inferred from the above discussions that the core values of the developmental state are not difficult to accommodate into the PPP policies. The reservations about the possibility of addressing the core values in the health sector PPPs might have developed either due to limitations in fully understanding what the core values are or due to prior experiences with the extent to which developmental state values constrain the possibility of working with the private sector. The possibility of actively involving the private sector is evident in that African countries such as South Africa with some elements of developmental state have effectively designed and implemented health sector PPP by issuing PPP policies to clarify the roles and responsibilities of the private sector.

5.2.5 Public-Private Dialogue as a Facilitator of PPP Initiatives

Public private dialogue as is an important input for PPP initiatives. The prevalence of adequate, formally established and policy supported PPD establishes a favorable ground for PPPs to flourish. The prevalence of formal PPD between the public and private health sector was investigated based on empirical evidences. Responses from the structured questionnaire reveal the following results. The majority of the respondents (72.5%) believe that the current health system of Addis Ababa does not have adequate and formally established PPD, while only 8.7% of the respondents agree that there is adequate PPD in the health sector. The proposition about variation of responses across the different sample categories can be rejected based on Kruskal Wallis test result. The P value of 0.510 (H= 2.31, df= 3) indicates that the respondents from HIV/AIDS, TB, reproductive health and non-clinical services almost uniformly believe that the

health system of Addis Ababa does not have adequate and formally established public private dialogue.

Conforming to the above results, almost all of the respondents who participated in the in-depth interviews reveal that the public and private health sectors of Addis Ababa do not have adequate dialogue. Ato Mecha from FMoH, for instance, indicated that PPD is just an ad hoc practice in the health sector and there is no policy, guideline or any rule that governs the PPD (Ato Mecha, August 4, 2014). Similarly, Ato Mengistu from AAHB indicated that in what they call "public wing", private sector representatives, usually through professional associations, are invited to participate in quarterly meetings and annual review meetings (ARM) (Ato Mengistu, August 4, 2014). But this is not formal, institutionalized and hence lacks sustainability.

All the other informants from public and private hospital, private clinic associations and sub-city health departments unanimously agree that there is no adequate, formally established and policy supported PPD in the health sector. Stressing the importance of health sector PPD, Ato Bayisa from FMHACA points out that even the elementary and ad hoc interactions that they are making with the private health sector are adding value in terms of understanding the needs, limitations, interests and concerns of the private sector (Ato Bayisa, August 8, 2014). However, he also believes that PPD in the health sector lacks policies, guidelines and structure.

The lack of adequate PPD in the health sector implies that the policy environment for PPP is at an early stage. Empirical findings on African health sector governance largely converges with finding from Addis Ababa's health sector in that formally established and well planed PPDs are either non-existent or are very limited. As PPDs establish the spirit of mutual trust and confidence among the public and private sectors, the absence of such practices constrains the development of favorable ground for full scale PPP which involves complex legal, administrative and financial implications. From the perspective of systems theory, the public and private health sectors that are generally working within the larger system (the health sector) need to develop strong relationship and interaction to yield synergy in their operations. Similarly, from the point of view of institutional theory, interactions and the dialogue should be formally established and governed by predictable set of rules and regulations.

PPP in the health sector requires the identification of potential projects and service areas that can be delivered through this approach. As clearly discussed in chapter two, the understanding of

potential PPP areas in the health sector paves the way for both the development of PPP policies and their effective implementation. In the decentralized and democratized health system, identification of promising PPP areas is the responsibility of both the private and public health sectors. PPDs and other collaborative activities play an important role in the process of identifying potential PPP areas. The extent to which relevant PPP areas are identified and understood in the health sector of Addis Ababa was investigated and analyzed. Responses from the summary of the questionnaire analysis reveal the following results.

Most of the respondents (71.5%), who filled the structured questionnaire (table 5.1b), believe that potential areas of PPP in the health sector of the city are not adequately indentified and understood while only 17.4% of the respondents believe that the potential areas of the health sector PPPs are adequately identified and understood. Though respondents from TB-DOTs category have the highest level of disagreement (mean rank= 119.27), based on Kruskal Wallis test result, it can be inferred that there is no significant variation in responses across the four respondent groups of HIV/AIDS, TB, reproductive health and non-clinical services. The P value of 0.976 (H= 0.21, df= 3) indicates that responses across the different PPP types are almost similar at the 0.05 level of significance.

The above results were triangulated with responses from key informant interviews. In this regard, Ato Mecha from FMoH, who participated in the in-depth interview, reveals that one of the key challenges of implementing PPP is lack of sufficient knowledge of the promising areas of PPP. To quote his statements:

> *In our efforts to develop PPP framework, absence of clear information about the potentially promising areas of PPP in the health sector has constrained our efforts. In fact, I strongly believe that the identification of potential PPP projects should be based on practical research and should not be a rush decision. As no study is so far made to identify potential PPP areas, our PPP framework is going to be a general framework which is less interesting for the private investor in health (Ato Mecha, August 4, 2014).*

Ato Seid from a public hospital also points out that despite the growing interest of the government to introduce PPP as health care delivery approach, potential areas are not so far sufficiently studied and identified (Ato Seid, August 12, 2014). Ato Yimer from AAFMHACA

also confirms that PPP areas are not properly studied, identified and understood (Ato Yimer, August 8, 2014). Almost all the other respondents are not sure whether the relevant government agency has conducted a study and identified promising PPP areas in the health sector. Some of the respondents, however, suggest areas such as laboratory, diagnostic imaging, hospital management, facility construction and health service equipments are potentially appealing areas for PPP in the health sector of Addis Ababa.

A preliminary PPP framework developed by FMoH to guide the development of PPP in all regions including Addis Ababa indicates the following as possible areas of PPP.

- Concession with Diaspora and foreign health sector investors
- Commercial franchising of some health services
- Contracting with for-profit private sector
- Leasing with for-profit and not for-profits organizations
- Management concession with local or foreign private companies
- Joint ventures with local pharmaceutical manufacturers
- Joint and collaborative training of health professionals with the private sector
- Social franchising of reproductive health and other services

It can be argued, however, that the identification of promising areas for PPP requires adequate study. As a preliminary document, the potential areas of health sector PPPs are not properly analyzed, identified and understood. The absence of thoroughly identified, analyzed and understood PPP area, as Ato Mengistu from AAHB argues, has visibly hampered the effective implementation of PPP programs. He testifies his argument with his observation as follows:

> *A PPP project that we started with a foreign investor in one of the public hospitals in Addis Ababa turned out to be less effective due to the lack of prior identification, analysis and understanding of the service. We even did not study and understand if eye care service is a potentially promising area for PPP. As we started the initiative with good faith and passion without carefully understanding the peculiar nature of the service, we ultimately ended up with serious conflicts with the foreign partner (Ato Mengistu, August 4, 2014)*

It is both theoretically and empirically established that lack of clearly identified PPP areas negatively affects the development of PPP initiatives. Responses from the structured questionnaire indicate the following results. The majority of the respondents (58.2%) who filled in the structured questionnaire (table 5.1b) agree that the absence of clearly identified PPP areas has negatively affected PPP practices. Respondents from HIV/AIDS category have the highest level of agreement (mean rank= 140.94) while respondents from non-clinical service category reveal the lowest level of agreement (mean rank= 112.21). However, at the 0.05 level of significance, the Kruskal Wallis P value of 0.183 (H= 4.85, df= 3) clearly indicates that responses across the different sample categories of HIV/AIDS, TB, reproductive health and non-clinical services are not significantly different. This indicates that respondents from different groups have almost uniform responses.

Similarly, almost all the key informants, who participated in the in-depth interview, reveal that lack of clearly identified PPP areas have in some way constrained the development of PPP initiatives. Ato Mecha from FMoH, for instance, pointed out that though some private investors come up with PPP proposals, the government is not in a position to accept and process the projects due to lack of understanding about the PPP areas that are believed to add value to the health sector goals (Ato Mecha, August 4, 2014).

5.3 Legal Framework for Managing PPPs in the Health Sector

Legal framework is an important requirement for PPP programs to succeed. In the absence of legal framework, regulating relationship among the partners will be a challenging task as pointed out in the theoretical frameworks under the institutional theory, principal agent theory and rational choice theory. The legal framework in the existing PPPs in Addis Ababa was investigated using both primary and secondary data. The presentation of data, analysis and interpretations of the results are discussed below.

Table 5.2(a): Legal Framework for PPP in the Health Sector (N=242)

PPP Programs		Strongly Disagree		Disagree		Neutral		Agree		Strongly Agree		Total		Kruskal Wallis Test	
		N	%	N	%	N	%	N	%	N	%	N	%	Mean Rank	KW Values
Adequate_LF	1	10	23.8%	23	54.8%	5	11.9%	3	7.1%	1	2.4%	42	100.0%	120.08	H= 0.92 df= 3 P= 0.821
	2	28	29.2%	36	37.5%	16	16.7%	9	9.4%	7	7.3%	96	100.0%	126.21	
	3	11	32.4%	13	38.2%	4	11.8%	5	14.7%	1	2.9%	34	100.0%	120.25	
	4	22	31.4%	32	45.7%	6	8.6%	5	7.1%	5	7.1%	70	100.0%	116.50	
Total		71	29.3%	104	43.0%	31	12.8%	22	9.1%	14	5.8%	242	100.0%		
Rights_ Interests	1	11	26.2%	20	47.6%	7	16.7%	1	2.4%	3	7.1%	42	100.0%	116.35	H= 0.43 df= 3 P= 0.935
	2	29	30.2%	34	35.4%	10	10.4%	16	16.7%	7	7.3%	96	100.0%	123.07	
	3	9	26.5%	15	44.1%	5	14.7%	4	11.8%	1	2.9%	34	100.0%	118.94	
	4	21	30.0%	22	31.4%	15	21.4%	7	10.0%	5	7.1%	70	100.0%	123.68	
Total		70	28.9%	91	37.6%	37	15.3%	28	11.6%	16	6.6%	242	100.0%		
Com_oriented	1	7	16.7%	12	28.6%	10	23.8%	9	21.4%	4	9.5%	42	100.0%	138.29	H= 5.91 Df= 3 P= 0.116
	2	23	24.0%	33	34.4%	11	11.5%	17	17.7%	12	12.5%	96	100.0%	125.64	
	3	9	26.5%	17	50.0%	4	11.8%	1	2.9%	3	8.8%	34	100.0%	105.10	
	4	19	27.1%	28	40.0%	6	8.6%	13	18.6%	4	5.7%	70	100.0%	113.71	
Total		58	24.0%	90	37.2%	31	12.8%	40	16.5%	23	9.5%	242	100.0%		
Tax_Comp_ Pro	1	17	40.5%	14	33.3%	1	2.4%	6	14.3%	4	9.5%	42	100.0%	115.00	H= 0.99 df= 3 P= 0.801
	2	39	40.6%	22	22.9%	11	11.5%	16	16.7%	8	8.3%	96	100.0%	120.09	
	3	9	26.5%	16	47.1%	5	14.7%	3	8.8%	1	2.9%	34	100.0%	121.13	
	4	21	30.0%	25	35.7%	7	10.0%	11	15.7%	6	8.6%	70	100.0%	127.51	
Total		86	35.5%	77	31.8%	24	9.9%	36	14.9%	19	7.9%	242	100.0%		
Contradiction	1	5	11.9%	10	23.8%	20	47.6%	5	11.9%	2	4.8%	42	100.0%	135.32	H= 3.97 df= 3 P= 0.265
	2	21	21.9%	28	29.2%	28	29.2%	14	14.6%	5	5.2%	96	100.0%	119.53	
	3	6	17.6%	17	50.0%	7	20.6%	2	5.9%	2	5.9%	34	100.0%	105.04	
	4	15	21.4%	16	22.9%	27	38.6%	7	10.0%	5	7.1%	70	100.0%	123.91	
Total		47	19.4%	71	29.3%	82	33.9%	28	11.6%	14	5.8%	242	100.0%		
Cont_doc_ Sign	1	18	42.9%	12	28.6%	6	14.3%	4	9.5%	2	4.8%	42	100.0%	108.55	H= 5.79 df= 3 P= 0.122
	2	29	30.2%	40	41.7%	18	18.8%	8	8.3%	1	1.0%	96	100.0%	116.54	
	3	10	29.4%	14	41.2%	5	14.7%	4	11.8%	1	2.9%	34	100.0%	120.12	
	4	15	21.4%	29	41.4%	8	11.4%	11	15.7%	7	10.0%	70	100.0%	136.75	
Total		72	29.8%	95	39.3%	37	15.3%	27	11.2%	11	4.5%	242	100.0%		
Strong_ mechanisms	1	12	28.6%	18	42.9%	2	4.8%	6	14.3%	4	9.5%	42	100.0%	126.38	H= 0.97 df= 3 P= 0.809
	2	32	33.3%	28	29.2%	19	19.8%	13	13.5%	4	4.2%	96	100.0%	124.55	
	3	12	35.3%	13	38.2%	4	11.8%	3	8.8%	2	5.9%	34	100.0%	115.85	
	4	23	32.9%	30	42.9%	4	5.7%	11	15.7%	2	2.9%	70	100.0%	117.13	
Total		79	32.6%	89	36.8%	29	12.0%	33	13.6%	12	5.0%	242	100.0%		

Source: Author's Survey, 2014

5.3.1 Adequacy of Legal Framework for PPP

An assessment was made to understand the extent to which the existing PPP programs in Addis Ababa are governed by sufficient legal frameworks. Results from questionnaire responses, regarding adequacy of legal framework, indicate the following. Responses from the structured questionnaire (table 5.2a) reveal that the majority (72.3%) of the respondents do not agree with the prevalence of adequate legal framework to govern existing PPPs. Only few (14.9%) of the respondents agree with the availability of adequate legal frameworks in the health sector of the city. More importantly, Kruskal Wallis P value of 0.821 (H= 0.92, df= 3) indicates that the respondents in all the four PPP types have similar views regarding the adequacy of legal frameworks at the 0.05 level of significance. The slight difference in the level of agreement is that while respondents from non-clinical services indicate the highest level of disagreement (mean rank= 116.50), respondents from TB category have the highest level of agreement (mean rank= 126.21).

Similarly, results from key informant interviews indicate that PPP programs in the health sector currently do not have adequate legal framework. Ato Tadesse from MoFED strongly argues that there is almost no legal framework to guide PPP practices in Ethiopia as well as Addis Ababa in all sectors including health. As a result, he points out that the practices that are at the early stage are seriously suffering from governance problems some of which are ending up in conflicts and even court disputes (Ato Tadesse, August 5, 2014). Specific to the health sector, Ato Mecha from FMoH has similar views in that the current PPP initiatives in the health sector are being governed by the existing laws that are by no means appropriate and adequate in accommodating the peculiar issues of PPPs in the health sector. To quote his expressions:

> *We started PPPs in health out of passion and commitment to do something better in health service delivery. I can say we are implementing the PPPs and collaborations in the absence of adequate legal framework to guide the practices. In some cases we are using laws that are less appropriate to PPP and in most cases we are using simple memorandum of understanding that are neither binding nor comprehensive in terms of accommodating the relationships among the private and public partners(Ato Mecha, August 4, 2014)*

Almost all the respondents who participated in the in-depth interviews strongly argue that the current PPP practices lack legal framework. The views of respondents from the public and private organizations are similar in this regard.

It can be argued based on the responses from the in-depth interviews and structured questionnaire that the existing PPP practices in the health sector lack adequate legal framework. This argument is also supported by information from secondary sources. The PPP legal framework of countries such as South Africa, Ghana, Tanzania and Nigeria begins with dedicated national PPP legislation that applies to all sectors. From this national PPP legislation, the health sector developed sector specific regulations, directives and guidelines that specify and clarify the duties, responsibilities, risk and benefit sharing schemes and contract administration details that govern both the public and private health sector. These details of legal framework are clearly lacking in the health sector of Ethiopia as well as Addis Ababa. Several studies (Asubonteng, 2011; ADB, 2013; FMoH, 2013 and USAID, 2012) clearly indicate that there is no specifically dedicated legal framework to govern PPPs in Ethiopia in general and in Addis Ababa in particular. Specifically, in the health sector, FMoH (2013) reveals that the existing PPP practices in the health sector are being implemented in the absence of sufficient legal framework.

From the perspectives of institutional theory, as discussed in earlier sections, the absence of adequate legal framework has several implications. As institutions are governed by a set of rules, regulations and standards of operation, the absence of these in organizations in general and PPPs in particular leads to lack of consistency and predictability. The existing PPP practices in the health sector in Addis Ababa such as HIV/AIDS, TB, reproductive health and non-clinical services may face the consequences of lack of legal framework such as inter-organizational conflicts, lack of predictability of behavior and operational consistency due to the lack of legal framework. It can also be argued that the principal (the public sector) and the agent (the private sector) may not effectively discharge their respective duties and responsibilities in the absence of appropriate and adequate legal framework.

The absence of adequate legal framework puts serious challenges in effectively addressing the rights and interest of the partners. The consequence of absence of legal framework was analyzed using the responses from the structured questionnaire. Data from the structured questionnaire (table 5.2a) points out that the majority of the respondents (66.5%) feel that the needs and

interest of the partners are not effectively addressed in the existing PPP programs in HIV/AIDS, TB, reproductive health and non-clinical services while only few (18.2%) feel that the needs and interest of stakeholders are fairly accommodated. Based on the Kruskal Wallis P value of 0.935 (H= 0.43, df= 3), it can be argued that respondents from all the categories of HIV/AIDS, TB, reproductive health and non-clinical services do not significantly vary.

The above results are also confirmed by qualitative data from key informant interviews. Accordingly, Ato Kelifa from a private hospital strongly argues that the collaboration in HIV/AIDS, TB and reproductive health services, for instance, fails to accommodate the interest of the private investor due to lack of legal frameworks. It fails to allow the partners to negotiate and ensure their respective interest in terms of financial and non-financial benefits (Ato Kelifa, September 3, 2014). Similarly, Ato Belete from a sub-city health department expressed his views as follows:

> *I cannot say the public and private organizations have negotiated and re-negotiated sufficiently to make sure that their needs and interests are accommodated in the existing PPP practices. The absence of proper legal environment is the key barrier for the problem. These are the areas where we want to put efforts in the future and the commitment should come from the FMoH (Ato Belete, August 11, 2014)*

A slightly different argument is given by W/t Meklit from a public hospital in favor of somehow improving room for the accommodation of needs and interest of the partners through time as partners are practically learning on how to accommodate interest (W/t Meklit, August 12, 2014). Attributing the problem to the lack of legal framework to specifically govern PPPs in the health sector, almost all other participants agree that the partners in the existing PPPs are not satisfied with how the process ensures their needs and interest.

The above analysis can be interpreted from the point of view of rational choice theory. As clearly discussed in chapter two, in a benefit optimizing environment, both the public and private health sectors which are participating in PPPs need to negotiate and re-negotiate in such a way that their needs and interest are accommodated as fairly as possible. For a private hospital participating in the delivery of ART for instance, there is no point in involving in PPPs if its interest is not incorporated in the PPP venture. The same is true for other services including TB and

reproductive health. It can also be argued that legal provisions governing PPPs in health are mainly supposed to address the issues of rights, needs, concerns and interest of both parties in such a way that the relationships mutually benefit the partners.

5.3.2 Commercial Orientation of PPPs in the Health Sector

New Public Management in general and PPP in particular is an important paradigm shift in terms of governing the public sector using important principles from the private sector. These essentially include issues such as generating profit, competitive environment and relationships between the provider and regulator. The extent to which the existing PPPs in the health sector of Addis Ababa are commercially oriented in terms of generating reasonable profits was analyzed as follows.

Data from structured questionnaire reveals that majority of the respondents (61.2%) believe that the existing PPP practices are not supported by rules and regulations that allow the private health sector to generate profit while only 26% of the respondents provide favorable answers. There are variations in responses among the different respondent categories in which HIV/AIDs respondent groups indicate the highest level of favorable response (mean rank= 138.29) and reproductive health respondent groups have the highest level of unfavorable response (mean rank (105.1). This implies that, relatively, PPP related to reproductive health services lack commercially oriented provisions and practices in terms of generating profits for the private partner. However, the Kruskal Wallis P value of 0.116 (H= 5.91, df= 3) infers that responses obtained from the four PPP categories are not significantly different at the 0.05 level of significance.

Data from key informant interviews also confirms the above results. Accordingly, Ato Abatneh, the head of a private hospital strongly argues that the existing public private collaborations in HIV/AIDS and TB in particular are not commercially oriented. He points out that there is no mechanism that the private sector can generate profit by delivering ART or providing TB care services to the patients (Ato Abatneh, August 7, 2014). A different argument by Ato Mecha from FMoH is that even though the existing PPPs in the areas of HIV, TB and reproductive health do not have specifically agreed profits to be generated by the private hospital or clinic, the private partner can use the collaborative relationships for patient harvesting purpose. According to the respondent, patient harvesting refers to the opportunity that private hospitals and clinics get to

attract more and more customers as a result of delivering the services which are covered by PPP. He expresses patient harvesting practice as follows:

> *Profit generation for private health providers is indirectly attained. As customers visit private health facilities for ART, TB or reproductive health services, they also receive other services for payment. I can argue safely that health institutions covered under PPP programs harvest more patients than those not covered in the programs. I also understand that the future of PPPs in health should explicitly indicate the financial and non-financial benefits that will accrue to the private partner (Ato Mecha, August 4, 2014)*

Except the above argument that PPPs in the existing health sector are indirectly commercially oriented, almost all other respondents indicate that the existing PPPs such as HIV/AIDS and TB are not commercially oriented. Ato Petros from AACCSA, for instance, strongly argues that the absence of commercial orientation in the existing PPPs in the health sector is mainly attributed to the lack of clear legal environment. For him, as a key principle in PPP, had there been legal provision governing partnership projects, it could have established the room for the private health sector on how it can generate fair profit from its services (Ato Petros, August 14, 2014).

Interpreting the results from the perspectives of the rational choice theory, both the public and private health sectors make a rational and purposeful decision when engaging in PPPs in health services. PPPs in the health sector are generally used when there are convergences of interest and there should be legal provision for negotiation and re-negotiation among the parties to ensure value for money for the public sector and reasonable profit for the private sector. Business principles advocated in NPM as well as PPP are applied by ensuring the commercially oriented partnerships in health services in which the main incentive for the private partner is embedded in the expected profit among other things.

The commercial orientation of PPPs under the principles of NPM, the rational choice and principal-agent theory are also evaluated based on the extent to which PPP initiatives address legal issues such as tax, competition, procurement, partnership regulation and other legal concerns. Majority of the respondents (67.3%) who filled in the questionnaire believe that issues of tax, competition and regulatory mechanisms are not properly established in the existing PPPs in Addis Ababa. On the other hand, 22.8% of the respondents believe that business issues

including tax and competition are adequately incorporated. Kruskal Wallis P value of 0.801 (H= 0.99, df= 3) indicates that respondents from HIV/AIDS, TB, and reproductive health have responses which are not significantly different from each other at the 0.05 level of significance. The implication is that, in all the four PPP programs covered in this study, PPP programs do not address issues of tax, principles of competitive service delivery and regulatory mechanisms.

Conforming to the above quantitative results, respondents who participated in the in-depth interviews almost unanimously agreed that existing PPPs in the health sector of the city are established based on existing weak and less relevant legal environment and fails to address the above issues.

From the point of view of the institutional theory discussed in chapter two, lack of rules, regulations and operational mechanisms puts the existing PPP initiatives at a risk of failure to ensure institutional sustainability. It also implies that the existing PPPs are vulnerable to mal-administration and corrupt practices in addition to the lack of proper tracking and collection of taxes generated from the operation of the PPPs.

5.3.3 PPP Contracts and Health Service Delivery

Public private partnerships (PPPs) involve contractual agreement between the public and private sector partners with clearly defined roles, rights, obligations, benefits and risks. Whether the existing PPPs in the health sector are based on standard contract documents signed and agreed between the two parties was investigated. Results from the responses of the structured questionnaire reveal that majority of the respondents (69.1%) believe that standard contracts are not signed and agreed in the existing PPP projects. Only few (15.7%) of the respondents have favorable response indicating that contracts are signed and agreed in the PPP projects. Confirming the above arguments, respondents from the non-clinical service category indicate the highest level of agreement (mean rank= 136.75) which implies that in contracting out non-clinical hospital services, there is the practice of signing a standard contract document before entering into PPP projects. However, based on Kruskal Wallis P value of 0.122 (H= 5.79, df= 3)) it can be inferred that responses among the four PPP programs are not significantly different from each other at the 0.05 level of significance.

In addition to the prevalence of standardized contract document, the possible contradiction of the existing PPP documents with other legal provisions of the country and the city government was also investigated. Data from the structured questionnaire indicates that a total of 48.7% of the respondents do not believe that PPP documents contradict with other legal documents while 33.9% of the respondents are neutral about the availability of contradictions. Overall, 82.6% of the respondents are either not clear about the existence of contradictions or do not agree about the existence of contradictions. Only 17.4% of the respondents believe that the existing PPP documents contradict with other legal provisions. Although respondents from HIV/AIDS program showed higher rate of agreement (mean rank = 135.32), the Kruskal Wallis P value of 0.265 indicates that responses do not significantly vary at 0.05 level of significance.

All the respondents from public hospitals who participated in the in-depth interviews indicated that the existing PPPs in general and HIV/AIDS and TB-DOTs collaborations in particular are based on simple memorandum of understanding (MoU) and do not have standard contract documents at all. This view is also shared by Ato Mecha from FMoH. He points out that the lack of legal framework in health sector PPPs is partly reflected in the lack of contract documents to guide project specific PPPs. The view of W/ro Almaz from a private clinics association is quoted as follows:

> *Due to the lack of detailed contract document, our partnership to provide TB care is more or less governed by informal relationships and mutual understanding. We make ad-hoc decisions for ad-hoc problems. The good thing is that there is fairly good understanding from both sides of the partners in terms of solving problems in a mutually beneficial manner. In the absence of contract document, it would have been very difficult to resolve conflicts that may arise from our relationships (W/ro Almaz, September 5, 2014)*

Ato Ketema, a respondent from a sub-city health department also underscores that PPPs in the health sector that are based on MoU are affecting their regulatory mandate in general and tracing malpractices and sources of conflicts in PPPs in particular (Ato Ketema, August 12, 2014). Ato Ermias, a team leader from a public hospital has a slightly different argument and cites the practice in the contracting-out of non-clinical support services within public hospitals. He points out that contracting-out is based on the procurement proclamation of the government and

subsequent regulations and hence has contract documents signed between the partners (Ato Ermias, September 8, 2014). It can be inferred from the data that except for non-clinical services all the remaining three PPP programs lack formal contracts except MoUs that are based on mutual cooperation and voluntary relationships.

It is theoretically argued that the public sector should have a strong contract administration mechanism to ensure that PPP agreements are fairly and consistently enforced. Empirical studies on the health systems of some African countries also reveals that PPPs that are established and operated based on formal contract administration mechanisms yield positive outcomes to both the public and private sector. In the existing PPP practices in Addis Ababa's health sector, the fact that most of the PPP projects are based on MoU might have contributed to the weakness of the enforcement mechanism. Data from the structured questionnaire indicate that majority of the respondents (69.4%) believe that the existing PPPs in the health sector of Addis Ababa do not have strong enforcement mechanism which the public sector uses to make sure that agreements are implemented. Although 18.6% of the respondents believe that agreements can be enforced, Kruskal Wallis test indicates no significant variation in responses of the sample respondents from the four categories. The P value of 0.809 (H= 0.97, df= 3) infers that respondents from HIV/AIDS, TB, reproductive health and non-clinical services responded almost similarly at the 0.05 level of significance.

Results from key informant interviews almost converge with the above results. Accordingly, Ato Abatneh, a respondent from a private hospital argues that the main enforcement mechanism used so far is supportive supervision of private facilities involved in the delivery of HIV/AIDS, TB and reproductive health services. Supportive supervision is a regular visit that involves checking the progress and performance of the PPP projects and providing technical and advisory support (Ato Abatneh, August 7, 2014).

On the other hand, Ato Mecha from FMoH strongly argues that there is no strong and effective enforcement mechanism of PPP agreements (Ato Mecha, August 4, 2014). This view is equally shared by almost all the respondents who participated in the in-depth interviews. A different response is, however, provided by Ato Seid, a public hospital manager who cited the mandate of the legal experts at AAHB and the human resource department of the respective hospitals as responsible units to monitor and ensure the enforcement of PPP agreements. He argues that legal

experts from AAHB and the human resource team are discharging the responsibilities of legal and administrative compliance of PPP projects respectively (Ato Seid, August 12, 2014). The argument by the hospital manager can be counter argued from a different perspective. As the public hospitals in Addis Ababa do not have their own legal departments, they obtain legal services from the AAHB in case disputes and conflicts arise between the partners. On one hand, it would be very challenging in terms of accessibility to have legal experts from the center (AAHB) for all the public hospitals under the city government. On the other hand, enforcement of contracts is not a reactive process in which legal experts take the case to the courts and win in litigations. As PPPs are mutually supportive ventures, the enforcement mechanism should be a proactive process which should be governed by the principles of dialogue, joint problem solving and private sector self-regulation. When this later approach is considered, it can be argued that even the non-clinical services that have relatively better PPP contracts have weak enforcement mechanisms.

Interpreting the above results from the perspectives of institutional theory, as both the private and public sector partners who are engaged in the delivery of HIV/AIDS, TB-DOTS, reproductive health and non-clinical hospital services, they have their own set of rules and regulations. These general and separate set of rules and regulation are less relevant when applied to PPPs. An attempt to use old legal framework to govern new institutions runs the risk of failure in addressing peculiar issues that are specific to the health sector PPP. From the perspective of principal-agent theory, enforcing agreements in PPP projects is not about top-down approach that involves carrot and stick. Lack of PPP legal and regulatory environment leads to a tendency to apply ad-hoc and restrictive approaches some of which are outside the principle of governance of PPP projects. The situation of the regulatory environment and the extent to which it contributes to efficiency, effectiveness and creating an enabling environment is summarized in the table below.

Table 5.2(b): Legal Framework for PPP in the Health Sector (N=242)

PPP Programs		Strongly Disagree		Disagree		Neutral		Agree		Strongly Agree		Total		Kruskal Wallis Test	
		N	%	N	%	N	%	N	%	N	%	N	%	Mean Rank	KW Values
Efficiency_ effect	1	10	23.8%	25	59.5%	3	7.1%	2	4.8%	2	4.8%	42	100.0%	115.46	
	2	26	27.1%	42	43.8%	11	11.5%	12	12.5%	5	5.2%	96	100.0%	123.65	H= 0.46
	3	10	29.4%	14	41.2%	5	14.7%	1	2.9%	4	11.8%	34	100.0%	122.15	df= 3
	4	22	31.4%	24	34.3%	13	18.6%	11	15.7%	0	0.0%	70	100.0%	121.86	P=0.928
Total		68	28.1%	105	43.4%	32	13.2%	26	10.7%	11	4.5%	242	100.0%		
Enabling_ supp	1	6	14.3%	17	40.5%	1	2.4%	9	21.4%	9	21.4%	42	100.0%	140.23	
	2	22	22.9%	40	41.7%	11	11.5%	17	17.7%	6	6.3%	96	100.0%	115.86	H= 4.67
	3	9	26.5%	13	38.2%	6	17.6%	3	8.8%	3	8.8%	34	100.0%	111.68	df= 3
	4	16	22.9%	22	31.4%	14	20.0%	14	20.0%	4	5.7%	70	100.0%	122.77	P=0.198
Total		53	21.9%	92	38.0%	32	13.2%	43	17.8%	22	9.1%	242	100.0%		
Disabling_ const	1	3	7.1%	13	31.0%	8	19.0%	13	31.0%	5	11.9%	42	100.0%	113.20	
	2	9	9.4%	16	16.7%	26	27.1%	32	33.3%	13	13.5%	96	100.0%	122.55	H= 3.54
	3	4	11.8%	3	8.8%	8	23.5%	9	26.5%	10	29.4%	34	100.0%	139.76	df= 3
	4	6	8.6%	16	22.9%	17	24.3%	24	34.3%	7	10.0%	70	100.0%	116.17	P=0.315
Total		22	9.1%	48	19.8%	59	24.4%	78	32.2%	35	14.5%	242	100.0%		

Source: Author's Survey, 2014

5.3.4 Regulatory Environment and the Room for the Development of PPPs

Public private partnerships (PPPs) generally start smaller at the early state and gradually develop into full scale and advanced ventures. This, however, needs a favorable condition for both the public and private partner. The regulatory framework of PPPs should optimize efficiency and effectiveness in health service delivery so that the projects provide sustainable incentives to both partners. The reality in the existing PPPs in the health sector of Addis Ababa was analyzed using information from different sources.

Data from the structured questionnaire reveals that the majority (71.5%) of the respondents believe that the issues of efficiency and effectiveness are not well articulated in the existing PPPs of the city. Only few (15.2%) of the respondents indicate that the issues of efficiency and effectiveness are accommodated in the regulatory framework. More importantly, Kruskal Wallis P value of 0.928 (H= 0.46, df= 3) infers that respondents from all the four PPP categories responded in the same way with no significant difference at the 0.05 level of significance. On the

contrary, however, 59.9% of the respondents believe that the existing regulatory environment is favorable for PPPs while 26.9% of the respondents provided unfavorable responses.

Respondents' opinion about the rules and regulations of the health sector PPP was also investigated. As indicated in table 5.2 (b) above, 59.9% of the respondents do not believe that the health sector PPPs have enabling rules and regulations while only 20% of the respondents are neutral. On the other hand, only 26.9% of the respondents feel that the health sector PPPs agree with the statements about the existence of enabling rules and regulations. The proposition about homogeneity of responses among the PPP programs cannot also be rejected at the 0.05 level of significance as the P value of 0.198 indicates similarity of responses among the four PPP programs. Similarly, 46.7% of the respondents believe that the health sector PPPs have more disabling and constraining rules and regulations in Addis Ababa City while 24.4% of the respondents are neutral about the issue. Overall, 71.1% of the respondents either agree or are neutral about the disabling and constraining nature of rules and regulations. However, there is no significant variation in responses among the four PPP programs in Addis Ababa. The Kruskal Wallis P value of 0.315 reveals that the proposition about homogeneity of responses cannot be rejected at the 0.05 level of significance.

The analysis of responses from the structured questionnaire is triangulated with the information obtained from key informant interviews. Ato Ermias from a public hospital argues that due to the lack of strong legal framework, institutional capacity and the weak private sector, it is practically difficult to say both efficiency and effectiveness are obtained in the existing PPPs (Ato Ermias, September 8, 2014). Ato Yimer from AAFMHACA has a different view regarding the regulatory environment and the room for efficiency and effectiveness. He emphasizes that since there is no separate regulatory framework for managing PPPs in the health sector, private health institutions engaged in PPPs in Addis Ababa are regulated by the existing proclamations, regulations and directives that are common to both the public and private health sector. He also argues that despite its strict emphasis to standardize the health sector based on the 4Ps (premises, professionals, products and practices), the existing PPPs are encouraged to operate based on cost minimization and wastage reduction (efficiency) and achieving their desired goals to the extent possible (effectiveness) (Ato Yimer, August 8, 2014).

On the other hand, Ato Abatneh, a respondent from a private hospital points out that one cannot talk about issues of efficiency and effectiveness in the absence of dedicated legal and regulatory framework. As efficiency and effectiveness are outcomes of dialogue, practice, negotiation and continuous learning, the traditional regulatory framework within which the existing PPPs are operating may not allow the optimization of efficiency and effectiveness. He also argues that the existing rules and regulations that are traditionally used to guide PPP initiatives are generally disabling and constraining the health sector partnerships (Ato Abatneh, August 7, 2014).

Similarly, W/ro Almaz, a respondent from private clinics association argues that the existing rules and regulations which were used to regulate the health sector in general are not encouraging to the development of PPP initiatives. She emphasizes that the new standards for private clinics, for instance, are strong barriers not only for clinics that are interested in PPPs but also for all the private health institutions providing conventional health services (W/ro Almaz, September 5, 2014).

The expression by Ato Petros from AACCSA is worth quoting:

> *For PPPs in the health sector and for that matter PPPs in all sectors to develop, the legal and regulatory environment should be revisited and adjusted to accommodate the peculiar nature of PPPs. If you initiate an interesting PPP project idea and take it to the relevant ministry or any government agency, the first question you face is where is the legal framework. If you pick up the previous laws, they do not fit into PPP features. So I strongly argue that the existing laws and regulation do not in any way encourage the development of PPPs (Ato Petros, August 14, 2014)*

The government policy towards the private sector in general and PPP projects in particular is not discouraging. However, the existing rules and regulations which are not designed in light of the peculiar nature of PPPs do not give room for PPP initiatives to flourish. Finding from empirical studies on PPPs in developing countries clearly imply that if PPPs as alternative health service delivery approach are to develop, new legal and regulatory framework need be established by considering all the technical, financial, administrative and legal complexities of PPPs in the health sector.

5.4 Summary of Findings

The data presentation, analysis and interpretation conducted in this chapter are used to effectively answer the second research question under section 1.3 of chapter 1, which is "to what extent do the policies, legal and regulatory frameworks of the government give room for PPP in the health service delivery in Addis Ababa?" Based on the analysis and interpretation of data collected through in-depth interviews, structured questionnaire and document reviews, the following major findings are drawn in response to the basic research question under consideration.

- The political ideology of the incumbent government gives room for the participation of the private sector in service delivery in general and health service provision in Addis Ababa in particular. This is also explicitly reflected in the economic policies of the government except only limited sectors that are exclusively reserved for the government. However, unlike countries such as South Africa, Ghana, Tanzania and Nigeria, the specific roles that the private sector can play are not clearly articulated in the policy documents.
- The public health sector is not adequately working with the private sector on common issues that are essential to both parties. Though early practice of working together on common issues paves the way for the development of PPP policies and leads to full scale PPP practices, the existing level of cooperation and collaboration between the public and private health sectors is minimal.
- The existing PPP practices are operating without PPP policies that govern the initiatives. Neither national nor health sector specific policies are currently available to guide PPP practices in the health sector. As a result the existing PPP projects in Addis Ababa are based on ad hoc provisions which are vulnerable to interpretation errors that may end up in conflicts among the partners.
- The health sector of Addis Ababa does not have formally established and continuous public private dialogue (PPD). Despite the importance of PPD in bringing the public and private health sectors on board to pave the way for the development of mutual trust and common understanding that would add value to policy development, the health sector of the city does not have formally established PPD forum.

- Addis Ababa's health sector does not have adequate legal framework that guides the operational issues of PPP practices. As a result, the existing PPP initiatives are based on other proclamations and regulations that do not fit into the peculiar nature of PPPs in the health sector.
- The existing PPP practices in Addis Ababa are not commercially oriented mainly due to the lack of appropriate legal environment. As a result, the business principles of generating reasonable profit, competition and other important issues are not accommodated.
- Except the contracting-out of non-clinical services, the existing PPP initiatives in Addis Ababa's health sector do not have formally signed and agreed PPP contracts that regulate the behavior of both partners. The current practice of using simple MoU is leading to problems in managing the relationships between the public and private partners.
- The regulatory environment in the existing health sector of the city is not generally encouraging for the development of PPPs. The fact that the existing PPPs operate under the framework of the pre-existing laws has somehow affected the proliferation of PPP initiatives and programs.

Therefore, it can be argued that the policies, legal and regulatory frameworks of the incumbent government do not provide adequate room for the development of PPPs in the health service delivery in Addis Ababa.

Chapter 6: Institutional Capacity for Managing PPP in the Health Sector of Addis Ababa

6.1 Introduction

It was found out in chapter five that the existing health sector PPP initiatives are performing under, generally, unfavorable policy, legal and regulatory environment. The institutional capacity of the public sector will be assessed in chapter 6 in the context of effectively initiating, planning, implementing and controlling PPP projects in the health sector. This chapter, which tries to effectively answer research question number 3 under section 1.3 of chapter 1, focuses on institutional capacity in Addis Ababa's health sector, investigates the capacity of employees and managers to execute health sector PPP programs and assess the procurement system of the public sector in terms of effectively implementing PPP initiatives. Data to address this research question was collected through in-depth interviews, structured questionnaire and review of relevant documents. Table 6.1 below summarizes the responses obtained from individuals who filled the structured questionnaire under issues related to institutional capacity for managing PPPs in the Health sector of Addis Ababa which will be followed by analysis, triangulation with interview results and interpretation.

Table 6.1: Institutional Capacity in the Health Sector (N=242)

PPP Program		Strongly Disagree		Disagree		Neutral		Agree		Strongly Agree		Total		Kruskal-Wallis Test	
		N	%	N	%	N	%	N	%	N	%	N	%	Mean Rank	KW Values
N_PPP_unit	1	10	23.8%	12	28.6%	12	28.6%	7	16.7%	1	2.4%	42	100.0%	127.54	H= 1.36 df= 3 P= 0.714
	2	18	18.8%	39	40.6%	28	29.2%	9	9.4%	2	2.1%	96	100.0%	122.18	
	3	12	35.3%	12	35.3%	2	5.9%	2	5.9%	6	17.6%	34	100.0%	110.00	
	4	15	21.4%	23	32.9%	26	37.1%	6	8.6%	0	0.0%	70	100.0%	122.54	
Total		55	22.7%	86	35.5%	68	28.1%	24	9.9%	9	3.7%	242	100.0%		
PPP_unit_H	1	14	33.3%	15	35.7%	6	14.3%	7	16.7%	0	0.0%	42	100.0%	111.25	H= 2.04 df= 3 P= 0.564
	2	26	27.1%	34	35.4%	22	22.9%	13	13.5%	1	1.0%	96	100.0%	119.60	
	3	10	29.4%	11	32.4%	6	17.6%	3	8.8%	4	11.8%	34	100.0%	123.13	
	4	17	24.3%	22	31.4%	17	24.3%	10	14.3%	4	5.7%	70	100.0%	129.46	
Total		67	27.7%	82	33.9%	51	21.1%	33	13.6%	9	3.7%	242	100.0%		
People Trained	1	10	23.8%	23	54.8%	6	14.3%	2	4.8%	1	2.4%	42	100.0%	119.20	H= 1.19 df= 3 P= 0.755
	2	31	32.3%	38	39.6%	13	13.5%	11	11.5%	3	3.1%	96	100.0%	118.65	
	3	12	35.3%	13	38.2%	3	8.8%	2	5.9%	4	11.8%	34	100.0%	117.46	
	4	19	27.1%	27	38.6%	10	14.3%	12	17.1%	2	2.9%	70	100.0%	128.75	
Total		72	29.8%	101	41.7%	32	13.2%	27	11.2%	10	4.1%	242	100.0%		
Ext_ expertise	1	6	14.3%	18	42.9%	11	26.2%	7	16.7%	0	0.0%	42	100.0%	126.37	H= 0.98 df= 3 P= 0.807
	2	17	17.7%	39	40.6%	25	26.0%	12	12.5%	3	3.1%	96	100.0%	123.16	
	3	8	23.5%	15	44.1%	6	17.6%	3	8.8%	2	5.9%	34	100.0%	111.96	
	4	17	24.3%	23	32.9%	17	24.3%	10	14.3%	3	4.3%	70	100.0%	120.94	
Total		48	19.8%	95	39.3%	59	24.4%	32	13.2%	8	3.3%	242	100.0%		
Neutral_ role	1	6	14.3%	15	35.7%	10	23.8%	11	26.2%	0	0.0%	42	100.0%	141.92	H= 5.21 df= 3 P= 0.157
	2	23	24.0%	41	42.7%	23	24.0%	7	7.3%	2	2.1%	96	100.0%	116.10	
	3	10	29.4%	10	29.4%	7	20.6%	2	5.9%	5	14.7%	34	100.0%	124.49	
	4	19	27.1%	29	41.4%	11	15.7%	8	11.4%	3	4.3%	70	100.0%	115.20	
Total		58	24.0%	95	39.3%	51	21.1%	28	11.6%	10	4.1%	242	100.0%		
Free_conf_ interest	1	11	26.2%	10	23.8%	11	26.2%	9	21.4%	1	2.4%	42	100.0%	129.46	H= 3.37 df= 3 P= 0.338
	2	21	21.9%	33	34.4%	23	24.0%	13	13.5%	6	6.3%	96	100.0%	127.88	
	3	10	29.4%	15	44.1%	4	11.8%	1	2.9%	4	11.8%	34	100.0%	110.37	
	4	22	31.4%	25	35.7%	9	12.9%	11	15.7%	3	4.3%	70	100.0%	113.39	
Total		64	26.4%	83	34.3%	47	19.4%	34	14.0%	14	5.8%	242	100.0%		
Lead_ capacity	1	13	31.0%	15	35.7%	6	14.3%	4	9.5%	4	9.5%	42	100.0%	122.69	H= 1.12 df= 3 P= 0.771
	2	28	29.2%	44	45.8%	9	9.4%	13	13.5%	2	2.1%	96	100.0%	116.23	
	3	10	29.4%	10	29.4%	8	23.5%	3	8.8%	3	8.8%	34	100.0%	128.28	
	4	21	30.0%	25	35.7%	8	11.4%	11	15.7%	5	7.1%	70	100.0%	124.72	
Total		72	29.8%	94	38.8%	31	12.8%	31	12.8%	14	5.8%	242	100.0%		

Source: Author's Survey, 2014

6.2 Institutional Structure to Manage PPPs in the Health Sector

It is theoretically established that the ability to plan and implement PPP programs largely depends on the prevalence of adequate institutional capacity which in turn depends among other things on the availability and appropriateness of PPP structure.

As health sector PPPs involve multi-sectoral issues, PPP initiatives should be institutionalized at national level in such a way that problems that are related to all sectors can be addressed at national level. The availability of national PPP unit was assessed using data collected from several sources. As indicated in table 6.1 above, 35.5% and 22.7% of the respondents disagree and strongly disagree respectively about the availability of national PPP unit. In other words, the majority of the respondents (58.2%) who filled in the structured questionnaire believe that there is no national PPP unit within the appropriate government ministry. While 13.6% of the respondents argue for the availability of national PPP unit, 28.1% of the respondents are not sure about the existence of national PPP unit in Ethiopia. Kruskal Wallis P value of 0.714 (H= 1.36, df= 3) infers that the implied proposition about homogeneity of responses across the different categories of HIV/AIDS, TB, reproductive health and non-clinical services cannot be rejected. Therefore, at the 0.05 significance level, it can be inferred that responses across the four PPP types are homogeneous.

The availability of PPP unit within the health sector is also essential for the smooth implementation of PPP programs. It is indicated in table 6.1 that 33.9% and 27.7% of the respondents respectively disagree and strongly disagree about the availability of PPP unit within the health sector. This indicates that the majority of the respondents (61.6%) who filled in the structured questionnaire believe that the health sector lacks PPP unit, while 21.1% of the respondents do not know whether or not the health sector has PPP unit. Kruskal Wallis P value of 0.564 (H= 2.04, df= 3) indicates that at the 0.05 level of significance, it can be inferred that responses across respondents from HIV/AIDS, TB, reproductive health and TB are almost homogeneous. It can, therefore, be argued that the health sector does not have properly established, empowered and mandated PPP unit to provide policy direction and leadership support to the existing PPP programs.

The success in PPP programs is an ultimate outcome of leaders and employees' knowledge and skill to effectively design and implement PPP programs in the health sector. Capacity building in

PPP programs essentially requires training of employees and managers in the public sector in different areas of PPP processes. Data from the structured questionnaire (table 6.1) indicates that 71.5% of the respondents believe that no training is provided to leaders and employees to effectively design and implement PPP initiatives while only 11.3% of the respondents indicated favorable response. Kruskal Wallis P value of 0.755 (H= 1.19, df= 3) also indicates that the implied proposition of homogeneity of responses across respondent groups cannot be rejected at the 0.05 level of significance. Therefore, it can be inferred that respondents for HIV/AIDS, TB, reproductive health and non-clinical services responded in the same way. More importantly, 68.6% of the respondents who filled in the structured questionnaire believe that public sector officials do not have sufficient leadership capacity to effectively guide PPP initiatives in the health sector.

At the early stage of PPP, technical assistance needs to be utilized from external experts until in-house capacity is developed in the different technical and procedural aspects of the programs. In Addis Ababa's health sector, although the utilization of external technical assistance is more pronounced, data from the structured questionnaire (table 6.1) indicates a different result. The majority of the respondents (59.1%) do not agree about the adequacy of the support from external expertise. Only few (16.5%) of the respondents believe that the external expertise is sufficiently utilized while 17.6% of the respondents remained neutral. At the 0.05 level of significance, the Kruskal Wallis P value of 0.807 (H= 0.98, df= 3) infers that the implied proposition about the homogeneity of responses across respondents from HIV/AIDS, TB, reproductive health and non-clinical services can be accepted.

Both theoretical and empirical literature indicates that employees and/or units that are responsible to facilitate PPP initiatives should play neutral and advisory roles. This implies that the role of PPP experts and units is just to establish favorable environment and pave the way for effective PPP processes and not to play the game themselves. In this regard, the practice in the existing PPP programs in Addis Ababa's health sector indicates that the entities that design PPP programs are generally outside both public and private health sector and hence fair level of neutrality is expected. The analysis of responses from the questionnaire (table 6.1) indicates that 39.3% and 24% of the respondents disagree and strongly disagree respectively about the neutral role of employees. This, in other words, indicates that the majority (63.3%) of the respondents believe that entities that participate in the design and implementation of PPP programs do not

play neutral and advisory role. The implied hypothesis about homogeneity of responses across the different sample groups can be accepted at the 0.05 level of significance. The Kruskal Wallis P value of 0.157 (H= 5.21, df= 3) infers that responses across HIV/AIDS, TB, reproductive health and non-clinical respondent categories are almost similar with no significant variation.

On the other hand, 60.7% of the respondents do not believe that employees and managers are free from conflict of interest in promoting public interest goals while only 20% of the respondents believe that employees and managers are free from conflict of interest. The implied hypothesis about homogeneity of responses cannot be rejected at the 0.05 level of significance. The Kruskal Wallis P value of 0.338 implies that responses from the four PPP programs are almost similar.

Leadership capacity in the health sector of Addis Ababa in terms of strategically leading PPPs was also investigated. As indicated in table 6.1, majority of the respondents (68.6%) who filled the structured questionnaire believe that there is leadership capacity gap in the health sector of the city to conceptualize and effectively introduce PPP initiatives. Only 18.6% of the respondents provided favorable responses about adequacy of leadership capacity in the health sector of the city. Based on the P value of 0.771 (H= 1.12, df= 3), it can be argued that responses obtained from the four PPP categories of HIV/AIDS, TB, reproductive health and non-clinical services are almost homogeneous at the 0.05 level of significance.

Regarding national PPP unit, Ato Tadesse from MoFED indicated that after a long-standing struggle to establish PPP unit at the national level, the government finally approved a PPP institutionalization team within MoFED. The PPP institutionalization team is currently studying the governance structure of PPP including its duties, responsibilities, and leadership as well as vertical and horizontal relationships with other sectors. He clearly indicated that, so far, except a steering team to establish the unit, no responsible unit or agency is available at national level (Ato Taddesse, August 5, 2014).

Reflecting on the implication of lack of national PPP unit, Ato Mecha, from FMoH strongly argues that the lack of national PPP unit or agency has seriously affected the development of health sector PPP policy as well as the smooth operation of the existing PPP practices. According to the respondent, most of the health sector PPP issues such as land, customs procedures, access to finance and local government support are outside the mandate of the health sector. The

establishment of national PPP agency or unit would have resolved problems of the private investor which are related to the above issues. Whether the PPP initiatives come from the health, agriculture, education, energy or telecom sectors, the national PPP unit would have addressed the problems by closely working with the individual sectoral ministries (Ato Mecha, August 4, 2014). These views are also well noted by Ato Petros from AACCSA who pointed out that as Ethiopia is currently in the process of accession to WTO and enhancing its involvement in the global business, the need to establish national PPP agency/unit/department is inevitable. He also indicated that AACCSA is highly interested to have PPP unit at national level to pave the way for the development of PPP policies at industry or sectoral levels (Ato Petros, August 14, 2014).

It can be inferred from the above facts that Ethiopia does not have national PPP unit within the federal and regional government structure. The review of empirical literature in chapter two reveals that countries with good PPP practices started the initiative by institutionalizing PPP units at the national level. For instance, Tanzania established national PPP secretariat under the office of the Prime Minister to effectively play coordination and stewardship role at national level from where sectoral ministries can benefit. The implication of the lack of national PPP unit is that the different sectors and ministries will develop and implement fragmented and inconsistent PPP policies that do not only lead to lack of harmony in the PPP projects but also inability to address common development objectives. It also implies that the health sector of Addis Ababa will be constrained to effectively design and implement PPP projects within its own jurisdiction in the absence of national PPP unit mandated with cross sectoral issues.

The availability of PPP units within the health sector was also discussed through in-depth interviews. In this regard, Ato Mecha strongly argues that the availability of strong, empowered and clearly mandated PPP team is required at all levels of the health system. He also pointed out that the FMoH has established a PPP focal team within the Resource Mobilization Directorate to facilitate the PPP policy development and also provide general guidance to the existing PPP programs in the health sector. However, this PPP focal team is an ad hoc collection of experts that lacks formal institutional mandate supported by clear structure, system, human resource and leadership. Therefore, it can be argued that the focal team does not have sufficient capacity and autonomy to provide policy advice as well as leadership of the existing PPPs (Ato Mecha, August 4, 2014).

A respondent from AAHB, Ato Mengistu, on the other hand, indicated that there is neither PPP unit nor PPP focal person at the health bureau level. He expressed his views as follows:

> *"Despite the rapid growth of the private health sector in Addis Ababa and the growing need for PPP in the health sector of the City, the institutionalization of PPP is yet to be done" (Ato Mengistu, August 4, 2014).*

Institutional theory explains the processes by which structures, policies, rules, norms, and routines are established as authoritative guidelines for social behavior. From the perspective of institutional theory, the absence of national and sector based PPP unit in the health sector implies that the PPP initiatives that are prevalent in the health sector do not have clearly identified responsible body. Stability and ongoing operation as key characteristics of institutions is literally questioned in the existing health system of the city due to the lack of PPP units that govern the day-to-day activities and behavior of PPP initiatives. Conforming to the above facts, empirical literature on PPPs in developing countries indicates that the lack of clearly mandated and responsible body at national and health sector levels hampers not only the effective management of existing PPP programs but also the development of new PPP initiatives in the health sector.

In the Addis Ababa's health sector, whether employees and managers have received adequate training in PPPs was investigated. Ato Yimer, a key informant from AAFMHACA revealed that except few orientations about the importance and future prospects of PPP in the health sector, employees and managers did not receive any formal training that builds their capacity in PPP processes (Ato Yimer, August 8, 2014). At the FMoH level, on the other hand, Ato Mecha, who is a team leader and the focal person for PPP at the ministry, has received formal training about PPP approaches and processes in the health sector. However, he expresses the limitation of the trainings in the following way:

> *I understand PPP in the health sector involves several complex issues such as accounting and finance, legal and contract administration, PPP planning, monitoring and evaluation and many other important issues. The training we received is limited to some general issues about the justification of PPPs, how it applies in the health sector, the potential to apply PPP in the Ethiopian health sector and the different models of PPP that are available to be used in the Ethiopian health sector. The technical issues which are very essential for the actual implementation of PPPs are not covered in our training (Ato Mecha, August 4, 2014)*

Respondents such as Ato Mengistu from AAHB, Ato Sitotaw from one Sub-city Health Department and Ato Hailu from a public hospital unanimously indicated that no staff from their respective organizations has so far received any training on PPP. The data and arguments above generally inform that despite several PPP initiatives that are being practiced in the health sector, the employees and leaders who are expected to design and effectively implement PPP programs are not trained in PPP process and technical issues. This implies that both the existing and future prospects of PPPs are at stake in terms of efficiency and effectiveness. It is also possible to argue that the existing PPP initiatives are operating without sufficient knowledge and skill of employees and leaders.

The idea to introduce and apply PPP models in Addis Ababa's health sector heavily depends on development partners. In this regard, Ato Petros from AACCSA pointed out that the attempt to introduce PPP in the different sectors of the government including the health sector is mainly driven by external technical assistance. This view is also reflected by Ato Seid from a public hospital who expressed his reflection in the following way:

> *Right from the very beginning, the pressure to reform the health sector in general and the need for the enhanced involvement of the private sector in health service delivery in particular originated from development partners. As a result, the public sector was offered assistance on technical matters including the modalities of engaging the private health sector. So, I argue that external expertise is better utilized during the introduction of PPP initiatives (Ato Seid, August 12, 2014)*

Regarding the utilization of external expertise, Ato Mecha from FMoH and Ato Mengistu from AAHB have almost similar reflections. They emphasized that the contribution of the Private Health Sector Program which is funded by USAID is remarkable in terms of providing policy advocacy for PPP as well as developing the private health sector in order to pave the way for full scale PPP initiatives. Ato Mecha strongly argues that PHSP played a key role in technically assisting the public sector on how to engage the private sector through PPP approach. He also revealed that the PPP policy framework is being developed for the health sector with expert assistance obtained from PHSP. According to the respondent, in addition to raising the awareness of the top leadership towards the significance of PPP in the health sector, PHSP is playing important roles in guiding the implementation of the existing

PPP initiatives in the areas on HIV/AIDS, TB and malaria in Addis Ababa and beyond. However, given the newness of the whole concept of PPP in Ethiopia as well as Addis Ababa, the expert support being obtained from external development partners is not sufficient (Ato Mecha, August 4, 2014).

Similarly, Gebreyohannes, from PHSP indicated that the introduction and development of PPP in Addis Ababa's health sector is mainly conducted by the expert assistance from PHSP. He also argues that due to lack of the required expertise in both public and private health sectors about the conceptual and technical issues of PPP, experts are assigned by PHSP to assist the health sector on how to work together through PPP models. However, he stressed that the PHSP's efforts to build PPPs in the health sector faces some resistances from the public sector officials who strongly believe in government based health service delivery. Therefore, according to the informant, PHSP's support to the health sector includes not only the technical issues of PPPs but also changing the attitudes of leaders towards PPP in health service delivery. He strongly argues that the current technical supports as well as awareness creation are not sufficient in terms of bringing the desired change in PPP (Dr. Gebreyohannes, March 3, 2015).

Based on the above information, it can be argued that external expertise, though playing an important role in developing PPP capacity in the health sector of the city, it is not adequate. This, on the other hand, implies that in the absence of sufficient external technical support in the various aspects of PPPs, it will be challenging for the health sector to use its internal capacity and develop full scale PPP in the health sector due to the technical complexity of PPP models.

Regarding the professional neutrality of employees and leaders, Ato Mecha argues that since most of the existing PPPs such as HIV/AIDs and TB are designed by development partners, there is a belief that they play fairly neutral and advisory roles with less conflict of interest. The government also believes that the external development partnership and the need to enhance the participation of the private sector through PPPs in the equitable interest of both the public and private partners. With this in mind, the design and implementation of PPP programs in the areas of HIV/AIDS, TB and malaria are conducted with neutrality and with negligible conflict of interest (Ato Mecha, August 4, 2014).

All the other respondents, who participated in the in-depth interviews, however, strongly argue that neutrality and low conflict of interest cannot be maintained in the absence of legal and regulatory framework, autonomous PPP unit or department and adequate in-house HR capacity to manage PPP process.

6.3 Skills of Employees and Managers to Execute PPP Programs

The effective implementation of PPP program in the health sector requires adequate skills of employees and managers that are able to plan, implement, monitor and evaluate the programs. This section specifically focuses on the investigation of the knowledge and skills of employees in the key areas of PPP program planning, implementation and monitoring skills, financial management and accounting skills, legal knowledge and contract administration skill and PPP program evaluation, reporting and learning skills. Table 6.2 indicates the summary of responses from 242 individuals who filled in the structured questionnaire.

The success of PPP programs largely depends on its ability to forecast the future and have goals that extend beyond short term achievements. This in turn depends on the PPP planning capacity of employees and managers. As indicated in table 6.2 below, 41.7% and 28.5% of the respondents who filled in the structured questionnaire believe that the PPP planning skill of employees and managers are low and very low respectively. In other words, a total of 70.2% of the respondents feel that employees and managers in the health sector do not have the required skill for PPP program planning. The table also reveals that only 16.1% of the respondents provided favorable responses in terms of planning skill while 13.6% of the respondents believe that employees and managers have average skills. It is also revealed that more respondents from HIV/AIDs category rated higher skills (mean rank= 132.30) while respondents from TB category indicated relatively lower rating. The Kruskal Wallis P value of 0.156 (H= 5.22, df= 3) infers that at the 0.05 significance level, the proposition about the homogeneity of responses across different sample groups cannot be rejected. This implies that respondents from HIV/AIDS, TB, reproductive health and non-clinical health services have uniform responses to the above question.

Table 6.2: Skills of Employees and Managers to Execute PPP Programs

PPP Program		Very Low		Low		Average		High		Very High		Total		Kruskal-Wallis Test	
		N	%	N	%	N	%	N	%	N	%	N	%	Mean Rank	KW Values
Prog_plan_ Skill	1	10	23.8%	17	40.5%	6	14.3%	5	11.9%	4	9.5%	42	100.0%	132.30	H= 5.22 df= 3 P= 0.156
	2	35	36.5%	38	39.6%	9	9.4%	12	12.5%	2	2.1%	96	100.0%	110.06	
	3	9	26.5%	15	44.1%	6	17.6%	2	5.9%	2	5.9%	34	100.0%	122.06	
	4	15	21.4%	31	44.3%	12	17.1%	11	15.7%	1	1.4%	70	100.0%	130.44	
Total		69	28.5%	101	41.7%	33	13.6%	30	12.4%	9	3.7%	242	100.0%		
Impl_Monit_ Skill	1	12	28.6%	19	45.2%	7	16.7%	1	2.4%	3	7.1%	42	100.0%	118.88	H= 2.21 df= 3 P= 0.529
	2	32	33.3%	42	43.8%	4	4.2%	10	10.4%	8	8.3%	96	100.0%	115.15	
	3	10	29.4%	12	35.3%	8	23.5%	1	2.9%	3	8.8%	34	100.0%	125.10	
	4	16	22.9%	31	44.3%	10	14.3%	10	14.3%	3	4.3%	70	100.0%	130.04	
Total		70	28.9%	104	43.0%	29	12.0%	22	9.1%	17	7.0%	242	100.0%		
Fin_acct_skill	1	11	26.2%	16	38.1%	6	14.3%	4	9.5%	5	11.9%	42	100.0%	129.43	H= 2.03 df= 3 P= 0.567
	2	30	31.3%	42	43.8%	9	9.4%	8	8.3%	7	7.3%	96	100.0%	115.43	
	3	10	29.4%	14	41.2%	6	17.6%	4	11.8%	0	0.0%	34	100.0%	117.35	
	4	17	24.3%	30	42.9%	10	14.3%	9	12.9%	4	5.7%	70	100.0%	127.08	
Total		68	28.1%	102	42.1%	31	12.8%	25	10.3%	16	6.6%	242	100.0%		
Legal_cont_ skill	1	10	23.8%	19	45.2%	5	11.9%	6	14.3%	2	4.8%	42	100.0%	128.30	H= 1.06 df= 3 P= 0.787
	2	31	32.3%	34	35.4%	13	13.5%	10	10.4%	8	8.3%	96	100.0%	122.64	
	3	9	26.5%	15	44.1%	6	17.6%	3	8.8%	1	2.9%	34	100.0%	122.46	
	4	24	34.3%	26	37.1%	11	15.7%	8	11.4%	1	1.4%	70	100.0%	115.39	
Total		74	30.6%	94	38.8%	35	14.5%	27	11.2%	12	5.0%	242	100.0%		
Eva_rep_ lrn_skill	1	12	28.6%	13	31.0%	4	9.5%	8	19.0%	5	11.9%	42	100.0%	125.07	H= 3.17 df= 3 P= 0.366
	2	25	26.0%	28	29.2%	13	13.5%	20	20.8%	10	10.4%	96	100.0%	129.30	
	3	8	23.5%	17	50.0%	5	14.7%	3	8.8%	1	2.9%	34	100.0%	110.85	
	4	17	24.3%	32	45.7%	10	14.3%	9	12.9%	2	2.9%	70	100.0%	113.83	
Total		62	25.6%	90	37.2%	32	13.2%	40	16.5%	18	7.4%	242	100.0%		

Source: Author's Survey, 2014

The PPP program implementation and monitoring skill of employees and managers was also investigated. Under this skill category, 43% and 28.9% of the respondents (table 6.2) who filled the structured questionnaire believe that the program implementation skill of employees and mangers is low and very low respectively indicating a total of 71.9% unfavorable responses. This implies that employees and managers in the health sector do not have adequate skill of implementing and monitoring PPP programs. As the summary of the table indicates only a total of 16.1% of the respondents believe that employees and managers have high or very high skill, while 12% of the respondents indicated average skill. Respondents from non-clinical service

category have ratings in favor of higher skills (mean rank= 130.04) while respondents from TB category generally indicated lower ratings (mean rank= 115.15). However, the implied hypothesis about homogeneity of responses across the different sample groups cannot be rejected at the 0.05 level of significance. The Kruskal Wallis P value of 0.529 (H= 2.21, df= 3) infers that responses across HIV/AIDS, TB, reproductive health and non-clinical respondent categories are almost homogeneous.

The financial management and accounting skill of employees and managers in the health sector is also evaluated as generally low. As the summary of results in the table 6.2 above indicates, 42.1% and 28.1% of the respondents rated the financial management and accounting skills of employees and managers as low and very low respectively. In other words, a total of 70.2% of the respondents argue that employees and managers in the health sector do not have the required financial management and accounting skill to effectively implement PPP programs. The table also reveals that, only 16.9% of the respondents provide favorable response indicating high and very high skills while 12.5% of the respondents believe that they have average skill. Respondents from the HIV/AIDs category showed the tendency to argue for higher skills (mean rank= 129.43), while respondents from TB category indicated lower ratings (mean rank= 115.43). However, the P value of 0.567 (H= 2.03, df= 3) indicates that, at the 0.05 level of significance, the overall results indicate that the responses from all the four PPP types do not significantly vary from each other.

The assessment of legal knowledge and contract management skill of employees and managers also indicates generally low results. The summary of results in the table 6.2 above indicates that 38.8% and 30.6% of the respondents respectively rated low and very low legal knowledge and contract management skill. This, in other words, means that a total of 69.4% of the respondents believe that, employees and managers in the health sector lack adequate legal knowledge and contract administration skill. As indicated in the table, only 16.2% of the participants responded in favor of higher skills of employees and managers, while 14.5% of the respondents rated average skill. Though relatively higher rating is provided by respondents from HIV/AIDs category (mean rank= 128.30), the Kruskal Wallis P value of 0.787 (H= 1.06, df= 3) indicates that at the 0.05 significance level, the proposition about the homogeneity of responses across different sample groups cannot be rejected. This implies that respondents from HIV/AIDS, TB,

reproductive health and non-clinical health services have uniform responses to the above question.

Similarly, it is found out that the PPP program evaluation, reporting and learning skill of employees and managers in the health sector is not adequate. Table 6.2 above indicates that 37.2% and 25.6% of the respondents who filled in the structured questionnaire believe that the PPP program evaluation, reporting and learning skills in the health sector is low and very low respectively. Therefore, it can be argued that a total of 62.8% of the respondents argue that the health sector does not have adequate PPP program monitoring, reporting and learning skill. Only few, (23.9%), of the respondents rated in favor of higher employee and manager skill while 13.2% of the respondents rated average. Respondents from TB category have the tendency to rate employees and managers as higher skills (mean rank= 129.30), while respondents from reproductive health group indicated generally lower skills (mean rank= 110.85). However, based on the Kruskal Wallis P value of 0.366 (H= 3.17, df= 3), it can be inferred that at the 0.05 level of significance, responses across the four PPP types of HIV/AIDS, TB, reproductive health and non-clinical services do not have significant variation.

The analysis of results obtained from the in-depth interview also largely converges with the above findings. Ato Mecha from FMoH, strongly argues that with the existing weak planning capacity, PPPs cannot grow to the expected level. He also pointed out that even the existing collaborations in the health sector are facing challenges related to predictability and sustainability due to lack of proper planning. Ato Mecha also emphasizes that employees and managers in the health sector do not have the required skill to implement and monitor PPP programs. He asserts that even the existing public private collaborations in the areas of HIV/AIDS, TB and malaria are facing critical problems due to the lack of sufficient capacity to implement and monitor. Overall, he indicated the scarcity of required skill in the following way:

> *I can argue that the employees' and managers' skills in all the aspects of PPP management are very low. As no specific capacity building training program is so far conducted in specific skill categories, no one can argue that employees and managers can effectively manage the financial, legal and administrative issues of PPP programs (Ato Mecha, August 4, 2014)*

Ato Yimer from AAFMHACA has also almost similar views. He pointed out that the health sector is actually practicing some PPP initiatives without PPP execution skill. For Ato Yimer, with the existing poor planning, implementation, financial management, contract administration and evaluation skills, the health sector cannot successfully utilize PPP ideas that are appealing to the health sector in terms of improving accessibility, quality and equity. His argument also implies that the employees and managers in the existing health system do not have the required skill in any of the PPP management areas (Ato Yimer, August 8, 2014).

A discussion with Dr. Gebreyohannes, from Private Health Sector Program (PHSP), clearly confirmed that the employees and managers in the health sector do not have sufficient skill in the areas of PPP planning, implementation, financial management, contract administration and evaluation and reporting. As a result, Gebreyohannes argued, let alone advanced and higher level PPP programs, even the existing public private collaborations in the areas of HIV/AIDS and TB are facing several challenges. He expressed the skill gap as follows:

> *We expected this introductory level PPPs would pave the way for higher level PPPs once the public and private health sectors build mutual trust and confidence. However, we now came to understand that the key challenges are related to lack of appropriate skill to plan and implement the PPPs. Even record keeping and reporting PPP achievements and challenges has been a key problem among the employees and managers (Dr. Gebreyohannes, March 3, 2015)*

Respondents who participated in the in-depth interviews from the sub-city health departments almost unanimously confirmed that there is a critical shortage of skill in executing PPP programs in the health sector. Ato Hyder a team leader at a sub-city health department, for instance, asserted that the shortage of skill in PPP planning, implementation and evaluation is equally available among employees and managers. He also argued that if PPP execution skill is to be created in the health sector, it has to begin from building the capacity of employees and managers in the health sector (Ato Hyder, August 11, 2014).

The review of employees and managers profiles who are currently managing public private collaborations in the health sector reveals that there are no employees and managers who have received formal education or specific training in the areas related to PPP. An important finding, here, is also that most of the employees who are directly involved in handling collaboration

initiatives are health professionals who do not have educational background related to planning, monitoring and evaluation, financial management and contract administration.

The analysis of responses from the structured questionnaire, in-depth interviews and relevant documents indicates that the health sector of Addis Ababa does not have adequate PPP planning, implementation, financial management, contract administration and evaluation skills. The lack of appropriate administrative and managerial skill in the health sector PPPs, as the empirical literature in chapter two points out, is a common challenge for most African countries attempting to introduce PPPs for health service delivery. This implies that attempts to introduce PPP programs as health service delivery approach should provide critical attention to capacity building in the skill areas identified. It was also thoroughly discussed in chapter two that the institutional capacity building process of the public sector should essentially include human capital management strategies to develop and utilize key experts who are usually obtained from the competitive labor market. It is also emphasized that the failure to have highly qualified staff in the PPP units will ultimately lead to poorly designed and managed PPP projects in the individual government ministries. It can be argued that given the existing weak level of employees' and managers' skill in planning and implementing PPPs, future PPP initiatives which require more advanced and sophisticated planning, financial management and contract administrations skills will run the risk of failure. Moreover, while capacity building activities should begin from the top leadership down to the lower level and then to employees, lack of adequate planning skill among the mangers implies that PPP initiative will fall short of attaining their long-term strategic objectives.

6.4 Procurement System as Institutional Capacity in the Health Sector PPPs

It was found out from the data and discussions under section 6.3 that the skills of employees and managers in the existing health system are generally low and inadequate in terms of effectively executing both the existing public private collaboration programs and the future advanced PPP initiatives in the health sector. This section primarily focuses on the assessment of the procurement system and its ability to effectively accommodate PPP programs in the health sector. The table below shows the summary of results of the respondents who filled in the structured questionnaire.

Table 6.3a: Procurement System and Practices in Health Sector PPPs (N= 242)

PPP Program		Strongly disagree		Disagree		Neutral		Agree		Strongly agree		Total		**Kruskal-Wallis Test**	
		N	%	N	%	N	%	N	%	N	%	N	%	Mean Rank	KW Values
Clr_frml_opn_cri	1	11	26.2%	16	38.1%	7	16.7%	7	16.7%	1	2.4%	42	100.0%	123.67	H= 0.66 df= 3 P= 0.882
	2	25	26.0%	40	41.7%	12	12.5%	12	12.5%	7	7.3%	96	100.0%	122.82	
	3	8	23.5%	14	41.2%	6	17.6%	4	11.8%	2	5.9%	34	100.0%	125.88	
	4	20	28.6%	30	42.9%	9	12.9%	8	11.4%	3	4.3%	70	100.0%	116.26	
Total		64	26.4%	100	41.3%	34	14.0%	31	12.8%	13	5.4%	242	100.0%		
Clr_comp_hndl	1	14	33.3%	13	31.0%	5	11.9%	9	21.4%	1	2.4%	42	100.0%	114.80	H= 2.39 df= 3 P= 0.495
	2	22	22.9%	37	38.5%	16	16.7%	10	10.4%	11	11.5%	96	100.0%	126.54	
	3	8	23.5%	11	32.4%	6	17.6%	6	17.6%	3	8.8%	34	100.0%	130.47	
	4	17	24.3%	35	50.0%	5	7.1%	10	14.3%	3	4.3%	70	100.0%	114.25	
Total		61	25.2%	96	39.7%	32	13.2%	35	14.5%	18	7.4%	242	100.0%		
Proc_prac_mon	1	12	28.6%	14	33.3%	7	16.7%	6	14.3%	3	7.1%	42	100.0%	131.43	H= 5.31 df= 3 P= 0.150
	2	35	36.5%	35	36.5%	15	15.6%	8	8.3%	3	3.1%	96	100.0%	114.26	
	3	8	23.5%	11	32.4%	7	20.6%	4	11.8%	4	11.8%	34	100.0%	140.79	
	4	27	38.6%	22	31.4%	9	12.9%	10	14.3%	2	2.9%	70	100.0%	116.10	
Total		82	33.9%	82	33.9%	38	15.7%	28	11.6%	12	5.0%	242	100.0%		
Cor_actn_doc	1	11	26.2%	15	35.7%	6	14.3%	7	16.7%	3	7.1%	42	100.0%	129.07	H= 4.34 df= 3 P= 0.227
	2	33	34.4%	37	38.5%	10	10.4%	11	11.5%	5	5.2%	96	100.0%	112.69	
	3	8	23.5%	10	29.4%	9	26.5%	1	2.9%	6	17.6%	34	100.0%	138.26	
	4	18	25.7%	31	44.3%	9	12.9%	11	15.7%	1	1.4%	70	100.0%	120.90	
Total		70	28.9%	93	38.4%	34	14.0%	30	12.4%	15	6.2%	242	100.0%		
Cor_actn_prac	1	12	28.6%	19	45.2%	7	16.7%	3	7.1%	1	2.4%	42	100.0%	111.70	H= 3.00 df= 3 P= 0.392
	2	29	30.2%	32	33.3%	14	14.6%	18	18.8%	3	3.1%	96	100.0%	121.69	
	3	7	20.6%	11	32.4%	8	23.5%	5	14.7%	3	8.8%	34	100.0%	137.88	
	4	21	30.0%	26	37.1%	9	12.9%	11	15.7%	3	4.3%	70	100.0%	119.16	
Total		69	28.5%	88	36.4%	38	15.7%	37	15.3%	10	4.1%	242	100.0%		
Proc_doc_gg	1	7	16.7%	18	42.9%	6	14.3%	7	16.7%	4	9.5%	42	100.0%	135.90	H= 2.69 df= 3 P= 0.441
	2	25	26.0%	43	44.8%	10	10.4%	7	7.3%	11	11.5%	96	100.0%	119.69	
	3	10	29.4%	11	32.4%	6	17.6%	4	11.8%	3	8.8%	34	100.0%	122.51	
	4	26	37.1%	18	25.7%	11	15.7%	12	17.1%	3	4.3%	70	100.0%	114.84	
Total		68	28.1%	90	37.2%	33	13.6%	30	12.4%	21	8.7%	242	100.0%		

Source: Author's Survey, 2014

Empirical and theoretical literature in chapter two indicates that the existence of clear, formal and open criteria for selecting appropriate private partner will not only add value to the good governance of PPP projects, but also indicates the institutional capacity of the public sector to

manage PPPs. The availability of clear, formal and open selection criteria was assessed in the Addis Ababa's health sector. As the table 6.3a above indicates, 41.3% and 26.4% of the respondents who filled in the structured questionnaire respectively disagree and strongly disagree with the availability of clear, formal and open criteria. In other words, 67.7% of the respondents argue that there are no clear, formal and open criteria to select private partners. The summary of response also reveals that only 18.2% of the respondents believe that there is an appropriate selection criterion while 14% of them remained neutral. The Kruskal Wallis P value of 0.882 (H= 0.66, df= 3) infers that at the 0.05 significance level, the proposition about the homogeneity of responses across different sample groups cannot be rejected. This implies that respondents from HIV/AIDS, TB, reproductive health and non-clinical health services have uniform responses to the above question.

As PPP processes and outcomes may involve some conflict at any stage of the process, the availability of clear and transparent complaint handling procedure is an essential requirement. In the Addis Ababa's health system, complaint handling for the PPP participants is generally weak. Table 6.3a above indicates that 39.7% and 25.2% of the respondents disagree and strongly disagree with the availability of clear and transparent complaint handling procedure in the city's health sector. This shows that the majority (64.9%) of the respondents have unfavorable responses about the issue. While 21.9% of the respondents agree or strongly agree about the availability of clear and transparent procedure for complaint handling, 13.2% of them remained neutral. Respondents from reproductive health category tend to provide more favorable responses about the prevalence of clear procedure (mean rank= 130.47), while respondents from HIV/AIDS category showed more disagreements (mean rank= 114.80). However, the implied hypothesis about homogeneity of responses across the different sample groups cannot be rejected at the 0.05 level of significance. The Kruskal Wallis P value of 0.495 (H= 2.39, df= 3) infers that responses across HIV/AIDS, TB, reproductive health and non-clinical respondent categories are almost homogeneous.

Public private partnerships are vulnerable to maladministration and good governance problems which mainly emanate from the way procurement is managed. The existence of experience of closely monitoring and regulating procurement in the health sector PPPs was investigated. As stipulated in table 6.3a above, 33.9% and 33.9% of the respondents who filled in the structured questionnaire disagree and strongly disagree about the practice of closely monitoring and

evaluating PPP procurement practices. This, in other words, indicates that the majority (67.8%) of the respondents feel that there is no practice of closely monitoring and regulating PPP procurement practices in the health sector. It is also revealed that only few (16.6%) of the respondents have favorable response about the availability of monitoring and regulating procurement while 15.7% of the respondents remained neutral. While respondents from reproductive health category provided more favorable responses about the availability of close monitoring and regulation (mean rank= 140.79), respondents from the non-clinical service category showed more disagreements (mean rank= 116.10). However, the Kruskal Wallis P value of 0.150 (H= 5.31, df= 3) indicates that at the 0.05 significance level, the proposition about the homogeneity of responses across different sample groups cannot be rejected. This implies that respondents from HIV/AIDS, TB, reproductive health and non-clinical health services have uniform responses to the above question.

Whether the different procurement documents contain mechanisms for taking corrective action was also analyzed based on the responses from the structured questionnaire. 70% of the respondents do not believe that the procurement documents contain mechanisms for taking corrective action if PPP procurement goes wrong while 12.9% remain neutral. On the contrary, only 18.6% of the respondents feel that the PPP procurements have mechanisms for taking corrective actions. However, responses do not vary across the four PPP programs. The Kruskal Wallis P value of 0.227 implies that respondents from the four programs responded almost in a similar manner.

In response to ensuring good governance in PPP procurement system, both the procurement document and actual practices of procurement should have mechanisms of taking corrective action to rectify errors that may encounter in the procurement process. The practice in the health sector of Addis Ababa reveals that the public sector does not have proper mechanisms to correct error in procurement which is testified by the respondents who filled in the structured questionnaire. As table 6.3a above reveals, 36.4% and 28.5% of the respondents disagree and strongly disagree about the practice of taking corrective actions when procurement goes wrong. It is, therefore, found out that the majority of the respondents (64.9%) believe that corrective actions are not promptly taken to rectify errors that encounter in the procurement process. It is also revealed that while only 19.4% of the respondents provided favorable response above the practice of corrective action, 15.7% of them remained neutral.

It is theoretically established that procurement documents should generally promote principles of good governance. In this regard, majority of the respondents (65.3%) believe that the procurements documents do not generally promote the principles of good governance while 13.6% of the respondents are neutral about the issue. On the other hand, only 21.1% of the respondents believe that the PPP procurement documents promote the principles of good governance. However, the implied proposition about homogeneity of responses cannot be rejected at the 0.05 level of significance. The Kruskal Wallis P value of 0.441 implies that respondents from the four PPP categories have almost similar responses to the issue of promoting good governance principles.

Questionnaire results on issues related to good governance, partner selection procedure and other questions are summarized under the table below, which will be followed by discussions and interpretations.

Table 6.3b: Procurement System and Practices in Health Sector PPPs (N= 242)

PPP Program		Strongly disagree		Disagree		Neutral		Agree		Strongly agree		Total		**Kruskal-Wallis Test**	
		N	%	N	%	N	%	N	%	N	%	N	%	Mean Rank	KW Values
Proc_prac_gg	1	5	11.9%	28	66.7%	4	9.5%	4	9.5%	1	2.4%	42	100.0%	117.89	H= 6.21 df= 3 P= 0.102
	2	31	32.3%	35	36.5%	15	15.6%	11	11.5%	4	4.2%	96	100.0%	110.21	
	3	9	26.5%	10	29.4%	5	14.7%	4	11.8%	6	17.6%	34	100.0%	131.54	
	4	12	17.1%	28	40.0%	12	17.1%	13	18.6%	5	7.1%	70	100.0%	134.27	
Total		57	23.6%	101	41.7%	36	14.9%	32	13.2%	16	6.6%	242	100.0%		
Sel_no_discrm	1	11	26.2%	15	35.7%	9	21.4%	6	14.3%	1	2.4%	42	100.0%	119.02	H= 0.87 df= 3 P= 0.833
	2	23	24.0%	35	36.5%	16	16.7%	21	21.9%	1	1.0%	96	100.0%	123.87	
	3	9	26.5%	11	32.4%	5	14.7%	4	11.8%	5	14.7%	34	100.0%	128.03	
	4	21	30.0%	24	34.3%	11	15.7%	11	15.7%	3	4.3%	70	100.0%	116.56	
Total		64	26.4%	85	35.1%	41	16.9%	42	17.4%	10	4.1%	242	100.0%		
Sel_no_conf_int	1	14	33.3%	18	42.9%	3	7.1%	5	11.9%	2	4.8%	42	100.0%	109.89	H= 2.76 df= 3 P= 0.430
	2	27	28.1%	39	40.6%	13	13.5%	15	15.6%	2	2.1%	96	100.0%	119.07	
	3	11	32.4%	10	29.4%	6	17.6%	2	5.9%	5	14.7%	34	100.0%	123.99	
	4	11	15.7%	35	50.0%	13	18.6%	10	14.3%	1	1.4%	70	100.0%	130.59	
Total		63	26.0%	102	42.1%	35	14.5%	32	13.2%	10	4.1%	242	100.0%		

Source: Author's Survey, 2014

The issues of good governance in the PPP procurement system involve important requirements of transparency and open competition throughout the process. The review of literature also emphasizes that PPPs in general should be governed by market principles that are equally accessible and open to all applicants. The PPP procurement documents including procurement proclamations, regulations and specific directives as well as actual procurement practices should reflect the spirit and commitment to good governance principles.

The existing practice in the health sector PPPs of the city was evaluated in terms of good governance. As table 6.3b indicates, 41.7% and 23.6% of the respondents disagree and strongly disagree respectively about the adequacy of the existing procurement practice in terms of promoting good governance. This implies that the majority (65.3%) of the respondents believe that the existing procurement practice is inadequate to promote good governance in PPP programs. Only few, (19.8%), of the respondents have favorable response about the adequacy of the practice while 14.9% of them are neutral about the issue. Respondents from non-clinical service category have the highest favorable response (mean rank= 134.27) about adequacy of the procurement practices while respondents from TB category showed the highest unfavorable response (mean rank= 110.21). However, based on the Kruskal Wallis P value of 0.102 (H= 6.21, df= 3), it can be inferred that at the 0.05 level of significance, responses across the four PPP types of HIV/AIDS, TB, reproductive health and non-clinical services do not have significant variation.

Clear and objective partner selection procedure that gives little or no discretionary power to the selection team promotes the environment of open competition which ultimately helps the public health sector get the most competent partner. The practice in the existing public private collaboration indicates that the partner selection procedure has some rooms for the discretionary power of the selection team which is testified by the following information. As table 6.3b above indicates, 35.1% and 26.4% of the respondents disagree and strongly disagree with the discretion free selection procedure. In short, 61.5% of the respondents argue that the current selection procedure of the private partner gives some room for the selection team. It is also revealed that only 21.5% of the respondents believe that the selection procedure is free from individuals' discretionary power, while 16.9% of the respondents remained neutral. The implied hypothesis about homogeneity of responses across the different sample groups cannot be rejected at the 0.05 level of significance. The Kruskal Wallis P value of 0.833 (H= 0.87, df= 3) infers that responses

across HIV/AIDS, TB, reproductive health and non-clinical respondent categories do not have statistically significant variation.

The assessment of the partner selection procedure in terms of minimizing conflict of interest indicates that there is a room for conflict of interest. As indicated in table 6.3b above 42.1% and 26.0% of the respondents disagree and strongly disagree with the absence of room for conflict of interest. The result implies that a total of 68.1% of the respondents believe that the selection procedure in the existing public private collaboration initiatives has some room for conflict of interest to arise. Only 17.3% of the respondents argue that the partner selection procedure is free from conflict of interest while 14.5% of them remained neutral. While respondents from the non-clinical service group showed scoring tendency towards more favorable response (mean rank= 130.58), respondents from HIV/AIDs category indicated more unfavorable responses (man rank= 109.89). However, The Kruskal Wallis P value of 0.430 (H= 2.76, df= 3) indicates that at the 0.05 significance level, the proposition about the homogeneity of responses across different sample groups cannot be rejected. This implies that respondents from HIV/AIDS, TB, reproductive health and non-clinical health services have uniform responses to the above question.

The information obtained from in-depth interviews generally points out that the PPP procurement system of the health sector needs several improvements. W/ro Meselech from a private hospital strongly argues that in the absence of strong legal and regulatory framework for managing PPPs in the health sector, procurement procedure that specifically applies to PPPs is not expected. She stressed that characteristics of strong procurement system such as open competition, complaint handling procedure, close monitoring and corrective action and mechanisms for promoting good governance are all weak in the existing public private collaborations. She also asserts that the up-coming higher level PPPs in the health sector should not be managed by the existing weak procurement system. Her argument implies that the procurement system and capacity of the public sector in managing PPP procurement cannot accommodate the future PPPs that require strong, open and competition based procedure (W/ro Meselech, August 7, 2014).

The argument by Ato Taddesse from MoFED generally converges with the above information. He pointed out that in Ethiopia in general, and in the health sector in particular, the lack of strong

procurement system is mainly attributed to the absence of legal framework specifically developed for PPPs. As MoFED is nationally mandated to handle the policy issues related to PPP, the proclamations, regulations and the different directives that will follow the proclamations will effectively address problems associated with PPP procurement. In his words:

> *MoFED is nationally responsible to develop PPP procurement framework that can be applied across different sectors. Regional governments and individual government agencies may have their versions of internal directives on how to handle PPP procurements. However, I strongly argue that the existing procurement system does not in any way accommodate peculiar issues of PPP (Ato Tadesse, August 5, 2014)*

Ato Mecha from FMoH asserted that issues such as partner selection, principles of open competition, objectivity, and generally good governance principles in the existing PPP procurement are almost not practiced. His expressions are worth quoting:

> *Particularly at the early stage of public private collaboration in the areas of HIV/AIDS, TB and MCH, the focus of the government was to obtain the willingness and commitment of the private health sector to provide these services. Therefore, we did not focus on the standard procurement procedure and issues of good governance in procurement. In fact, private health institutions were initially skeptical of working with the public sector (Ato Mecha, August 4, 2014)*

Almost all the key respondents from the Sub-city health departments unanimously agree that the public sector does not have appropriate procurement mechanism that promotes openness, close regulation and monitoring and promotion of good governance principles. Ato Ketema, for instance, argues that the existing public private collaborations are operating just based on what he called “customary procedures” which are not specifically and formally developed to manage PPPs (Ato Ketema, August 12, 2014).

Slightly different information obtained from Ato Bulti, W/t Meklit and Ato Ermias, all from different public hospitals, reveals that the service contracting for non-clinical hospital services has relatively strong procurement system. According to the respondents, the procurement of support services such as security, catering and laundry services are being made based on the

procurement proclamations and directives issues by the government. The procurement for the contracting out of non-clinical support services is based on open competition, transparent procedure and the values and principles of good governance. All the procedures for the procurement of goods and services are also applied in the selection of private partner for the delivery of non-clinical hospital services. The key informants unanimously indicated that the shortage of private sector applicants in the non-clinical service delivery has strongly affected the procurement process. Though standard and transparent procurement procedures are in place, ad hoc decisions are sometimes made due to the lack of sufficient number of applicants for the delivery of specific non-clinical service (Ato Bulti, September 5, 2014; W/t Meklit, August 12, 2014; Ato Ermias, September 8, 2014).

The review of relevant documents in Ethiopia reveals that there is no specifically developed procurement system to manage PPP projects. However, the FDRE Procurement and Property Administration Proclamation 649/2009 and the subsequent directive issues by MoFED in 2009 can accommodate important aspects of PPP procurement. The proclamation and directive clearly stipulate that procurement of services should be conducted based on transparent and fair procedure with no discrimination of the candidates. The different procurement modalities such as open tendering, procurement through request for proposal restricted tendering, procurement through request for quotation and direct procurement can be applied in the health sector PPPs. Moreover, the existing mechanisms of ensuring good governance in the procurement process such as the complaint handling board for perceived and actual procurement defects can be applied to the existing PPP programs until specific procurement framework and systems are designed for PPP initiatives.

Theoretically, procurement in PPP programs should promote the principles of competition and merit. Though competitive and merit based procurement is mainly attained through clear, formal and open criteria, the evidences above indicate that Addis Ababa's health sector lacks this mechanisms in handling PPP initiatives. Transparency and open access to procurement information, the right to equality of access to competition for PPP projects are all questioned in the existing public private collaboration in the health sector. The practice of following up, regulating and taking corrective actions as well as managing conflict of interest in PPPs has been found to be weak in the health sector of Addis Ababa.

From the perspective of institutional theory, the absence of clear rules, regulations and procedures in the PPP procurement implies lack of predictability of behavior in both the public and private partners. Moreover, as rational choice theory strongly argues, in the absence of clear and predictable procurement system, the room for negotiation, competition and accommodation of mutual interest will be limited which ultimately constrains the ability of both the public and private partners to make rational and well-thought decision.

6.5 Summary of Findings

As indicated earlier, this chapter investigated the institutional capacity of the health sector of Addis Ababa in terms of managing existing public private collaborations and the future PPPs in health service delivery. The assessment of the institutional structure, skills of employees and managers and the procurement system revealed that there are several areas of improvement.

It was found out that clearly mandated and autonomous PPP units are not prevalent at both national and ministry levels. The lack of adequate training of officials and employees as well as inability to effectively utilize external expertise to build PPP management capacity was also observed. The interpretation of results generally indicated that the public health sector lacks both structural and leadership capacity to manage PPP programs. The employees and managers lack of adequate PPP planning, implementation, financial management, contract administration and PPP evaluation and reporting skills implies that both the existing and up-coming PPP programs are at stake in terms of sustainability and effectiveness.

The analysis of responses from different sources also revealed that the selection of private partners falls short of applying open, transparent criteria which compromises the principles of competition and merit. Weak practice of close monitoring and regulation of PPP processes was found out. The fact that the selection mechanisms give room for conflict of interest and discretionary decision of the selection team added to the absence of strong complaint handling system and practice puts the PPP procurement in Addis Ababa's health sector at the risk of poor governance.

Chapter 7: Risk Sharing and Mutual Support in the PPP Initiatives of Addis Ababa's Health Sector

7.1 Introduction

It was found out in the previous chapter that the institutional structure of the health sector is not capable of accommodating the peculiar nature of PPP projects. As the result of lack of appropriate PPP units at both national and health sector levels, the sustainability and effective performance of existing public private collaborations is seriously questioned. This problem added to the lack of adequate skills of employees and managers and inability to establish a well functioning procurement system has endangered the potential of Addis Ababa's health sector to utilize full scale PPPs in service delivery.

This chapter specifically answers the 4th research question stated in section 1.3 of chapter one as "To what extent are risks shared and the partners mutually support each other in the existing PPP programs in the health sector of Addis Ababa?" The chapter primarily focuses on the practice of identifying and efficiently allocating risks to the partner who can manage it better. It also investigates the prevalence of various risks in the health sector and the extent to which the public and private partners in the city mutually support each other throughout the development and implementation of PPP initiatives in the health sector. Data collected through structured questionnaire is analyzed and followed by data collected through in-depth interviews and secondary sources to effectively answer the research question.

7.2 Risk Identification and Allocation in Addis Ababa's Health Sector PPPs

One of the peculiar characteristics of PPPs is the identification and proper allocation of risks to the party that can manage it more effectively and efficiently. It was also emphasized that risks related to PPPs need to be identified and thoroughly analyzed prior to entering into contract. This section investigates the practices of risk identification, allocation, risk taking tendency, risk mitigation mechanisms and risk monitoring and evaluation system of the existing public private collaborations in the health sector of Addis Ababa. The table below contains the summary of results obtained from the structured questionnaire filled in by respondents. The analysis of response in the table will be followed by discussions of responses from key informants who participated in the in-depth interviews.

Table 7.1: Risk Identification and Allocation in the Health Sector PPPs

PPP Program		Strongly Disagree		Disagree		Neutral		Agree		Strongly Agree		Total		Kruskal-Wallis Test	
		N	%	N	%	N	%	N	%	N	%	N	%	Mean Rank	KW Values
Ris_iden_anal	1	10	23.8%	14	33.3%	8	19.0%	6	14.3%	4	9.5%	42	100.0%	137.50	H= 3.84 df= 3 P= 0.279
	2	24	25.0%	46	47.9%	14	14.6%	8	8.3%	4	4.2%	96	100.0%	121.27	
	3	7	20.6%	19	55.9%	4	11.8%	4	11.8%	0	0.0%	34	100.0%	121.60	
	4	26	37.1%	25	35.7%	8	11.4%	7	10.0%	4	5.7%	70	100.0%	112.16	
Total		67	27.7%	104	43.0%	34	14.0%	25	10.3%	12	5.0%	242	100.0%		
Ris_alloc_private	1	9	21.4%	17	40.5%	8	19.0%	3	7.1%	5	11.9%	42	100.0%	130.96	H= 3.26 df= 3 P= 0.353
	2	27	28.1%	31	32.3%	18	18.8%	12	12.5%	8	8.3%	96	100.0%	126.39	
	3	10	29.4%	17	50.0%	4	11.8%	2	5.9%	1	2.9%	34	100.0%	107.91	
	4	22	31.4%	27	38.6%	9	12.9%	8	11.4%	4	5.7%	70	100.0%	115.72	
Total		68	28.1%	92	38.0%	39	16.1%	25	10.3%	18	7.4%	242	100.0%		
Ris_alloc_public	1	10	23.8%	15	35.7%	5	11.9%	7	16.7%	5	11.9%	42	100.0%	133.46	H= 2.97 df= 3 P= 0.396
	2	24	25.0%	38	39.6%	17	17.7%	10	10.4%	7	7.3%	96	100.0%	124.64	
	3	8	23.5%	18	52.9%	5	14.7%	1	2.9%	2	5.9%	34	100.0%	114.54	
	4	21	30.0%	29	41.4%	11	15.7%	7	10.0%	2	2.9%	70	100.0%	113.40	
Total		63	26.0%	100	41.3%	38	15.7%	25	10.3%	16	6.6%	242	100.0%		
Private_ready	1	10	23.8%	19	45.2%	6	14.3%	3	7.1%	4	9.5%	42	100.0%	125.24	H= 0.28 df= 3 P= 0.965
	2	30	31.3%	35	36.5%	14	14.6%	12	12.5%	5	5.2%	96	100.0%	119.51	
	3	10	29.4%	11	32.4%	8	23.5%	3	8.8%	2	5.9%	34	100.0%	124.06	
	4	20	28.6%	28	40.0%	10	14.3%	9	12.9%	3	4.3%	70	100.0%	120.75	
Total		70	28.9%	93	38.4%	38	15.7%	27	11.2%	14	5.8%	242	100.0%		
Ris_mitig_private	1	10	23.8%	16	38.1%	6	14.3%	4	9.5%	6	14.3%	42	100.0%	132.14	H= 2.42 df= 3 P= 0.490
	2	22	22.9%	44	45.8%	15	15.6%	12	12.5%	3	3.1%	96	100.0%	123.17	
	3	9	26.5%	14	41.2%	5	14.7%	4	11.8%	2	5.9%	34	100.0%	122.26	
	4	24	34.3%	24	34.3%	13	18.6%	9	12.9%	0	0.0%	70	100.0%	112.46	
Total		65	26.9%	98	40.5%	39	16.1%	29	12.0%	11	4.5%	242	100.0%		
Ris_mitig_public	1	21	50.0%	12	28.6%	3	7.1%	3	7.1%	3	7.1%	42	100.0%	108.75	H= 3.17 df= 3 P= 0.367
	2	39	40.6%	31	32.3%	16	16.7%	6	6.3%	4	4.2%	96	100.0%	119.22	
	3	9	26.5%	16	47.1%	4	11.8%	2	5.9%	3	8.8%	34	100.0%	133.35	
	4	22	31.4%	30	42.9%	10	14.3%	7	10.0%	1	1.4%	70	100.0%	126.52	
Total		91	37.6%	89	36.8%	33	13.6%	18	7.4%	11	4.5%	242	100.0%		
Ris_M_E_system	1	14	33.3%	10	23.8%	8	19.0%	7	16.7%	3	7.1%	42	100.0%	131.45	H= 2.43 df= 3 P= 0.489
	2	31	32.3%	33	34.4%	16	16.7%	10	10.4%	6	6.3%	96	100.0%	124.13	
	3	9	26.5%	17	50.0%	4	11.8%	3	8.8%	1	2.9%	34	100.0%	120.85	
	4	26	37.1%	28	40.0%	6	8.6%	8	11.4%	2	2.9%	70	100.0%	112.24	
Total		80	33.1%	88	36.4%	34	14.0%	28	11.6%	12	5.0%	242	100.0%		

Source: Author's Survey, 2014

As affirmed in table 7.1 above, 43% and 27.7% of the respondents respectively disagree and strongly disagree with the practice of properly identifying and analyzing PPP related risks in the health sector of the city. This is to mean that 70.7% of the respondents believe that the health sector of Addis Ababa does not have the practice of identifying and analyzing PPP risks before entering into agreement. While 14% of the respondents remained neutral, only 15.3% of the respondents generally provided favorable response implying the prevalence of the practice. Respondents from HIV/AIDS category showed the tendency to favorably respond to the question (mean rank= 137.50), while respondents from non-clinical service category indicated the highest unfavorable responses (mean rank= 112.16). However, based on Kriskal Wallis test, the proposition about the homogeneity of responses across the different sample groups cannot be rejected at the significance level of 0.05. Accordingly, P value of 0.279 (H= 3.84, df= 3) suggests that respondents from HIV/AIDS, TB, reproductive health and non-clinical service groups responded almost in a similar manner.

The effective allocation of risks to public or private sector which usually follows appropriate identification and analysis helps partners to manage more efficiently due to their specific capacity as compared to the other partner. The practice in Addis Ababa's health sector generally indicates that risk allocation is also poor. Table 7.1 above indicates that PPP risks are not effectively allocated to both the public and private partner, who is for various reasons on a better position to manage the risk effectively. For instance, 38.0% and 28.1% of the respondents disagree and strongly disagree about the practice of allocating PPP risks in the health sector to the private partner which means that 66% of the respondents indicated no practice of risk allocation. Only a total of 17.7% of the respondents believe that risks are allocated to the private partner while 16.1% of the respondents have neutral response. Respondents from HIV/AIDS group indicate the highest favorable response (mean rank= 130.96), while respondents from reproductive health group showed the tendency to respond more unfavorably (mean rank= 107.91). It can be argued, however, that at the significance level of 0.05, the proposition about the homogeneity of responses across the four independent sample groups cannot be rejected. The Kruskal Wallis P value of 0.353 (H= 3.26, df= 3) infers that there is no statistically significant difference in the response patterns across the respondents from HIV/AIDS, TB, reproductive health and non-clinical services.

Similarly, the data in table 7.1 indicates that PPP risks are not properly allocated to the public sector. 26% and 41.3% of the respondents strongly disagree and disagree about the allocation of PPP risks to the public sector. Overall, a total of 67.3% of the respondents do not believe that PPP risks are properly allocated to the public sector in Addis Ababa City while only a total of 16.9% of the respondents favorably responded about the allocation of risks to the public sector partner. Although respondents from HIV/AIDS programs indicated the highest mean rank (133.46), the Kruskal Wallis P value of 0.396 (H= 2.97, df= 3) indicates that responses across the four PPP programs are not significantly different at the 0.05 level of significance.

When PPP programs are believed to yield higher benefit to the citizens, both the public and private sectors need to commit themselves to take reasonable risks that may occur in the PPP process. Particularly, as clearly discussed in chapter two, the readiness of the private sector to take PPP risks strongly determines the success and failure of PPP programs. In the health sector of Addis Ababa, the extent to which the private sector commits itself to take PPP related risks needs to be evaluated. As indicated in table 7.1 above, 38.4% and 28.9% of the respondents respectively disagree and strongly disagree with the readiness of the private sector to take risks even when the PPP initiative is clearly essential to the public. In general, 67.3% of the respondents believe that the private sector in Addis Ababa is not ready to take PPP risks regardless of the level of importance of the program to citizens. While 17% of the respondents have favorable response about the readiness of the private sector, 15.7% of the respondents remained neutral. Though respondents from HIV/AIDS group showed the tendency to favorably respond (mean rank= 125.24), the implied hypothesis of the homogeneity of the responses across different respondent groups cannot be rejected at 0.05 level of significance. The Kruskal Wallis P value of 0.965 (H= 0.28, df= 3) indicates that the proposition about the homogeneity of responses across the four independent sample groups cannot be rejected at the level of significance of 0.05. Therefore, it can be argued that responses are almost similar across respondent groups of HIV/AIDS, TB, reproductive health and non-clinical services.

PPP programs in general should clearly stipulate risk mitigation strategies for both the public and private partners. It is also clear that the private and public sectors have their own specific risk mitigation strategies based on their capability, experience and exposure of risks. In Addis Ababa's health sector, whether the partners have carefully developed risk mitigation strategies for PPP programs was investigated. In this regard, for instance, 36.8% and 37.6% of the

respondents (table 7.1) disagree and strongly disagree respectively about the practice of risk mitigation strategies in the public health sector. It can be argued that 74.4% of the respondents believe that the health sector PPP agreements do not clarify how the public sector can mitigate risks that may occur at any time in due course of the PPP program implementation. Only 11.9% of the respondents provided favorable response about the prevalence of risk mitigation strategies for the public sector, while 13.6% of the respondents remained neutral. Respondents from reproductive health group showed the tendency to favorably respond about the prevalence of PPP risk mitigation strategies (mean rank= 133.35), while respondents from HIV/AIDS indicate the highest unfavorable response (mean rank= 108.75). However, at the level of significance of 0.05, the implied proposition about the homogeneity of the responses across the four respondent groups cannot be rejected. The Kruskal Wallis P value of 0.367 (H= 3.17, df= 3) infers that respondents from all groups (HIV/AIDS, TB, Reproductive health and non-clinical services) have the tendency to respond in a similar way about the prevalence of risk mitigation strategy for the public health sector.

Risk mitigation strategy by the private sector was also found to be generally poor. As shown in table 7.1, 26.9% and 40.5% of the respondents strongly disagree and disagree respectively about the risk mitigation strategies by the private sector partner. Overall, this indicates that a total of 67.4% of the respondents do not believe that the private sector applies appropriate risk imitation strategies for its engagement in PPP programs in Addis Ababa. While 16.1% of the respondents are neutral in their response, only a total of 16.5% of the respondents believe that the private sector has appropriate risk mitigation strategies for PPP programs. Although, respondents from HIV/AIDS programs have the highest favorable response (mean rank= 132.14), the hypothesis about the uniformity of responses cannot be rejected at the 0.05 level of significance. The Kruskal Wallis P value of 0.490 (H= 2.42, df= 3) implies that responses across the four PPP programs are generally similar.

The implementation of PPP programs should be augmented by effective risk monitoring and evaluation system. As risk may occur at any time in due course of PPP implementation, scholars argue that an effective risk monitoring and evaluation system will help both the public and private partners to intervene and manage before they obstruct performances and outcomes. In Addis Ababa's health sector, as indicated in table 7.1 above, 36.4% and 33.1% of the respondents disagree and strongly disagree respectively about the prevalence of risk monitoring

and evaluation system. This indicates that 69.5% of the respondents argue that the health sector of the city does not have PPP risk monitoring and evaluation system. Only 16.6% of the respondents favorably respond about the prevalence of PPP risk monitoring and evaluation system while 14.0% of them remained neutral. Respondents from HIV/AIDS group showed the tendency to rate more favorably (mean rank= 131.45), while respondents from non-clinical support service groups have the highest unfavorable response (mean rank= 112.24). However, the implied proposition about the homogeneity of responses across the different respondent groups can be accepted at the level of significance of 0.05. As the P value of 0.489 (H= 2.43, df=3) indicates, the respondents from all HIV/AIDS, TB, reproductive health and non-clinical services responded almost in a similar manner.

The above analysis of results from the structured questionnaire is triangulated with data from in-depth interview to find out the convergence of arguments and effectively answer the research question under consideration. Regarding the practice of sufficiently identifying and analyzing PPP risks before entering into agreement, Ato Mecha argues that both the public and private health institutions do not make any specific risk identification and assessment. He points out that the government and development partners were more interested to make health services accessible to large population and did not give much attention to the issues of risk identification and sharing (Ato Mecha, August 4, 2014). However, Ato Mengistu from AAHB reveals that the low level of understanding of PPPs and their implication was responsible for the failure to include issues of risk identification and sharing. His statements are worth quoting:

> *At the early stage of the agreement, we didn't even think that these collaborations will involve any risk. Issues of risk identification, analysis and appropriate allocation were not seriously considered. Ultimately, we came to understand that risks of various types are inevitable regardless of the type of collaboration we are dealing with (Ato Mengistu, August 4, 2014)*

The arguments by Bayisa from FFMHACA and Gebreyohannes from Private Health Sector Program also confirm that the practice of properly identifying, analyzing and allocating risks is very low in the existing public private collaborations. Gebreyohannes, for instance, indicated that the collaborations in HIV/AIDS, TB and reproductive health are not effectively yielding the expected benefits for the private partner mainly due to the lack of proper identification and

allocation of risks. He further argues that as a result of inadequate information about risks in public private collaboration, the private health sector in Addis Ababa is not usually committed to engage in PPPs (Ato Bayissa, August 8, 2014; Gebreyohannes, March 3, 2015).

An argument from a different perspective is provided by Ato Ermias from a public hospital. He asserts that though risks are prevalent with different magnitudes, both the public and private sector organizations have their own informal and often mutually beneficial mechanisms of risk allocation. According to Ermias, as the collaboration develops through time, the partners in the health sector of Addis Ababa also developed close relationships and better ability to understand each others' capability and limitations. For him, risk identification and allocation should not necessarily be a formal process. It is something that gradually develops in due course of implementing the collaborative arrangements which is definitely used as a learning curve for all issues related to risk identification, analysis, allocation and mitigation strategies. As a result, he emphasizes that in terms of fairly sharing risks, both the private and public sector institutions in Addis Ababa are currently at a better position than they were when the initiatives were first started (Ato Ermias, September 8, 2014).

Key informants such as Ato Ketema from Sub-city health department, Ato Bulti from a public hospital and Ato Hyder from another Sub-city strongly argued that the public private partnership in Addis Ababa's health sector does not have the practice of formally identifying and sharing risks. They unanimously indicated that the low readiness of the private sector in taking PPP risks is mainly attributed to the lack of practice of identification, analysis and allocation of risks to the partner that can handle the risk better than the other. Endorsing the arguments by other informants, they also confirmed that the risk mitigation strategies as well as monitoring, evaluation and reporting systems are weak. They pointed out that since public private collaborations in the health sector of Addis Ababa is practiced based on ad hoc arrangements and simple MoUs in the absence of legal and institutional frameworks, weak risk identification, allocation and monitoring systems are expected limitations (Ato Ketema, August 12, 2014; Ato Bulti, September 5, 2014; Ato Hyder, August 11, 2014).

Converging with the above arguments, Ato Kelifa, a respondent from a private hospital, is highly concerned about the lack of formally established risk sharing system. His statements are quoted as follows.

> *We usually plan to import heavy duty medical equipment and other medical supplies hoping that the existing collaborative arrangements with the government will help us get the Return on Investment (ROI) as timely as possible. But we are not sure about the demand for the equipments and even the sustainability of our agreements with the government. As a result we often prefer to invest on areas where we can predict the outcome of our investment (Ato Kelifa, September 3, 2014).*

Ato Kelifa's concern about market and demand risks clearly indicates the lack of formally established risk identification and allocation system in the health sector of the city. The arguments also clearly imply that in the absence of well established risk sharing mechanism, the private health sector is not ready to take risks related to public private collaboration. Almost all the key informants who participated in the in-depth interviews unanimously confirm that risk identification, analysis and allocation are weak in the existing public private collaborations in the health sector of Addis Ababa. Most of the informants also attribute the poor risk sharing system and practice to the lack of legal and institutional frameworks within which the existing collaborations are operating. Moreover, it is learnt that low readiness of the private sector to take PPP risks is mainly attributed to the lack of the practice of risk identification and analysis which also severely hampers the ability of the partners to design proactive risk mitigation strategies. Almost all the informants also pointed out that the existing collaborations in the health sector lack formal mechanisms for monitoring, evaluating and reporting risks that may occur at any time in due course of implementing the partnership agreements.

The risk identification and sharing environment of the public private collaboration in the health sector of Addis Ababa can be discussed from the perspectives of institutional theory, systems theory and rational choice theory. From the point of view of institutional theory, the absence of rules, regulations and procedures to guide organizational activities leads to ad-hoc and often unpredictable practices. Therefore, it can be argued that the lack of legal and institutional mechanisms of risk identification and analysis has adversely affected the practice of appropriate risk allocation, mitigation strategies as well as monitoring and evaluation systems. From the perspective of systems theory, understanding the health sector of the City as a total system is important to conceptualize risk identification, allocation, and mitigation and evaluation strategies. First one has to visualize that both the public and private health sector, regardless of

their short term objectives, have the ultimate long-term goals of creating a healthy and productive society. With this fact in mind, the issue of identifying, allocating, mitigating and evaluating PPP related risks becomes an issue of sharing roles and responsibilities as integral components of the same system. From the perspective of rational choice theory, the private health sector is usually motivated by clearly established and measurable results and hence wants to make informed and rational decisions when considering the issues of risk taking. The tendency of the private health sector in Addis Ababa to deliberately avoid certain partnership initiatives, though they might be clearly beneficial to citizens, emanates from the rational decision to generate fair return on investment (RoI) from risky ventures.

7.3 Prevalence of Various Risks in the Health Sector PPPs

The ability of both the public and private sectors to identify and measure the types and levels of different risks helps them make informed decision about risk mitigation and management. Theoretically, PPPs in general and health sector PPPs in particular involve different types of risks that may occur at different stages of the PPP program with varying magnitudes. The prevalence of different risks, i.e., political, legal, bureaucratic, economic, market and financial risks in the existing public private collaborations in Addis Ababa was investigated using data from different sources. The summary of data obtained from the structured questionnaire is presented in the table 7.2 below and is followed by its analysis and interpretation.

Table 7.2: Prevalence of Various Risks in Addis Ababa's Health Sector PPPs

PPP Program		Very low		Low		Average		High		Very high		Total		Kruskal-Wallis Test	
		N	%	N	%	N	%	N	%	N	%	N	%	Mean Rank	KW Values
Pol_risk	1	4	9.5%	10	23.8%	8	19.0%	13	31.0%	7	16.7%	42	100.0%	120.06	H= 0.83 df= 3 P=0.834
	2	10	10.4%	14	14.6%	26	27.1%	27	28.1%	19	19.8%	96	100.0%	126.08	
	3	4	11.8%	3	8.8%	11	32.4%	13	38.2%	3	8.8%	34	100.0%	121.01	
	4	5	7.1%	20	28.6%	12	17.1%	25	35.7%	8	11.4%	70	100.0%	116.32	
Total		23	9.5%	47	19.4%	57	23.6%	78	32.2%	37	15.3%	242	100.0%		
Legal_risk	1	4	9.5%	3	7.1%	16	38.1%	14	33.3%	5	11.9%	42	100.0%	118.65	H= 1.15 df= 3 P=0.765
	2	4	4.2%	10	10.4%	32	33.3%	38	39.6%	12	12.5%	96	100.0%	126.81	
	3	3	8.8%	8	23.5%	6	17.6%	9	26.5%	8	23.5%	34	100.0%	121.49	
	4	7	10.0%	14	20.0%	14	20.0%	26	37.1%	9	12.9%	70	100.0%	115.93	
Total		18	7.4%	35	14.5%	68	28.1%	87	36.0%	34	14.0%	242	100.0%		
Bureau_risk	1	4	9.5%	9	21.4%	5	11.9%	18	42.9%	6	14.3%	42	100.0%	104.83	H= 5.93 df= 3 P=0.115
	2	5	5.2%	9	9.4%	15	15.6%	42	43.8%	25	26.0%	96	100.0%	130.02	
	3	2	5.9%	4	11.8%	11	32.4%	11	32.4%	6	17.6%	34	100.0%	108.07	
	4	2	2.9%	10	14.3%	11	15.7%	30	42.9%	17	24.3%	70	100.0%	126.34	
Total		13	5.4%	32	13.2%	42	17.4%	101	41.7%	54	22.3%	242	100.0%		
Econ_risk	1	6	14.3%	10	23.8%	12	28.6%	11	26.2%	3	7.1%	42	100.0%	106.52	H= 11.6 df= 3 P=0.009
	2	4	4.2%	19	19.8%	45	46.9%	17	17.7%	11	11.5%	96	100.0%	117.95	
	3	2	5.9%	4	11.8%	5	14.7%	14	41.2%	9	26.5%	34	100.0%	156.56	
	4	8	11.4%	14	20.0%	19	27.1%	23	32.9%	6	8.6%	70	100.0%	118.33	
Total		20	8.3%	47	19.4%	81	33.5%	65	26.9%	29	12.0%	242	100.0%		
Demand_ risk	1	12	28.6%	7	16.7%	2	4.8%	16	38.1%	5	11.9%	42	100.0%	99.45	H= 13.2 df= 3 P=0.004
	2	3	3.1%	13	13.5%	13	13.5%	45	46.9%	22	22.9%	96	100.0%	139.81	
	3	2	5.9%	6	17.6%	13	38.2%	8	23.5%	5	14.7%	34	100.0%	109.53	
	4	8	11.4%	15	21.4%	9	12.9%	27	38.6%	11	15.7%	70	100.0%	115.44	
Total		25	10.3%	41	16.9%	37	15.3%	96	39.7%	43	17.8%	242	100.0%		
Finance_risk	1	0	0.0%	8	19.0%	6	14.3%	13	31.0%	15	35.7%	42	100.0%	117.57	H= 1.91 df= 3 P=0.592
	2	3	3.1%	6	6.3%	13	13.5%	38	39.6%	36	37.5%	96	100.0%	128.13	
	3	1	2.9%	2	5.9%	7	20.6%	12	35.3%	12	35.3%	34	100.0%	122.22	
	4	4	5.7%	7	10.0%	9	12.9%	30	42.9%	20	28.6%	70	100.0%	114.41	
Total		8	3.3%	23	9.5%	35	14.5%	93	38.4%	83	34.3%	242	100.0%		

Source: Author's Survey, 2014

With various magnitudes of prevalence, PPPs in the health sector involve political risks. For the purpose of this dissertation, political risk generally refers to the change in government ideology and public policy that may have adverse implication for the role of the private sector in service delivery. As indicated in table 7.2 above, 19.4% and 9.5% of the respondents rated the

prevalence of political risk in the health sector PPPs as low and very low respectively. This generally means that 28.9% of the respondents believe that the health sector PPPs involve low level of political risk. On the other hand, 47.5% of the respondents believe that political risk in the health sector PPPs of the City is generally higher, while 23.6% of the respondents argue for average level of political risk. From the responses, it can be argued that 71.1% of the respondents believe that the health sector PPPs of Addis Ababa involve average to very high political risks. Respondents from TB category tend to argue for the prevalence of higher political risk (mean rank= 126.08), while those from non-clinical service groups rated political risk as generally low. However, the proposition about the homogeneity of responses across the different respondent categories cannot be rejected at the level of significance of 0.05. Based on the Kruskal Wallis P value of 0.834 (H= 0.83, df= 3), it can be inferred, therefore, that the responses from all the four categories, i.e., HIV/AIDs, TB, reproductive health and non-clinical services is generally similar.

Almost all the literature reviewed for the purpose of this study unanimously indicates that PPPs need legal and regulatory frameworks to operate effectively. However, it is also evident that PPPs in general involve some level of legal risk at some level in the program implementation. Legal risk, which generally refers to changes in the rules and regulatory environments, was investigated in the PPP programs of the health sector of Addis Ababa. As indicated in table 7.2 above, 14.5% and 7.4% of the respondents respectively rated the prevalence of legal risks as low and very low. Overall, 21.9% of the respondents believe that the PPP programs in the health sector of the City are generally low. On the other hand, a total of 50% of the respondents believe that Addis Ababa's health sector involves high or very high legal risk. The data also reveals that a total of 78.1% of the respondents believe that there are average to very high legal risks in the health sector PPPs. Respondents from TB category showed to rate the PPP legal risks are generally higher (mean rank= 126.81) while respondents from non-clinical service groups have the tendency to rate as generally lower (mean rank= 115.93). However, the Kruskal Wallis P value of 0.765 (H= 1.15, df= 3) infers that the proposition about the homogeneity of responses across different sample groups cannot be rejected at the significance level of 0.05. Therefore, it can be argued that respondents from HIV/AIDS, TB, reproductive health and non-clinical service categories have almost similar responses about the prevalence of legal risks.

Bureaucratic risk, which generally refers to the decline in the efficiency and effectiveness of public bureaucracy in terms of governing PPP programs, was investigated. In this regard, table

7.2 above indicates that 13.2% and 5.4% of the respondents rated the prevalence of bureaucratic risk in Addis Ababa's health sector as low and very low respectively. Overall, only 18.6% of the respondents believe that bureaucratic risk in the health sector PPPs is generally low. On the other hand, a total of 64% of the respondents believe that the health sector PPP of the City involves high to very high bureaucratic risk. Moreover, 81.4% of the respondents believe that the health sector PPP programs have average to very high bureaucratic risk. Respondents from TB category tend to rate bureaucratic risks are generally higher (mean rank= 130.02), while respondents from HIV/AIDS groups showed the tendency to rate as generally lower. However, the proposition about the homogeneity of responses across the four respondent groups cannot be rejected at the level of significance of 0.05. The Kruskal Wallis P value of 0.115 (5.93, df=3) infers that respondents from the four PPP programs responded in almost homogeneous manner.

Economic risk, i.e., fluctuation in inflation rate, foreign currency and input prices are considered as key risk areas in PPP programs. The understanding of the prevalence of economic risk in Addis Ababa's health sector helps the partners to make informed decision in risk sharing and mutual support strategies. In the health sector of the City, as table 7.2 above reveals, 19.4% and 8.3% of the respondents rated the prevalence of economic risk as low and very low respectively. Overall, 27.7% of the respondents believe that the health sector PPPs involve lower economic risk. On the other hand, a total of 38.9% of the respondents believe that the health sector involves high to very high economic risk. In general, 72.4% of the respondents believe that the health sector PPPs in Addis Ababa have average to very high economic risk. While respondents from reproductive health sample group have the tendency to show the highest rating (mean rank= 156.56), respondents from HIV/AIDS sample group indicated the lowest rating (mean rank= 106. 52). The proposition about the homogeneity of responses across the different independent sample groups is rejected at the significance level of 0.05. The Kruskal Wallis P value of 0.009 (H= 11.61, df= 3) indicates that there is a statistically significant difference in responses across the respondents from HIV/AIDS, TB, reproductive health and non-clinical service groups. The statistically significant difference in responses across the four PPP programs is attributed to the fact that respondents from reproductive health program have the highest perception of economic risk. This generally implies that there is relatively higher level of risk perception in reproductive health program as compared to other PPP programs.

Market and demand risk which refers to changes in the demand and preference of the service is one of the risk categories involved in PPP programs. As clearly discussed in chapter 2, the prevalence of high demand risk adversely affects the motivation of the private sector to engage in PPP initiatives. As indicated in table 7.2 above, 16.9% and 10.3% of the respondents respectively rated the prevalence of market risk as low and very low respectively. Overall, while a total of 27.2% of the respondents believe that Addis Ababa's health sector PPPs involve lower risk, a total of 57.5% of the respondents believe that the health sector PPPs have higher market risk. In general, 72.8% of the respondents rated the prevalence of market risk from average to very high. As the data clearly reveals, there is high variation in responses from the four independent samples. Therefore, at the significance level of 0.05, the proposition about the homogeneity of responses across the different sample groups is rejected. As the Kruskal Wallis P value of 0.004 (H= 13.28, df= 3) indicates, the respondents from HIV/AIDS, TB, reproductive health and non-clinical service groups have significantly different responses. This variation is attributed to the fact that respondents from TB sample group showed the tendency to have higher ratings (mean rank= 139.81), while respondents from HIV/AIDS have generally lower ratings (99.45) about the prevalence of market risk in health sector PPPs. However, the above overall results imply the perception of high level of market and demand risk in PPP programs.

Finally, in PPP programs, lack of capital and access to finance, which is generally referred to as financial risk also determines the success or failure of the initiatives. In Addis Ababa's health sector, as table 7.2 above indicates, a total of only 12.8% of the respondents believe that the health sector PPPs involve lower risk, while a total of 72.7% of the respondents argue that there are higher financial risks involved in the health sector PPPs. Overall, 87.2% of the respondents believe that the health sector PPP programs in Addis Ababa involve average to very high financial risks. While respondents from TB sample group have the tendency to rate financial risks as generally higher (mean rank= 128.13), respondents from non-clinical service group indicated generally lower ratings (mean rank= 114.41). However, based on the Kruskal Wallis test, the proposition about the homogeneity of responses among the different samples cannot be rejected at the level of significance of 0.05. The P value of 0.592 (H= 1.91, df= 3) implies that, responses about the prevalence of financial risk in PPPs are generally similar across the samples drawn from HIV/AIDS, TB, reproductive health and non-clinical groups.

The analysis of responses from structured questionnaire above reveals that the existing collaborations in the health sector of Addis Ababa have several risks of different magnitude. In order to enhance the depth of understanding about the prevalence of risks and their implications, responses from in-depth interviews with relevant informants is analyzed as follows. Ato Degu from a private hospital strongly argues that the attitude of the government towards the private health sector is one of the clearly visible political risk areas. He emphasizes that the structure of Addis Ababa's health system, which is predominantly expressed by big public sector and bureaucratic delivery of health services, can be considered as political risk. The justification is that since the role and contribution of the private health sector is not clearly articulated and demonstrated both at policy and practice levels, the government may change the existing ad hoc relationships at any time, posing significant risk to the private partner (Ato Degu, September 3, 2014).

On the other hand, the arguments by Ato Yimer from AAFMHACA and Ato Mecha from FMoH are slightly different from Degu's. They assert that the dominance of the public health sector cannot be considered as a risk as long as the government is willing and committed to co-opt the private sector as its strategic partner. Right from the beginning, the EPRDF-led government has made clear that the private sector plays irreplaceable role in the development process of the country. However, both Yimer and Mecha unanimously agree that political and legal risks to both the public and private partners are clearly visible but emanate mainly from the absence of well-developed policy, legal and regulatory framework to guide the public private collaborations in the health sector (Ato Yimer, August 8, 2014; Ato Mecha, August 4, 2014). Almost all the other respondents who participated in the in-depth interviews agree that political and legal risks which are often complementary are prevalent in the health sector PPPs mainly due to the low level of development of PPP in the health sector of the city.

Respondents have a serious concern about the level of bureaucratic risk in the health sector PPPs in Addis Ababa. In this regard, Bulti and Ermias, both from different private hospitals argue that the current level of efficiency of the public bureaucracy cannot take the PPPs any further. The statement provided by Bulti is worth quoting.

> *Regardless of several attempts to improve the efficiency and effectiveness of the government bureaucracy over the past couple of years, we are witnessing a*

> *deteriorating efficiency and low performance in the government bureaucracy in general and those which are working with the private health sector in particular (Ato Bulti, September 5, 2014).*

The above statement clearly implies the prevalence of bureaucratic risk in the health sector that may adversely affect the motivation of both existing and potential investors in the health sector PPPs. On the other hand, respondents such as Mengistu from AAHB, Bayisa from FMHACA and Ketema from one Sub-city strongly argue that problems related to the bureaucratic inefficiency are not significant risk areas as long as the partners establish formal and consultative dialogue forums and design mechanisms to trace and resolve bureaucratic bottlenecks on the spot. However, they also admit that, though the magnitude varies, the health sector of the city involves bureaucratic risks associated with the efficiency and effectiveness of the government institutions (Ato Mengistu, August 4, 2014; Ato Bayissa, August 8, 2014; Ato Ketema, August 12, 2014). The analysis of responses provided by almost all respondents indicates that the bureaucratic risks which are reflected by low efficiency and effectiveness are mainly attributed to several factors. Some of these include the hierarchical and procedural nature of the traditional public sector, lack of sufficient employees in public institutions, lack of appropriate skill and attitude of the already existing employees and low level of motivation of employees working in the public sector (e.g. Ato Mecha, August 4, 2014; Ato Hailu, September 9, 2014)

The prevalence of bureaucratic risk has several implications for the success and failure of public private collaborations in the health sector. On one hand, the private health sector which is already characterized by relatively higher efficiency and effectiveness loses its motivation and positive energy when encountered with bureaucratically rigid and inefficient systems. On the other hand, the prevalence of bureaucratic risks in the health sector usually triggers undesirable behaviors of getting into corrupt practices to get things done promptly and effectively.

The fluctuation of inflation rate and foreign currency which is generally described as economic risk is considered as relatively less challenge by most respondents who participated in the in-depth interviews. Ato Mecha from FMoH pointed out that since most of the health commodities are purchased directly using development funds from global markets, fluctuations in the inflation rate, though high, may not have significant adverse impact (Ato Mecha, August 4, 2014). This view is also shared by Ato Bayisa from FFMHACA and Ato Abayneh, from a private hospital,

who described the economic risk as relatively manageable (Ato Bayisa, August 8, 2014; Ato Abayneh, August 7, 2014). Almost all the other respondents confirm that fluctuation in foreign currency is high and considered as high risk for items that are purchased from international markets. In this regard, Ato Hailu and W/t Meklit both from public hospital argue that some of the outsourced non-clinical services are annually increasing in cost due to high inflation and fluctuation in foreign currency, both of which are affected by input prices. According to the respondents, private companies who are delivering non-clinical services through outsourcing modality always perceive increasing inflation and instability of foreign currency as high risk area (Ato Hailu, September 9, 2014; w/t Meklit, August 12, 2014).

The above empirical evidences indicate that the existing PPPs in the health sector involve market and demand risk. The findings from the analysis of the questionnaire responses are also confirmed by information from in-depth interviews. In this regard, Ato Mecha from FMoH, for instance, argues that particularly at the early stage of the collaboration for HIV/AIDS, TB and reproductive health services, there was low interest of citizens to go to private facilities to obtain these services. There was misunderstanding that these services should only be given by the public sector. According to Ato Mecha, the low interest of citizens to obtain the services is only due to low awareness and cannot be considered as high demand risk (Ato Mecha, August 4, 2014). However, most of the respondents agree that no matter what the reason may be, at the early stages of the public private collaboration in the areas of HIV/AIDS, TB and reproductive health, the interest of the public to obtain services from private facilities was low. Respondents such as Ato Kiros, Ato Kelifa and W/ro Meselech clearly consider the low interest of patients as demand risk in the health sector PPPs (Ato Kiros August 5, 2014; Ato Kelifa, September 3, 2014; W/ro Meselech, August 7, 2014).

Lack of access to capital, i.e., financial risk is almost equally agreed by the respondents. The existing collaborations in the health sector of the City face shortage of capital as financial institutions do not have specific loan arrangements for these PPPs. Gebreyohannes from PHSP, for instance, strongly argues that as Addis Ababa's private health sector is generally at its infant stage, there are clearly visible challenges in obtaining sufficient capital to expand the facilities and enhance the quality of the service delivered through PPP modality (Gebreyohannes, March 3, 2015). Respondents from private hospitals such as Ato Seid, Ato Hailu and Ato Degu strongly

emphasize that the existing PPPs are not progressing as expected due to the shortage of capital to expand the services and improve accessibility.

The analysis of both the questionnaire and interview responses above reveals that the existing collaborations in the health sector have several risks which are of different magnitude. Despite some divergence in views regarding the magnitude of political, bureaucratic and economic risks among the key informants, it can be argued that the existing PPPs involve average to very high risk to the private partner. Firstly, risk perception is generally evaluated from the private partners' point of view and most of the key informants from the private sector perceive that political, legal, bureaucratic, economic market and financial risks are clearly evident in the health sector PPPs. Secondly, despite their tendency to attribute the risks to different reasons, key informants from the public sector also perceive that health sector PPPs involve different risks. As clearly discussed in chapter two, the prevalence of high risk in PPPs leads to low motivation of the partners. More specifically, a partner (whether public or private) that considers the risks as unmanageable may decide to refrain from engaging in the PPP initiative or get the guarantee that the existing risk will be fairly allocated and shared with the other partner. It was also clarified in chapter two that whenever PPPs involve certain risks and the private sector is skeptical to get into such PPPs the government encourages and motivates the private sector through different support schemes. The practice in Addis Ababa's health sector regarding the government support to the private sector is discussed below.

7.4 Government Support to the PPP Initiatives in the Health Sector

The prevalence of various risks, as found out in the previous section, implies that many of the risks discourage the private health sector from engaging in PPP programs. The literature also indicates that the government should support the PPP initiatives particularly at the early stage of the programs. The legitimate argument is that the prevalence of high and various risks added to the low level of risk taking tendency of the private sector significantly hampers the development of PPP initiatives at the early stage. In the health sector of Addis Ababa, the adequacy of the support provided by the government to the PPP initiatives to encourage the private sector is investigated under this section. Particularly, the extent to which the government provides subsidies, access to finance, tax relief, duty-free and other customs privileges and access to

market are investigated. The table below, which is followed by analysis and discussion, presents the summary of results obtained from the structured questionnaire filled in by respondents.

Table 7.3: Government Support to the PPP Initiatives in the Health Sector

PPP Program		No Support		Insufficient		Average		Sufficient		Very Sufficient		Total		Kruskal-Wallis Test	
		N	%	N	%	N	%	N	%	N	%	N	%	Mean Rank	KW Values
Subsidy	1	28	66.7%	12	28.6%	1	2.4%	1	2.4%	0	0.0%	42	100.0%	105.62	H= 3.64 df= 3 P= 0.303
	2	54	56.3%	22	22.9%	8	8.3%	8	8.3%	4	4.2%	96	100.0%	125.28	
	3	17	50.0%	11	32.4%	3	8.8%	2	5.9%	1	2.9%	34	100.0%	129.60	
	4	38	54.3%	23	32.9%	7	10.0%	2	2.9%	0	0.0%	70	100.0%	121.91	
Total		137	56.6%	68	28.1%	19	7.9%	13	5.4%	5	2.1%	242	100.0%		
Access_finance	1	26	61.9%	14	33.3%	0	0.0%	2	4.8%	0	0.0%	42	100.0%	114.00	H= 3.83 df= 3 P= 0.281
	2	60	62.5%	25	26.0%	7	7.3%	3	3.1%	1	1.0%	96	100.0%	116.33	
	3	17	50.0%	8	23.5%	5	14.7%	3	8.8%	1	2.9%	34	100.0%	137.41	
	4	38	54.3%	23	32.9%	7	10.0%	2	2.9%	0	0.0%	70	100.0%	125.36	
Total		141	58.3%	70	28.9%	19	7.9%	10	4.1%	2	0.8%	242	100.0%		
Tax_relief	1	26	61.9%	11	26.2%	3	7.1%	2	4.8%	0	0.0%	42	100.0%	117.24	H= 19.1 df= 3 P= 0.001
	2	62	64.6%	20	20.8%	10	10.4%	2	2.1%	2	2.1%	96	100.0%	115.67	
	3	10	29.4%	11	32.4%	6	17.6%	5	14.7%	2	5.9%	34	100.0%	163.94	
	4	47	67.1%	16	22.9%	3	4.3%	3	4.3%	1	1.4%	70	100.0%	111.44	
Total		145	59.9%	58	24.0%	22	9.1%	12	5.0%	5	2.1%	242	100.0%		
Duty_free_other	1	29	69.0%	9	21.4%	3	7.1%	0	0.0%	1	2.4%	42	100.0%	103.62	H= 15.3 df= 3 P= 0.002
	2	55	57.3%	24	25.0%	11	11.5%	4	4.2%	2	2.1%	96	100.0%	119.36	
	3	11	32.4%	9	26.5%	6	17.6%	4	11.8%	4	11.8%	34	100.0%	158.15	
	4	41	58.6%	18	25.7%	6	8.6%	4	5.7%	1	1.4%	70	100.0%	117.36	
Total		136	56.2%	60	24.8%	26	10.7%	12	5.0%	8	3.3%	242	100.0%		
Mkt_access_Dm	1	5	11.9%	7	16.7%	12	28.6%	14	33.3%	4	9.5%	42	100.0%	128.19	H= 1.06 df= 3 P= 0.788
	2	10	10.4%	19	19.8%	34	35.4%	28	29.2%	5	5.2%	96	100.0%	119.77	
	3	3	8.8%	10	29.4%	7	20.6%	6	17.6%	8	23.5%	34	100.0%	127.47	
	4	4	5.7%	18	25.7%	29	41.4%	13	18.6%	6	8.6%	70	100.0%	116.96	
Total		22	9.1%	54	22.3%	82	33.9%	61	25.2%	23	9.5%	242	100.0%		

Source: Author's Survey, 2014

At the early stage of PPPs in general, governments support the private sector by granting subsidies to encourage and motivate the participation in PPP programs. In Addis Ababa's health sector, the availability and adequacy of government subsidy to PPP programs was investigated. As indicated in table 7.3 above, 28.1% and 56.6% of the respondents respectively indicated that

there is insufficient government subsidy and there is no subsidy at all. In other words, 84.7% of the respondents believe that the government subsidy provided to the private sector participating in PPPs is either inadequate or nonexistent. Only 7.5% of the respondents believe that the government subsidy is sufficient or very sufficient. While respondents from reproductive health category have the tendency to rate government subsidy in the health sector more favorably (mean rank= 129.60), respondents from HIV/AIDS tend to rate the prevalence and adequacy of subsidy more unfavorably (mean rank= 105.62). However, as it can be understood from the Kruskal Wallis test results, the proposition about the homogeneity of responses across different sample groups cannot be rejected at the level of significance of 0.05. The P value of 0.303 (H= 3.64, df= 3) infers that respondents from all the four independent sample groups responded in the same way.

Lack of access to finance is one of the key risk areas for the private sector. Under these circumstances, the government is expected to share the financial risk of the private sector by providing access to finance using various mechanisms. As indicated in table 7.3 above, the assessment of the provision of financial access to the private sector reveals the following results. 28.9% and 58.3% of the respondents indicated that there is insufficient provision of access to finance and no access to finance respectively. Overall, 87.2% of the respondents believe that the government provides either insufficient access to finance or no access at all for the private sector participating in the health sector PPP initiatives. On the other hand, only 4.9% of the respondents believe that the provision of access to finance by the government is sufficient or very sufficient while 7.9% of the respondents rated it as average. Respondents from reproductive health sample group tend to rate access to finance as generally sufficient (mean rank= 137.41), while respondents from HIV/AIDS showed the tendency to rate as generally insufficient (mean rank= 114.00). However, based on the Kruskal Wallis P value of 0.281 (H= 3.83, df= 3), the proposition about the homogeneity of responses across different sample groups cannot be rejected. Therefore, it can be argued that respondents from HIV/AIDS, TB, reproductive health and non-clinical service groups responded almost in a homogeneous manner about the prevalence and adequacy of access to finance.

New entry of the private sector in PPP projects is usually followed by remarkable investment and the government support and encouragement to such initiatives can be reflected by providing tax relief to the private sector. As can be revealed from table 7.3 above, 24% and 59.9% of the

respondents rated the provision of tax relief as insufficient and nonexistent respectively. The overall result indicates that 83.9% of the respondents believe that the government does not provide adequate tax relief or does not provide tax relief at all for the private sector institutions participating in public private collaboration. On the other hand, only 7.1% of the respondents favorably responded about the government's provision of tax relief for the private sector. The Kruskal Wallis P value of 0.001 (H= 19.12, df= 3) indicates that the proposition about the homogeneity of responses across the four independent samples can be rejected at the significance level of 0.05. Therefore it can be safely argued that the respondents from HIV/AIDS, TB, reproductive health and non-clinical services have significantly different responses regarding the prevalence and adequacy of tax relief provided to the private sector. This statistically significant variation is attributed to the fact that respondents from reproductive health sample groups showed the highest favorable response (mean rank= 163.94) while respondents from non-clinical service category tended to provide the lowest rate about the provision of tax relief (mean rank= 111.44). Despite the variations, the overall results indicate that tax relief provided to PPP programs is either very insufficient or non-existent at all.

Theoretically, the government wishing to encourage the development of PPPs provides support to the private sector through duty-free privileges and other customs related benefits. The assessment of the practice in Addis Ababa's health sector reveals the following results. Table 7.3 reveals that 24.8% and 56.2% of the respondents rated the provision of customs related benefits as insufficient and nonexistent at all respectively. Overall, 81% of the respondents believe that the duty-free and customs related benefits provided by the government as a support to the private sector is not encouraging at all. On the other hand, only 8.3% of the respondents believe that the government is providing sufficient to very sufficient customs related benefits for the private sector participating in public private collaborations. The proposition about the homogeneity of responses across the four independent sample groups can be rejected at the level of significance of 0.05. The Kruskal Wallis P value of 0.002 (H= 15.38, df= 3) reveals that respondents from HIV/AIDS, TB, reproductive health and non-clinical services have significantly different responses. This variation in responses is because, respondents from reproductive health sample groups indicated the highest favorable rating (mean rank= 158.15) while respondents from HIV/AIDS showed the tendency to rate more unfavorably (mean rank= 103.62). However, the

overall ratings generally imply inadequacy or lack of duty free and other incentives provided by government to PPP initiatives.

Finally, governments usually share the market and demand risk of the private sector by implementing deliberate intervention to increase access to market and create demand for services provided through PPP arrangement. In Addis Ababa's health sector, the investigation of the practice of supporting the private sector through the creation of market and enhancement of demand for services shows the following results. As indicated in table 7.3 above, 22.3% and 9.1% of the respondents rated market development and demand creation of the government as insufficient and nonexistent respectively. Overall, 31.4% of the respondents unfavorably responded about the prevalence and adequacy of government's effort to develop market access and increase citizens' demand for PPP based health services. On the other hand, a total of 34.7% of the respondents believe that the government is making fairly sufficient effort to develop access to market and increase the demand for services delivered through PPP arrangements. Respondents from HIV/AIDS sample group rate more favorably about the government's support to increase market access and demand (mean rank= 128.19), while respondents from non-clinical services tended to rate more unfavorably (mean rank= 116.96). However, as the overall results indicate, the proposition about the homogeneity of responses across the different independent sample groups cannot be rejected at the significance level of 0.05. The Kruskal Wallis P value of 0.788 (H= 1.06, df= 3) suggests that respondents from HIV/AIDS, TB, reproductive health and non-clinical services have almost similar responses.

The above analysis of responses from the structured questionnaire is triangulated with information from in-depth interviews. Though the government is supposed to support the private sector to motivate and encourage them to participate in collaborations, the existing reality indicates that public support to the private sector is generally low. Almost all the respondents who participated in the in-depth interviews confirmed that the government is not doing anything specific to encouraging the private health sector. Ato Mecha, from FMoH, for instance, clearly admitted that the government's support to the private sector is almost non-existent. His statements are quoted as follows.

> *In the first place, even the government is not clear about the types of support to be provided to the private sector. Moreover, the lack of clearly established policy,*

legal and institutional framework in the areas of PPPs is mainly responsible for the low support to the PPP initiatives (Ato Mecha, August 4, 2014)

The argument by Ato Yimer from AAFMHACA is similar to the above. Specifically, he pointed out that, the current relationship between the public and private sectors focuses more on regulation and control than support and cooperation. According to Yimer, support to the PPPs should be based on predictable policy and institutional frameworks (Ato Yimer, August 8, 2014). Gebreyohannes from PHSP, W/ro Almaz from Private Clinic Owners Association, Ato Ketema from Health Department of one Sub-city and Ato Kelifa from a private hospital have almost similar views regarding government support to PPP initiatives. They all confirmed that, given the very low level of private health sector in Ethiopia in general and in Addis Ababa in particular, the supports provided by the government are highly required. They also unanimously indicated that the government does not have formal mechanisms of assisting the PPPs. Practically, there is no meaningful support provided by the government to encourage PPPs in the health sector. According to the respondents, better jobs are rather done by development donors working in the health sector. The PHSP, for instance, has interventions to support the development of PPP in the health sector by building the capacity of the private health sector. Its PPP support activities include the following:

- the development of policy framework for the participation of the private sector in the delivery of public services,
- capacity building trainings for the private health sector,
- improving access to credit to the private health care providers,
- Improving the quality of private sector based health services by supporting the licensing, accreditation and standardization efforts of the government, and
- Strengthening the capacity of private health service associations such as Higher Private Health Education Institutions Association (HPHEIA) and Medical Association of Physicians in Private Practice of Ethiopia (MAPPP-E).

  (Gebreyohannes, March 3, 2015; W/ro Almaz, September 5, 2014; Ato Ketema, August 12, 2014; Ato Kelifa, September 3, 2014).

All the above supports provided to the private sector in order to encourage PPPs in health services are exclusively provided by development donors and not by the government. Based on

the review of literature in chapter two, it can be argued that the development of the private sector is the responsibility of the government particularly at the early stage of the PPPs. More importantly, due to the fact that the private health sector in the City is at a low level of development, the role of the government in supporting PPPs by encouraging the private sector is even higher. However, the information from both the structured questionnaire and in-depth interviews reveals that the formal and informal support of the government to encourage PPPs is either negligible or nonexistent at all.

7.5 Summary of Findings

It was clearly indicated at the outset that the purpose of this chapter pertains to answering the research question number 4 as stated under section 1.3 of chapter 1: “to what extent are risks shared and the partners mutually support each other in the existing PPP programs in Addis Ababa’s health sector?” The analysis and discussion of data from various sources reveal the following important points that are specifically relevant in terms of effectively answering the research question under consideration.

Firstly, it was learnt that the practice of effectively identifying, analyzing and understanding PPP related risks is found to be low in Addis Ababa’s health sector. As a result, effective and efficient risk allocation to the party (either private or public) that can better handle the risk is not adequately practiced. Moreover, lack of sufficient understanding of risks has hampered the motivation and readiness of the private sector to take risks and engage in public private collaborations. Besides, risk monitoring and evaluation systems as well as mitigation strategies are not common practices in the existing PPP initiatives in the health sector.

Secondly, though with varying magnitude, the existing collaboration programs in Addis Ababa’s health sector involve different risks. Political, legal, bureaucratic, economic, market and financial risks are identified in the health sector and their prevalence is contextually described. The implications of the prevalence of these risks are also found to be different for the public and private sectors. More importantly, the prevalence of the risks and the level of influence also clearly inform the partners on how to share the risks. Specifically, risks that are deemed to reduce the motivation and readiness of the private sector indicate that the government should share the risks through deliberate interventions to support the private sector and encourage them to participate in PPP initiatives.

Finally, it was found out that despite the expectations at the early stage of PPPs, the government's support to the existing PPP initiatives is very low. The government does not have mechanisms and practices of supporting the private sector institutions who participate in public private collaborations. The efforts made by development partners such as PHSP of the USAID program are more pronounced in terms of supporting and encouraging the private health sector to participate in PPP initiatives. Therefore, except the efforts made by development partners, the mutual support in general and the government's deliberate assistance to encourage PPPs in the health sector in particular are not encouraging.

Chapter 8: Conclusion and Recommendations

8.1 Introduction

The main objective of this research is to explore the policies, practices and challenges of public private partnership in the health sector of Addis Ababa. There are strong and convincing justifications for studying the environment of PPPs in the health sector. Firstly, despite the theoretically appealing arguments for PPP in health service delivery, there is still little empirical research conducted in Ethiopia as well as Addis Ababa about the policies, legal and regulatory environment for the application of PPP as service delivery approach. There is also scanty knowledge about institutional and structural issues surrounding the implementation of collaborations in the health sector. This dissertation is also motivated by the unresolved controversies about the practices and mechanisms of sharing risks and mutually supporting each other in public private partnership processes. Theoretical lenses of institutional theory, systems theory, principal-agent theory and rational choice theory were applied to analyze and interpret data to effectively answer the research questions. The analysis and interpretation of results was also made based on the conceptual model developed in chapter two of this dissertation.

Using a mixed concurrent triangulation strategy and giving emphasis to qualitative aspects, the study investigated the status of the health sector of Addis Ababa and pointed out the implications for PPP as alternative health service delivery approach. It also analyzed the policy, legal and regulatory frameworks and their appropriateness for the application of PPP as health service delivery approach. The institutional capacity of the public sector for managing both the existing public private collaborations and future PPP initiatives in the health sector was also investigated. Moreover, practices and challenges of risk sharing and mutual support between public and private partners were examined. Using relevant theoretical and conceptual frameworks developed in chapter two, the analysis and interpretation of primary and secondary data has led to key findings, which the researcher believes have effectively answered the 4 research questions posed under section 1.3 of chapter 1. The following conclusion, theoretical contributions, directions of future research and policy recommendations, which are thoroughly informed by analysis and interpretation of data, are drawn.

8.2 Major Conclusions

The conclusion drawn under this section is related to the individual research questions and analysis and interpretation of data conducted in separate chapters (chapter 4 to 7) to answer the research questions. This section restates the research questions in chapter 1 and presents the major conclusion reached as answers to the basic questions as follows.

I. **What are the challenges in the existing health sector that imply the need for public-private partnership in Addis Ababa?**

- The analysis of information in chapter 4 revealed that the health sector of Addis Ababa still undergoes several challenges despite all the efforts made by the public sector and development partners. Despite a strong commitment of the government to address health issues in Addis Ababa, attempts to deliver health services using a strong public sector orientation (philosophy of welfare state) did not adequately address the health needs of the citizens.
- Health service delivery in Addis Ababa is still low as compared to even many sub-Saharan African countries. Though the growth in investment in the health sector has remarkably improved the health status of the country in many aspects, majority of the health indicators are at the lowest level when compared with other developing countries. As theoretically discussed in chapter 2, whatever institutions, structures and systems are laid down by the government, the objectives of accessibility, service coverage, efficiency and effectiveness in public service delivery cannot be achieved using the public sector alone.
- The HSDPs so far implemented, the MDGs in general and HSDP IV in particular have ambitious health sector goals to improve the health status of the city with particular emphasis to diseases such as HIV/AIDS, TB, malaria, and maternal and child health which are known to have high socio-economic and public health impacts. These health services, which are universally, referred to as issues of global and national health sector priorities that require more than the public sector intervention.
- The dynamics of service delivery approaches mainly depend on the changes in the nature and scope of the services. Following the rapid urbanization and associated life style changes, prevalence and impact of non-communicable diseases is also recognized as the focus area of the health sector demanding attention in Addis Ababa.

Practically, though both the public and private health sectors are involved in the treatment and management of the above diseases and health concerns, the integrated and cooperative approach, i.e., partnership between public and private sectors is believed to more effectively address the health challenges related to non-communicable diseases.

- The health sector governance appears to give heavy emphasis to the public sector and its bureaucratic structures which implies the strong welfare orientation of the government. The position and role of the private health sector is not clearly visible in the governance structure of the Addis Ababa's health sector. Though the private health sector in Addis Ababa in particular has been growing over the last few years, the public health sector does not consider the private sector as an important component of the total health system. As a result, health sector plans, performances and reports clearly marginalize the role played and the contribution made by the private health sector in addressing the health sector goals in Addis Ababa.
- The growth of health sector assets such as health facilities and human resources indicate that the involvement of the private sector is also remarkable in health sector investments particularly in urban areas. In Addis Ababa, although the private sector owns and operates the largest number of private hospitals and pharmaceutical businesses, this potential is not adequately utilized to achieve the health sector goals and targets set by the HSDPs.
- While the high turnover of health professionals from public health facilities implies migration to the health facilities in urban areas, the knowledge, skill and time of the health professionals is practically utilized by both the public and private health facilities. The concept of resource sharing, cooperation and coordination which are important aspects of well functioning PPPs would help the health sector to efficiently utilize the existing scarce health professionals in the country. However, the inability to conceptualize the health sector as a total system and the public and private sectors as integral and complementary constituents of the system has led to a fragmented use of the workforce.
- Theoretically, information about the achievements and challenges of the health sector should reflect the efforts of both the public and private health sector. In reality,

however, the health information system of Addis Ababa's health sector appears to strongly focus on the public sector structure while in practice information from the private health sector would have added value to health sector planning and decision making. Since health related information from the private sector is not systematically collected, analyzed and carefully integrated into the national HMIS, the achievements of the government in the health sector as well as future directions are more likely based on inadequate and even distorted information. As clearly stipulated in chapter 2, well functioning PPPs can lead not only to coordination of efforts and resources but also to coordination of information.

- Health care financing in Addis Ababa appears to be heavily dependent on foreign assistance from bilateral and multilateral sources and out-of pocket payments. While the former is clearly unpredictable and less sustainable in terms of achieving the long-term goals of the health sector, the later is generally unaffordable for people who live under multidimensional poverty. Partnership with the private sector can be considered as a potential area of financing the health sector through well-designed and mutually agreed arrangements.
- The regulatory environment of private health care providers is more top-down/external. The current regulatory role of the government in Addis Ababa is not based on the spirit of mutual trust, cooperation and mutual understanding of working towards the same health sector goals. Though theoretically regulation through cooperation and partnership is more powerful in favorably shaping the behavior of the private sector, the regulatory environment in the existing health system is mainly characterized by unhealthy relationship between the regulator (the principal) and the regulated (the agent).

In a nutshell, it can, therefore, be argued that the status and realities in the existing health system in Addis Ababa call for collaboration with the private health sector which should be informed by appropriately designed PPP model.

II. To what extent do the policies, legal and regulatory frameworks of the incumbent government and the city Administration give room for PPP in the health service delivery in Addis Ababa?

- The political ideology of the incumbent government gives room for the participation of the private sector in service delivery in general and health service provision in particular. This is also explicitly reflected in the economic policies of the government except that there are limited sectors that are exclusively reserved for the government. However, the specific roles that the private sector can play are not clearly articulated in the policy documents. Despite government's pronouncements that the private sector is an engine of development, the relationships between the public and private sectors in general and the approaches to PPP in particular are not clearly articulated anywhere in the policy and strategy documents.
- The public health sector is not adequately working with the private sector on common issues that are essential to both parties. Though early practice of working together on common issues paves the way for the development of PPP policies and leads to full scale PPP practices, the existing level of cooperation and collaboration between the public and private health sectors is minimal.
- The existing PPP practices are operating without PPP policies that govern the initiatives. Neither national nor health sector specific policies are currently available to guide PPP practices in the health sector of Addis Ababa. As a result, the existing PPP projects are based on ad hoc provisions which are vulnerable to interpretation errors that may end up in conflict among the partners.
- The health sector of Addis Ababa does not have formally established and continuous public private dialogue (PPD). Despite the importance of PPD in bringing the public and private health sectors on board and paving the way for the development of mutual trust and common understanding that would add value to policy development, the health sector of the City does not have formally established PPD forum.
- Addis Ababa's health sector does not have adequate legal framework that guides the operational issues of PPP practices. As a result, the existing PPP initiatives are based on other proclamations and regulations that do not fit into the peculiar nature of PPPs in the health sector.

- The existing PPP practices are not commercially oriented mainly due to the lack of appropriate legal environment. As a result, the business principles of generating reasonable profit, competition and other important issues are not adequately accommodated.
- Except the contracting-out of non-clinical services, the existing PPP initiatives in the health sector of Addis Ababa do not have formally signed and agreed PPP contracts that regulate the behavior of both partners. The current practice of using simple MoUs is leading to problems in managing the relationships between the public and private sector partners.
- The regulatory environment in the existing health sector is not generally encouraging for the development of PPPs. The fact that the existing PPPs operate under the framework of the pre-existing laws has somehow affected the proliferation of PPP initiatives and programs.

Therefore, it can be concluded that the policies, legal and regulatory frameworks of the incumbent government and the City Administration do not provide adequate room for the development of PPPs in the health service delivery in Addis Ababa.

III. How does the current institutional capacity of the public sector influence the effective implementation of PPP initiatives in the health sector of Addis Ababa?

- PPP initiatives are not institutionalized at national level. Despite government's interest to involve the private sector in public service delivery, there is no unit or department or government agency that coordinates and provides policy support for PPP programs. As a result, the existing PPP initiatives in the health sector are being implemented using ad-hoc arrangements that are developed by development partners, the government and private sector entities.
- The health sector does not have properly established, clearly mandated and empowered unit or department that coordinates PPP initiatives in the sector. Neither the Federal nor the City government has specifically designated PPP office within the health sector structure. The existing public private collaborations are being implemented without clear institutional framework and leadership.

- Despite several existing collaborations between the private and public health sector in Addis Ababa, employees and leaders are not adequately trained to design and implement PPP initiatives. There is also leadership gap in the health sector in terms of providing strategic and policy direction to the health sector PPP initiatives. It was also found out that employees' skills in the areas of PPP project planning, implementation and monitoring, finance and accounting, legal knowledge and contract management and monitoring and reporting are generally low. Therefore, it can be concluded that the existing PPP initiatives are being implemented with inadequate leadership and employee skills.
- Technical expertise is utilized from external sources at the early stage of the PPPs. Though the support from PHSP is highly pronounced in introducing and promoting PPP initiatives in the health sector of Addis Ababa, it is found out that the expert assistance is not sufficient in terms of building strong and sustainable PPP culture in the health sector of the city.
- It is found out that PPP experts and focal units generally play neutral and advisory role. Less conflict of interest was observed in the process of designing and implementing public private collaboration in the health sector of the city.
- The health sector of Addis Ababa lacks clear, formal and open criteria for selecting the private partner. Procurement of partners based on ad hoc arrangements has not only led to several complaints from the private sector but also has compromised the principle of good governance which is an essential requirement for success in PPP initiatives.
- Partners who are dissatisfied with any decision in the PPP procurement process do not have clear and transparent complaint handling procedure. A conflict that may arise at any stage of the collaboration is not resolved using predetermined and clear conflict resolution tools.
- The absence of practice of closely monitoring and evaluating PPP procurement processes and the lack of transparent and open competition gives room for the discretionary power of the procurement team. Therefore, it can be concluded that the process and practice of selecting the private partner in the health sector of Addis Ababa does not adhere to the basic principles of good governance in PPPs.

In a nutshell, it can be safely concluded that the existing institutional framework and capacity of the public sector is not adequate and appropriate to manage both the existing and future PPP initiatives in the health sector of Addis Ababa.

IV. To what extent are risks shared and do the partners mutually support each other in the existing PPP programs in the health sector of Addis Ababa?

- Risks related to PPPs in the health sector of Addis Ababa City are not identified and analyzed before entering into public private collaborations. Both the public and private sectors do not have adequate and up-to-date information about the types, characteristics and chance of occurrence of risks before engaging in collaborative ventures.
- The lack of careful identification and analysis of risks at the early stage of PPPs has also adversely affected the practice of allocating risks to the party (either public or private) that can manage them better. It can also be concluded that in the existing public private collaborations, risks are not appropriately and fairly allocated to the parties.
- The private health sector in Addis Ababa is not ready to take risks even though the PPP initiatives are beneficial to the citizens. This tendency is partly attributed to the lack of sufficient knowledge and information about the risks in the health sector PPPs.
- Even though the public private collaborations in the health sector of the city involve several risks, both the public and private sectors do not have risk mitigation strategies.
- Moreover, the existing health sectors PPPs do not have effective risk monitoring and evaluation system. Monitoring, evaluating and learning from risks is not generally considered as an important aspect of collaboration between the public and private health sectors in Addis Ababa.
- It is found out that public private collaboration in Addis Ababa's health sector, though at the emerging stage, has several types and levels of risks which have implications for careful risk sharing and mutual support. Political, legal, bureaucratic, economic, market and financial risks are remarkably high in the existing collaborations.

- Although the existence of different types and levels of risks in PPP initiatives theoretically calls for fair risk sharing and government support to encourage the private partner, no meaningful support is currently provided by the government to the private sector in Addis Ababa. The government has provided little or no practical support to the private health sector in the areas of subsidy, access to finance, tax relief and duty-free privileges and creation of demand for PPP delivered health services.

8.3 Contribution of the Study to the PPP Body of Knowledge

This dissertation aims to investigate the policies and practices of PPPs in the health sector of Addis Ababa and came up with the findings and conclusions outlined under section 8.2 above. Two approaches, namely the policy sector approach and governance approach were used to operationally define PPP for the purpose of this dissertation. The analysis of health sector PPPs was also made based on the NPM framework using institutional theory, systems theory, rational choice theory and principal-agent theory. This section discusses the theoretical contributions of the findings in this dissertation from the perspectives of NPM reforms and the above theories.

Within the NPM framework, PPPs in the health sector imply the shift from government to governance in which polycentric and multi-level governing system of health services substitutes the traditional and hierarchical approach to health service delivery of the welfare state. The findings in this dissertation, however, imply that the health sector of Addis Ababa in particular does not comply with the theoretically appealing concept of governance. The theoretical tenet that PPPs in the real sense of governance lead to gradual erosion of boundaries between market and hierarchy does not hold true in the health sector of Addis Ababa. Government structures, traditional hierarchies and public sector dominance of health service delivery as visible characteristics of the health sector of Addis Ababa imply that the central argument of systems theory is not adequately applied in PPPs where welfare orientations dominate public service delivery. Although in PPPs in general governments and the private sector are increasingly interdependent through cooperation, collaboration and mutual support, it is difficult to yield interdependence in highly government dominated and welfare oriented structures of public administration.

The findings in this dissertation also imply that public service delivery through the public sector structures and highly welfare oriented approaches leads to failure in adequately rewarding and

motivating employees, which ultimately lead to low efficiency, lack of sufficient and capable employees and high turnover as clearly revealed in chapter 4. Moreover, financial pressure, failure to enhance accessibility of public services and inability to effectively attain public sector goals are some of the characteristics of strictly welfare-oriented health services which use the traditional public bureaucracy to deliver public services.

An important and critical issue that emerges from the findings of this dissertation is the conditions under which PPPs emerge and develop. Unlike the historical background of NPM reforms which were born out of neo-liberal thoughts of small government, PPPs as both sector policy and governance approach can be applied outside the neo-liberal ideologies. The contexts within which PPPs are emerging and developing in the health sector of Addis Ababa in particular imply that governments do not necessarily need to apply a neo-liberal line of thought to adopt and utilize PPPs as public policy and service governance approach.

The theoretical argument that the development of PPPs should be guided by appropriate legal and regulatory framework is also confirmed by this study. As the findings of this dissertation imply, when PPPs as governance approach in public service delivery are not appropriately institutionalized, the theoretically appealing benefits of accessibility, risk sharing and mutual support are clearly blurred. PPPs in public service delivery in general and healthcare provision in particular lack sustainability, predictability and stability of operation when the processes are not carefully augmented by rules, regulations and procedures. More importantly, as the findings imply, the principles and values of good governance in PPPs can only be promoted in the presence of policies and legal frameworks that guide the decisions, actions and behaviors of both the public and private partners. The findings also suggest that in the absence of strong legal and regulatory framework for PPPs which are developed with the aim of substituting regulatory government with regulatory governance, the government will remain the only regulator of non-state actors in general and the private partner in particular.

The conception and development of PPP initiatives that are not supported by adequate institutional capacity building are likely to fail. The findings of this dissertation imply that the prevalence of separate institutional structures, adequate leadership competency and employee skills and external technical support are at the heart of capacity requirements for effectively designing, implementing and benefiting from PPP as a governance approach. The study

confirmed that PPPs implemented without sufficient institutional support are at the risk of failure in terms of resilience and stability.

Failure to conceptualize the health sector of the country as a total system has adverse implications on the application of PPPs. As both the public and private health sectors influence one another to maintain their activity, the behavior of one sector directly or indirectly affects the other sector. The findings from the health sector of Addis Ababa imply that issues of risk sharing, mutual support and regulatory governance are only possible under the environment of shared vision between the public and private health sectors. The study confirmed that constructive and sustained public private dialogue with the spirit of systems thinking, commitment from both sides to reach mutually beneficial decisions and collaborations through clearly articulated and contract based relationships are required for healthy and sustainable PPPs.

At the early stage of PPPs where the environment is loose and both the public and private partners do not have sufficient information and capacity to engage in PPPs, the responsibility to nurture the private sector and promote PPP culture lies on the government. The findings of this dissertation imply that as the private sector, by its very nature, is governed by rational choice of optimizing its benefits directly or indirectly, risk sharing in PPPs that does not consider this reality will fail to gain the willingness and commitment of the private sector. Needless to say, the private sector is mainly interested in a given engagement if the financial and non-financial benefits in the short or long run outweigh the costs. This is clearly revealed by the low level of readiness of the private health sector in Addis Ababa to take risks and engage in PPPs even when the initiatives are highly beneficial to the citizens.

The low level of the development of the private sector and its bounded rationality in terms of information about PPPs justify the government's intervention to support and encourage the private sector to engage with the public sector in the delivery of services through PPPs. From the perspectives of the principal-agent model, the relationships between the public and the private sector are established based on the interests and autonomy of operation from both sides. However, as clearly discussed in chapter two, the public sector (in this case the principal) is expected to regulate, support, reward and motivate the private sector (in this case the agent). The findings also imply that in the absence of weak PPP structure, unspecified performance contracts

and ambiguous mandates PPPs will likely fail to achieve the desired goals for both partners. Moreover, conflicts of interest and governance problems are also likely to arise.

8.4 Directions of Future Research

This dissertation came up with answers to the research questions outlined under section 1.3 of chapter one using mixed concurrent triangulation strategy. It also used a distinct theoretical framework and conceptual model developed in chapter 2 for data analysis and interpretation. However, the research processes and ultimate findings of this study suggest several future areas of research which are stated below.

- The inherent research limitations of this dissertation as indicated in chapter 1 call for the need to conduct further and more refined study. The sampling method used to collect quantitative data, the intrinsic limitations of qualitative approach; the theoretical and conceptual models utilized in this study are all methodological choices which have their own limitations. Though, the research design and approach used in this study are well informed by the nature of the research questions, future researchers may carry on similar studies to answer the research questions raised in this dissertation using a different research design and approach to test consistency and regularity of the findings.
- The findings of this study also suggest future areas of research following the footsteps of the outcomes of this research. Firstly, the study has come up with some peculiar findings such as the possibility of applying PPPs in any political context regardless of the ideological choice of the incumbent government. To this end, the author suggests further studies to be conducted on how governments using developmental state ideology and revolutionary democracy can engage the private sector in general and apply PPP in public service delivery in particular. Secondly, there are unanswered aspects of the research questions in this dissertation. For instance, the impact of institutional capacity on risk identification, allocation and sharing in PPP initiatives can be studies using quantitative research design. Moreover, the mechanisms and technical procedures for sharing risks in the health sector PPPs also merit another detailed empirical study.
- The conceptual model developed for this dissertation is applied for the health sector of Addis Ababa. The author strongly suggests this model to be examined using research in a different context and location. Specifically, further study can be conducted on how the

conceptual model can work in the health sector of the other regional states of Ethiopia. This is mainly because the level of development of the private sector and the progress in PPPs are different in Addis Ababa and other regional states. Replicating the conceptual model applied in this study in relatively developed regions (Tigray, Amhara, Oromia and SNNPR) as well as the emerging four regions (Afar, Somali, Benishangul Gumuz and Gambella) may lead to similar or different findings.

- A series of future researches are also recommended by expanding the conceptual framework developed and used in this study. Firstly, though a public interest goal is an important component of the conceptual model developed in chapter two of this dissertation, it was not empirically analyzed. Future researchers can focus their studies on how public interest goals such as equity, inclusiveness, accountability and affordability can be promoted and ensured in health sector PPPs of Addis Ababa. Secondly, the cause and effect relationships among the constructs in the conceptual model indicated in chapter two merit further researches in Addis Ababa. Finally, future researchers can expand the conceptual model developed for this dissertation by reviewing additional and emerging literature in the areas of PPP.
- There are several reforms and changes that are taking place in the health sector of Ethiopia as well as Addis Ababa. For instance, it was revealed during the in-depth interviews that Ethiopia is in the process of revising its health policy in the context of new political, economic and social developments. Moreover, the USAID's Private Health Sector Program (PHSP), which is currently nurturing and supporting health sector PPPs in Addis Ababa, will phase out handing over the coordination of PPP initiatives entirely to the government. Therefore, re-evaluating the conceptual model of this dissertation after the above two developments may lead to a different set of research findings.

8.5 Policy Recommendations

The findings and conclusion in this study indicate that there is a need to further engage the private health sector through PPP approach. However, the policy environment for the private sector participation in general and PPP in particular needs to be improved to resolve the challenges and limitations of the Ethiopian health sector. The following recommendations are therefore forwarded for policy makers.

- Policy makers need to find mechanisms on how the private sector can be further involved in the delivery of public services. Future public policies should provide adequate room for the participation of the private sector in the delivery of health services.
- The policies and strategies of the government should clearly articulate the role that the private sector can play and identify mechanisms.
- The government should issue specific policies, strategies and working guidelines for PPP at a national level that can be operationalized and adopted at sector level.
- Adequate and specific legal frameworks that are harmonized and aligned with the existing law of the land are also required to facilitate the implementation of PPP initiatives. Based on this, the health sector can develop its own internal and sector specific standard operating procedures for the planning, implementation, monitoring and evaluation of PPP projects within the health system.
- Policies and strategies to engage the private sector through PPPs should carefully balance the public interest goals of equity, inclusiveness, accountability and affordability with the private sector goals of profit orientation and return on investment.
- PPP policies and strategies should incorporate provisions to institutionalize PPP at both national and sector level. National PPP agency can be established under a relevant ministry such as MoFED while PPP unit or department can be structured under the FMoH. Following the decentralized and democratized health system of the country, Addis Ababa Health Bureau as well as the Health Bureaus of the Regional States should form PPP coordination units at state, zonal and woreda levels.
- The introduction of PPPs in the health sector should be augmented by intensive and extensive capacity building program to enhance the competence of the leaders and employees' skills to plan, implement and manage PPP projects in the health sector. Beyond the health sector, the author also recommends the establishment of PPP center of excellence that can serve as a national capacity building hub. Notwithstanding the need to utilize external expertise at the early stage of PPP, in-house capacity should be built through sustainable and institutionalized capacity building programs.
- PPP as an approach to public service delivery should be essentially based on the values and principles of good governance. Policy makers and practitioners should provide serious attention openness and transparency in the selection of private partners. Pre-

determined and open criteria should be developed and applied with strict principles of competition and merit. Moreover, the relationship between the two partners should be governed by constructive dialogue and a spirit of mutual trust that can further promote good governance in PPPs in the health sector. Complaints, conflicts and bottlenecks should be proactively managed to prevent PPP initiatives from governance failures.

- The risk sharing and mutual support environment of the existing PPPs need to be improved. There should be clear mechanisms and guidelines for risk identification and allocation between the public and private partners who are involved in PPPs in the health sector. Both the private and public sector institutions should develop risk mitigation strategies to proactively manage the consequences of various risks that may occur at any stage in due course of implementing PPP initiatives. More importantly, policy makers should identify mechanisms and strategies on how the public sector in Ethiopia can encourage and empower the private health sector to take risks and further involve in PPPs. Policy makers can also consider the issue of how deliberate supports such as subsidies, tax relief, customs privileges, access to finance and market creation can be provided to the emerging private partner.

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Appendix A: Sample Questionnaire Distributed to Respondents

Addis Ababa University
College of Business and Economics
Department of Public Administration and Development and Management
PhD Program in Public Management and Policy

Research Title: "*Public Private Partnership in the Ethiopian Health Sector: The Case of Addis Ababa City*"

Questionnaire to be filled by public and private sector employees who are familiar with and participated in public private partnership programs in the health sector of Addis Ababa

Introduction:

Thank you for your willingness to participate in this study as a respondent. This questionnaire is used to collect data for the PhD research entitled "Public Private Partnership in the Ethiopian Health Sector: The Case of Addis Ababa City". Your experiences and opinions will significantly add value as an input to this thesis. I assure you that the information you provide will be used only for academic research purpose and anonymity of the respondent will be maintained throughout the research process. Thank you for your cooperation.

1. *Your organization*

☐ *Public Hospital*
☐ *Private Hospital*
☐ *Private Clinic*
☐ *Private Contracting Agency*

2. *Your level of education*

☐ Diploma and TEVET

☐ First Degree

☐ Second Degree and above

3. Year of Experience in the health sector in general

☐ 5 years and below
☐ 6 to 10 years
☐ 11 to 15 years
☐ 16 to 20 years
☐ 21 years and above

4. Your current position _____

5. Type of PPP program in your organization

☐ HIV/AIDS

☐ TB

☐ Reproductive Health

☐ Non-clinical service contracting out

☐ Other (Please specify) _____

6. Public Private Partnership: Policy Environment

For the following questions, please put (X) mark in the box corresponding to your preferred response using the scale below

5: Strongly Agree 4: Agree 3: Neutral 2: Disagree 1: Strongly Disagree

No	Questions	Scales				
		5	4	3	2	1
1	The political ideology of the incumbent Ethiopian government gives sufficient room for the participation of the private sector in public service delivery.					
2	The economic policy of the Ethiopian government gives adequate room for the private sector participation in service delivery.					
3	The roles that the private sector can play in service delivery are clearly articulated in the policy and strategy documents of the government.					
4	The public health sector in Addis Ababa is adequately working in partnership with the private sector					
5	The partnership with the private sector in Addis Ababa is governed by coherent policies that lay down clear objectives and principles of partnership					
6	The prevalence of clear policies and strategies positively contributes to the effectiveness of PPP practices in the health sector					
7	The core values of developmental state ideology can be incorporated into the PPP policies in the health sector					
8	There is adequate, formally established and policy supported dialogue forum between public and private health sector in Addis Ababa city.					
9	The relevant areas of PPP are clearly identified and understood in the health sector of Addis Ababa City.					
10	Due to lack of clarity about relevant and feasible PPP areas, the practice of PPP in the health sector of Addis Ababa City is negatively affected.					

7. Public Private Partnership: Legal and Regulatory Framework

For the following questions, please put (X) mark in the box corresponding to your preferred response using the scale below

5: Strongly Agree 4: Agree 3: Neutral 2: Disagree 1: Strongly Disagree

No	Questions	Scales				
		5	4	3	2	1
1	There is adequate legal framework to govern and regulate PPP practices in the health sector of Addis Ababa City.					
2	The current PPP practices in the health sector of Addis Ababa effectively address the rights and interests of the stakeholders					
3	The PPP rules and regulations are commercially oriented to generate reasonable profit for the private partner in Addis Ababa.					
4	Issues related to tax, competition, procurement and other regulatory concerns are well addressed in the current health sector PPP practices of Addis Ababa.					
5	The PPP contract document has some contradictions and mismatch with other legal provisions of the Addis Ababa and Ethiopia.					
6	Standardized contract documents are prepared, clearly understood and signed among parties before involving in PPP practices in Addis Ababa					
7	The public health sector has strong mechanisms for fair and consistent enforcement of PPP contracts in Addis Ababa City.					
8	The PPP regulatory framework currently in practice optimizes efficiency and effectiveness in health service delivery in Addis Ababa.					
9	The current PPP in the health sector of Addis Ababa is dominated by more enabling and supportive rules and regulations					
10	The current PPP in the health sector of Addis Ababa is dominated by more disabling and constraining rules and regulations					

8. Public Private Partnership: Institutional Capacity

For the following questions, please put (X) mark in the box corresponding to your preferred response using the scale below

5: Strongly Agree 4: Agree 3: Neutral 2: Disagree 1: Strongly Disagree

No	Questions	Scales				
		5	4	3	2	1
1	There is national PPP unit or institution that coordinates and leads PPP initiatives at higher level					
2	There is specifically designated unit or division within the health sector to implement, monitor and evaluate PPP initiatives.					
3	Public officials and employees are adequately trained to effectively design and implement health sector PPP programs in Addis Ababa.					
4	External expertise is sufficiently utilized in effectively designing health PPPs and implementing them in Addis Ababa.					
5	The units or departments that design and/implement PPP programs in the					

	health sector of Addis Ababa City play neutral and advisory role					
6	Employees and managers in PPP units and departments are free from conflict of interest and only promote pure public interest goals					
7	The public sector officials have adequate leadership capacity in effectively governing PPP programs in the health sector of Addis Ababa					

9. Capacity of Public Sector Managers

How do you evaluate the capacity of public sector managers and experts working on PPP initiatives in terms of the following? Using the scale below, please put (X) mark in the box corresponding to your preferred response.

5: Very high 4. High 3. Average 2. Low 1. Very low

No	Questions	Scales				
		5	4	3	2	1
1	PPP program and project planning skill					
2	PPP performance implementation and monitoring skill					
3	PPP financial and accounting skill					
4	PPP legal knowledge and contract management skill					
5	PPP evaluation, reporting and learning skill					

10. Public Private Partnership: Risk Sharing and Mutual Support

For the following questions, please put (X) mark in the box corresponding to your preferred response using the scale below

5: Strongly Agree 4: Agree 3: Neutral 2: Disagree 1: Strongly Disagree

No	**Questions**	**Scales**				
		5	4	3	2	1
1	Risks related to PPP are sufficiently identified and analyzed prior to interring to contract agreements in Addis Ababa's health sector					
2	PPP risks are effectively allocated to the private partner whenever it can manage them better					
3	PPP risks are effectively allocated to the public partner whenever it can manage them better					
4	The private health sector in Addis Ababa is ready to take risks associated with PPP contracts whenever the program is beneficial to the community					
5	The PPP documents in the health sector of Addis Ababa contain adequate risk mitigation strategies for the private partner.					
6	The PPP documents in the health sector of Addis Ababa contain adequate risk mitigation strategies for the public partner.					
7	Risk monitoring and evaluation system is incorporated in the PPP monitoring and evaluation practices of Addis Ababa's health sector.					

11. Prevalence of Risks in Health PPPs

Please evaluate the level of prevalence of different risks in the health sector PPPs of Addis Ababa using the following scale and putt (X) mark in the box corresponding to your preferred response.

5: Very high 4. High 3. Average 2. Low 1. Very low

No	Questions	Scales				
		5	4	3	2	1
1	Political risk: change in government ideology and public policy against the role of the private sector and PPP					
2	Legal risk: change is rules and regulatory framework					
3	Bureaucratic risk: Decline in the efficiency and effectiveness of the public bureaucracy					
4	Technological risk: Obsolescence of equipments due to change in technology					
5	Economic risk: Fluctuation in inflation rate, foreign currency, input prices so on					
6	Market and Demand risk: change in the demand and preference for the service					
7	Financial Risk: Lack of capital, loan supply by banks etc					

12. Government's Support scheme for health PPPs

Please, evaluate the level of support provided by the government to encourage the private sector to involve in health sector PPP in Addis Ababa City using the following scale and putting (X) mark in the box corresponding to your preferred response.

5: Very sufficient 4: Sufficient 3: Average 2: Insufficient 1: No support

No	Questions	Scales				
		5	4	3	2	1
1	Subsidy to the private sector participating in PPP in health					
2	Access to finance for the private sector participating in PPP health					
3	Guarantee for PPP projects					
4	Tax relief for the private sector participating in PPP health					
5	Duty free and other customs privileges for the private partner					
6	Increasing access to market and creating demand for health services through PPP					

13. Public Private Partnership: Procurement Policy and Practice

For the following questions, please put (X) mark in the box corresponding to your preferred response using the scale below

5: Strongly Agree 4: Agree 3: Neutral 2: Disagree 1: Strongly Disagree

No	Questions	Scales				
		5	4	3	2	1
1	The public health sector of Addis Ababa City already has clear, formal and open criteria for selecting appropriate private partner					
2	There is a clear and transparent complaint handling procedure for private sector PPP candidates who are dissatisfied with the PPP procurement decisions.					
3	The procurement practice in the health sector PPP of Addis Ababa is closely monitored and regulated					
4	Corrective actions are promptly taken to rectify errors and limitations in the PPP procurement document					
5	Corrective actions are promptly taken to rectify errors and limitations in the PPP actual practices					
6	The current procurement procedure document in Addis Ababa's health PPPs is adequate in promoting good governance					
7	The current procurement actual practice in Addis Ababa's health PPPs is adequate in promoting good governance					
8	How the partner is selected in the health sector of Addis Ababa does not give room for the discretion of the selection team					
9	How the partner is selected does not give room for conflict of interests					
10	How the partner is selected gives equal treatment to both public and private sector applicants					

Appendix B: Interview Guide for Key Informant Interviews

Addis Ababa University
College of Business and Economics
Department of Public Administration and Development Management
PhD Program in Public Management and Policy

Research Title: "*Public Private Partnership in the Health Sector of Addis Ababa City: Policies, Practices and Challenges"*

In-depth structured interview protocol to collect data from key informants in the public and private sector

Interview Date: _____ Time: _____

Location: _____ Organization: _____

Qualification of the interviewee: _____ Year of experience: _____

Current Position: _____ Interviewer: _____

Introduction:

Thank you for your contribution to this thesis as a respondent. This interview is conducted to collect data for the PhD research entitled "Public Private Partnership in Ethiopian Health Sector: The Case of Addis Ababa City". Your experiences and reflections will significantly add value as an input to this thesis. I assure you that the information you provide will be used only for academic research purpose and anonymity of the respondent will be maintained throughout the research process. Thank you for your cooperation.

1. Health Services in Addis Ababa City: Challenges and Implications

1.1. How do you evaluate the status of public sector health service delivery in Addis Ababa?
1.2. What do you think are the challenges facing health service delivery in Addis Ababa City in the following areas?
   a. Maternal and child health
   b. TB diagnosis and treatment
   c. HIV/AIDS related services
   d. Health facility: adequacy, quality, accessibility etc..
   e. Health professionals: Adequacy, professional, motivation etc.
   f. Pharmaceutical supply and services
   g. Health financing: Adequacy, self-sufficiency, sustainability etc

2. Public Private Partnership: Policy Environment

2.1. Do you think that the Ethiopian government's political ideology gives sufficient room for private sector participation in public service delivery?

2.1.1. If yes, what are the indicators of this?

2.2. Do you think that the roles of the private sector in public service delivery are clearly articulated and stipulated in the policy documents of the government?

2.2.1. Can we have some examples of these from the constitution, sector policies and strategies and different programs of the government?

2.3. Do you think that the public health sector is adequately working in partnership with the private sector?

2.3.1. How can we elaborate on this? What are some of the indicators of this?

2.3.2. Do you think that the partnership with the private sector in Addis Ababa is governed by coherent policies that lay down clear objectives and principles of partnership?

2.3.3. How do you relate the success and failure of PPP practices with the presence and absence of PPP policies in the health sector of Addis Ababa?

2.4. Can you tell us some of your practical experiences about success and failure stories of PPP practices in the health of Addis Ababa and their relations to policy issues?

2.5. How do you think can the core values of the developmental state ideology of the incumbent (government putting people first) be incorporated into the PPP policies in the health sector?

2.6. Do you think that there is formally established and policy supported dialogue between public and private sector in health in Addis Ababa?

2.7. Can you please tell us your experiences on how public private dialogue is conducted in the health sector of Addis Ababa?

2.8. Do you think that the relevant areas of PPP are clearly identified and understood in the health sector of Addis Ababa City?

2.8.1. How does this affect the design and implementation of PPP initiatives?

3. Public Private Partnership: Legal and Regulatory Framework

3.1. Do you think that there is adequate legal framework to govern and regulate PPP practices in the health sector in Addis Ababa?

3.1.1. Can you please tell us your experiences on how PPP governance and regulation is affected by the presence/absence of rules, regulations, standard operating procedures etc?

3.1.2. How do the PPP practices in the health sector of Addis Ababa address the rights and interests of the stakeholders?

3.1.3. How do you think can the PPP rules and regulations be commercially oriented to generate reasonable profit for the private partner?

3.2. Do you believe that issues regarding tax, competition, procurement and other regulatory concerns are well addressed in the current PPP practices in the health sector of Addis Ababa?
   3.2.1. What contradictions and mismatches do you see between the PPP contract documents or any other PPP legal documents and other proclamations of the country and Addis Ababa?
   3.2.2. Do you think that standardized contract documents are prepared, clearly understood and signed among parties involving in PPP practices in Addis Ababa?
   3.2.3. Can you please tell us some of your practical experiences and observations on this issue?
3.3. Do you think that the public health sector has strong mechanisms for fair and consistent enforcement of PPP contracts in Addis Ababa City?
3.4. What challenges do you see in enforcing PPP-agreements in Addis Ababa's health sector, fairly and consistently?
3.5. How do you explain the PPP regulatory framework in terms of optimizing efficiency and effectiveness in health service delivery?
3.6. Do you think that the PPP in the health sector is dominated by enabling and supporting regulation or disabling and restraining regulation?
   3.6.1. Can we have some practical examples for these?

4. Public Private Partnership: Institutional Capacity

4. Is there a national or health sector PPP unit that coordinates PPP initiatives and programs at the higher level?
   4.1.1. Which institution, division or unit implements PPP initiatives in the health sector of Addis Ababa?
   4.1.2. Do you believe that public officials and employees are adequately trained to effectively design PPP programs and effectively implement?
4.2. What practical experiences can you share us on how the capacity of the officials and employees affects the effectiveness of PPP in the health sector?
4.3. Do you believe that external expertise is sufficiently utilized in effectively designing health PPPs and implementing them in Addis Ababa?
4.4. What are the reasons and implications of this?
4.5. How do you evaluate the capacity of the public sector officials and relevant employees in Addis Ababa's health sector in terms of the following:
   4.5.1. PPP program planning skill;
   4.5.2. PPP contract design and administration skills;
   4.5.3. PPP performance monitoring skills;
   4.5.4. PPP financial and accounting skills;
   4.5.5. PPP legal skills;
   4.5.6. PPP evaluation, reporting and learning skills;

4.6. Do you believe that the units/divisions/units that design and/implement PPP programs in the health sector play neutral and advisory role and promote pure public interest goals?
   4.6.1. Can you please provide some explanations and examples on this issue?
4.7. Generally, how do you evaluate the strategic leadership capacity of the public sector officials in effectively governing PPP programs in the health sector of Addis Ababa?

5. Public Private Partnership: Risk Sharing and Mutual Support

5.1. Do you think that PPP risks are sufficiently identified and analyzed prior to interring to contract agreements in Addis Ababa?
   5.1.1. What do you think are the reasons for this?
   5.1.2. How are PPP risks in the health sector allocated to the party that can better manage them?
5.2. Do you believe that the private health sector in Addis Ababa is ready to take risks associated with PPP contracts for initiatives that are beneficial to the community?
   5.2.1. What do you think are the reasons for this?
   5.2.2. What are the consequences and implications of this?
5.3. Do you believe that the PPP contract documents in the health sector have adequate risk mitigation strategies for both public and private sectors?
5.4. What strategies are usually used by public and private health sector actors to mitigate or reduce PPP risks?
5.5. Do you believe that the PPP monitoring and evaluation practices in health also incorporate risk monitoring and evaluation system?
   5.5.1. What do you think are the reasons for this?
   5.5.2. What do you think are the effects and implications of this?
5.6. How do you evaluate the prevalence of the following risks in the PPP practices in the Ethiopian health sector?
   5.6.1. Political risks;
   5.6.2. Bureaucratic risks;
   5.6.3. Technological risks;
   5.6.4. Economic and market risks;
   5.6.5. Financial risks;
5.7. What supports are provided by the government to encourage the private sector to take reasonable risks in PPP initiatives in health service delivery?
5.8. What do you think should be done by both the public and private sector actors to improve risk-taking behavior in public private partnerships?

6. Public Private Partnership: Procurement Policy and Practice

6.1. How do the public sector partners select the "appropriate" private sector partner in health service PPP programs?

6.2. Do you believe that the public sector already has clear and formal criteria for selecting appropriate private partners?

6.3. What do you think are the implications of this to the effectiveness of PPP programs in health?

6.4. How do you evaluate the procurement procedure and practice of the PPP initiatives in Addis Ababa's health sector in terms of the following:

6.4.1. Openness and clarity of the procurement policy;

6.4.2. The extent to which the selection rules do not give room for the discretion of the selection team (as objective as possible);

6.4.3. The extent to which the selection criteria do not give room for conflict of interest;

6.4.4. The extent to which the procurement procedure and selection criteria give fair and equal treatment of public and private sector bidders;

6.5. How do people who are dissatisfied with PPP procurement decisions present their complaints to the relevant public sector institution?

6.6. Do you believe that the PPP procurement practice in health is closely monitored and regulated?

6.7. What do you think are the implications of this?

6.8. Overall, how do you evaluate the PPP procurement procedure and practice in terms of promoting good governance and minimizing maladministration?

Thank you for your time and contribution

Appendix C: How Kruskal Wallis Tests were calculated

The quantitative aspect of this study used Statistical Package for Social Sciences (SPSS) version 20 to calculate Kruskal Wallis test values. Once data was encoded into the SPSS spreadsheet, cleaned and edited for errors, the following procedure was applied to obtain Kruskal Wallis test values.

Analyze → Non-parametric tests → Legacy dialogs → K-independent samples → Enter the variable to be tested in the **Test Variable** box → Enter the PPP program in the **Grouping Variable** box → Click **Define Range** → Enter the minimum and maximum values of the **Grouping Variable** (PPP programs) → Click **Continue** → Click Ok.

Example: the hypothesis about the homogeneity of responses among the 4 PPP programs for the variable "Private Sector Role" was tested using the above procedure and the output below was generated.

Kruskal Wallis Tests

	Type of PPP program	N	Mean Rank
The role that the private sector can play in service delivery	HIV/AIDS	42	115.85
	TB-DOTs	96	114.04
	Reproductive Health	34	123.90
	Non-Clinical Services Outsourcing	70	133.96
	Total	242	

Test Statistics[a,b]

	The role that the private sector can play in service delivery
Chi-Square	4.101
df	3
Asymp. Sig.	.251

a. Kruskal Wallis Test

b. Grouping Variable: Type of PPP program

Remark: *The above statistical outputs are generated by running the analysis for item number 3 in table 5.1a in chapter 5 (The role that the private sector can play in service delivery).*