Realist evaluation of Public Private Partnerships in the Kuwait health care system

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Abstract

The aim of this study is to evaluate the Public Private Partnership (PPP) implementation in Yaco Adan Diagnostic Centre (YADC), part of the Kuwaiti health care system, by critically examining its effect on the health care system objectives.

The literature review describes the health care system structures, functions, objectives and goals. Public health care systems are often recognised for being effective and equitable, while private health systems are recognised for their efficiency and choice (responsiveness). The Kuwaiti health care system is then reviewed, and the challenges facing the system discussed. The origin of PPP, its objectives, and its place in the health sector, are subsequently examined.

The research critically appraises, using a realist perspective, whether the introduction of PPP in the Kuwaiti health care system has enhanced health system objectives: efficiency, effectiveness, equity and choice. The thesis includes a preliminary study and a main study. The realist evaluation approach was adopted to explore how PPP, as a programme, introduces mechanisms to improve health system objectives, in the Kuwait context, with the aim of producing detailed answers to the questions of what makes PPP work, for whom, and in what circumstances. The preliminary study tested the practicality of the concepts identified in the literature and ensured that the PPP concept is readily understood among the research sample. The main study consisted largely of semi-structured interviews with 4 key stakeholder groups (public, private, financial and regulatory/advisory bodies). A customer experience questionnaire with a 5th stakeholder (patients) was also undertaken to determine the overall level of service provided at YADC. A document review was provided where appropriate to triangulate the findings.

The research findings are significant in that they have shown that the recent PPP experience in the Kuwaiti health sector has a significant impact on the health care system levers (resource allocation, organisation, service provision and finance) by introducing various mechanisms (processes) that facilitate improved achievement of health care system objectives. These mechanisms reflect maximum utilisation and streamlining of resources, decentralisation of organisations, a customer-centred approach in service provision, and introducing incentives into the financial structure. All in all, it seems that PPP has the potential to achieve the health care system objectives better and create better value if implemented well and in the right context. The impact of PPP on health care has been to maintain its effectiveness and equity (public sector values) while significantly introducing efficiency and choice (private sector values). However, the research has highlighted barriers to the PPP process, including an unstable political environment, insufficient legal and financial frameworks, inexperienced government bodies and health care managers with limited knowledge of the PPP. Additionally, there has been a lack of clearly documented goals and deficiencies in the detail of the PPP contract. The research found that despite the government’s long-term commitment the PPP model left many issues unclear, providing no allowance for population growth, scientific development, the need for continually updating technology and technical equipment. This indicates that there is scope for considerable improvement in the drafting of the initial contract including a degree of flexibility to allow for future health needs.

This research recommends health care policy makers and managers to ensure PPP objectives such as reduced cost, elimination of bureaucracy, private sector involvement and profitability are maintained, while protecting the key health care system objectives of efficiency, effectiveness, equity and choice.
Statement of Originality

This thesis and the work to which it refers are the results of my own efforts. Any ideas, data, images or text resulting from the work of others (whether published or unpublished) are fully identified as such within the work and attributed to their originator in the text, bibliography or in footnotes. This thesis has not been submitted in whole or in part for any other academic degree or professional qualification. I agree that the University has the right to submit my work to the plagiarism detection service TurnitinUK for originality checks. Whether or not drafts have been so-assessed, the University reserves the right to require an electronic version of the final document (as submitted) for assessment as above.
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<td>BOO</td>
<td>Build Own Operate</td>
</tr>
<tr>
<td>BOT</td>
<td>Build Operator Transfer</td>
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<tr>
<td>BTO</td>
<td>Build Transfer Operate</td>
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<tr>
<td>CATS</td>
<td>Capture, Assess, Treat and Support Services</td>
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<td>CMO</td>
<td>Context Mechanism Outcome</td>
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<td>CSF</td>
<td>Critical Success Factors</td>
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<td>DOH</td>
<td>Department of Health</td>
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<td>GP</td>
<td>General Practitioner</td>
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<td>ISTC</td>
<td>Independent Sector Treatment Centres</td>
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<td>ICATS</td>
<td>Integrated Clinical Assessment and Treatment Services</td>
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<td>MOH</td>
<td>Ministry of Health</td>
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<td>NGO</td>
<td>Non-governmental Organisation</td>
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<td>NHS</td>
<td>National Health Service</td>
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<td>NHSE</td>
<td>National Health Service Executive</td>
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<td>NPM</td>
<td>New Public Management</td>
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<td>OBC</td>
<td>Outline Business Case</td>
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<td>PPP</td>
<td>Public Private Partnership</td>
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<td>PFI</td>
<td>Private Finance Initiative</td>
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<td>SOC</td>
<td>Strategic Outline Case</td>
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<td>SWOT</td>
<td>Strengths, Weakness, Opportunities, Threats</td>
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<tr>
<td>WB</td>
<td>World Bank</td>
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<td>WHO</td>
<td>World Health Organisation</td>
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<td>YADC</td>
<td>Yiaco Adan Diagnostic Centre</td>
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Chapter 1 – Introduction

1.1 Introduction

The debate concerning management of health care systems is ongoing: is it the government’s role or the private sector’s role? Each party has its own arguments, advantages and disadvantages, so perhaps a third way raises the possibility of achieving the best of both sides. The aim of this research is thus to evaluate the Public Private Partnership (PPP) in the Kuwaiti health care system – Yiaco Adan Diagnostic Centre (YADC) – by critically examining its effect on the health care system objectives of effectiveness, efficiency, equity and choice. A realist evaluation approach has been adopted aiming to produce detailed answers to the questions of what makes PPP work, for whom, and in what circumstances. Finally the study will present conclusions and recommendations aimed at improving PPP implementation in Kuwait for policy makers and health care managers.

This chapter begins with the rationale of the study, followed by statements of the research aim and objectives. A description of the research methodology and structure is then made to provide an overview of the study.

1.2 Rationale

Health care systems (the arrangement in which health care is delivered) have always been a top economic and political priority for any government worldwide (Folland, Goodman and Stano, 2007). The healthcare system arrangement is a complete network of agencies, facilities, technologies, financing mechanisms, supporting workforce that provide support for the provision of health care for a population. In order to achieve the goals of health care systems (which are health, consumer satisfaction and minimum financial risk) the objectives of effectiveness, efficiency, equity and access are required (WHO, 2000), as illustrated in Figure 1.1, below. PPP’s have increasingly been implemented within health care sectors worldwide in order to improve the performance of health services provided and achieve the objectives of health care systems (Atun, 2008).
PPP is an arrangement in which the government and the private sector mutually reform or undertake a traditionally public activity (Savas, 2005). It is a governance tool requiring a continuing active role from the government, which retains responsibility for the function while in most cases delegating the actual production activity to the private sector (Savas, 2005). PPP is regarded as an innovative approach to introduce private sector capability within the public domain (Cappellaro and Longo, 2011). Such an arrangement depends upon key principles which include 1) infrastructure and service delivery provided by the private sector partner, 2) long-term commitment by public and private partners, and 3) the public sector retains ownership of the asset (Sabri, 2010).

The national government in the state of Kuwait has traditionally been responsible for providing public services such as health care. The basis of the Kuwaiti health care systems was mainly established in the mid-twentieth century when the GCC governments utilised the large increase in oil revenue and implemented a complete health care and social welfare programme, which is free to all citizens. Generally health care provision in Kuwait seems to be effective (Business Monitor International, 2011).
However, there are various issues facing the health care system of Kuwait at present that pose a continuing challenge for policy makers, and which may affect the health of the population if not addressed. The Kuwaiti government generally lacks the essential management skills required to run care facilities effectively (McKinsey, 2007). There is increasing pressure on public health services (due primarily to rapid demographical and epidemiological changes), which result in difficulty in meeting demand and sustaining quality. Consequently there is increased public dissatisfaction with the health care system (McKinsey, 2007).

The Kuwaiti government has attempted a number of reforms to modernise and expand the existing health system infrastructure to meet upcoming demand and to improve the performance of the current health care system as a whole. Such reforms have realised the potential role of the private sector.

For example, in 2002, the first PPP occurred in the Kuwaiti health care sector through the creation of YADC. YADC was established with the aim of offering unparalleled clinical services to Adan hospital, physicians and patients. In spite of this experience, there are controversial opinions within the government and between professionals regarding the value added and applicability of private sector involvement within health care (Almutairi and Salama, 2007).

Although the Kuwaiti government has long-term experience with the private sector, the PPP experience is still relatively new (EMRO, 2002). Hence, clear strategies may be required to integrate public and private sectors better to improve the way the partnership is implemented.

The thesis will therefore review the relatively new PPP experience in the Kuwaiti health care system, in order to draw recommendations for policy makers and health care managers to improve PPP implementation. The recent PPP experience in the Kuwaiti health care system will be assessed by examining the impact of PPP on healthcare function and determining whether it has fulfilled the health objectives of effectiveness, efficiency, equity and access.

1.3 Aim

The aim of the study is to evaluate the PPP experience in the Kuwaiti health care system, by critically examining its effect on the health care system objectives.
1.4 Objectives

The objectives for the research are:

1) To provide thorough background information regarding the definition, components, goals, performance, financial and organisational structure of health systems for policy purposes.
2) To review the Kuwaiti health care system including national health care statistics and challenges.
3) To explain the origins of PPPs, their objectives, arrangements being used in the health care sector, and the various advantages and disadvantages of such arrangements.
4) To undertake a realist evaluation of the implementation of PPP in the Kuwaiti health care system.
5) To draw conclusions and to suggest recommendations for the future use of PPP in Kuwait.

1.5 Research methodology

The stages that will be undertaken throughout this study are illustrated below:

1.5.1 Stage 1 – Literature review
The literature review will involve obtaining information from various sources including textbooks, trade/academic/and professional journals and magazines, the internet, and institutional and statutory publications. This stage will address objective 1, above, by reviewing the PPP concept and the structure of health care systems (including the role of PPP in health).

1.5.2 Stage 2 – Examination of literature review findings
Issues and concerns that are raised in the literature review will be translated into an examination as part of the dissertation fieldwork.
1.5.3 Stage 3 – Fieldwork

This stage will address objective 2 by studying the specific PPP case in Kuwait using realist evaluation. The opinions of various health industry professionals regarding the use of PPP will be sought via interviews.

1.5.4 Stage 4 – Analysis of results and final conclusions

Findings from the fieldwork will be analysed and evaluated in relation to the literature review and conclusions will be drawn. This will address objective 3.

Published academic, trade and grey literature will be searched in a systematic way using online databases, journals and relevant reports/documents. Sources include:

- Trade, academic, and professional journals and magazines:
- The internet:
  EBSCO, the Ministry of Health Website, PUBMED
- Libraries:
  University of Surrey Library, British Library, University of London Library.
- Personal communications with experts in the field

Interviews with professionals from the Kuwaiti Ministry of Health, board members and other professionals.

1.6 Structure of the thesis

1.6.1 Chapter 1 – Introduction

Chapter 1 reviews the rationale for the study and provides a brief background to the research. The research aims, objectives, methodology and proposed structure are identified.

1.6.2 Chapter 2 – Health care systems

Chapter 2 provides information regarding the definition, components, goals, performance, financial and organisational structure of health systems for policy
purposes. It begins by providing a brief description of the importance of such systems in improving health and reviews different health system definitions. A detailed investigation into key frameworks used to examine health system performance, components, elements, goals and context is then made with an emphasis on the relationship between such aspects.

1.6.3 Chapter 3 – Kuwaiti health care systems

Chapter 3 will examine the Kuwaiti health care system in detail. It will provide a background of Kuwait, and documentation of the Kuwaiti health care system including national health care statistics and challenges. The role of the government and the private sector in health is also examined. Finally, details of the Kuwaiti government projections for health care is provided.

1.6.4 Chapter 4 - PPPs

Chapter 4 reviews the use of PPPs in the health care sector. It begins by explaining new public management (NPM) theory as the basis for PPP. PPP is then defined as a concept and its objectives are highlighted. Following this, a detailed examination of PPP delivery and the different forms of PPP arrangements being used in the health care sector is made, and the specific advantages and disadvantages of these are highlighted. The chapter also reviews the critical success factors and barriers facing PPP implementation.

1.6.4 Chapter 5 – Research strategy

Chapter 5 explains the logic behind the development of the research strategy. It begins by describing different epistemological considerations and then outlines several key philosophical positions. The chapter then highlights differences between qualitative and quantitative research, and explains the selected strategy appropriate for this research – the case study. Key issues of research acceptability, reliability and validity are then highlighted. Following this, the chapter discusses the methods for case study research under a realist evaluation perspective, the methods for data analysis (such as interviews, observations, focus groups and questionnaires) and the research sampling strategy.
1.6.5 Chapter 6 - Research design

Chapter 6 explains the research method used to collect and examine data. A realist evaluation approach has been adopted to examine the first PPP experience in the Kuwaiti health care system, YADC. Realist evaluation research aims to produce detailed answers to the questions of why PPP and its implementation work, for whom, and in what circumstances. This means that this research investigates how and why PPP has the potential to cause desired changes. A two-phase research process was selected (a preliminary study followed by a main study) to facilitate the collection and analysis of data to prepare the initial hypothesis, followed by further data collection and analysis to refine this.

1.6.6 Chapter 7 - Preliminary study data analysis

Chapter 7 presents the findings and analysis of the pilot study. The pilot study analysis consists of two parts. The first part highlights (in the format of a table) various themes derived from the interviewees’ direct responses. The second part briefly discusses such themes and the relationship between them, in relation to the findings of the literature review.

1.6.7 Chapter 8 - Pilot study discussion, conclusion and proposals for further research

Chapter 8 discusses the results of the pilot study, making connections with the concepts, ideas and theories outlined in the literature review. A brief pilot study conclusion is then provided, after which proposals for further research are outlined.

1.6.8 Chapter 9 - Main study findings and analysis

Chapter 9 presents the findings of the main study, which consisted largely of semi-structured interviews with four key stakeholders (public, private, financial and regulatory/advisory bodies). A customer experience questionnaire with the fifth stakeholder (end-users) was also undertaken. Furthermore, document review is
provided where appropriate to substantiate the findings. Data analysis was carried out through a framework approach. As various methods of data collection were undertaken, the chapter analyses the data under two sections. The first section, semi-structured interview analysis, is divided into two parts. Part 1 identifies the numerous themes derived from the interview responses, while Part 2 discusses such themes and highlights their relative importance. The second section analyses the findings from the customer satisfaction questionnaire qualitatively through description. Finally all data are mapped and re-synthesised to produce mechanisms that help PPP achieve the health care objectives better (mapping – stage 5 of the framework approach).

1.6.9 Chapter 10 – Discussion of the findings of the main study

Chapter 10 begins by discussing the principal findings of the main study, highlighting the various contexts required and mechanisms triggered by the PPP experience. This is followed by a discussion of the impact of such findings for the health care sector and policy makers. Connections between such findings and the theories outlined in the literature review are then highlighted. Finally, the chapter concludes with a discussion of the limitations of the research, and provides recommendations for further research.

1.7 Chapter summary

This chapter began by identifying the research aim and highlighting the rationale for the study. The research objectives, methodology and proposed structure were then described to provide an overall outline of the study.
Chapter 2 – Health Care Systems

2.1 Introduction

This chapter aims to provide background information regarding the definition, components, goals, performance, financial and organisational structure of health systems for policy purposes. It will begin by providing a brief description of the importance of such systems in improving health and will review different health system definitions proposed by various literature sources. A detailed investigation into key approaches/frameworks used to examine health system performance, components, elements, goals and context is then made, with an emphasis on the relationships between such aspects.

2.2 An introduction into health care systems

2.2.1 The importance of health care systems

The primary function of a health care system is the improvement of health (Atun and Menabde, 2008). It is suggested by the World Health Organisation (WHO) that between the years 1952 and 1992, almost half the improvements in global health were attributable to the use of innovative skills and technology in health care systems (Atun and Menabde, 2008). Schultz (1980) even notes that improving health, which is often measured by life expectancy and adult survival rates, enhances economic productivity and growth.

Nonetheless, Atun and Menabde (2008) argue that despite rising investments in health care, health care system performance in many countries is still deficient in terms of equitable population health, financial risk protection and user satisfaction (described in detail below). Similarly, Londoño and Frenk (1997) note that countries at different economic development stages and with different forms of political systems are seeking to find improved means of regulating, financing and delivering health services. Consequently, numerous researchers are aiming to find innovative conceptual and functional models for health systems, by analysing its major
components and goals, context and performance (Hsiao, 2003). This is described further under section 2.2.3, below

2.2.2 Health care systems defined

National health care systems worldwide are diverse and complex (Cassels, 1995). Hsiao (2003) notes that although health systems have been widely analysed and compared on an international level, there is still no standard and consistent definition of what they are. It is argued that numerous meanings and vague concepts have resulted in misinformed policy planning and general confusion. On this note, Roemer, (1991) indicates that general models drawn to compare different health care systems are very often conveyed in an abstract manner to allow for every potential variation. He himself defines a health system as 'the combination of resources, organisation, financing, and management that culminate in the delivery of health services to the population'. Nonetheless, Hsiao (2003) suggests that policy officials and researchers continue to seek a meaningful, standard definition so as to understand what mechanisms will enhance a health system’s performance, and what components result in different health outcomes worldwide.

More conventional definitions have described health systems in terms of capacity indicators and activities such as the number of beds or physicians per hospital (Hsiao, 2003). This includes work put forth by Roemer (1991), who suggests that a health system ought to be explained by five categories of activity: 1) productive resources, 2) organisation of programmes, 3) economic support mechanisms, 4) management methods and 5) service delivery. Nonetheless, it is argued that such a model fails to describe sufficiently why such activity characteristics are of importance and the impact of a variation in their arrangement (Hsiao, 2003).

Other researcher-proposed definitions focus on relationships between institutional actors and fund flows within health systems (Atun and Menabde, 2008; Hsiao, 2003). For example, Hurst (1992) describes health systems as flows of funds and payment methods between different population groups and institutions. In arriving at this concept, Hurst utilises findings by Evans (1981), which describe different market and non-market relationships between four key groups of actors in health systems that include the population served, health care providers, third-party players and government regulators. Thus, Hurst’s definition categorises seven key
subsystems of financing and delivery of health care: three voluntary insurance systems (private reimbursement, private contract and private integrated models); three compulsory insurance or tax-funded models (comprising public reimbursement, public contract and public integrated models) and direct, voluntary, out-of-pocket payment (Hurst, 1991; OECD, 2001)

Moreover, health systems are also illustrated as frameworks consisting of a series of actors and functional components such as financing, regulation, resource allocation and service provision (Hsiao, 2003; Murray and Frenk, 2000). Frenk (1994), for example, first depicts the health system as a group of relationships between five key actors: health care providers, the population, the state, the organisations that generate resources, and other sectors that produce services with health benefits. He then notes four key levels of policy at which health system reform operates: systematic, programmatic, organisational and instrumental (Cassels, 1995). He explains that systematic changes deal with equity concerns through changes to institutional arrangements for regulation, finance and service delivery; programmatic changes are concerned with efficiency by specifying a common, collective health care interventions package (Atun and Menabde, 2008; Cassels, 1995); organisational changes deal with technical efficiency by enhancing productivity and service quality; and finally, instrumental policy changes guarantee increased performance through producing required information, research, technology and human resource development (Atun and Menabde, 2008). Nonetheless, it is argued by Hsiao (2003) that while such models categorise a health system by its internal functions, they do not clarify the goals of, and interrelationships between, such functions, and how variations in structuring such functions influence certain outcomes (Cassels, 1995).

More recent definitions include that proposed by the WHO’s World Health Report (2000), which describes health systems as the totality of activities whose main aim is to ‘promote, restore or maintain health’. This focuses on the outcomes and performance measurement of health systems, and explains health system functions such as stewardship, resource creation, service provision and financing, with particular focus on the role of government. It is argued, however, by Hsiao (2003), that the report did not sufficiently examine the relationship between a health system and a particular outcome such as the impact of certain aspects on a specific outcome or how a health system could be adjusted to attain a desired outcome.
Similarly, the World Bank (WB) Strategy for Health, defines health systems from the perspective of their functionality which, in turn, is defined by health service inputs (such as resource management), public and private service provision, financing and stewardship or management (Mills and Ranson, 2006).

Health systems are also examined and defined from an economic perspective (Janovsky and Cassels, 1996). Numerous health economists have described health systems by applying economic theories of supply and demand to investigate activities in markets that involve the health system (Jack, 1999). Janovsky and Cassels (1996) have specifically investigated the economic relationship between demand, supply and intermediary agencies which impacts on the supply–demand relationship. They maintain that the demand side includes individuals, households and populations whose actions effect health outcomes, while the supply side includes institutions, which generate human and material resources for health care, service providers (public, private or non-profit organisations), individuals and informal unpaid carers. Agencies, however, include government bodies responsible for health care financing, regulation and purchasing, and other institutional purchasers such as private insurers, or public insurance funds that identify different health requirements and purchase both clinical and support services via an array of contractual mechanisms (Atun and Menabde, 2008). Alternatively, it is suggested that a health system can be examined on both macro and micro levels (Jack, 1999; Feldstein, 1993). The macro level concentrates on the general scope and scale of the health sector, its size, shape and operations, while the micro level investigates actions of individual firms and households (Ackley, 1961; Berwick, 2002). However, Hsiao (2003) argues that microeconomic theory has provided minimum clarification for macro-level outcomes such as overall health status.

Hsiao (2003), on the other hand, has developed a framework that illustrates key components of a health system that are related to, and which can explain, collective outcomes. He notes that such system components affect the behaviour of individuals and firms which in turn determines the resultant outcomes, and thus conceptualises a health system as "a means to an end" which "exists and evolves to serve societal needs". He defines a health system by "those principal casual components that can explain the system's outcomes. These components can in turn be employed as policy instruments to alter the outcomes." These components are referred to as 'control knobs', which can be altered by policy makers to influence outcomes, to
achieve a desired goal. He also notes that achieving certain goals depends also on the interactions between all the control knobs.

2.3 Health system components and goals

A health system consists of elements that work together to influence the achievement of health system goals (Atun and Menabde, 2008). While these goals may differ in importance between different countries, effectively many are similar as discussed further below. Several authors have thus developed frameworks (some of which are mentioned above – Frenk 2000, WHO 2000, and Hsiao, 2003) that measure the performance of health systems and conceptualise health system components, elements and goals (Hsiao, 1992).

One of such framework is the WHO Performance Assessment Framework (PAF), which is used to compare the performance of WHO member countries in the WHO World Health Report 2000 (WHO, 2000). The WHO PAF measures health system performance with regard to the achievement of several goals that include the average level and distribution of health, the average level and distribution of responsiveness, and fairness in financial contribution (Atun, and Menabde, 2008). Under such a framework, health system tasks set to achieve such goals consist of 1) personal and non-personal health services, 2) raising, pooling and allocating revenue to acquire such services, 3) investing in people and facilities, and stewardship (of the resources, responsibilities and expectations delegated).

Furthermore, authors such as Hsiao (2003) have also described health system goals as “good health for all, financial risk protection for all, and satisfaction of the people.” He notes that health systems should be concerned with improving the level and distribution of such goals in order to guarantee equity. He also explains that there are intermediate goals, such as the improvement of access, quality, and service efficiency, which critically influence the three key health system goals. As noted above, there are five key components (referred to as ‘control knobs’) of a health system, which can be used and adjusted by policy-makers to attain health system goals. Each component consists in turn of numerous instruments. The five components include the following:
1. Financing and its organisational structure
2. Macro-organisation of provision
3. Payments (to individuals and organisations)
4. Regulations
5. Persuasion and influence of people’s beliefs, expectations and preferences.

However, it is also argued that to understand health systems and the interaction between their components and goals better, an understanding of the essence of system behaviour and thinking is required. System thinking stems from disciplines like engineering and computing. Checkland (1981) argues that a system is a group of interacting elements that form a whole. Senge (1990) also notes that the interaction of the elements results in a particular system activity, and that this influence (referred to as ‘feedback’) can be positive or negative in nature. Similarly, systems can be closed or open; closed systems are fully independent of the activity around them, while open systems interact and interrelate with their environment.

Atun and Menabde (2008) thus suggest that health systems in particular demonstrate all major features of complex dynamic systems. This, they argue is primarily due to such systems containing numerous interrelating feedback loops, and that the consequences of choices and actions taken are usually intangible and thus not directly noticeable. They also suggest that health systems contain several non-linear relationships making it challenging to envisage outcomes precisely due to specific interventions relating to a system element. More importantly, Atun and Menabde (2008) explain that such relationships expand further than system elements, and emphasise that health systems are especially connected to the ‘context within which they exist’ (Plsek and Greenhalgh, 2001). They suggest that a framework that examines health system functions should, at the same time, examine the context with which it interacts. A new framework was thus developed which builds on previous frameworks developed by WHO (2000), Hsiao (2003) and Frenk (2000), and is illustrated in Figure 2.1, below:
A distinctive feature of this framework is that it includes the demographic, economic, political, legal and regulatory, epidemiological, socio-demographic and technological contexts within which health care systems exist. The authors maintain that examination of ‘contextual elements’ allows for the verification of health system opportunities and threats in both the short and long term.

As illustrated by Figure 2.1, above, the authors identify four levers for policy-officials managing the health system. Variation of such levers allows for the realisation of different health system objectives and goals. Similarly to the previous frameworks discussed, key health system goals for this framework are health, financial risk protection and consumer satisfaction. Intermediate goals include equity, choice, efficiency and effectiveness, and are frequently noted by others as ultimate goals in themselves. Levers of the health system include:
1) stewardship and organisational arrangements – the policy and regulatory environment, stewardship function and structural arrangements for purchasers, providers and market regulators;
2) financing – collection and pooling of funds;
3) resource allocation and provider payment systems – the allocation of funds and accessible resources such as human resources, capital investment or equipment, and the payment mechanisms for health service providers; and
4) service provision – services provided by the health sector.

Table 2.1 below illustrates major health care system institutional components, and provides a brief description of their roles (Cassels, 1994).

<table>
<thead>
<tr>
<th>The government</th>
<th>Establishments responsible for health care finance, regulation, purchase and provision.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service providers</td>
<td>These include public, private and non-governmental organisations (NGOs) working in institutional surroundings like hospitals or general practitioner (GP) practices, providing clinical and support services.</td>
</tr>
<tr>
<td>Resource institutions</td>
<td>Such institutions include universities, and medical and public health schools, which provide the human and material resources for health care.</td>
</tr>
<tr>
<td>Institutional purchasers</td>
<td>Such institutions include insurance funds, district health authorities or health maintenance organisations. These institutions define health needs of certain populations and purchase clinical/support services through the use of contractual mechanisms.</td>
</tr>
<tr>
<td>Other sectoral agencies</td>
<td>Such agencies indirectly produce health benefits through the products or services they offer (such as education and housing).</td>
</tr>
<tr>
<td>Populations</td>
<td>Individuals or households which are the recipients of health care, purchasers of health care or can be employed to provide services.</td>
</tr>
</tbody>
</table>

Source: adapted from Cassels (1994)

Roberts et al. (2008) argue that although the numerous health system frameworks (as discussed above) can provide the means to address different challenges specific to different countries, such a wide range of frameworks can at times result in confusion regarding the notion of a health system and thus the ability to
plan different interventions. Similarly, Atun et al. (2005) note that the application of varying health system frameworks, which has resulted in various agencies putting forward varying definitions, measures and strategies, may obstruct positive collective action.

Despite the attempt to classify these frameworks into three types (perspective (WHO, 2000), analytical (Frenk, 2000) and deterministic and predictive (Hsiao, 2003)), all the health system frameworks reviewed show a distinct similarity that leads to a mutual understanding among researchers. Researchers describe these frameworks as multidimensional domains of actors and actions that lead to an eventual outcome, which societies share and value (Hsiao and Saidat, 2008). Thus, health system goals remain unchanged (while the action potential required to achieve them varies accordingly), independent of the type of health system in which they exist or the changes that occur in and around their environment.

Health system goals, although slightly varied in their definitions as provided by individual frameworks, provide similar indications to include the following features:

- Improvement of public health
- Limitation and protection of health related financial risk
- Provision of user satisfaction

(Hsiao and Saidat, 2008; Atun and Menabde, 2008).

2.4 A description of health system levers (control knobs)

2.4.1 Stewardship and organisational arrangements (regulation)

Regulation refers to the use of power by government to ensure the right actions are undertaken by health system actors. This vital role for any government involves rules, policies and penalties. Regulation in general aims to influence: 1) market entry and exit strategies, 2) remuneration of providers, 3) quality and distribution of services, and 4) standard and quality (Mills and Ranson, 2006).

Effective regulation has a significant role in achieving health system goals especially when it is associated with clear incentives, behaviour alteration and innovative organisational structure (Roberts et al., 2008). For health policy actors to
make a significant change they need to consider their capability of enforcing processes and utilising resources, ensuring political assistance with good use of information monitoring and the inducement that this will bring to the society.

The WB's concept of stewardship involves frameworks to create policies that govern the entire health system, in which interactive exchange occurs between institutional and non-institutional players. This structure will give rise to data generation and validation for the decision-making process (World Bank, 2009).

According to WHO (2000), "the health of the people must always be a national priority". The authorities concerned should take a permanent approach in their dealings with regard to health issues. The WHO suggests that the stewardship role should be given to Ministries of Health and any policy should cover private providers' markets and private financing together with public resources. Taking such steps ensures effective operation of the health system and the achievement of public interest. There are various strategies through which stewardship can exert its influence. These include a strong information portal, the power to bring together diverse groups to form coalitions and the measures to promote and discharge incentives both directly and indirectly. Thus, stewardship policies and plans need to invest more in a cohesive framework of incentives rather than relying too much on a monopolistic leadership style.

2.4.2 Financing (collection and pooling of funds)

In order to sustain a reliable health care system, structured around human capital and consumable resources, financial input is required. Financial resources account for investment costs of building and equipment, health care staff and consumables. The way in which these financial resources are being generated and managed poses key questions to policy makers and financial planners. Such professionals have the responsibility of designing systems to fulfil social, political and economic policy objectives (Gottret et al., 2008). The European Observatory on Health Care Systems Series argues that expenditure crises have created major changes in financing strategies in several countries since the 1970s. It is suggested that rising expenditure and resource shortages present decision makers with three choices: containing costs, increasing funding or a combination of the two. As public borrowing
is considered to be a poor option in the long term, the shift is growing towards alternative means of finance to fund health care.

Health care financing fulfils three key tasks: collecting revenues, pooling revenues (risks) and purchasing services. Such functions can be integrated in one organisational body or divided between various institutions, adopting the decentralisation scheme. The collection of revenue is significant and is carried out either by government or the private sector. There are numerous mechanisms of fundraising, each having different implications, and which are often judged by their ability to improve the health care intermediate objectives of equity, efficiency, effectiveness and quality. Under government, health care could be financed by government revenue, tax or social insurance. In the private sector it can be undertaken by private insurance funds or out-of-pocket payment directly from patients (see Figure 2.2, below). Leiter and Theurl (2009) argue that these different public and private finance methods may have different effects on the equity of financing, and thus health care utilisation and its status. In addition each of those financing models will have different degrees of risk pooling and risk reduction. It is also suggested that a link exists between the financing structure and efficiency in health care service provision.

Figure 2.2 - Health care financial model

![Health care financial model diagram]

Source: Atun (2008)
2.4.3 Resource allocation

Resource allocation refers to the allocation of funds and accessible resources such as human resources, capital investment or equipment, and the payment mechanisms for health service providers (Atun and Menabde 2008). In the last decade or so, resource allocation has had an influential role in health systems. Government and insurers are responsible for managing the better part of distribution of resources from source to provider. This pushes the purchaser to be actively involved in the resource allocation process to justify receipt of resources. The decentralisation process also provides government with a clear distinction between the purchase of health service and the provision of health service (Elk et al., 2009).

Purchasing means “the transfer of pooled resource to service providers on behalf of the population for which the funds were pooled” (Kutzin, 2001). In some systems, for instance in England, separate agents and local commissioners of services, purchase services. Therefore the transfer of resources should be directed towards these purchasers. To provide equity and efficiency in an ideal health care system requires an even distribution of resources according to specific needs. In Europe, capitation is the means through which resources are allocated, thus calculating purchaser’s budgets. However, political negotiations, historical trends and lowest bids still rule across various other health systems (Elk et al., 2009). Stages of purchasing are illustrated in Table 2.2 below.

Table 2.2 - The stages of purchasing health services

<table>
<thead>
<tr>
<th>Stages in Purchasing</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Assess needs of population</td>
</tr>
<tr>
<td>2 Identify cost-effective strategies to identify scope for change</td>
</tr>
<tr>
<td>3 Relate strategies to existing services to identify scope for change</td>
</tr>
<tr>
<td>4 Consult public, patients, and professionals on their values and priorities</td>
</tr>
<tr>
<td>5 Draw up health service objectives and priorities</td>
</tr>
<tr>
<td>6 Draw up contract specifications</td>
</tr>
<tr>
<td>7 Agree on contracts with providers, including service quantity, quality, and cost</td>
</tr>
<tr>
<td>8 Monitor performance of providers directly and through surveys</td>
</tr>
<tr>
<td>9 Feedback information into next round of needs assessment, priority setting and contracting</td>
</tr>
</tbody>
</table>

2.4.4 Service provision

Service provision describes how services are provided by the health sector. It is concerned with organisations that provide the service, the activities and tasks within such organisations, and the interactions between these. Regarding service provisions in health care organisations, Roberts, Hsiao, Berman and Reich (2008) have identified three key strategies. First, 'who does what strategies' which relate to the private versus public debate and the convergences between them (as illustrated in Figure 2.3). Secondly ‘incentive strategies’, which deal with the inducement produced by the connection between service providers and the rest of the system (such as the introduction of competition and contracting-out). Thirdly, ‘managerial strategies’ which concern the operational aspect of delivering services such as corporatisation, TQM and decentralisation.

![Figure 2.3 - Organisational structure](image)

Source: Londoño and Frenk (1997)

**Decentralisation**

On a general note, decentralisation is defined as the shift or diffusion of power in public planning, management and decision making from the national to the sub-national level or from higher to lower levels of government (WHO, 1990). A philosophical interpretation of decentralisation describes it as an important political
thought or idea that involves communities, while at a pragmatic level it is often suggested as a means of overcoming the administrative constraints exerted by institutions by transferring the development role from the centre to the periphery (WHO, 1990).

In health care, decentralisation occurs for many reasons including technical, political and financial reasons. Technically, it improves administrative and service delivery provision. Politically, it motivates local bodies and gives greater local ownership, shifting power from a central structure and decreasing ethnic and/or regional tensions. On a financial note, it seeks to increase cost efficiency, provide control of local resources to local owners, and increase self-accountability (WHO, 1990). The WHO (1990) argues that decentralisation facilitates equity by bridging the gap of unmet demands and local empowerment, thus boosting efficient health performance. Nonetheless, it is vital that decentralisation processes contain clearly defined tasks, roles and functions, as well as appropriate laws enforced and respected by all. It is the responsibility of the local body to ensure this transition in a holistic manner.

In the public sector, decentralisation can take various forms (de-concentration, delegation and devolution) depending mainly on the timing of the execution of different functions (WHO, 1990). The distinction between each type of decentralisation centres around the legal status. In practice, these should not be treated as individual forms as they might cross over each other during the course of a country’s health improvement. The WHO highlights that PPP is an example of decentralisation which could involve delegation and devolution.

2.5 A description of health care system goals and objectives

Based on the frameworks examined above, it is clear that the three key intrinsic goals for a health care system are the following:

1. Health
2. Responsiveness
3. Fairness in financial contribution.

Based on the WHO Performance Assessment Framework (PAF) the indicator for health is in turn the health of the community, which is determined by looking at
mortality, morbidity and life expectancy. Similarly, responsiveness is assessed based on people's perception of their encounter with the health system in specific areas such as dignity, autonomy, confidentiality, prompt attention, quality of basic amenities, access to social support networks during care and choice of provider. Finally, fairness in financial contribution is assessed by the distribution of households' financial contributions to the health system.

Murray and Frenk, (2000), argue that such goals and objectives should be regularly monitored by countries, and should be the foundation for assessing the performance of health care systems. Thus on this basis, the research will utilise such goals as the basis for assessing the performance of PPP.

Similarly, health care objectives identified by Hsiao (2003) and Atun and Menabde, (2008), include the following:

1. Effectiveness
2. Efficiency
3. Choice
4. Equity

Equity (defined as a society's requirement for justice and fairness):

Equity as an objective of health systems can be explained as universal equal access to health care (Mooney, 1986). Equity serves as the principle that is applied in recognising the achievement of the three goals of health status, financial risk protection and consumer satisfaction. Such a concept looks at whether the system produces an allocation which meets society's requirement for justice (Knowles et al., 1997). It should be noted that equity is not the same as equality, as a strictly equal distribution of a budget may be quite unfair as some areas could have legitimate claims on more resources than the others e.g. more population size or less per capita income etc (Mooney, 1986). Thus equity can be best observed as a fair allocation of resources or treatments among different individuals or group. The combination of 'equal inputs for equal need' and 'equal access for equal need' might be the most practical way of describing equity (Mooney, 1986). Measuring equity or fairness in the allocation of resources according to the needs of individuals or groups remains debatable among various researchers.
Effectiveness (defined as the capability of producing an intended result)

Effectiveness in health care can be described as the extent to which a health care target can be achieved (Hutton, 2000). If service targets are not met then resources utilised will be lost and any leading process will be considered inefficient. Hence effectiveness is a pre-requisite of efficiency. In health care, effectiveness is typically displayed as physical units such as cost per saved years of life or prevented cases. Traditionally health care challenges are compared by accumulating various indicators into one measure or by using measures that are multidimensional, like quality of life measurements (Hutton, 2000).

Several indicators are used to determine the effectiveness of a health system. Regardless of the WHO’s efforts to promote positive health indicators, the majority of effectiveness measurements still focus on negative or inefficient processes such as mortality rates, prevalence of disease in a particular area etc. Positive health or the effectiveness of a health system can be measured by using indicators such as treatment rates or vaccination rates that predict potential disease incidence, or by estimating future disease prevalence e.g. low birth weights or vaccination rates (Hutton, 2000).

The public demand for health systems to do more than just improve health has put pressure on policy makers to increase the effectiveness and scope of the health system. Nowadays, a reform in health care involves measuring the health system performance through health outcomes, quality of care, patient satisfaction and system responsiveness. Thus, many countries now put greater emphasis on consumer or patient satisfaction which is considered to be a means of achieving a safe and greater level of health care provision that meets the demand for both health and satisfaction goals (Hutton, 2000).

Efficiency (defined as making good, thorough, and/or careful use of resources, without over consuming)

Efficiency of health care is measured on the basis of the utilisation of resources in the best possible manner (Wenzel, 1997). Efficiency relates to resource inputs (such as cost, in the form of labour, capital and equipment), or intermediate outputs (such as numbers treated and waiting times), and the final health outcome (quality-adjusted life years, lives saved, life years gained). In other words it refers to
the amount of resources getting used (inputs) and the extent to which they are being utilised to produce services (outputs).

The growing demand for health care services compared to available funds and their priority allocation is a challenging area in health economics (Hutton, 2000). Policy makers need to find the right balance between resources and their efficient use. The increase in ageing population, rising health care costs, limited funds and greater influx of technology related interventions have made efficiency analysis key in health care reforms. Similarly, Wenzel (1997) argues that although using limited resources to create better services is ideal, there may not always be fair allocation of resources, or resources can simply work under one set of circumstances but fail under another.

It is important to investigate carefully different types of efficiency under each health input (costs, in the form of labour, capital, or equipment) in order to evaluate a particular targeted reform (lives saved, life years gained, quality-adjusted life years) (Wenzel, 1997). Two types of efficiencies are generally considered by health economists: technical efficiency that includes cost (input), and result efficiency (outputs) (Knowles et al., 1997). The former is described as a given outcome achieved under the lowest possible resource allocation and the latter as the best possible outcome achieved under a set resource allocation. Allocative efficiency, also referred to as Pareto efficiency, is a type of efficiency that looks beyond the cost effective means of resource allocation (Knowles et al., 1997). It analyses ways in which treatment measures for one group can adversely affects the condition of another group. This could involve evaluations regarding what type of treatment should be provided and to whom.

**Choice**

Today, patients are seeking greater engagement in health care choices, increasing the demand for high-quality information about clinical options. Providing support for informed choice is not straightforward due to challenges faced by clinicians, health systems and consumers (Hutton, 2000).

Healthcare systems are striving and reaching for an excellent standard of care. According to the Institute of Medicine (IOM), quality is defined as, “degree to which health services for individuals and populations increases the likelihood of the desired health outcomes and are consistent with the current professional knowledge”. (Donaldson et al, 1992)
Governments have become more concerned about knowing how patients perceived the quality and type of care they receive and the settings in which they receive this care. Therefore, reliance on surveys to measure these perceptions has greatly increased (Hutton, 2000). Medical practitioners and health care organisations are carrying the responsibility for evaluating patient satisfaction. These surveys provide information on patient perceptions related to treatment ethics, communication transparency, and perceived barriers to the provision of services and other forms of care. Data from such surveys combined with statistical data collected simultaneously will improve the system's responsiveness and choice. This data is also used to facilitate public service messages and drive more knowledge-based decision making among patients (Hutton, 2000).

2.6 Chapter summary

Chapter 2 examined the definition, components, goals, performance, financial and organisational structure of health systems for policy purposes. It provided background information describing the importance of such systems in improving health. Key frameworks used to examine health system performance, components, elements, goals and context were investigated with an emphasis on the relationship between such aspects. Providing clarity about these concepts will aid in the examination of the role of PPP in fulfilling the health objectives of effectiveness, efficiency, equity and access. This research will adapt the system framework developed by Atun (2008), as the framework of choice for PPP evaluation.

The following chapter will describe the Kuwaiti health care system, its history, standards, statistics, organisational structure and challenges.
Chapter 3 – Kuwaiti health care system

3.1 Introduction

This chapter describes the Kuwaiti health care system in detail. It will begin by providing a brief background of Kuwait as a country, after which it will provide details of the nation’s health care system, its history, standards, statistics, organisational structure and challenges. The role of the government and the private sector in health is also examined. Finally, detail of the Kuwaiti government’s future prospects for health care is provided.

3.2 An introduction to Kuwait

Kuwait, located in the north west of the Arabian Gulf, is bordered by Iraq, Saudi Arabia and the Arabian Gulf. The estimated population in 2006 was 3 million, with only one third being Kuwaiti citizens (Kuwait Government Online). Kuwait enjoys an open economy, relying primarily on its crude oil reserves, which in turn represent 10% of the world’s reserves. Such reserves make Kuwait one of the richest nations in the world relative to its small population (Kuwait Government Online).

3.3 A history of the Kuwaiti health care system

The history of Kuwait’s health care system dates back to the early twentieth century, with the opening of the first medical centre, established by the British, in 1904 (Al Mutairi, 2007). Later in 1912, doctors from the USA (the American mission) set up their first hospital with the Amir’s approval, on the condition that it provided health care services to the Kuwaiti people in addition to the American mission (WHO, 2006a). Today, Kuwait’s health care system is recognised as one of the most developed in the Middle East (Business Monitor International, 2011). Its achievement in terms of health indicators are even within average European standards of health and health care (WHO, 2006a).

The infrastructure of the Kuwaiti health system was initiated in the late 1940s as part of the overall welfare system that was initiated with the dramatic realisation of
oil income. This resulted in a high level of health status and good standard, accessible health services. Since then the health sector growth rate has been 4.5% per annum (Business Monitor International, 2011).

At present, the Kuwaiti health system is provided mainly by the public sector, which represents 80% of the service. The private sector, however, although representing only around 20% of the service, is growing rapidly (WHO, 2006a)

3.4 Health indicators

Health care indicators provide a guide and a marker of the level of health in a country. According to the WHO (2009), Kuwait has achieved very good health standards on an international level. For example, a health status indicator such as life expectancy for the Kuwaiti population at birth was 77.4 in 2007, while the infant mortality rate was 9.4 in 2003 (WHO, 2009). Similarly, total population access to health services was 100% in 2007. Between 2003 and 2006 most of the health status vital indicators have improved such that they are now in line with average European standards (Kuwait Medical Association, 2009)

3.5 Kuwaiti health care system structure

The organisational structure of the health system in Kuwait is based on a central MOH and district regional units.

3.5.1 The Ministry of Health

The Kuwaiti Ministry of Health (MOH) is one of the biggest ministries in Kuwait. Founded in 1936, it is responsible for setting strategies, financing, resource allocation, regulation, monitoring and evaluation of health care as well as for service provision to the end-users. Its overall organisational structure (see Figure 3.1, below) consists of 13 departments: medical services, dental health, health service support, drugs and equipment supply, nutrition and drug control, blood transfusion and laboratories, technical affairs, financial affairs, legal affairs, administrative affairs, planning and follow up, public health and private service. Recently, a new organisational structure was proposed by the Kuwait Medical Society in Kuwait Health Forum (The Challenge and Solutions of Reforming Kuwait's Health Care
System) which includes proposals for decentralisation, hence flexibility for future modernisation (Kuwait Medical Association, 2009). The current organisational structure, according to the Eastern Mediterranean Regional Health Systems Observatory, EMRO, seems to suffer from a duplication of roles among different departments with an overlap of responsibilities, especially as the MOH is in charge of financing and service provision as well as monitoring and evaluation of such provision (WHO, 2006a).

3.5.2 Health districts

The MOH has divided Kuwait into six health districts, each providing one general hospital, a number of primary health care centres and specialised clinics: Kuwait capital (Amiri hospital), Jahara district (Jahara hospital), Sabah district (Sabah medical area and Sabah hospital), Hawaili district (Mubarak hospital), Farwania district (Farwania hospital) and Ahmadi district (Adan hospital). Each of these health district acts as an independent unit with roles and responsibilities assigned by the MOH. Such responsibilities fall within four main areas; 1) provision of health services to the citizens of the area according to the MOH’s guidelines, 2) ensuring the provision of different levels and specialties of health care, 3) the implementation of training and development for MOH employees, and 4) establishing a comprehensive database (WHO, 2006a).
3.5.3 Primary care

Primary health care is provided by 74 health centres well allocated in residential areas, most of them offering a range of health services that include family medicine, maternity care, childcare, a dental clinic and a specialised clinic. Each centre has its own pharmacy that provides free medication based on prescriptions by doctors. Free curative and preventive services are provided for the public, available 24 hours a day in most primary centres. Similarly, routine check-ups and preliminary investigations are available in most of these centres. Such primary care centres also provide access to hospitals and other specialised centres through a referral system (UK Border Agency, 2010).

3.5.4 Secondary care

Secondary health care is provided by the six regional hospitals (mentioned above), with the seventh hospital (Jaber Hospital) opening soon. There are also two other government hospitals – a military hospital and a Kuwaiti oil company hospital – that provide their services to their organisation’s members and their families (WHO, 2006a).

In addition to that there are specialised (tertiary) health centres which include the following:
1) The Transplant centre – Hamed Alessa
2) The ENT centre
3) Kuwait cancer control centre – Maki Jummah
4) Neurosurgery hospital – Ibin Sina
5) Orthopedic hospital – Alrazzi
6) Psychiatric hospital
7) Kuwait centre for allergies
8) Chest hospital
9) Maternity hospital
10) Rehabilitation hospital
Citizens are eligible for free access and treatment based on referral from primary health care centres. Non-citizens however have to subscribe to the health insurance scheme, managed by the government, and which costs 50 KD a year, and 2 KD per visit to secondary care (UK Border Agency, 2010; Business Monitor International, 2011). The majority of such secondary and tertiary hospital infrastructure was established in the early 1980s and went through modernisation programmes in the 1990s (Al Mutairi, 2007). However it should be noted that Kuwait has not seen the opening of a new general hospital in the last 25 years.

3.5.5 Health care insurance

The health care system in Kuwait covers the Kuwaiti citizens through a national insurance scheme that provides comprehensive coverage for access to all government health care facilities including drugs and prescribed equipment. Non-citizens however have to pay fees for non-emergency services and get government-subsidised medicines. Nonetheless, this scheme, introduced six years ago, has its problems and is currently being reviewed by the government.

3.6 Health care developments and reform

The Kuwaiti government has made a few attempts to reform the health care system over the last 20 years. These attempts have not achieved their target mainly due to a lack of leadership, political support and government stability. The last reform was in 2006 when the MOH announced its plan for multiple health projects around the country with a budget of $3.47bn. However this has yet not been followed by any specific plan, causing many to argue that it is more like a populist policy that fades away when government cabinets change (Business Monitor International, 2011).

Despite this, health care in Kuwait has started to see improvements in quality, with the MOH adopting service quality recognition systems, internationally known as accreditation schemes, where external assessment is used to assess the level of health service performance in relation to established standards. This is an attempt by the MOH to ensure continuous improvement in health institutions and to encourage positive competition (Business Monitor International, 2011). Furthermore, the MOH has also announced its plans for improving its information system through an initiative for national electronic health care systems responsible for delivering central
electronic health care networks between MOH departments, clinics and employees. This is to improve the delivery of prescriptions, investigation results and audit processes.

There has also been a renovation initiative, initiated in 2008, that allocated small budgets to modernise most of the old and run down health care facilities across the country (Business Monitor International, 2011). In 2009, the Kuwait medical society forum “the challenge and solution of reforming Kuwait’s health care system”, put forward a number of valuable recommendations for the MOH’s future reform, which include the following: 1) restructuring the organisational structure of the MOH toward decentralisation, 2) treating each general hospital as an independent unit with its own operations and budgets (thus empowering the management with full control and responsibility for achievement), and 3) encouraging partnership with NGOs. The recommendations also highlighted the fact that the financial burden on the MOH is escalating due to population growth and increases in the cost of health care provision (medication, HR, equipment), and thus the need for encouraging private organisations to invest in such vital areas. Consequently it has been strongly advised that the regulations need to be changed and institutional organisations need to adapt in order to account for the contribution of the private sector (Business Monitor International, 2011; Kuwait Medical Association, 2009).

Nonetheless, regardless of the overall good health indicators achieved by the Kuwaiti health sector (see above), it is still maintained that the health sector in Kuwait “remains largely underdeveloped” (Oxford Business Group, 2007). This is especially in terms of efficiency and service quality, due to many of the issues discussed below.

3.7 Challenges facing the health care system

According to the Kuwait Cooperation Strategy and Kuwait Medical Association, Kuwait has achieved significant development at socio-economic levels including access to public health services. However, in spite of its major developments, Kuwait’s health sector is prone to disintegration unless its service delivery and management undergoes radical overhaul (Kuwait Medical Association, 2009; WHO, 2006).
3.7.1 Bureaucracy and management

The regulatory structure of Kuwait's health administration is outdated. Policies dating back to the 1980s need to be replaced through strategic policy reviews, fresh insights to organisational structure, advanced health informatics and modern skills, and a set of researchers and policy makers engaged to boost overall health management standards. Kuwait suffers from an aging health care infrastructure and facilities, with the latest hospital being built in 1981. Such an issue has led to an accumulation of serious service issues (Al Mutairi, 2007). Similarly, a major area of concern in hospitals is patient waiting times. These have increased due to problems such as surgical backlogs and a decline in the patient-to-hospital-bed ratio. As a result, patients seeking immediate care are starting to turn to private practices or medical tourism (Al Mutairi, 2007; State Audit Bureau of Kuwait, 2004).

3.7.2 Demographic challenge

The Kuwait Pharmaceuticals and Health Report has indicated that the population will almost double by 2030. Currently the vast majority of the population in Kuwait are younger than 30 and more than half of these are younger than 20 (Business Monitor International, 2011). Thus by 2030, 8% of Kuwaitis will be over 60 years old, and by 2050 this figure will rise to 25%. An aging population will see an increase in chronic diseases such as cardiac and pulmonary complications, mental disorders and cancers. Furthermore, chronic heart disease, accidents and mental health are already leading causes of death in the Kuwaiti population. According to the WHO, this represents 60% of the overall burden of chronic diseases in the Eastern Mediterranean region (Kuwait Medical Association, 2009; WHO, 2006). Despite the large financial resources stabilising the economy and the situation being masked by high oil revenue, the implications of such demographic changes could be devastating (Business Monitor International, 2011). This is especially because the vast majority of the population still rely on government free health services. Figures 3.2 and 3.3, below, illustrate the high adult obesity rates across the GCC and the projected increase in required treatments in certain regions.
Figure 3.2 - Adult obesity rates across GCC countries (2008)

![Adult obesity rates across GCC countries (2008)](image)

Source: WHO

Figure 3.3 - Projected increase in treatments needed by 2025 in GCC

![Projected increase in treatments needed by 2025 in GCC](image)

Source: Mckinsey & company report 2007

3.7.3 Cost of health services

The cost of medical services is escalating worldwide and in Kuwait specifically due to demographic changes. Figure 3.4 illustrates how health care
expenditure has risen over the past few years and is projected to further increase with time. In order to contain this expected shift, more public and private investment is required to bring quality and quantity in service providers together with strong evidence-based monitoring of shifts in disease burdens in the Kuwaiti population. This will also be used to carry out strategic assessments aimed towards improving development of the domestic workforce rather than relying (as is the case now) on procuring foreign qualified health professionals (Kuwait Medical Association, 2009).

A sizeable increase in Kuwait’s expatriate population, together with increasing demand for advanced health care delivery, has put financial pressure on local health authorities (Kuwait Medical Association, 2009). Therefore Kuwait needs to focus on its social health insurance system, like many other developing regions. This could provide a long term solution for growing health concerns. The political will is required to cope with these issues and to find suitable economic solutions (Al Mutairi, 2004). Not only does investment in health care reforms control escalating unit costs but it will also improve the public’s perception about growing health disparities. Public satisfaction will drive down litigation costs that often result from impoverished health care administration.

Figure 3.4 - Kuwait health expenditure 2006-2014
3.7.4 Health service management

Improving health care service delivery requires professionals that are capable of leading complex health care initiatives towards successful and timely completion. High standard service provision infrastructure depends on strong leadership and strategic decision making. This will involve creating an economic balance between managing health funds and provision of swift health care services to a growing population. Investing in management capacity development, identifying suitable candidates for top jobs in health administration, their training and development are therefore key steps required to achieve this objective (Kuwait Medical Association, 2009).

It is maintained that in order to address growing concerns regarding service delivery, management and leadership in health care departments, a clear vision is required (Al Enezi, 2006). Kuwait, for example, needs to address its workforce shortages, especially of doctors and nurses. They are the first line of contact between patients and other strategic partners at the point of service provision. A plan is required to establish more advanced teaching settings, including medical colleges and research institutions, that could increase the supply of top class local professionals. These professionals should be better equipped to adapt to and understand cultural and social settings. It is argued that such individuals could be suitable candidates for future management roles as they will have thorough knowledge of their respective health care environment (WHO, 2006).

It is also important to take note of the need for developing a long term strategic plan to address future health care needs and facilities. This is important as many Kuwaitis are travelling abroad to find treatment due to lack of, or absence of, quality services within local hospitals. Hospital management systems and processes thus require exceptional upgrades in order to meet growing future demands (Kuwait Medical Association, 2009; Al Enezi, 2006).

The absence of policy making is a major concern as without it no clear steps can be taken to improve Kuwait's health care system. Currently, there is no central body that governs and constitutes ethical or regulatory guidelines (medical law) for health services in Kuwait. Lack of constructive regulations, together with the absence of long term policy making, is negatively affecting Kuwait's health care infrastructure. Kuwait's recent budget surplus (KD 6.3 billion for 2007/08) suggests
that more needs to be spent on areas of planning and strengthening central governance with lines of communication channelling across local authorities to understand their immediate needs and future demands. It is thus argued that Kuwait's health care sector is recognised to be in extreme need of critical budget spending from this surplus (Kuwait Medical Association, 2009).

3.7.5 Public expectation

The Kuwaiti parliament stated in a special study published in 2007 that Kuwait suffers from health service recession on various dimensions, including medical, managerial, facilities and technical (Al-Mutairi, 2007). This recession or deterioration has not only reflected itself on the end-user patients and their families, but also on professionals working within the MOH (Al Mutairi, 2007). Kuwaiti public expectation for health service standards has been increasing in the last few years in parallel with the economic boom seen in different sectors in Kuwait and in surrounding countries such as UAE and Qatar (Oxford Business Group, 2007; Business Monitor International, 2011). Kuwaiti citizens' high awareness of health care developments, especially in the western world, has led to demands for high-end medical services with better quality and better facilities. This thus represents a major challenge for Kuwait's government.

Similarly, according to the Kuwait Economic Society Public Opinion Survey in 2007, health care in Kuwait came third in terms of urgent priority for issues to be improved by national government (Business Monitor International, 2011). The MOH has been facing difficulties in keeping up with the level and demand required. For example, the MOH still on numerous occasions relies on overseas treatment for citizens (Business Monitor International, 2011; State Audit Bureau of Kuwait, 2004).

Furthermore 'wastah' (a Kuwaiti term, meaning 'connectedness') has been defined as a syndrome which has a very dangerous effect on health services, as people without medical priority bypass the waiting time and create major unfairness to eligible people. (Al Mutairi, 2007).

3.8 The role of the private health sector

Private health care in Kuwait has been thriving over the last five years, filling market gaps and seizing opportunities mainly in secondary and tertiary health services (WHO, 2006a). Although government provides comprehensive health services, there
is still a belief that government services are deteriorating in quality and are overcrowded (Kuwait Medical Association, 2009; A; Enezi, 2006). There are 11 private hospitals with hundreds of private specialised clinics scattered around the country. The perception is that the services they provide are of higher quality and they are generally being utilised by a wealthier class. The MOH regulates and monitors the licensing and operation of private sector facilities through a specialised department. The recent establishment of the department was part of an attempt to encourage private sector initiatives to take a more advanced role in health care provision within the country (WHO, 2006a). Reports show that the growth of the private sector will continue due to increasing demand, although according to market forecasts the public sector will still dominate (Business Monitor International, 2011).

3.9 Decentralisation

The Kuwaiti government has been convinced recently by a number of consultation agencies to decentralise its health system organisation with the aim of better performance of the health service through enhancing efficiency, effectiveness and quality (WHO, 2006b). However, the MOH’s attempt to decentralise has been controversial. The health district areas with their district boards have good organisational structure, led by experienced managers and generally provide better health services (WHO, 2006a). Such a structure has the potential to provide a sound platform for decentralisation, which can provide enhanced efficiency in service delivery and better use of resources. However this structure has its drawbacks, which include lack of flexibility on human resource issues such as use of incentives and bonuses for new recruitment or reward on performance for existing staff. In addition the budget and resources, such as equipment and facility extension for health districts, are allocated centrally and mostly not according to local team needs (WHO, 2006a). Furthermore there is a lack of a database and information about utilisation capability as most of the strategic planning and operation information is held in MOH central departments. Such issues prevent any creative attempts for adding value by district management. These rigid restrictions are not adequately justified by the MOH according to health district officials (WHO, 2006a).

In addition, it has been highlighted that the MOH lacks clear regulation which deals with the private sector at various levels, such as facility management, equipment standards and monitoring, as the existing regulations only deal with registrations and
licensing (WHO, 2006a and b). Furthermore, communication between the central department of the MOH and district management has been criticised and described as weak. This weakness is revealed through a lack of coordination and a duplication of operational issues (WHO, 2006a and b).

3.10 Chapter summary

This chapter described the Kuwaiti health care system. It provided a background of Kuwait as a country, its health care system, history, standards, statistics, organisational structure and challenges. The role of the government and the private sector in health was also examined.
Chapter 4 – Public Private Partnerships

4.1 Introduction

This chapter contains a review of the use of PPPs in the health care sector. It begins by explaining the origins of PPPs, making reference to the concept of market failure and increasing private sector involvement in the provision of public services worldwide. PPPs are then defined and PPP objectives highlighted. Following this, a detailed examination of PPP delivery and the different forms of PPP arrangements being used in the health care sector, particularly in the UK, is made, and the specific advantages and disadvantages of these are highlighted. The chapter then examines the critical success factors (CSF) of PPPs and the various barriers facing PPP implementation.

4.2 The origin of PPPs

4.2.1 The nature of public services

National governments in numerous countries worldwide are traditionally responsible for providing public services such as health, education and defence (Froud and Shaoul, 2001). Such services, provided by a government to its citizens, are a commodity that society considers should be produced in quantities and distributed in ways different to those in a free market (Corry, 1997). It has been argued that the private sector would not be able to provide such services profitably, and may produce them in an unacceptable and insufficient manner to society (Corry et al., 1997).

In general terms, the public sector is defined as “those parts of the economy which are not controlled by individuals, voluntary organisations or privately-owned companies” and includes both national and local government, and government-owned firms (Das and Nandy, 2008). The private sector however is defined as “those parts of the economy not run by the government”, which includes households, sole traders/partnerships, companies and voluntary bodies (Das and Nandy, 2008).

Corry et al. (1997) suggest that a public service must have three main features: accessibility (which affects the price at which it can be offered); quality (to meet user needs and wants); and efficient delivery (efficient use of resources such as land,
labour and capital). In providing public services, the public sector must therefore have a means for ensuring equity and geographical availability, for controlling price, and for being responsive to users' needs to improve quality, and for ensuring efficiency and technological innovation in delivery (Pessoa 2006). However, lack of resources, technical expertise and management in the public sector hinders the efficient and effective provision of such services (Froud and Shaoul, 2001), as explained in section 4.2.2 below.

4.2.2 The public vs. private debate in the provision of public services

Corry et al. (1997) argue that public provision often suffers from various factors such as producer capture, political interference, lack of competition and constraints on investment. Producer capture refers to a condition where the service is operated to benefit existing management/employees instead of the service users, thus resulting in low efficiency and innovation. Similarly, political interference refers to situations where elected officials take irrational decisions on the operation of public organisations, thus hindering the ability of management teams to consider long term strategy planning. Lack of competition due to a lack of new providers can also result in a lack innovation and a reduced incentive to cut costs. Finally, as the state often considers the totality of government borrowing, there may be serious constraints on investment, with numerous public service organisations suffering from underinvestment. It is noted that since 1976 capital spending in crucial parts of the public sector, such as health and education, has largely decreased in absolute terms and as a percentage of total spending in the area. Consequently public services often have low standards of customer care worldwide (Pessoa, 2006). Similarly, Propper (2000) notes that the absence of a market force makes the public sector less efficient than the private, and that the often bureaucratic and inflexible management structure of government means that consumer demands and satisfaction are overlooked.

Over the past two decades there has been an increasingly strong focus worldwide on making the public sector more efficient, innovative, flexible and cost effective (Weihe, 2008). Peters and Pierre (2003) argue that the emphasis on performance and service delivery has increased relative to traditional public values of universality, equality and legal security. Similarly, private provision has increasingly
been injected into the public sector by means of various partnerships, as will be
explored in further detail below (Corry et al., 1997).

In comparison to the public sector, the private sector is often associated with
strengths that ultimately stem from their aim to maximise profits (in the case of for­
profit organisations) and increased competition among different players. These
strengths include improved efficiency, innovation, quality and customer care. Private
sector organisations are also noted for their improved management standards with
better paid and motivated staff, and for their investment in research and development
being sufficient to initiate new and innovative techniques (Pessoa, 2006).

However, many sources identify particular flaws with private sector provision.
Corry et al. (1997) note two key problems. The first is concerned with the potential
weaknesses of private sector provision itself, which stems from its ultimate goal of
maximising profits. This goal may give the provider incentives that contradict those
required to deliver public services, and they may thus not operate in the public’s
interest. This may manifest itself in various ways such as cutting costs by reducing
quality, or worsening employee terms thus reducing incentive to improve quality.
Similarly, private providers may also face pressure from shareholders, interested in
maximising dividend income in the short term, thus preventing long-term planning.
On the other hand it is argued that private not-for-profit organisations may overcome
such issues as they may have a stronger commitment to maximising quality without
exploiting regulators weaknesses to cut costs. Nonetheless it is noted that because
such organisations are not aiming to maximise profits, there may be reduced
efficiency and innovation.

The second key issue stems from the attempt to mesh public and private
interests. This can result in accountability structure problems (particularly in
partnership arrangements) which can negatively affect users/purchasers. This issue
was discussed further in section 3.5.1.

Another key argument for public over private provision rests on the
predominance of market failure within the private sector (see for example Corry et al.,
1997). A market is defined as “reconciliation of quantity decisions of buyers and
sellers through price adjustment” (Begg et al., 2003). Although the theory is that
markets produce goods and services demanded at the right quantity and the lowest
cost, the reality is that inefficient results can occur leading to market failure (Dolan
and Olsen, 2002). Various sources of distortion can occur that lead to market failure
such as absence of information, uncertainty of demand, imperfect competition (monopolies), externalities, adverse selection, moral hazard, and supplier-induced demand (Folland et al., 2007).

Pessoa (2006) highlights that market failure for health care services often results in a notable under-provision. The presence and extent of uncertainty in health care for example, is such that an individual does not know when he/she will be ill and what treatment he/she will need (Dolan and Olsen, 2002). This will later be manifested by insurance market which itself lacks rigour and efficiency (Folland et al., 2007). Health insurance can induce demand by the end-user and/or supply by the service provider leading to abuse of the service (moral hazard). Suppliers can also be affected by moral hazard as insurance can tempt the health care provider to over prescribe treatment. Thus moral hazard can negatively affect the allocation of resources and therefore result in welfare loss (Dolan and Olsen, 2002). Another inefficiency associated with insurance is that Insurance companies tend to prefer low risk patients and tend to have high premiums for high risk patients, referred to as "cream skimming" (Dolan and Olsen, 2002). This is the process of adverse selection, which in a free market can mean that health insurance is too expensive for those most in need.

Another source of market failure in the health sector, noted above, is absence of information. Trusted, up-to-date information is very often complex and expensive to access, resulting in a significant lack for consumers (Folland et al., 2007). In addition to this, the wrong information can have catastrophic impact on consumers. Similarly the concept of supplier induced demand is predominant in this sector (Dolan and Olsen, 2002). Consumers often depend on and trust that the doctor will act in their best interest, expecting that a doctor will recommend the right treatment and provide it. However, doctors in unethical situations can maximise their profit by selling unnecessary services ranging from requesting further investigation to carrying out surgical operations (De Jaegher and Jeger, 2000). The fact that there is no set protocol for every medical condition facilitates this issue. Society therefore relies on the ethical code for medical practice; however it is questionable whether this is enough to ensure all doctors can be trusted (Farley, 1986).

The imperfect competition created by monopolies (Folland et al., 2007) is a further source of market failure in the sector. Large care institutions have an incentive to expand and provide a wider range of specialised services. These institutions can
develop monopoly power within the health care market, becoming the price maker (Mougeot and Naegelen, 2005). Likewise, the existence of externalities (the slipover effect), (Shackley and Healey, 1993) which is defined as the impact of one person's behaviour on another person's utility, can also result in market failure. In a free market, for example, there may be an under-provision of vaccinations (a positive externality), which will in turn will impose a negative cost on society.

Thus the question arises of whether such distinct features in the health care sector mean that there is a need for some form of government intervention. Generally, economic theory suggests that in providing public goods and services market failure and equity considerations do require government intervention (Pessoa, 2006). However, as noted above, the absence of a market force makes the public sector less efficient than the private, and the often bureaucratic and inflexible management structures of the government mean that consumer demands and satisfaction can be overlooked (Propper, 2000).

However, in addition to efficiency, which the private sector market force provides, communities are also concerned with fairness and equity, which are in principle the main motives behind the creation of many public services including health (Jaegher and Jegers, 2000). The argument therefore is to what extent government/public sector intervention should extend (Maynard, 1986). Strategies to improve both efficiency and equity often differ, and the question of whether governments should intervene and in what ways, how, and when is debatable (Mintz and Schwartz, 2000).

Based on progress in and changes to public services in Britain over the past two decades, the following classification of public sector intervention is suggested (Le Grand and Robinson, 1984):

1. As a provider – this is the situation where the public sector owns and operates all service delivery facilities, employs all service employees, and has sole managerial control over price, geographical location, quality and efficiency.
2. As a purchaser – this is the situation where private companies undertake service provision and the public sector provides the finance via numerous purchasing agents that contract with the private sector providers. Through contract requirements, the public sector can achieve its aims regarding price,
geographical accessibility and quality, while encouraging efficiency via competition between different private providers for service contracts.

3. As a regulator – this is the situation where private providers offer a service in the market, at a price, geographical availability and quality that is regulated by the public sector.

In general terms, the first model (the state as a provider) is often noted to have failed for reasons highlighted above such as producer capture, political interference, lack of competition/efficiency and investment constraints (Corry et al., 1997). Today this model is being increasingly replaced by the second and third models through various PPPs.

4.2.3 The rise of the PPP concept

The PPP concept is not new (Nisar, 2007); it is suggested that the term can be traced back to the 1960’s urban renewal projects that expanded in the USA (Das and Nandy, 2008). However over the past 15-20 years in particular, there has been increasing and extensive support for this concept, with partnership approaches being promoted on numerous levels worldwide (Blanc-Brude and Strange, 2007). To attain certain policy goals, the European Union (EU) encourages this approach, at the supranational level, through operating with numerous member states and local agencies (CEC, 1996). Similarly, at a national level, governments worldwide are progressively moving away from public service provision towards increased private sector involvement through PPP (Leach et al., 1994). It is noted that PPPs were first introduced in the early 1980s by the UK Conservative government as a means of increasing private sector involvement in the provision of public infrastructure projects (Sadka, 2006). In the 1990s in particular, PPP started to become a key tool of public policy and a popular method of procurement for public infrastructure projects in the UK (Bing et al., 2005). Silva and Rodrigues (2005) also argue that the rapid and widespread acceptance of PPP is supported by the notion that partnerships are a cost efficient and effective means for executing public policy across a variety of policy agendas. By mid-2007, there had been over 800 projects signed in the UK since 1992 (Blanc-Brude and Strange, 2007). Similarly in the EU, over 1,000 PPPs reached financial close (with a capital investment of 200 billion euros) by 2007 (Blanc-Brude
and Goldsmith, 2007). In the USA, PPPs are also becoming widely accepted, especially in the road sector (Mattei, 2006).

In general terms the PPP concept probably originated from the theory and practice of NPM, an approach that originated in Anglo-Saxon countries (UK, USA, Canada and Australia) since the 1980s to modernise and reform the public sector (Skietrys et al., 2008). The essence of this movement was that an increased focus on market principles such as competition would lead to increased cost efficiency without hindering government objectives (Boston et al., 1996). PPP is often perceived as a new term in the area of public management, allowing for the use of private sector tools and mechanisms in the implementation of public sector services (Lider, 1999).

The section below provides a detailed examination of NPM, highlighting its definition, origin, advantages and positive aspects, disadvantages and implications.

4.3 NPM

4.3.1 Definition and scope of NPM

NPM plays an important role in the public sector of many economically developed countries. NPM is a management philosophy, which seeks to modernise the public sector and to describe the movement of public sector reform worldwide (Boston et al., 1996). It is considered a global phenomenon which, although originating in the developed countries, has today penetrated other parts of the world, triggering significant changes in government policies. NPM is an organisational theory that concentrates on the implementation and shift from public administration to public management (Oehler-Sincai, 2008). Tolofari, (2005) has defined NPM as “an approach in public administration that employs knowledge and experience acquired in business management and other disciplines to improve efficiency, effectiveness, and general performance of public service in modern bureaucracy.”

Scarce resources, an increased emphasis on enhanced quality of public services, and a view of ‘doing more with less’ have encouraged governments to adapt NPM theories with the aim of achieving better efficiency and cost-effectiveness (Ross et al., 2000). NPM has also been referred to as ‘new managerialism’, an ideological stance which questions the welfare state or wellbeing of society (Hood, 1991). Furthermore, NPM can be viewed as a theory within administrative research
concentrating on social engineering. All in all, it maintains a valid perspective framework to support governments in structuring and managing the public sector. Boston (1991) notes that this framework is driven from a theoretical idea regarding organisation and management that is influenced by economics and political science.

NPM is centred on the concept of introducing private sector management practices into the public sector, empowering managers, measuring performance, increasing competitive pressure and budgeting. It has also impacted on human resource management by triggering decentralising of wages, influencing individual employment contracts, total quality management and performance-based pay. In other words, NPM is about maintaining public sector resources and sustaining government capacity by replacing its highly centralised structure with a decentralised management entity where decisions on finance, resource allocation and service delivery are made closer to the point of delivery and citizen/client needs (Murray and Frenk, 2000). In addition to this, NPM also looks into transforming routine types of work into work that is more satisfying by multi-skilling and continuous training (Ross et al., 2000).

Therefore, NPM's main hypothesis is that a market orientation in public sector institutes will enhance cost efficiency for governments without imposing negative effects on other government objectives such as equity. Different market mechanisms have been used to overcome governmental bureaucracy; the conventional hierarchical authority is moving more towards an increased adoption of contracts, internal pricing and service outsourcing (Kolthoff et al., 2007).

NPM has thus highlighted the separation of politics and management (Walsh, 1995). The Audit Commission (1999) has also argued that politicians should focus on setting strategies and policy targets for managers, rather than being concerned with detailed operational matters. Although there is much controversy regarding the implementation of NPM, its concept has played a significant role in public administration theory and practice since the late 1970s (Simonet, 2008).

In addition to this, Hood (1991) indicates that NPM has merged economic theories (public choice theory and principle agent theory) that focus on choice and transparency, with private sector management practices and techniques that focus on results and performance.

Barzelay (2001) has highlighted the extensive range and breadth of the literature associated with NPM. Despite this, it is suggested that the majority of NPM
studies discuss five core aspects that represent the underlying philosophy of the theory (Hays and Kearney, 1997). These include the following:

1. Downsizing – reducing the size of government;
2. Managerialism – using business protocols in government;
3. Decentralisation – moving decision making closer to the service recipients;
4. Debureaucratisation – restructuring government to emphasise results rather than processes;
5. Privatisation – directing the allocation of government goods and services to outside firms.

Such aspects are derived from business philosophies of the private sector, and are aimed at reducing the scope of public sector activity.

4.3.2 Origins of NPM

NPM reforms are an evolution of the neoliberal ideas of the early 1980s, which were in turn supported by the development of information technology and the involvement and growth of management consultancies as advisers for government reform. Similarly, NPM reforms were a response to the financial crises of the 1980s, which triggered the quest for efficiency and improved methods to reduce government costs in the developed world (Simonet, 2008). The role of the welfare state and its institutional character was being reviewed especially in areas where the quality of public services was deteriorating and distrust towards government services was growing. This liberalisation of public administration by utilising private sector tools thus came to be known today as NPM (Kolthoff et al., 2007).

NPM has generously borrowed from the concept of capitalism (Tolofari, 2005). NPM is in favour of the argument that humankind is the sole judge of human progress; the only way to assess progress is by examining the wellbeing of society. From the utilitarian perspective, welfare or progress is the “greatest happiness for the greatest number”. NPM thus introduced modern economic theory of utilitarianism into public administration and made capitalism work in public services (Tolofari, 2005). However, it is argued that the transition made by NPM is from a capitalist economy to a capitalist society, where activity is focused on the principle of competition (Rolland, 2005). Some theories also suggest that governments today
should be cautious, as capitalism has in the past led to crisis, and history is likely to repeat itself. (Tolofari, 2005; Rolland, 2005)

NPM reforms have also been determined by a number of factors that include social, economic, technological and political factors. From the perspective of economics, the worldwide fiscal slowdown associated with the public debt and high unemployment rates of the 1970s has led many leading developed countries such as the USA, UK and Japan to pursue a common route in identifying a solution to the economic recession.

In addition, the political driver of NPM is also an equally important factor. New liberal ideas introduced by both political ‘New Right’, such as Reagan in the USA and Thatcher in the UK in the late 1970’s had a great influence on NPM. Such governments’ liberal ideas influenced a new policy focused on reducing the scope of government intervention in the economy, as well as monopolies of services, all with the aim of enhancing accountability and giving consumers a significant voice. Reforms introduced by the new governments aimed at introducing market mechanisms in which governments are run like a business, in order to allocate resources effectively, introduce efficient mechanisms, and encourage rational decision making and enterprise (Tolofari, 2005).

Furthermore, socio-demographic factors have also contributed to NPM. The greater demand for public reforms is based on a change in the relationship between governments and their citizens, a change in the democratic society with an increased level of awareness among citizens, more assertive NGOs, and the growing role of the mass media.

Information and computing technology is another factor that has significantly contributed to the emergence of NPM. Such a factor has contributed to the rapid spread of the concept and its mechanisms around the globe. Similarly, improved information technology has also facilitated the link between different entities by providing the tools and structures to enable management reform.

It is also maintained that NPM has primarily emerged from two main principles. The first is managerialism, which originates from the distinction between the terms ‘administration’ and ‘management’. Social scientists perceive administration as a separate discipline that has its own theory, processes and skills. Management, however, is the practice of utilising all available resources and empowering people and groups in different social contexts to optimise efficiency and effectiveness in the
process of producing goods or services to obtain a desired result (Pettinger, 2002). Pollitt (1993) has stated that managerialism involves the following:

- Continuous increase in efficiency
- The use of 'ever-more-sophisticated' technologies
- A labour force disciplined to productivity
- Clear implementation of professional management role
- A manager being given the right to manage.

The second principle is based on indirect control, which is derived from the values of democratic societies. It aims to create appropriate values and incentives in order to be more sensitive to the growing needs and demands of society. According to Walsh (1995) the second principle is characterised by the following:

- Continuous improvement in quality
- Importance of devolution and delegation
- Decent information systems
- Emphasis on contracts and markets
- Importance of audit and inspection.

Osborne and Gaebler (1992) highlight that an entrepreneur utilises resources in a new way to optimise outcome; this applies equally to the private sector, the public sector, and to voluntary or third party sectors. They suggest that governments should thus ensure the following:

1) Steer, not row, such that governments obligation should be to insure that services are provided but not necessarily to provide them themselves
2) Empower society to handle their own issues
3) Encourage competition in services rather than monopolising the service
4) Be driven by mission, rather than rules
5) Be result oriented by funding outcomes rather than inputs
6) Meet the needs of customers, not of the bureaucracy
7) Focus on earning money rather than spending it
8) Invest in preventing problems rather than solving crises
9) Decentralise authority
10) Handle matters by influencing market forces rather than creating public programmes.

However, according to Osborne and Gaebler (1992), market mechanisms are only half of the equation. Markets are impersonal and, even under the most controlled situations, tend to create inequitable results. Osborne and Gaebler (1992) stress that market mechanisms must be paired with “the warmth and caring of families and neighbourhoods and communities”. Thus if entrepreneurial governments aim to stay away from administrative bureaucracies, they must embrace both market and community (Osborne and Gaebler 1992).

4.3.3 The role of citizens and NPM

The previous UK Labour government (1997-2010), which followed the Thatcher policy on NPM, embraced the community by addressing citizens, concentrating on four processes: activation, empowerment, responsibilisation, and abandonment. The activated citizen was seen as the active, self-sustaining individual rather than the passive recipient of government support. This concept was promoted among communities; in health for example, the active citizen would be an expert patient who adopts a healthy lifestyle and manages his own wellbeing which ultimately will lower the demand on the health service and reduce costs. Reform by the Labour government has been hybrid: on the one hand it developed a social and communitarian model, while on the other it sought to liberate individuals from the state (Clarke, 2005).

Clarke (2005) also highlights that perceiving citizens as a consumer of public services has been a growing concern; such a consumer culture has generated an expectation of a high level of choice. In parallel with the individual’s high expectation, public services have looked and continue to look backward and inadequate. The Labour government in the UK reformed public services, aiming to empower citizens by emphasising the role of choice and voice. Choice, as well as being a desirable right for citizens, is also a driving force for improvement in the public sector. Blair (2004) stated that, “In reality, I believe people do want choice, in public services as in other services. But anyway, choice isn’t an end in itself. It is one important mechanism to ensure that citizens can indeed secure good school and health services in their communities. Choice put the lever in the hands of parents and
patients so that they as citizens and consumers can be a driving force for improvement in their public services. We are proposing to put an entirely different dynamic in place to drive our public services; one where the services will be driven not by the government or by the manager but by the user - the patient, the parent, the pupil and the law-abiding citizen."

Osborn and Gaebler (1992) thus note that such entrepreneurial governments promote competition between service providers. This type of work also inspired the Clinton administration in the USA in two key ways: first by providing citizens with a voice and choice, and second by initiating competition between service organisations. However it is argued that although the idea of choice has been used as a tool for privatisation of public services, it could be misused by individuals to pursue their self-interest (Clarke, 2005). In addition, although both choice and voice are mechanisms adapted by the new Labour government to empower citizens, there is still much ambiguity regarding the range and scope of such tools in determining who gets to choose, as well as whose voice will be heard (Clarke, 2005).

4.3.4 Advantages and positive aspects of NPM

Several scholars (for example Larbi, 2005; Tolofari, 2005) in public administration set the philosophy and perspective for NPM in response to the different factors that initiated the concept. Nonetheless, it is thought that NPM provides three main contributions to the field of public management theory and practice. The first is a better focus on performance-motivated institutions and their mechanisms that in turn lead to advances in public management science. The second is an international platform and comparison to the research of the state management reform. The third is the integrated use of economic, sociological and other advanced conceptual modules.

The philosophy of NPM and its research is currently utilised by different disciplines such as public administration (budgeting, procurement, organisation and evaluation), accounting and control (performance measurement and audit), management, economics and public policy. Barzelay (2001) highlights the significance and influence of NPM on programme design and operation in specialist sectors such as health and social services.

However, despite the intensity and breadth of available literature discussing the characteristics and applications of NPM, little exists regarding the key theories on
which NPM is based. On the whole, there are six possible principle theories for NPM. These are 1) management and business administration, 2) public choice theory, 3) principle agent theory, 4) transaction cost economics, 5) microeconomic theory, and 6) the new economic sociology.

All in all, the topic of NPM and its contribution to the field of public management is still evolving in different fields of practice. It seems that the debate about value added by NPM will continue. Regardless of whether it has been examined and perceived as a reform, phenomenon, approach, or even as a philosophy, it is clear that NPM played a significant role in the improvement experienced by modern societies in the last three decades. NPM has left its mark in public management literature and has created a potential for theory grounded practice.

4.3.5 Disadvantages of NPM

Various researchers (for example Oehler-Sincai, 2008; Larbi 2005; Polidano, 1999) raise several issues and concerns, which according to them, have not been adequately addressed by NPM reforms. They claim that NPM reforms conceal weaknesses; the notions of decentralisation, corporatisation and agentification could, in the absence of a powerful independent and autonomous monitoring institution, result in integrity violation. Public integrity violation can vary from corruption and abuses, to unethical social behaviour in the working environment (Kolthoff et al., 2007). Despite the lack of empirical evidence, Bovens (1996) highlight examples of cases and allegations related to such managerial shifts in government, which have generated public concern. Such cases involve private enterprise of civil servants, agency heads subcontracting with firms they were personally involved with in various ways (i.e. stock, board membership or social relation) and extra bonuses and financial incentives for top civil servants and agency heads.

The Institute of World Economy demonstrate in their analysis of NPM's strengths and weaknesses (Oehler-Sincai, 2008) that disincentivisation goes in parallel with incentivisation in their significance for policy success. It is emphasised that NPM mechanisms, governance, collaborative governments or PPPs will not last without mutual trust between the partners and competent civil servants and officials. Hence in order to avoid potential failure, the supervising and monitoring of governments activities by authorised third parties (who should control through disincentivisation and incentivisation) seems crucial (Oehler-Sincai, 2008; Kolthoff et al., 2007)
Furthermore, Frederickson (1999) criticises NPM reforms by stating that "in democratic settings government agencies and their officials in bureaucratic hierarchies are more ethical than self-interested individuals or firms in competitive markets". He maintains that NPM has stripped government of its principle of being a selfless public service body. Similarly, other critics argue that NPM has caused a fall in ethical standards by creating a conflict of interest, which could in turn eradicate democracy in public services, substituting it with greed and favouritism.

Numerous literature sources have also discussed the issue of 'value' in private and public organisations. There are contradictory opinions on what the main values of each sector are, whether these values have something in common, and whether there has been a shift in such values with time. Jacob (1992) describes this relationship as a syndrome, one as a commercial moral syndrome and the other as a guardian syndrome. He argues that despite the validity and importance of both moral syndromes, an organisation becomes confused about where it fits (Jacob, 1992). Other authors also warn about such moral confusion, which is likely to turn governmental bodies into 'hybrid organisations' that are more likely to face integrity violations. Such issues and concerns regarding the difference between the public and private sectors remain controversial.

Furthermore, the United Nations Research Institute for Social Development report (Larbi, 1999) has also disclosed several limitations of NPM. This report has stated that a strong emphasis on cost reduction has led to a replacement of highly professional management teams with ones economising on managerial standards. It is also claimed that NPM, in the long run, carries a destabilising risk effect, the impact of which on public services could be irreversible (Larbi, 1999). In the UK health sector for example, where the internal market was applied to the National Health Service (NHS), resources were being directed to management and paper work rather than to front line service provision. Moreover, it is argued that fragmentation caused by NPM mechanisms has led to a loss of public and traditional channels of accountability. As functions of government were being divided among a number of agencies, many of which are private or outsourced, accountability was becoming more difficult to monitor (Larbi, 1999).
4.3.6 Implications of NPM

From a practical point of view, however, it is suggested that NPM mechanisms could prove to be a good fit in certain public modules more than others. This depends highly on the type and scope of activity, whether such sectors are technology or personnel focused, and whether or not a competitive environment can be achieved. Variations in such elements results in different conclusions on the fit of NPM (Oehler-Sinca~2008).

On a general note, the NPM reforms of the 1980s and 1990s have generated a real passion for implementation in many countries throughout the world. Today, there are more advanced forms of NPM evolving which are increasingly being met with caution. On this issue, the World Bank highlighted in their 1997 report, 'The State in a Changing World', two key approaches to address such reforms. The first is to match the role of the state to its capabilities, without expanding its activities beyond it resources. The second is to reinforce the role of the state by empowering public institutions to ensure competent regulation and monitoring.

4.4 PPP defined

There have been numerous definitions of PPP and the phrase itself encompasses a variety of concepts and practices (Silva and Rodurigues, 2004). It has been suggested that PPPs have taken longer to establish in countries like the USA due to significant confusion over their exact meaning (Taylor, 2007). Generally however the term refers to a contractual agreement between public and private sector entities, which together enhance the delivery and operation of public infrastructure projects such as roads, prisons and hospitals (Das and Nandy, 2008). In other words, it is an arrangement where a public service is delivered together with the private sector (Corry et al., 1997). It is thus perceived as a tool that replaces conventional approaches of contracting public services (Hodge and Greve, 2007). Zhang (2005) notes that the concept shifts the role of public sector clients from being owners/operators of infrastructure projects into purchasers of long-term services from the private sector, which is often responsible for designing, building, financing and operating the asset. Similarly, according to Pollock and Price (2004), PPPs are “time, and cost-specific agreements between the state and a private consortium for infrastructure-based service provision. The consortium undertakes responsibility for
financing, designing, and constructing (or refurbishing) a facility, and for providing services. The government (or service user) provides the consortium with a revenue stream that is used to repay debts, fund operations and provide a return to investors”.

Taylor (2007) identifies various misconceptions of PPP noting that they are not solely about financing public construction projects, politicians delivering off-balance sheet infrastructure, or making unaffordable projects affordable. Instead he suggests that PPPs are “a true partnership in which public and private entities jointly assume responsibility for delivering the service, based on the type of service required and analysis of the risks involved’, highlighting that their ‘ultimate aim is to provide optimal value for money’.

Skietrys et al. (2008) have also explained that the term PPP encompasses a variety of structures that can deliver a project or service. They note that this depends on a specific country’s policy, and can range from fairly short term management contracts with minimal capital expenditure through concession contracts which may encompass the design, build, finance and operation of services, to joint ventures where public and private sectors share ownership of the service. In general, however, they suggest that the ‘essence’ of a PPP is that “it is a NPM theory that can be realised in practice – contractual time-defined means of interaction between the public and private sector capacitating consolidation of resources to reach a new quantitative or qualitative level”.

Different institutions have also developed broader definitions of PPP. The Canadian Council for PPPs has noted that “a PPP is a cooperative venture between the public and private sectors, built on the expertise of each partner that best meets clearly defined public needs through the appropriate allocation of resources, risks and rewards”. Similarly the National Council for PPPs has stated that “a PPP is a contractual agreement between a public agency (federal, state, or local) and a private sector entity. Through this agreement, the skills and assets of each sector (public and private) are shared in delivering a service or facility for the use of the general public. In addition to the sharing of resources, each party shares in the risk and rewards potential in the delivery of the service and/or facility.”
4.5 PPP objectives

The Higher Education Funding Council for England, (1997) has highlighted three main public client objectives relating to PPPs. These include:

1. The use of private sector funds, technologies, managerial skills and operational efficiency.
2. The transfer of design, construction and operational risks, as well as revenue stream risks and technological deterioration risks to the private sector.
3. Better value for money, by achieving improved services at lower costs, than can be obtained by traditional public procurement routes.

Blanc-Brude and Strange, (2007), and Taylor (2007) have also reinforced that a fundamental PPP objective is the distribution of design, construction and operation risks among numerous stakeholders, from a public client to a private project company best placed to manage them. It is even suggested that the benefits of efficient risk management by the private sector (reducing construction and operating costs and delays) largely compensates for the cost of risk-pricing by private financiers (Grout, 1997). Similarly Das and Nandy (2008) have noted that among the prime reasons for PPP is the implementation of key public projects at an accelerated rate, and the provision of expert management capacity and new innovative technologies from the private sector. Research has also highlighted that PPPs resolve many of the problems of traditional public procurement, which are primarily that of large cost overruns and delays (Flyvbjerg et al., 2002).

Das and Nandy (2008) argue that PPP is being supported in numerous countries as a means of economic progress and development. On this issue, Taylor (2007) makes reference to the worldwide infrastructure gap, which is the result of rising demand for new improved services and declining investment in these areas, and reinforces that PPPs aim to address this gap. Likewise, he suggests that PPP use and support grew in the UK in 1992 particularly in response to increasing demands for infrastructure renewal, better quality public services and more efficiency and transparency in the assignment of public money. It is thus emphasised that the fundamental objective of such partnerships is the delivery of enhanced services with increased efficiency and savings (hence more VFM).
4.6 PPP Delivery

4.6.1 The constituents of an efficient PPP

Grimsey and Lewis (2004) highlight that a central feature of PPPs is 'bundling' rather than private sector involvement. This is because under traditional procurement, the asset can also be designed and built, and the facility managed, by private sector providers under separate contracts. However, under PPP arrangements the asset and service contracts are joined, with one private sector consortium (project company) responsible for designing building, financing, operating and maintaining the asset.

In general, the role of the public and private sectors under PPP arrangements is mainly based on that developed in the UK, Australia, Canada and South Africa (Grimsey and Lewis, 2004). The public sector defines the service it requires from the private sector via output specifications, and purchases the flow of services (from an asset), only to the extent that the service is provided satisfactorily. The purchase of services is via a unitary charge payment, a figure agreed in PPP negotiations (Taylor, 2007). This payment allows for escalation provisions to account for price rises independent of the project company. The project company, on the other hand, is often responsible for owning and operating the asset, and for delivering the service to agreed standards throughout the lifetime of the project (15-30 years). Consequently, risks of cost overruns and delays rest with the private sector. In addition to payment mechanisms, PPP contracts also provide information regarding penalties for breach of contract terms and specify grounds for termination due to non-performance. At the end of the contract, the built asset is returned to the public sector, in the condition as when it was built, where it can then be operated by the government or a new PPP contract (Taylor, 2007).

Zhang (2006) notes that performance based PPP contracts in which the public sector states 'what needs to be achieved' with clear descriptions/expectations, rather than 'how to get the job done', promote increased innovations in such projects. The Office of Federal procurement policy (1998) set out four key factors of performance based contracts. These include: 1) outcomes, 2) performance specifications/standards, 3) compensation coupled with incentives/disincentives, and 4) monitoring and measurement techniques.
Similarly, a study by Skietrys, Raipa and Bartkus (2008) identifies three key prerequisites for efficient partnerships: 1) need, 2) the political, legislative and administrative environment, and 3) communication. It is argued that needs must be identified and ranked in order of priority to enable the identification of strategies and actions. They note that actions/strategies are in turn bound by the political, legal and administrative environment, and thus suggest that the environment must have a dependable and stable policy and contract regulations that settle requirements and allow for international best practices in common types of PPP contracts. Thirdly, they suggest that good internal and external communication is essential to ensure risks are identified, objectives are clearly defined and information is adequately distributed among different players (Atun and Menabde, 2008). It is noted that ensuring these factors are present will allow for the establishment of partnerships with enhanced synergy.

4.6.2 PPP Types and classifications

There are numerous types of PPP arrangements, however these are generally divided into the following broad and general categories (Corry et al., 1997):

1. The level of private sector freedom which can include two alternatives:
   a. Privately owned organisations, regulated by statutory authorities
   b. Privately owned organisations, operating under contract to public authorities.

2. Sources of finance for current operations and for servicing debt, which includes three alternatives:
   a. Finance completely from public funds (collective demand)
   b. Finance completely from private funds (individual demand)
   c. A mixture of the two.

3. Sources of investment funds, which include two alternatives:
   a. Public, from taxation or through government borrowing
   b. Private from banks, equities, etc.

They note that there are several variations of the above categories, and have examined three key forms that have been primarily utilised in the UK in particular: 1) private sector service delivery subject to state regulation only, 2) contracting out arrangements, and 3) the private finance initiative (PFI). The first type, where the
private sector delivers the services, subject to state regulation only, and demand is individualised, is today often not being referred to as a PPP. Under this arrangement, the state is not financing the operations or purchasing the service, it is only maintaining the role of a regulator. Such regulation can be in the form of price, rate of return, quality, market structure and access. This structure is manifested through the privatisation of utilities that were previously in the public sector, which now have regulated offices such as Ofgem and Opraf. In the health care sector, however, there is as yet no similar organisation to these. Nonetheless, the National Health Service Executive (NHSE) does regulate key aspects of the health quasi-market.

The second common form of PPP is the contracting-out arrangement, where the private sector maintains the role of service provider, but the service is financed by the public sector. Finally, the third common type of PPP is the PFI. Under the PFI arrangement, the private sector not only provides the service, but is also responsible for financing the construction and running costs over a long term period (15-30 years). Corry et al. (1997) note that the key feature of this arrangement is the ‘time-profile of expenditure’ by the public sector.

Furthermore, they acknowledge that there are other diverse PPP arrangements related to the above mentioned three, such as joint ventures, which offer the private sector equity shares and influence in a private sector directed company. Other authors such as Abdel (2007) categorise the wide array of PPP arrangements adopted by government into two general approaches. The first is a finance-based approach, in which private financing is used to tackle the infrastructure gap. Such projects are funded from user fees and project demand. It is suggested that this approach represents the earliest forms of PPP such as build, operate and transfer (BOT), Build Transfer and Operate (BTO) and Build Own and Operate (BOO) arrangements (WB, 1998; Kumaraswamy and Morris, 2002). The second approach is a service based one where the aim is to use the skills, innovations and management of the private sector to optimise the time and cost efficiencies in ‘service’ delivery. This includes the Design, Build, Finance and Operate (DBFO) arrangements in the UK, where projects are funded primarily by government, with or without user fees, although still utilising private financing (Abdel, 2007).

Similarly, Reichelt and Bachmann (2006) classify the different forms of PPP based on the perspective of risk allocation with regard to the refinancing of investment. Their classification thus consists of three types. The first is financially
free standing PPPs where the risks are fully transferred to the private sector (e.g. toll tunnels). The second is joint venture PPPs where the risks are completely transferred to the private sector partner, with some public sector finance contribution. Finally, the third is where the private sector sells services to the public sector and risks are shared between the two parties.

In addition to the above classifications, the Canadian Council for PPPs (Clark et al., 2007), has clearly drawn a spectrum of PPPs specifying the numerous contractual and institutional arrangements used worldwide. Table 4.1 describes such arrangements.
Table 4.1 - Contractual and institutional arrangements worldwide

<table>
<thead>
<tr>
<th>Contractual/Institutional Arrangement</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Government</td>
<td>No private sector involvement with accountability directed towards government officials.</td>
</tr>
<tr>
<td>Public corporation/agency</td>
<td>No private sector involvement with accountability directed towards government appointed Board of Directors.</td>
</tr>
<tr>
<td>Design-build</td>
<td>The private sector designs and builds infrastructure to meet public sector performance specifications, often for a fixed price. Risk of cost overruns is transferred to the private sector (This is often not considered a PPP).</td>
</tr>
<tr>
<td>Operation-maintenance Service-license</td>
<td>A private operator, under contract, operates a publicly owned asset for a specified term. Ownership of the asset remains with the public sector.</td>
</tr>
<tr>
<td>Finance only</td>
<td>A private entity, usually a financial services company, funds a project directly or uses various mechanisms such as a long-term lease or bond issue.</td>
</tr>
<tr>
<td>Design-build-operate</td>
<td>The private sector designs and constructs a new facility under a long-term lease, and operates the facility during the term of the lease. The private partner transfers the new facility to the public sector at the end of the lease term.</td>
</tr>
<tr>
<td>Lease-develop-operate</td>
<td>The private party leases an existing facility from a public agency, invests its own capital to renovate, modernize and or expand the facility, and then operates it under a contract with the public agency.</td>
</tr>
<tr>
<td>Build-own-operate-transfer</td>
<td>A private entity receives a franchise to finance, design, build and operate a facility (and to charge user fees for a specified period, after which ownership is transferred back to the public sector.</td>
</tr>
<tr>
<td>Build-own-operate</td>
<td>The private sector finances, builds, owns and operates a facility or service in perpetuity. The public constraints are stated in the original agreement and through ongoing regulatory authority.</td>
</tr>
<tr>
<td>Buy-build-operate</td>
<td>Transfer of a public asset to a private or quasi-public entity usually under contract that the assets are to be upgraded and operated for a specified period of time. Public control is exercised through the contract at the time of transfer.</td>
</tr>
<tr>
<td>Privatisation</td>
<td>No government involvement</td>
</tr>
</tbody>
</table>

Source: Canadian Council for Public-Private Partnerships

On a different note, McQuaid (2000) lists and examines different factors that can in turn affect the type and characteristics of PPPs. He suggested that five key and general components can be grouped to form a set of characteristics for a partnership,
and suggests that these have a direct effect on the efficiency and effectiveness of a partnership and the degree of power within it (McQuaid, R., (2000).

These include:

1. **What**: The purpose of the partnership (either strategic or project driven)
2. **Who**: The main players in the partnership and their relationship
3. **When**: The timing or development stage of the partnership, and the changes in relationships with time
4. **Where**: The spatial dimension of the partnership
5. **How**: The implementation mechanism of the partnership.

### 4.6.3 Key PPP stakeholders

Stakeholders are the party that have interest in an enterprise or project. According to Taylor (2007) there are five main stakeholders in a PPP. These include:

1. **The public sector client**
   
   This is the Government which is required to provide public services to society through various agencies, departments and authorities. The Government initiates the PPP process through an expression of interest (EOI).

2. **The project company**
   
   This consists of a consortium of private sector partners that often consist of a building firm, a bank and a facility management company, established as a separate legal entity known as a special purpose vehicle (SPV).

3. **Financial partners**
   
   These consist of equity providers, debt financiers and different types of government aid such as taxes and bonds.

4. **Regulatory and advisory bodies**
   
   At various stages of the project, legal, financial and technical advice is sought from a variety of sources (which include public sector bodies representing wide-ranging public interests at all levels).

5. **Customers/end-users**
   
   The public are not a technical or contractual partner in a PPP contract. The project is initiated however from the customers and end-users demand/need. Customers are members that make payments on a usage basis during a project’s
operational phase, while end-users have an indirect relationship to the service provided, such as taxpayers.

4.6.4 The PPP process

The main stages in a typical PPP contract are illustrated in Figure 4.1, below, with specific reference to the main tasks and role of Government in each stage.

![Figure 4.1 - Main stages of a typical PPP contract](image)

- **Define service need**
  - Government role: Customer and network planner.
  - Service needs are identified and outputs determined, allowing for scope for innovation.

- **Appraisal**
  - Government role: Network planner, protector of environment, representative of public interest.
  - Different alternatives are examined and financial consequences, including other risks, are evaluated.

- **Business case**
  - Government role: Network planner and funding.
  - Risks and benefits are quantified and net benefits are established. A cost-benefit analysis (PSC) is undertaken. Funding and project approval is obtained.

- **Project development**
  - Government role: Project Manager.
  - Project resources are assembled (steering committee, project director, probity auditor and procurement team). A project plan is also created.

- **Bidding process**
  - Government role: Concession grantor.
  - The expression of interest invitation is developed and issued. Responses are evaluated and a shortlist prepared. A project brief is issued and bids are evaluated.

- **Project finalisation review**
  - Government role: Network planner, representative of public interest.
  - Value for money is confirmed, and policy intent is achieved.

- **Final negotiation**
  - Government role: Concession grantor, funding.
  - Negotiation framework and team are established, probity review undertaken, contract executed and financial close achieved.

- **Contract management**
  - Government role: Inspector, overseer, contract manager.
  - Handover to contract management team is undertaken, management responsibilities are formalised, project delivery is finalised, variations to contract are handled, service outputs are monitored, and the integrity of the contract is maintained.
4.7 Trends and specific types of PPP in health care

4.7.1 The use of PPP around the world

According to the American Federal Highway Association (FHwA) statistics in 2005 (Abdel, 2007), Europe and the Far East had the largest share of PPP projects funded and completed between 1985 and 2004. Both regions have mainly used a combination of the finance based and service based approaches to PPP. Europe, however, is noted to have the highest usage of service-based DBFO arrangements. On the other hand PPP implementation in North America has not been as widespread, with certain arrangements such as the DB/DBOM being more favoured than others such as the BOT/BTO (FHwA, 2005). Nonetheless, although numerous governments displayed a strong interest in PPPs, there have been various barriers and obstacles hindering their implementation, as explained further in section 4.5.

All in all, it is suggested that the considerable worldwide interest in PPPs in numerous governments across Europe, South Africa, North America and Asia Pacific is primarily attributable to the experiences of the UK in developing schools, hospitals, prisons, roads and defence facilities (Noble and Jones, 2006). Similarly Abdel (2007) notes that the UK is often perceived, worldwide, as a model and exemplary country for its use of PPPs due to its widespread experiences with numerous forms of PPP procurement models and payment mechanisms. Harris (2004) also notes that, unlike the UK where there is a somewhat structured PPP programme, other nations are using PPPs for the delivery of certain projects in a minimal and limited way. Originally, in the late 1980s the UK was employing the usage-based, direct toll, BOO/BOT contract arrangements, such as in the Channel Tunnel (HMSO 1986). However, after the establishment of the PFI in 1992, the UK has expanded to the use of shallow-toll DBFO contracts and performance based DBFO contracts. For the above reasons, the UK experience of PPP in health care will be examined in more detail in section 4.7.3, below.
4.7.2 An account of PPP in health care around the world

PPPs, specifically in the health care sector, have evolved rapidly in the 1990s, particularly as a means of addressing specific diseases in the developing world (i.e. within a specific-disease context). Over the past few years, however, interest in using PPPs to enhance and improve health services for a wider array of health problems has increased worldwide (WHO, 2002). Barr (2007) notes that, although prior to 1990 the term PPP seldom appeared in health care-related articles, the use of the term steadily increased between 1990 and 2004. Nonetheless, he argues that the evidence indicating success of such partnerships is mixed and noted that there is limited information available to assess PPP effectiveness in this field. He notes that there has been limited research addressing the use of PPP to improve health delivery systems for a large array of health problems. It is also highlighted that there was no common and clear understanding of the features/factors of a PPP, and under which situations such partnerships would be particularly favourable. This is primarily because PPP's have traditionally been perceived as providing infrastructure solutions. The significance of PPP's in service delivery, however, by improving aspects such as equity, efficiency, effectiveness and choice, is often overlooked (Cappellaro and Longo, 2011). Similarly, with regard to research availability, PPPs in healthcare service delivery are generally under evaluated (Sekhri, Feachem, and Ni, 2011). Therefore more research is required as well as more cases implemented, in order to gain a better appreciation of PPP's strengths and weaknesses in this field (Sekhri, Feachem and Ni, 2011).

4.7.3 Specific forms of PPP in health care

In the Health care sector, the scope and scale of PPPs vary in relation to the financing and delivery of health care services (Atun, 2008). Figure 4.2, below, illustrates different PPP arrangements in the UK health care system.
In the NHS there is increased use of private funding for capital projects through PFI schemes (Greenaway et al., 2004). PFI involves the transfer to the private sector of infrastructure projects which were traditionally provided by the public sector. They involve three groups: (1) the public sector, (2) the private sector, and (3) the bank/financial agency (Grout, 1997). The private sector funds, builds and owns the asset, and the public sector purchases the flow of services from the asset over a period of about 10-30 years. The absence of a link between the public sector and the financial agency and arrangement to pay for services only on satisfactory delivery allows projects to be treated differently for accounting purposes from publicly funded ones, and affects the structure of cash flows, the allocation of risk and the incentives to deliver. The aim of such schemes is therefore to cut public spending to stay within public sector borrowing limits, while maintaining high investment levels (Bing et al., 2005).

The 1997 Labour government eagerly adopted the PFI concept and several large hospital projects were approved. This resulted in the largest hospital building programmed in the history of the NHS (Department of Health, 1998). By 2006, 146
projects valued at £6 billion were being undertaken under PFI arrangements (Atun, 2008).

The degree of private funding in PFI schemes can vary from full private sector funding to joint ventures, where private sector costs are partly covered by public funds and partly from private sources. Similarly, public sector purchase of such services can be direct, fixed, or the project may be self-standing in which the public sector simply monitors commitment to the contract (Grout, 1997).

In the health sector, there is a basic government policy to allow for provision of hospitals under the PFI. Unlike many projects for roads and prisons, a consortium known as a special purpose vehicle, establishes itself as a legal entity and raises the necessary finance for the hospital. This consortium includes construction, IT, ethical supplies, domestic services and pharmaceuticals supplies corporations (Froud and Shaoul, 2001). Although the provision of the hospital is by the SPV, the clinical services remain under NHS control. Local NHS Trusts are health service bodies that enter into such arrangements and pay the consortium a regular fee for the use of the hospital. NHS trusts will also employ some of the staff such as doctors and nurses.

The PFI process is summarised in Figure 4.3, below.

Figure 4.3 - The PFI Process

```
Strategic outline case (SOC)

Outline business case (OBC)

Preparation for procurement

Procurement process

Full business case (FBC)

Contract award
```

Source: Adopted from NHS Executive, 1999.

As illustrated above, the NHS Trust must first prepare and submit to the Department of Health (DH) an SOC outlining all feasible options (NHS Executive,
1995). The NHS Trust then makes the case for the proposed investment (with all options being assessed in terms of their relative costs and benefits, risks and uncertainties, affordability and purchaser support) in the OBC, and an option is recommended. This option has an estimate of the capital cost based on standard NHS costing (Gaffney et al., 1999b), and is referred to as the public sector comparator (PSC), a benchmark against which the private finance alternatives are assessed (Froud and Shaoul, 2001). The FBC, which must be approved by the DH and the Treasury, presents the private sector design, compares private and public finance, and is tested against value for money, risk transfer and affordability criteria. If the PFI option presents better value for money than the PSC then the preferred partner and the Trust together prepare the FBC for consideration by the health authority, NHS executive, and the Treasury (Froud and Shaoul, 2001).

4.7.5 PPP in service delivery

Atun (2008) argues that supporters of private sector involvement in the health sector believe that it can promote competition, value for money and innovation and provides patients with increased choice. PPPs in service delivery have taken the following approaches:

- Privatisation of services through the sale or transfer of assets
- Outsourcing of publicly funded services from the private sector
- Introduction of private-sector management practices.

4.7.5.1 Privatisation of services through the sale or transfer of assets

This form of PPP has occurred in primary care (which consists of non-hospital services like GPs and is responsible for 90% of NHS activity), pharmacies and dentists. It includes the recent trend towards privatisation of GP surgeries and the privatising of the commissioning function of primary care trusts (Unite-Amicus, 2007). Traditionally, GPs run their own surgeries, but are legally considered part of the NHS. In 2006 large corporations like Boots, Virgin and American corporations like United-Health Europe started to takeover GP surgeries. This is due to a new contract model referred to as ‘the alternative provider of medical services’ (APMS), which is
being used to bring the private sector into GP services (Pollock and Price, 2006). The government has in fact recently awarded the contract for a 7,000 patient practice in Barking and Dagenham to Care UK, a private company, and several others are to be signed. The issues regarding this are discussed under section 2.6.2.

With regard to the privatisation of the commissioning function of primary care trusts (PCTs), in June 2006 the DH advertised for large companies to tender for the management functions of PCTs, and is setting up a list of companies that PCTs can contract to carry out part or all of PCT health service commissioning. The concern with many is that private companies may potentially influence strategic primary care decisions (Unite-Amicus, 2007).

4.7.5.2 Outsourcing of publicly funded services from the private sector

Unite-Amicus (2007), the trade union, in its report describe how this form of PPP has occurred in elective surgery, diagnostic centres and management support. Independent Sector Treatment Centres (ISTC), for example, are private sector clinics contracted within the NHS and specialising in common elective surgery, such as cataract operations or hip replacements, and diagnostic procedures. The NHS signs contracts with private companies to carry out this work for a fixed overall price, paid regardless of the number of operations being performed. Two phases of ISTC have occurred, the first costing £1.7 billion and the second £3.75 billion.

Similarly, there are various privately run Integrated Clinical Assessment and Treatment Services (ICATS) and Capture, Assess, Treat and Support Services (CATS), which are centres that carry out diagnostic tests, perform some operations, and have the authority to refer patients to hospitals and treatment centres. Such private centres are currently found in Cumbria and Lancashire.

4.7.5.3 Introduction of private sector management practices

The NHS has also introduced new financial systems and private sector management practices such as ‘payment by results' in which service providers (such as NHS hospitals) are paid by NHS trusts instead of being given a budget guaranteeing funding in advance. This however does not apply to the private ISTC, as
noted above. In April 2006, this system of ‘payment by results’ was used for over 80% of hospital work.

4.8 Advantages and disadvantages of various forms of PPP

4.8.1 General advantages and disadvantages of PPP

There are various advantages and disadvantages associated with PPPs. Before elaborating on the specific advantages and disadvantages of PPP in health care (section 3.5.2 and 3.5.3), a more general description is provided below.

Several authors have argued that among the strengths of PPP is the element of risk transfer between appropriate parties best able to manage them (Taylor, 2007). Quiggin (2005) notes that PPPs yield improved VFM by achieving an optimal allocation of risk. It is assumed that the private sector can provide services more efficiently and with greater innovation than the public sector (Nisar, 2007); the same service is provided at a lower cost thus ensuring VFM. According to the National Audit Office (2003), VFM is measured against a number of alternatives such as the business case, the PSC and benchmarking costs. The PSC criterion in particular is often used, suggesting a comparison of costs and quality after PPP implementation.

Numerous types of risks may emerge during the lifecycle of a PPP project, related often to design, construction and development, performance, operating cost, revenue variability and termination (Nisar, 2006). Zhang (2005a) has stressed that PPPs require appropriate allocation and management of risks by both public and private sectors.

The World Bank (2007) also notes that PPP benefits include enhancing efficiency in project execution, improving implementation capacity, reducing public sector risk and organising financial resources by allowing limited public funds to be used for other purposes. Similarly, Taylor (2007) argues that PPPs allow for extensive economic growth, increased expertise and asset operators, and lower total costs to the public (based on whole life costing) for infrastructure projects. Similarly, Spackman (2002) suggests that accounting considerations and the issue of debt reduction by the public sector plays a considerable role in the British PPP process. Quiggin, (2002) suggests that the PPP evaluation procedure is biased in favour of the PPP option,
noting that rejection of the PPP option often results in rejection of the project as a whole.

Nonetheless, although PPPs have been justified on many of the issues mentioned above, research has not extensively considered the end-users' perspective (Ahmed and Ali, 2006).

Despite the above noted advantages, several authors have highlighted that PPP arrangements also have associated disadvantages (Hastings, 1996). The OECD (2001) compares PPP to a ‘black box’, noting that while inputs and outputs in the system are visible, the means and procedures facilitating the transformation are not. Silva and Rodrigues (2004) made particular reference to various ‘unknown parameters’ such as the use of fund sources, the distribution of responsibility and accountability in PPP programme implementation, the role of local players and the extent of institutional involvement. Consequently it is suggested that it is difficult to assess partnership efficiency effectively and to compare PPP with services being operated within traditional public procurement and management frameworks. Similarly, Stewart (2003) has noted that lack of transparency in numerous PPP arrangements is due to the increasing use of subcontracting within partnership contracts, and the ensuing fragmentation and institutional complexity within the public sector. It is also noted that this results in lack of clarity regarding accountability structures (Hood, Fraser, and McGarvey, 2006).

Quiggin, (2005) makes reference to the impact of long-term inflexible PPP contracts on public sector governments in particular. It is suggested that such contracts will cause the public sector to lose any benefits that can arise from the entry of new competitors, and to lose the ability to alter contract terms significantly in response to changing needs and conditions. Any contract variations must be negotiated with the private sector partner and often entail additional and substantial costs and delays.

Furthermore, Blanc-Brude and Strange (2007) note that a particular area of concern for PPPs is the cost of funds, which is noted to be higher than the cost of public funds. Similarly, Palmer (2001) maintains that private financing in PPPs often results in unnecessary increases in costs.

It has also been described that there are various problems associated with partnership such as unclear goals and resource costs, as well as divergences in management practices and philosophies between partners. McQuaid (2000) suggests
that a lack of clarity in terms of goals is a main trigger for problems and partnership failure, as it can result in misunderstandings and insufficient coordination among players. Such problems are enhanced especially if certain partners have hidden goals and agendas. Similarly problems may occur concerning large resource costs, which are particularly linked to staff time spent in discussions and decision delays associated with necessary consultation with numerous partners.

4.8.2 Advantages and disadvantages of various forms of PPP in the UK health sector

4.8.2.1 Private funding:

PFI

Ideally PFI schemes should combine the skills and resources of a range of parties and transfer risks to parties most able to handle them. The public sector has been criticised for cost and time overruns with regard to construction, and it was believed that the private sector has the management and innovation skills to avoid such problems. As the private sector will be responsible for designing and managing a facility for a period of time, it will incentivise them to design the underlying asset with a view to minimising operating costs, and with the aim of completing projects on time (Bing et al., 2005). Another incentive to perform is that payment is directly linked to performance. For the government this is an attractive option as the costs of hospitals will not appear as an immediate lump sum payment in public expenditure (Grout, 1997).

However, use of PFI in the health sector in particular has been noted to be controversial and opposition towards it has remained strong (Nicholson, 2000). It is claimed that PFI arrangements lead to lack of flexibility (Atun, 2008), which is a particular problem for the health care sector as clinical practices are rapidly changing. Thus, the disadvantage of signing long term contracts is that minor changes in building projects could be very expensive (Bing et al., 2005). Similarly, over a 30 year period, although buildings may become obsolete as clinical practices change, NHS Trusts will still be liable to pay maintenance and facility management costs (Atun, 2005). Therefore it is argued that PFI in health care should be based on projections of future needs rather than local affordability (Gaffney et al., 1999b). PFI schemes are also believed to be too complex to manage, and have a wider impact on NHS funds (Nicholson, 2000). As a result, in order to contain overall NHS costs,
future services may be cancelled due to lack of funding (Nicholson, 2000). Another
disadvantage is that PFI has been associated with reduced hospital capacity, such as
bed numbers, due to the private sector seeking to maximise profits. In spite of this, it
is argued that reductions in bed capacity are due to wider trends in service provision
(to increase day surgery and reduce unnecessary hospital stays).

4.8.2.2 Private ownership:
Privatising GPs

The aim of this form of PPP is to provide greater capacity to reduce the
problems of increases in diseases such as diabetics and heart disease. However, it is
argued by certain trade unions (see Unite-Amicus, 2007, for example) that large
corporations often employ GPs on short-term contracts and have a high staff turnover.
Therefore such GPs may not have local knowledge of their patients or the
commitment that traditional GPs have. Another disadvantage is that international
corporations' profits may go to shareholders rather than be re-invested in the NHS.

Privatising the commissioning function of primary care trusts

The private sector may have innovative management skills that could benefit
primary care trusts. A disadvantage of this is that private companies can influence
strategic primary care decisions and thus may decide what treatment patients receive
and who provides it (Unite-Amicus, 2007). It can result in a conflict of interests
(sending patients to private ISTCs or private hospitals in order to maximise profits).

4.8.2.3 Outsourcing of publicly funded services from the private sector:
ISTC

The aim of such centres is to provide extra capacity in order to reduce NHS hospital waiting lists. The second phase of ISTCs were claimed to increase competition (Unite-Amicus, 2007). However, unlike NHS hospitals that are subject to payment by result, ISTC contracts guarantee full funding regardless of the number of operations performed. This can result in unnecessary costs, and it has been noted that ISTCs have been paid 11.2% more than the NHS for each operation. Another disadvantage is that ISTCs only take on routine, uncomplicated cases, and are not
required to train junior doctors. Taking away routine cases from the NHS means that junior doctors will not be getting the needed practice which could affect long-term service delivery. As a result of these issues, no further ISTC developments will be undertaken in the UK.

ICATS and CATS

By offering primary care based assessment and treatment services to patients, these centres reduce demand for secondary care and thus reduce waiting lists. However, trade unions have argued that a potential danger is that such centres could result in a conflict of interest - referring patients to their private ISTC or private hospitals (Unite-Amicus, 2007).

4.8.2.4 Introduction of private-sector management practices - Payment by results

Again unions argue that such a system would put hospitals in competition with each other to attract patients and thus result in improved efficiency. However, this system can create an incentive to treat patients with less complex conditions that can be ‘pushed through the system quicker’ in order to treat more patients (thus more pay). On the other hand, patients in need of more care and time may be left out. Similarly, it prevents hospitals from planning, as they will not know how much income they will have (Unite-Amicus, 2007).

4.9 Critical success factors and barriers to PPP

4.9.1 Critical success factors

There have been several studies on CSFs for PPPs. Jacobson and Choi (2008) has noted that success as a concept is generally complex and difficult to describe. Jugdev and Muller (2005) suggested that success is ‘context dependent’, affected primarily by a general majority consensus. Others have explained that success refers to public-private win-win results (Zhang, 2005a).

All in all, Zhang (2005a) explains that the classification and examination of CSF’s for PPPs was initiated by a pressing need for a suitable procurement protocol.
for constructive and positive partnerships, which ensures that private sector funds, managerial skills and operational efficiencies are appropriately utilised to benefit public and private interests.

Early research and discussions about PPP CSFs was made by Tiong (1996), who identified six CSFs to secure BOT contracts. These include 1) entrepreneurship and leadership; 2) right project identification; 3) strength of the consortium; 4) technical solution advantage; 5) financial package differentiation; and 6) differentiation in guarantees. Tiong and Alum (1997) have undertaken further research to identify unique elements of winning proposals in competitive BOT contracts from the CSFs of technical solution advantage, financial package differentiation and differentiation in guarantees. Furthermore, research was also undertaken by Gupta and Nrasimham (1998) who describe other CSFs to secure BOT contracts such as the ability to provide a suitable transfer package, built-in flexibility for future growth and changes, and a short construction period (Zhang, 2005a).

Zhang (2005a) suggests that a PPP project procurement protocol should be based on a public-private win-win principle and have, on this note, identified various CSFs for PPP. He recommends that such a principle would establish a positive and constructive environment, supporting private sector participation and ensure that privatised projects and services are delivered at public acceptable standards and quality. It is also suggested that the PPP schemes should be well structured to prevent wastage of resources. On this note, he identifies and investigates five main CSFs including various sub-factors based on an international questionnaire. The five main CSFs are 1) favourable investment environment, 2) economic viability, 3) reliable concessionaire consortium with strong technical strengths, 4) sound financial package and 5) appropriate risk allocation via reliable contractual arrangements (Zhang, 2005a). Success sub-factors include partnering skills, sound financial analysis and appropriate risk allocation in contractual agreements.

Similarly, Leiringer (2006) notes that to be more innovative and thus more successful, PPPs must also promote collaborative and cooperative working, design freedom, long-term commitment and risk transfer. It is also suggested that ‘effective, regular and varied communication channels can facilitate collaborative and innovative behaviour’ and that ‘clear identification of risk allocation throughout the project’ is vital.
4.9.2 Barriers to PPP

Zhang (2005) has conducted a questionnaire survey that identified various potential barriers to PPP, in infrastructure development in particular. These include the following:

- **Social, political and legal risks** - Such risks include an unstable political environment, a poor legal framework with unenforceable contracts, increased government restrictions and public resistance.
- **Adverse and hostile economic and commercial settings** - Such conditions include limited economic strengths within an uncertain economic environment, including uncertainties in demand and supply during the long contract period.
- **Inefficient public procurement frameworks** - Such inefficiency is a result of public clients failing to incorporate PPP projects in their development plans (thus impacting on project revenues). Other negative factors include poor project definition and lack of transparency at tender stage in particular and high transaction costs.
- **Lack of established and advanced financial engineering techniques** - This barrier results from complex project financing, improper accounting treatment of PPP projects, and public clients’ misleading cost comparisons with projects procured traditionally.
- **Public sector problems** - These include inexperience government bodies with limited knowledge of the PPP concept and a general resistance to change.
- **Private sector problems** - These include a lack of PPP players, private sector players lacking managerial expertise and risk management, and inexperienced project management teams.

4.10 Chapter summary

Chapter 4 examined the use of PPPs in the health care sector. The chapter began by explaining the origins of PPP, making reference to the concept of market failure and increasing private sector involvement in the provision of public services worldwide. PPPs were then defined and PPP objectives highlighted. Following this a detailed examination of PPP delivery and the different forms of PPP arrangements used in the health care sector, particularly in the UK, was made, and the specific
advantages and disadvantages of these were highlighted. The UK health care system was chosen as a model for reference to the Kuwaiti health care system as the UK government has led the PPP experience in the health care sector through expanding the role of the private sector within the NHS, in both the financing and the delivery of health care services. Also in both nations health care provision is largely the responsibility of the national government. The chapter then examined the CSFs of PPPs and the various barriers facing PPP implementation.
Chapter 5 - Research Strategy

5.1 Introduction

This chapter aims to explain the logic behind the development of the research strategy. It begins by describing different epistemological considerations and then outlines several key philosophical positions such as positivism, interpretivism and more specifically realism. The chapter then describes different methodological considerations, highlighting differences between qualitative and quantitative research. The selected strategy appropriate for this research, the case study, is then explained, with a focus on the background, types, strengths and weaknesses of case studies. An explanation of the key issues of research acceptability, reliability and validity is then made. Following this, the chapter discusses the methods for case study research from a realist evaluation perspective, the methods for data analysis (interviews, document review and questionnaires) and the research sampling strategy.

5.2 An overview of different philosophical considerations

The philosophical perspective assumed sets the foundation for the research strategy and aids in the selection of a suitable methodology and methods for data analysis and interpretation (Saunders, et al., 2009). Ontology is a branch of philosophy that examines the nature of reality or being (Sarantakos, 1998). Epistemology however, also known as the 'theory of knowledge', is a branch of philosophy concerned with the nature and scope of knowledge and the components of valid knowledge (Saunders, et al., 2009). Similarly, Gray (2004) suggests that epistemology sets the philosophical foundation for judgements on reasonable and sufficient knowledge. Mason (2002) notes that it concerns the utilization of principles and laws by researchers to decipher knowledge in the social world (social occurrences and events). On a general note, epistemology deals with the issues of what knowledge is, how knowledge is acquired, what individuals know and how they know what they know (Encyclopaedia of Philosophy, 1967).

There are two key theories of knowledge acquisition around which there has been much debate: empiricism and rationalism (Goldman, 2002). Empiricism holds
that knowledge can be obtained a priori (Landesman, 1997). In other words empiricists maintain that evidence for all reliable knowledge and beliefs is gained through experiences from and through the five human senses (Morton, 2003). Committed and dedicated empiricists include Francis Bacon (1661-1626) who is recognised for the logical organisation of the scientific inquiry method (Russell, 1972). Bacon, together with Democritus (460-370 BC) and philosophers John Locke (1632-1704) and David Hume (1711-76), endeavoured to replace the method of deduction (rationalist) with induction as a method of acquiring knowledge (Van De Ven, 2007). It begins with an account of past and present empirical observation to illustrate and describe suggestions regarding the physical world.

Rationalism, on the other hand, is a theory of knowledge that emphasises the significance of independent principles, maintaining that knowledge is innate and instinctive (Goldman, 2002). Rationalists argue that knowledge is not based on sensory experiences, but rather on a prior principles and reason (Landesman, 1997). It is suggested that the most common beliefs and knowledge can be justified by intellectual insight (Morton, 2003). This theory states that many common beliefs can be warranted by intellectual insight regardless of the senses. O’Connor (1982) makes specific reference to the strong systematic nature rationalism assigns to knowledge. Plato (427-347 BC) was among the pioneer rationalists who suggested that an idea (in one’s mind) illustrates an object’s feature, thus humans learn about such objects via ideas rather than objects per se. Aristotle (384-322 BC) was a student of Plato and also supported such principles. Similarly, René Descartes (1596-1650), a significant rationalist during the Enlightenment period, noted that rationalism’s key feature was a belief that the laws controlling the physical world can be determined solely through mind reasoning (Russell, 1972).

5.3 Philosophical perspectives

Following on from the brief description of the theories of knowledge acquisition above, three key and different philosophical perspectives, positivism, interpretivism and realism, are described below. Such perspectives are concerned with the establishment and nature of knowledge.

In the field of social science, positivism is among the oldest theories, with several branches that have evolved over the years including logical positivism and
neo-positivism. The ontology of positivism is that reality is objective, based on order, and is detached from human perception. Its principles stress that science is based on universal laws, rules and actions. It denotes that humans are rational and governed by social laws (Sarantakos, 1998). The positivistic approach is recognised by strict hypothesis testing, variables being quantifiably measured and deductions made about an occurrence from a sample (Orlikowski and Baroudi, 1991).

Critics of positivism however argue that reality can only be described and characterised subjectively, not objectively, and that the positivistic emphasis on quantifiable measurement cannot depict the genuine essence of social behaviour (Robson 2002). On this note, numerous critics have suggested that the methods appropriate for the natural sciences are not suitable for the social sciences, and thus business and management research, as they do not provide explanations of how social reality is created, nor of human behaviours and actions. Robson (2002) has noted that this is especially because individuals have their own individual insights and interests. Furthermore, a typical positivist study does not attempt to explain or justify how a research hypothesis was originated (Kazi 2003).

In contrast to positivism, interpretivism maintains that a scientific model cannot be appropriately used to examine the complex social world (especially of business and management). This is because the focus of the social world (primarily people and their institutions) is unlike that of the natural sciences (Bryman, and Bell, 2007). Thus the ontology of interpretivism is that social reality is established and explained by people and their institutions. Interpretivists suggest that research procedures of social sciences should reflect the distinctiveness of humans and should allow the social society to understand the subjective meaning of social action.

Critics of interpretivism maintain that researchers seek to be somewhat detached in order to promote validity in their research (McDiff and Whitehead, 2002). Therefore it is argued that this perspective views social beings as simply objects of a study. Despite the fact that interpretivists adopt an epistemology that assumes the provision of a complete understanding of the social world, it fails to include the reality of hidden mechanisms and structures.

Realism, which stresses that there is a reality independent of the human mind, is yet another branch of epistemology. It is similar to positivism as it relates to the scientific enquiry approach of establishing knowledge, applying identical approaches to data collection and interpretation (Bryman, and Bell, 2007). Both perspectives
share a dedication to the view that an external reality exists, which researchers are aiming to study. Similarly, Leplin (1984) has described realism as being in part metaphysical and in part empirical, noting that it goes beyond experience yet is testable by experience. Van De Ven, (2007) has also noted that many forms of realism assume a subjective epistemology in which no predetermined methodologies exist that set a particular perspective of reality.

There are two key types of realism: direct realism and critical realism. Direct realism maintains that what we experience through our senses (what we observe) is actually reality as it is (thus the world is fixed). Thus direct realism proposes that the world is fixed, operating in the business environment at a single level of the individual, or the organisation. Critics of this form of realism include Bryman (2004) and Bhaskar (1982) who note that this view is superficial, as it does not acknowledge the existence of structures and generative mechanisms that underline and generate observable events.

In contrast, critical realism, a form of realism developed by Bhaskar (1979, 1998 abc), argues that what we experience through the senses are in fact sensations and images of the occurrences/objects in the world, not the objects/occurrences directly. Critical realists claim that illusions are a result of inadequate information. They thus suggest that there are two key ways of encountering experiences of reality: the first is the ‘thing’ itself and the sensations it puts forth, and the second is the mental processing that occurs a short time after the sensation meets our senses. Unlike direct realism, critical realism acknowledges the existence of multi-level investigation of the individual, the group and the organisation, all of which are capable of altering a researcher’s understanding of a social phenomenon. Similarly, Bhaskar (1989) refers to the existence of numerous social structures and mechanisms, noting that researchers will understand the social world only if they are aware of the social structures and mechanisms underlying it (which are not directly obvious through visual observation, but visible through their effects). Such underlying mechanisms determine how a social phenomenon occurs and works, and thus business research under a critical realist perspective aims to construct hypotheses about such mechanisms to search for their effects (Bryman, and Bell, 2007). Bhaskar maintains that by the use of the practical and theoretical processes of social sciences, one can determine what cannot be seen or identified. Accordingly, Dobson (2002) notes that one’s knowledge of reality is due to ‘social conditioning’ and the social players and
factors involved in knowledge acquisition. Thus Saunders et al., (2009) argue that a critical realist's view (that the social world is continually changing) corresponds more to the goal of business and management research (to grasp the reason for a phenomenon as a forerunner to suggesting change).

A key purpose of realistic evaluation is that it has an explanatory mission (Pawson and Tilley (2008). The fundamental question posed and answered is many-sided and versatile, as a realist evaluation seeks not to answer 'what works' but rather 'what works, for whom, in what circumstances and in what ways, and how'. These diverse questions encourage the researcher to examine the logic behind the different sections of programme stakeholder. Consequently this will result in various diverse conclusions, which many policy makers wanting to make clear-cut decisions may not appreciate. Before explaining the key principles of realistic evaluation, the concept of evaluation as a whole is briefly explained below.

Evaluation has been defined by the WHO (1998) as “the systematic examination and assessment of the features of an initiative and its effects, in order to produce information that can be used by those who have an interest in its improvement”. Weiss (1972) has also noted that the purpose of evaluation is to “measure the effects of a program against the goals it set out to accomplish as a means of contributing to the subsequent decision-making about the program and improving future program-making”.

Evaluation can also be summative or formative. Summative evaluation is undertaken at the end of a programme to determine the overall success and present retrospective analysis. Formative evaluation however is undertaken while the programme is being implemented, so as to guide further development of the programme. This therefore allows for continuous improvement and necessary adjustments to be made (Jackie, 2006).

Furthermore, Green and South (2006), highlight key principles for evaluating health programmes. These include the following:

1. Purpose – evaluation needs to have a purpose that is made clear from the start and in describing the findings.
2. Practicality – evaluation needs to be relevant to the wider community and the value generated should add to the improvement of the health care system.
3. Process – proper mechanisms that bring about change are as important as the outcome.
4. Peripheral (contextual) factors – the effect of context on the achievement of outcomes.

5. Probing – evaluation needs to present relevant explanations and contribute to theory development in addition to presenting clear input-output findings.


7. Participation – the involvement of all relevant stakeholders.

8. Plausibility – evaluation findings should contribute to all major stakeholders.

9. Power – evaluation needs to acknowledge the power structures within which it occurs, without being inhibited by them.

10. Politics – evaluation should contribute to policy making, with its findings providing managers and policy makers with evidence.

**5.3.1 Realist evaluation process**

There are four stages in accordance with the realist evaluation process:

Stage 1) Hypothesis development
Stage 2) Design of the study
Stage 3) Data analysis and synthesis
Stage 4) Refining the hypothesis.

Such stages are illustrated in Figure 5.1 below.
Realist evaluation starts with the formulation of an initial hypothesis or what is commonly referred to as Middle Range Theory (MRT). MRT is defined as "theory that lies between the minor but necessary working hypothesis and the all-inclusive system effort to develop a unified theory that will explain all the observed uniformities of the social behaviour, social organisation and social changes" (Merton, 1989).

The aim of MRT is to indicate how an intervention results in a specific outcome and in what circumstances. It can be developed from literature review, past experience, existing theory, research or key experts.

Realist evaluation is neutral, situated between positivism and relativism (Pawson and Tilley, 2008). It has established a strong causal ontology that can be inductive to begin with and deductive afterwards. The initial hypothesis, as expressed by the MRT, is used as a guide that helps indicate the type of data to be collected and the method of data collection.

Saunders, Lewis, and Thornhill (2009) have classified research into three main types: exploratory, descriptive, and explanatory. Realist evaluation is explanatory in nature (Pawson and Tilley 2008). This is because realist evaluators aim to describe the contextual layers to understand the source of problems and to determine the
mechanisms that explain the outcomes of an intervention (Pawson and Tilley 2008). Pawson and Tilley (2008) recommended the use of multiple methods that will focus on developing prototype Context Mechanism Outcome Configurations (CMOCs) for each outcome.

The realist evaluation approach is illustrated in Figure 5.2 below.

**Figure 0.2 - Generative causation**

From Figure 5.2 above, it can be seen that the causal association is not of one direct element (not X causes Y), rather it is a generative causation or an association of elements as a whole that influence the outcome. Pawson and Tilley (2008) highlighted that in this stage of research the data should be analysed in an attempt to produce the working hypothesis CMOC.

A realist evaluation mainly differs in the way it describes, not only the intervention and its outcome, but also the context and the underlying mechanism. In this case, causal explanations have to cover both the outcome norm and its exceptions. The CMOC proposition is the starting and end product of realist evaluation research. Realist evaluation principles are summarised below:

- Programmes
- Mechanisms
- Context
- Outcome
- Context mechanism outcome pattern configuration.

(Pawson and Tilley, 2008)
Programmes, in the realistic evaluation sense, are referred to as theories incarnate, which are rooted in social systems. It is suggested that realist evaluators view programmes as mature social interactions embedded in a multifaceted social world. To describe programmes, realistic evaluators use four linked concepts which include ‘mechanisms’, ‘context’, ‘outcome’ and ‘context mechanism outcome pattern configuration’.

Mechanism is the word used to explain what aspects about programmes and interventions result in certain effects. In other words, mechanisms represent the way in which effects are brought about. Realist evaluation as a route starts with the evaluator portraying the possible processes by which a programme could work as an introduction to testing them. Pawson, and Tilley (2008) have even noted that mechanisms often involve reasoning and resources and are frequently hidden.

Context describes the conditions for the operation of programme mechanisms. Contexts refer to the characteristics of the conditions in which programmes are introduced, which are pertinent to the operation of mechanisms. Such contextual thinking allows the reality evaluator to address the multifaceted questions of ‘for whom’ and ‘in what circumstances’ a programme will work to determine which contexts support or hinder a programme theory. Based on the character of the intervention, a context can, in addition to referring to a locality, also describe the interpersonal and social relationships, as well as technology, economic and political situations. Such contextual understanding is vital for policy makers.

Outcome patterns describe the intended and unintended effects of programmes resulting from the activation of mechanisms in a particular context. A programme is likely to have varied outcome-patterns due to the variation in context and mechanism activated.

Finally the context mechanism outcome pattern configuration refers to models that suggest how programmes activate mechanisms in different contexts to trigger alterations in behaviour, events or regulation. Such models suggest mechanism variations and context variations to explain and foresee outcome pattern vitiations. Mark et al., (2000) have suggested that a good realistic evaluation is one that explains the complex array of outcomes.

The realist evaluation considers the effect of different mechanisms operating at different levels, practitioners, managers, administrational, organisational.
Figure 5.3, below, illustrates how contexts can refer to various social layers including individuals (staff, patients), interpersonal relations (culture and beliefs), institutions or organisations and infrastructure (systems). In realist evaluation, these contexts interact with the programme mechanism to determine the outcome.

Following the description of key theoretical perspectives above, decisions can be made on the design of the following research. This research seeks to examine the PPP experience in the Kuwaiti health care sector and to find participants' subjective opinions and experiences. The thesis shares the view of researchers adopting a critical realistic evaluation approach.

5.4 A discussion of different research approaches: deductive and inductive approaches

Research approach is a term used to explain the means of designing a research project (Saunders, et al., 2009). There are two key approaches: deductive and inductive. A deductive approach is where the researcher develops a theory and hypothesis and designs a specific research strategy to test the hypothesis. An
inductive approach however is where the researcher first collects data, then develops a theory based on the data analysis.

Generally, a deductive approach is more associated with positivism (scientific research), while an inductive approach is linked to interpretivism. Saunders, et al (2009) on the other hand, argue that such association can be misleading and are of no applied advantage. Realism as a research philosophy applies both deductive and inductive approaches. Researchers such as Kazi (2003), and Carter and New (2004) note that retroduction is the key research strategy for realist evaluation. This allows for the examination of possible causal mechanisms and the settings through which potential outcomes will be achieved. As there is no specific research approach dedicated to retroduction, it is argued by Kazi (2003) that an inductive or deductive approach, or a combination of the two, can be used to evaluate a programme. In realist evaluation, a hypothesis or a provisional theory is first introduced on how the programme works. This theory is created through literature review, experience or pilot studies. This process of reality evaluation is a deductive one. In order to develop this theory, the researcher seeks to test, refine or disprove it through further data collection and investigation to generate further theoretical knowledge on what works for whom and in what circumstances. This is the inductive part.

5.5 Methodological considerations

For the research of management issues, two key methodological approaches are used: qualitative and quantitative. Sarantakos (1998) noted that based on the theoretical perspective and context of the application, both approaches are appropriate. Several researches have highlighted the distinctions between these approaches, indicating that such a division is fundamental and useful for classifying different methods of business research and for understanding the requirements for meaningful data examination (Eastbury-Smith et al. 2008; Bryman, and Bell, 2007).

 Nonetheless, numerous authors, in addition to highlighting the distinctions between such approaches, have also noted their similarities (Bryman, 2004). Blazter, et al (2001) suggest that such similarities allow for combinations of both methodologies in a particular research study (for example, qualitative research can be used for examining theories and may also include quantifications). Therefore several
Bryman, and Bell, (2007) explain that qualitative research consists of a research strategy, which relies on "words rather than quantifications in the collection and analysis of data". Similarly, Robson (2002) notes that qualitative data are specifically characterised by their richness as they allow the researcher to investigate an issue as realistically as possible. Examination of qualitative data generally involves the following: data summarisation, data classification, data structuring to determine relationships, the establishment and testing of proposals and the development of sound conclusions. Although Saunders et al., (2009) note that qualitative analysis can use either a deductive or an inductive research approach, Bryman (2004) suggests that as a research strategy it has an inductive view (in which theory is generated out of research) and intuitivist position.

A criticism of this research approach is that findings can be rather subjective as they can often be based on the researcher's views about certain issues and the personal relationship a researcher may form with the individuals studied (Bryman, and Bell, 2007). Similarly, another common disadvantage of this approach is that findings are hard to replicate owing to the unstructured and unsystematic nature of this kind of research. This can be due to the researcher deciding to focus on what they personally view as significant, rather than other issues, and due to participant responses being affected by factors such as personality, age and gender. Similarly, it is difficult to replicate qualitative data as interpretation of such data can be affected by a researcher's subjective views. Furthermore, other criticisms of this approach include the limited scope of the findings (one or two cases are not representative of all cases), and that this approach can lack transparency in how the research was conducted and how conclusions were arrived at.

On the other hand, quantitative research is research which stresses the importance of quantification in data collection and analysis. It adopts a deductive approach to the relationship between theory and research (emphasising the importance of theory testing), and adopts a positivist position (maintaining that reality is objective in nature). Similarly this approach argues that humans are governed by the social world in a similar way to how the natural world is established by firm laws (Sarantakos, 1998).
There are numerous criticisms of quantitative research, mainly deriving from the view that the natural sciences model is unsuitable for examination of the social world. Another criticism of this approach is that it involves an artificial and unauthentic measurement process. Similarly, Cicourel (1982) argues that the dependence on procedures such as structured interviews and self-completion questionnaires, and on controlling a situation to establish its outcome, impedes the link between research and real life.

5.6 The selected strategy: a case study

5.6.1 A background to case studies

Robson (2002) describes a case study as “a strategy for doing research which involves an empirical investigation of a particular contemporary phenomenon within its real-life context, using multiple sources of evidence.” Bryman, and Bell, (2007) explain that a case study involves a thorough and comprehensive examination of a single case, and explains that such a term is generally related to a location (workplace or organisation). Similarly, Yin (2009) emphasises the significance of the context within case study research, noting that the confines between the studied phenomena and its context are unclear.

Schramm (1971) has described how the essential aim of different types of case studies is the justification of a decision or group of decisions (explaining why they were taken, how they were executed and the consequent results). Similarly, Yin (2009) notes that case study research has a substantial capacity to provide answers to the ‘why’, ‘what’ and ‘how’ questions.

Case studies as a research strategy are often associated with qualitative research (as case study design usually tends towards qualitative methods like participant observation and unstructured interviews). Bryman, and Bell, (2007) and Yin (2009) however emphasise that this is not always necessary as case studies can often employ both quantitative and qualitative approaches. They explain that when the main research strategy is qualitative, the case study generally adopts an inductive approach between theory and research, whereas a quantitative strategy would result in a deductive approach. Data collection methods used in case studies are numerous (interviews, observations, documentary analysis and questionnaires) and can often be
combined. Yin (2009) notes that researchers employing a case study approach often make use of and triangulate several sources for data collection. He explains that triangulation describes the use of several data collection methods within one study to guarantee that the data collected is reinforcing itself.

It has also been suggested by researchers that the case study approach holds a unique position in evaluation research (see, for example, Cronback & Associates 1980). Yin (2009) has noted several key case study applications. One is for the purpose of describing the supposed informal connections in real-life interventions, which are too intricate for a survey or experimental approach. Another is to explain an intervention and the real-life context within which it exists. Case studies can also be utilized for demonstrating particular topics and areas within an evaluation in a descriptive manner. Furthermore, another application is to help the researcher to formulate his aim and hypothesis.

5.6.2 Types of case studies

Various researchers have suggested different types of case study design. On a general note, Hammersley and Gomm, (2000) indicate that case studies vary in relation to the number, size, and depth of cases examined, as well as the degree to which the case context (society and history) is acknowledged by the researcher. Yin (2009) distinguishes between four case study strategies: single case vs. multiple case and holistic case vs. embedded case. Single or multiple cases can either be embedded or holistic in character. A single case is used to represent a critical case or unique case like YADC. A holistic case study design involves a single unit of analysis (overall character of an organisation or programme). An embedded design however involves multiple units of analysis on various levels with the aim of deciphering coherent patterns of evidence (Yin 2009).

The single case approach is specifically justified in situations where the case is essential for the testing of a strong theory, or if the case is characteristic of a unique case. Similarly, Yin (2009), suggested that a single case study is appropriate if the study is dealing with a longitudinal research approach. Nonetheless, it is noted that knowing about other cases could be beneficial, as a single case study approach could result in the danger of selecting the wrong or inappropriate case and misunderstanding
the findings. Consequently, Yin (2009) suggests that data be collected from at least two cases, especially as findings from numerous cases are very often perceived as stronger and more persuasive. On the other hand, Yin (2009) points out that a disadvantage of multiple cases is the researcher’s available time and accessible resources.

Another classification of case studies is presented by Jensen and Rodgers (2001), including snapshot case studies, longitudinal case studies, pre-post case studies, patchwork case studies and comparative case studies. Snapshot case studies are thorough, objective investigations of a single case/entity at a particular point in time (including comparisons across sub-entities within the larger case study entity). Longitudinal case studies are the quantitative or qualitative investigation of a single entity at numerous points in time. Pre-post studies are the investigation of a single entity at two points in time divided by a particular incident (which largely affects case observations). Comparative case studies include a group of case studies of numerous entities with the aim of conducting cross-unit comparisons (with the use of qualitative and quantitative comparisons).

Furthermore, Stake (2000) has noted three key divisions of case studies: intrinsic, instrumental and collective case studies. Intrinsic case studies are used when the researcher is aiming to understand a specific case better, whereas an instrumental case study is used to obtain knowledge of a particular issue or to improve a proposed theory. Finally, a collective case study is an extended instrumental case study, which investigates numerous cases to decipher knowledge about an occurrence or population.

5.6.3 Criteria for judging the quality and acceptability of case study research

Four tests that involve the criteria of validly and reliably have been used to determine the credibility of social science research and findings (Yin 2009). These include 1) construct validity, 2) internal validity, 3) external validity, and 4) reliability. Although such criteria as reliably and validity are derived from quantitative research, various researchers such as Yin (2009) have particularly supported the application of such tests to qualitative case study research by specifically noting several tactics for dealing with such tests.
Validity refers to whether research findings are about what they seem to be about (Yin, 2009). In terms of evaluation, validity is the extent to which an evaluation measures what it aims to measure. Triangulation can be used to ensure validity by relating to different viewpoints to substantiate findings (Denzin, 1970). Triangulation can take numerous forms; data triangulation makes use of various sorts of data, while methodological triangulation combines several methodological standpoints and utilizes various methods. The essence of these different forms is to ensure validity will increase if findings emerge from different sources. Construct validity deals with the extent to which the researcher involves the identification of proper operational measures for the concepts being investigated. It deals with the degree to which a researcher question measure the existence of the constructs intended to be measured. Yin (2009) has highlighted the difficulty of this concept in case study primarily due to the difficulty of identifying the construct being examined. Similarly Riege (2003) explains that during the research phase a researcher needs to eliminate any subjective judgment to enhance constructive validity. Internal validity involves searching for a causal relationship in which one condition leads to another. Yin (2009) suggests that such a test applies to explanatory and causal studies, rather than descriptive or exploratory studies, as they investigate causal relationships. Similarly Yin (2009) mentions the problematic issue of this concept relating to case study in terms of making inferences (from previous to current occurrences). He claims that it is difficult to guarantee a high level of internal validity in relation to inferences. Furthermore Punch (2005) explains internal validity in terms of whether the research design is a true reflection of the reality examined. On this note, Pope, van Royen and Baker (2002), suggest that qualitative research would have high internal validity if the researcher provides a thorough description of real-life conditions, which provide a true image of the occurrence.

External validity (or generisability) involves the process of defining the area to which research results can be generalised. In other words, it is concerned with the extent to which researchers' findings can be equally applicable to different research situations. Bryman (2004) indicates that external validity is especially suited to case study research due to its inclination to make use of small samples. Similarly, Guba and Lincoln (1982) explain that in qualitative research generalisations are impractical as occurrences are not time or context free. Nonetheless, Patten and Appelbourn (2003) suggest that the degree of generalisablity of case studies can be established by
the strength and quality of the content descriptions, which in turn allow other researchers to establish the degree of 'transferability' of a specific case to other comparable cases.

Furthermore, reliability involves demonstrating that a study's procedures (data collection techniques and analysis procedures) can be repeated and will result in the same, consistent results (Yin 2009). Measuring reliability in qualitative research can pose some difficulties. Robson (2002) mentions 4 key threats which include the following: 1) subject or participant error, 2) subject or participant bias, 3) observer error and 4) observer bias.

5.6.4 Methods for case study research

Numerous methods can be employed in case study research to allow the researcher to achieve a holistic understanding of the case investigated. Methods for data collection such as interviews, surveys, observations and questionnaires can be used. Similarly, for analysing the qualitative data collected, various techniques are available such as thematic analysis, content analysis, discourse analysis and narrative analysis. The two sections below will first consider the methods for data collection used (primarily interviews), and the methods for data analysis (thematic analysis).

5.6.5 Interviews

Khan and Cannell (1957) describe an interview as focused dialogue between two or more individuals. There are various advantages associated with interviews both as a data collection method in itself, as well as specifically within case study research. Yin (2009) highlights the significance of interviews for case study research by explaining that because most case studies deal with human affairs, interviews will enable information to be gathered, described and explained from the perspective of specific interviewees. Similarly, Arksey and Knight (1999) indicate that interviews enable the researcher to decipher the essence of the lives, habits, practices and emotions of individuals to a greater degree than other research methods. Interviews also enable the researcher to amend and make clear any misconceptions on the part of the respondents (Sarantakos, 1998), and their analysis is often considered less problematic than other research methods which may require the examination of long, complicated documents and questionnaires. Furthermore, within an interview new and
important concerns may arise which can provide a different and innovative focus into the research (Bryman 2004).

On the other hand, interviews as a method of data collection can also pose some disadvantages. It has been suggested that because an interview is a social interaction between different people, numerous problems such as inconvenience (intrusion of privacy on the part of the respondent), bias, or the interviewer effect (in which unnatural settings, such as the use of tape recorders, result in different answers by interviewees) can result (Corbetta, 2003). Furthermore, authors such as Denscombe (2003) also note that time and money restrictions may be limiting factors of interviews.

There are various types of interviews with different purposes and applications. A common typology categorises interviews into one of the following: structured, semi-structured or unstructured interviews. Structured interviews involve the use of a set and standardized questionnaire within a structured interview schedule (Saunders, Lewis, and Thornhill, 2009). Questions are also presented to each respondent in the same tone to eliminate any bias. Such interviews are often referred to as quantitative research interviews as they are often used to collect quantifiable data (Saunders et al., 2009). Semi-structured interviews however, are not standardised and are often referred to as qualitative research interviews (King 2004). Within such interviews the interviewer has a selection of themes, which may be adjusted or omitted depending on the specific context and setting. This method is more time consuming in terms of data collection and involves more explanation and improvisation on the part of the interviewer. Unstructured interviews on the other hand, are informal interviews used to explore a general area of the researcher’s interest. Rather than preparing a list of questions, the interviewer simply has an idea of the aspects that need to be explored, and allows the respondent to talk freely about relevant issues. Thus such interviews are referred to as non-directive in nature.

Within a case study context, Yin (2009) notes, interviews tend to be open-ended to enable the exploration and examination of a respondent’s opinion on various issues. Nonetheless, this research will make use of semi-structured interviews in which a list of themes and questions will be covered, the order and nature of which may vary slightly depending on the specific context of the interview and respondents’ perspectives.
5.6.6 Questionnaires

A questionnaire includes all methods of data collection where one is asked to respond to a series of questions presented in the same order (Malhorta, 2006). Saunders, et al (2009) note that the design of a questionnaire affects its response rate as well as the reliability and validity of the data collected. He recommends that researchers ensure the careful design of individual questions and ensure that the layout is clear with a clear explanation of its purpose outlined.

It is also noted that pilot testing is beneficial along with carefully thought out administration of such questionnaires. Questionnaires are piloted to ensure that the wording of the questions will achieve their purpose and that the questions themselves have been presented in the best order to ensure a proper flow of information and avoid repetition. Questionnaires are also piloted to ensure that their questions are understood by the sample consulted, and to determine whether additional questions should be added or existing questions eliminated. The sample selected for the pre-test should be representative of that for the main study (Sekaran, 2000).

It has been suggested that questionnaires are often well suited for descriptive or explanatory research, where they are used in the form of opinion questionnaires to enable the research to describe the variability of a certain phenomenon. Saunders, et al (2009) also note that although such questionnaires can form the only means of data collection, it is more advantageous to link them with other methods.

There are numerous forms of questionnaires, depending primarily on the means of administration. These include self-administered questionnaires or interviewer-administered questionnaire (Sekaran, 2000). Self-administered questionnaires are often completed by respondents, and can include internet-mediated questionnaires (completed electronically), postal questionnaires (posted to respondents and returned by similar means after completion) and delivery and collection questionnaires, (given to respondents by hand and collected afterwards). Interviewer administered questionnaires include telephone questionnaires and structured interviews (where questions are asked in a set manner, without deviation). Saunders, et al (2009) highlight that the latter is not the same as semi-structured or unstructured in-depth interviews in which the interviewer is given a chance to contribute beyond the questions asked. The choice of questionnaire often requires
consideration of the research time frame, available budget, the type of data required and the research context (Sekaran, 2000).

5.6.7 Document review

Document review is a means of collecting data through reviewing documents related to the research (Department for Health and Human Services, 2009). It involves systemic procedures for reviewing documents and requires data to be extracted in order to produce empirical information (Bowen, 2009).

Documentary data includes written materials such as certificates, books, reports, newspaper clippings, public records or transcripts of speeches. It can also include non-written material such as DVDs or television programmes (Sauders et al., 2009). Such data could also be internal, such as records, or external, such as audits. Reviewing documents helps to understand the history and operation of the programme, and provides background information, to determine if implementation of a certain programme reflects the set plans (Department for Health and Human Services, 2009). Researchers often utilise such a method of data collection as part of a ‘within-company’ project or a case study of a specific organisation (Saunders et al., 2009).

Document review can be used to triangulate findings from other data collection methods such as interviews or questionnaires (Bowen, 2009). It allows the researcher to gather information from various sources to look for convergences within them, as well as to raise the credibility of the findings and reduce bias (Bowen, 2009). Yin (2009) has also highlighted that document review as a research method is especially well-suited to qualitative case studies as it helps the researcher obtain a holistic view of the case. However, although document review has been widely used to substantiate other research methods, it is also important to note that document review can be used as a standalone method (Bowen, 2009).

Undertaking document review includes finding, selecting and appraising data within documents. It first requires that all relevant documents are collected, after which the most appropriate for the research at hand are selected. This process often requires good communication with cases being investigated to obtain permission for access to such information. Communication with relevant stakeholders is also important in order to check the accuracy of the documents (Department for Health
and Human Services, 2009). Once appropriate documents are selected, the researcher should extract the meaning of the document and the contribution to the research (Bowen, 2009).

All in all, such a method of data collection has its advantages and disadvantages. Among its advantages are that it is relatively inexpensive, provides a good source of background information, and is usually unobtrusive and discrete. Disadvantages however, include the risk of having disorganised or inapplicable information, biased information because of the process of selective survival (in which only a part of the information is provided), and that the information can often be time consuming to gather and study (Department for Health and Human Services, 2009).

5.7 Methods for data analysis

Numerous methods for qualitative data analysis exist such as thematic analysis, content analysis, discourse analysis and narrative analysis.

5.7.1 Thematic analysis

Thematic analysis is a method of data analysis that includes the formation and application of codes to data, focusing on identifiable themes and patterns of behaviour. Themes have been defined as units originating from patterns such as local common sense constructs, professional definitions, literature, characteristics of the phenomena being studied, researcher values, theoretical orientation and personal experience with the subject matter (Bulmer, 1979). However, most researchers induce themes from text. The idea is to develop themes and to work out how they relate to each other within the data. This is what grounded theorists name open coding and what classic content analysts call qualitative analysis (Gibson, 2006). There are many helpful techniques for discovering themes in text. Gibson, 2006 has noted that these techniques are based on the following:

1. Word analysis (repetitions, key local terms and key words in context)
2. Thorough reading of larger portions of texts (compare and contrast, social science queries)
3. Planned analysis of linguistic features (metaphors and transitions)
4. Physical manipulation of texts (unmarked texts, cut and sort procedures)

There are many factors that influence the number of themes that are generated. These include who and how many people are looking for themes, and the type and quantity of text (Gibson, 2006).

The framework approach is a holistic data analysis method developed by Ritchie and Spencer (1994) which uses thematic analysis. The framework approach requires data to be filtered, charted and organized in a systematic manner, in line with major themes. It consists primarily of five key stages which include: 1) familiarization, 2) identifying a thematic framework, 3) indexing, 4) charting, and 5) mapping and interpretation.

The framework approach is explicitly oriented towards applied policy research although it has been applied in other research fields. It is characterised by allowing codes to be identified before subjecting the data to analysis and combining them with themes that emerge after data analysis (Dixon-Woods, 2011). The strength of this approach is that it helps to focus data extraction so that it is highly relevant to the research question. It is also useful in situations where theoretical frameworks already exist (Noyes and Lewin, 2011), as is the case with this research (see Figure 1.1).

On the other hand this approach is criticised on the grounds that it may be restricted to the chosen framework, without allowing new data or structures to emerge. To overcome this limitation a transparent and systematic process for selecting data for extraction needs to be demonstrated. This can be shown through standard extraction forms or templates for application of data (Noyes and Lewin, 2011).

5.8 Research sampling strategy

A sample is part of a larger population that is chosen for investigation. Traditionally, the process of sampling has been beneficial in situations where the factors of time and cost are constraints (Saunders, et al., 2009). Henry (1990) has also suggested that the use of sampling allows for a greater level of accuracy than a census. He argues that as data will be collected from a smaller number of cases, more time can be spent designing and piloting the process of collecting such information. Also a limited sample allows for more detailed information to be collected and more
time to search for unique cases. Furthermore, once the data is collected from a sample, more time can be spent, before analysis, examining the data for accuracy.

There are two key sampling techniques available to researchers: probability or representative sampling and nonprobability or judgemental sampling. The former is often associated with quantitative research methodologies where the research question or questions require the statistical estimation of a population's characteristics from a sample (to create generalisable data). Non-probability sampling however is mainly associated with qualitative research in which no generalisations are required, and the sample is based on the relevance of the cases to the research question or questions (Saunders, et al., 2009).

The process of probability sampling can be divided into four stages. The first is the identification of an appropriate sampling frame - a list of all cases in the population from which a sample can be selected. Second is the selection of a suitable sample size. Third is the selection of an appropriate sampling technique - common techniques include simple random sampling, systematic sampling, stratified random sampling, and cluster sampling, all of which give each unit of the population an equal and calculable probability of being selected. Fourth is the assurance that the sample is representative of the population.

On the other hand, non-probability sampling used in qualitative research focuses on a small case selected for a specific purpose. Patton (2002) has noted that the sample size in such studies is dependent on the research question or questions, and particularly what the researcher is seeking to discover, whether it will be reliable, and whether it can be accomplished within the accessible resources. The credibility and insights a researcher will attain from the collected data will be due more to the data collection and analysis skill rather than the size of the sample. Nonetheless, after selection of a sample size, a variety of sampling strategies can be selected such as purposive sampling, quota sampling, snowball sampling and convenience sampling. Purposive sampling is where the researcher uses judgment to choose the cases to form the sample. Such cases are believed to be best for answering the research question or questions (Hignett 2005). Quota sampling is where the researcher selects the sample to represent particular features of the population. It is a stratified sample, involving the non-random choice of a sample within strata (Barnett, 1991). Snowball sampling is a technique used when the identification of respondents from a desired sample is difficult. It is when later respondents are obtained from information provided by
earlier respondents. Convenience sampling is where a researcher selects cases randomly based on which is easiest to access.

5.9 Chapter summary

This chapter explains the rationale behind the development of the research strategy. It began by describing different epistemological considerations and outlined several key philosophical positions such as positivism, interpretivism and realism. Different methodological considerations were then described and the differences between qualitative and quantitative research were indicated. The selected strategy appropriate for this research, the case study, is then explained, with a focus on the background, types, strengths and weaknesses of case studies. An explanation of the key issues of research acceptability, reliability and validity was also provided. Following this, the chapter discussed the methods for case study research under a realist evaluation perspective, the methods for data analysis and the research sampling strategy. Figure 5.4 below illustrates a summary of the research approach for this study.

Figure 0.4 - Research approach summary

Source: Adapted from Saunders, Lewis, and Thornhill (2009)
Chapter 6 - Research Design

6.1 Introduction

Research design sets the plane for scientific inquiry and develops a step by step strategy to answer the research question. It is defined as "the framework or plan for study used as a guide in collecting data and analysing it" De Ven (2007). This chapter presents the rationale for the research method used to collect and examine data as a component of realist evaluation. The research design has been shaped by the research aim and objectives as mentioned in Chapter 1, in addition to some practical considerations relating to applying PPP in the health sector. A realist evaluation approach has been adopted to examine the first PPP experience in the Kuwaiti health care system - YADC. Realist evaluation research aims to produce detailed answers to the questions of why PPP and its implementation work, for whom, and in what circumstances. This research thus investigates how, and why, PPP has the potential to cause desired changes.

The chapter begins by providing a brief overview of the literature review, making specific reference to the issues and concerns raised. The research design of the preliminary study is then described, with information provided regarding the purpose of the preliminary study, its data collection and analysis techniques, sampling strategy and timeline. The chapter then details the research design for the main study, highlighting specific data collection methods, sampling strategy, timeline and data analysis. Figure 6.1 below provides an overview of the various stages undertaken in this research.
Figure 0.1 - An overview of the research stages undertaken

Literature Review

Formulation of Research Topic
- Health care system - components and objectives
- Kuwaiti health care system challenges
- NPM and PPP

Building of hypothesis

Preliminary study
- 5 Semi-structured in-depth interviews:
  - 2 Public sector
  - 2 Private sector
  - 1 Independent academic

Data analysis and Concept approval

Main Study
- 35 Semi-structured in-depth interviews:
  - with 4 key stakeholders: public, private, financial and regulatory/advisory bodies
- 600 Questionnaires
  - End-users - patient experiences
- Document review

Realist evaluation and data analysis
(CMO configuration)

Final Reflections, Discussions and Conclusion

Source: author generated
Chapter 2 examined the definition, structures, components, objectives and goals. It provided a description of the importance of such systems in improving health. It was explained that a health system consists of elements that work together to influence the achievement of health system goals (Atun and Menabde, 2008). While these goals may differ in importance between different countries, effectively many are similar. Several authors have thus developed frameworks that measure the performance of health systems and conceptualize health system components, elements and goals (Hsiao 1992). Examination of such frameworks enabled the researcher to select an appropriate health system framework as a basis for evaluation of PPP in health care.

Atun and Menabde (2008) have suggested that health systems in particular demonstrated all major features of complex dynamic systems. This, they argue, is primarily due to such systems containing numerous interrelating feedback loops, and that the consequences of choices and actions taken are usually intangible and thus not directly noticeable. More importantly, Atun and Menabde (2008) have also emphasised that a framework that examines health system functions should, at the same time, examine the context with which it interacts. They have in turn developed a new framework that builds on previous frameworks developed by WHO (2000), Hsiao (2003), and Frenk (2000). This framework was used by the researcher as the basis for the research hypothesis (see Figure 2.1 in Chapter 2).

Under this framework, Atun and Menabde (2008) identify four levers for policy officials managing the health system. Variation of such levers allows for the realization of different health system objectives and goals. Similarly to the previous frameworks discussed, key health system goals for this framework are health, financial risk protection and consumer satisfaction. Objectives include equity, choice, efficiency and effectiveness, and are frequently noted by others as ultimate goals in themselves. Levers of the health system include 1) organizational arrangements (the policy and regulatory environment, stewardship function and structural arrangements for purchasers, providers and market regulators), 2) financing (collection and pooling of funds), 3) resource allocation and provider payment systems (the allocation of funds and accessible resources such as human resources, capital investment or
equipment, and the payment mechanisms for health service providers), and 4) service provision (services provided by the health sector).

Following on, Chapter 3 describes the Kuwaiti health care system, providing a brief background of Kuwait as a country, and details its health care system, its history, standards, statistics, organisational structure and challenges. The health system in Kuwait is based on a central MOH and district regional units. The MOH is responsible for setting strategies, financing, resource allocation, regulation, monitoring and evaluation of health care, as well as for service provision to the end-users.

Although the literature highlights that there are overall good health indicators achieved by the Kuwaiti health sector, it is maintained that the health sector in Kuwait "remains largely underdeveloped" (Oxford Business Group, 2007). This is especially in terms of efficiency and service quality due to numerous challenges facing the system such as ageing health care infrastructure, rising population and consequent epidemiological changes, escalating costs of medical services, inadequate service management and rising public expectations for health services (Al Mutairi, 2007). It was also highlighted that despite the large financial resources stabilising the economy and the situation being masked by high oil revenue, the implications of such demographic changes could be devastating (Business Monitor International, 2011). Furthermore the dangerous effect of 'wastah' (a Kuwaiti term, meaning 'connectedness' in which people without medical priority bypass the waiting time and create major unfairness to eligible people) has been highlighted (Al Mutairi, 2007).

Chapter 3 also examines the role of the private sector in Kuwait, noting that as a result of the inefficiencies in government services, patients seeking immediate care are starting to turn to private practices or medical tourism (Al Mutairi, 2007; State Audit Bureau of Kuwait, 2004). Private health care in Kuwait has thus been thriving over the last 5 years, filling market gaps and capturing opportunity mainly in secondary and tertiary health services (WHO, 2006a).

Finally the chapter provides details of the Kuwaiti government’s future prospects for health care, noting that although the government has committed to reforming the health care system through several attempts over the past 20 years, such attempts have not achieved their targets due to a lack of leadership, political support and government stability. It should also be noted that during the collection of relevant literature sources for Chapter 3, the author noticed a significant lack of available data.
on health care management and policy in Kuwait. This indicates the importance of contribution to this field.

Chapter 4 of the literature review examined the use of PPPs in the health care sector. The chapter began by discussing the nature of public services, and the ongoing public vs. private debate in the provision of public services. Corry et al (1997) have argued that public provision often suffers from various factors such as producer capture, political interference, lack of competition and constraints on investment. Similarly, Propper (2000) has noted that the absence of a market force makes the public sector less efficient than the private sector, and that the often bureaucratic and inflexible management structure of the government can mean that consumer demands and satisfaction are overlooked.

The literature then made reference to the increasingly strong focus worldwide on making the public sector more efficient, innovative, flexible and cost effective (Weihe, 2008). Peters and Pierre (2003) argue that the emphasis on performance and service delivery has increased relative to the traditional public values of universality, equality and legal security. Similarly, private provision has increasingly been injected into the public sector by means of various partnerships as will be explored in detail further below (Corry, et al., 1997).

In comparison to the public sector, the private sector is often associated with strengths that ultimately stem from their aim to maximise profits (in the case of for-profit organisations) and increased competition among different players. These strengths include improved efficiency, innovation, quality and customer care. Private sector organisations are also noted for their improved management standards with better paid and motivated staff, and for their investment in research and development being sufficient to initiate new and innovative techniques (Pessoa, 2006).

However, the literature also makes reference to particular flaws with private sector provision. Corry et al (1997) note two key problems. The first is concerned with the potential weaknesses of private sector provision itself, which stem from their ultimate goal of maximising profits. This goal may give the provider incentives that contradict those required to deliver public services, and they may thus not operate in the public's interest. This may manifest itself in cost-cutting activities by reducing quality, or worsening employee terms thus reducing incentive to improve quality. The second issue stems from the attempt to mesh public and private interests. This can result in accountability structure problems (particularly in partnership arrangements),
which can negatively affect users/purchasers. Reference was also made to the concept of market failure; it is argued that what makes the health care sector unique, in comparison to markets for other commodities, is that it can have all the distinctive features of market failure present simultaneously (Dolan and Olsen, 2002) such as moral hazard, absence of trusted up-to-date information, imperfect competition and the existence of externalities (the slipover effect - the impact of one person's behaviour on another person's utility).

The chapter then considers whether such distinct features in the health care system suggest that government intervention of some form is crucial. Although the absence of a market force makes the public sector less efficient than the private sector, and can result in bureaucratic and inflexible management structures, communities are also concerned with fairness and equity, which are in principle the main motives behind the creation of many public services including health (Jaegher and Jegers, 2000). The chapter then highlights that strategies to improve both efficiency and equity health care objectives often differ, and the question of how governments should intervene, and in what way, is controversial among health managers and policy makers (Mintz and Schwartz, 2000).

Chapter 4 then explains the rise of the PPP concept, noting that the PPP concept probably originated from the theory and practice of NPM since the 1980s to modernise and reform the public sector (Skietrys, et al., 2008). The essence of this movement was that an increased focus on market principles such as competition will lead to increased cost efficiency without hindering government objectives (Boston, et al., 1996). PPP is often perceived as a new idea in the area of public management, in allowing for the use of private sector tools and mechanisms in the implementation of public sector services (Lider, 1999).

PPP objectives, such as the transfer of risks to parties best able to manage them and better value for money, have then been highlighted, followed by an account of the constituents of an efficient PPP, as well as the different forms of PPP arrangements used in health care. Specific advantages of PPP (such as risk transfer, VFM, enhanced efficiency in project execution and improved implementation) and disadvantages (such as potential lack of transparency, 'unknown parameters' regarding responsibility and accountability, and long-term inflexibility) were also highlighted.
The entire literature review has thus brought to light various issues and concerns that will be further examined in the main study of this research. All in all, it seems that PPP has the potential to achieve the health care system objectives better through introducing market tools that help the system perform better. The preliminary study and main study will further investigate whether the PPP experience in Kuwait does indeed achieve this.

6.3 Research design and its relation to realist evaluation

A realist evaluation design requires the development of a provisional theory in the research process so that this can be tested and refined. In this research the initial hypothesis was developed from both the literature review and a pilot study undertaken on site to consolidate the model used and to determine key stakeholders’ approval of the proposed research. The literature review has indicated that the health care system objectives (effectiveness, efficiency, equity and choice) need to be achieved in order to realize the ultimate health system goals (patient satisfaction, good health and financial protection). These outcomes depend on four main levers: regulation, service provision, resource allocation and organisation. The proposed conceptual model in this study suggests that PPP will improve the delivery of health care objectives in the Kuwaiti health care system (Figure 6.2). This improvement is associated with a direct relationship between PPP and health care system levers.
Due to the nature of the research a qualitative methodology was selected as the most appropriate method. The PPP experience in health care is relatively new and therefore there is limited empirical information regarding its performance. Qualitative methods would enable a deeper understanding of various aspects and social layers of the PPP experience. This would thus enable the researcher to determine why and how PPP works, for whom and in what circumstances (in accordance with the realist evaluation approach).

6.4 Case selection

YADC is the case selected for investigation in both the preliminary and main studies of this research. Established in 2002, YADC is the first experience of PPP in the Kuwaiti health care system. YADC is owned by Yiaco, a pharmaceutical and medical service company listed on the Kuwait Stock Exchange. YADC is the first and only PPP project in the Kuwaiti health sector providing clinical services. The PPP contract, which includes design, construction, equipment, maintenance and operation, was signed with the MOH in 2002 for a period of 10 years, commencing in November 2005. Currently the YADC has around 200 employees and operates for 7 days a week, 24 hours a day (YADC website). It provides a comprehensive range of tests and services such as clinical laboratory services, radio diagnostics and nuclear medicine (YADC website).

The centre, which consists of a 6,800m² facility, is directly linked with Adan Hospital, which is one of the 6 major regional hospitals in Kuwait (YADC website). Communication is facilitated by an advanced computer system and an extensive courier system to facilitate specimen handling and result reporting (YADC website).

6.5 Research design for the preliminary study

A pilot study was undertaken to improve and assess the validity of the research questions, ensure that respondents are able to answer the questions, and
improve data collection and analysis techniques. Pilot studies reduce possible future errors in research as the method of the fieldwork can be improved accordingly (Saunders, Lewis, and Thornhill 2009).

The interview questionnaire was initially reviewed with the researcher's supervisor and colleagues to assess the representativeness and appropriateness of the questions posed. Saunders, Lewis, and Thornhill (2009) have also noted that the nature of the pilot study (the number of people with whom the researcher pilots the questionnaire and the number of pilot tests) depends on the research questions, objectives, time and money resources available. As part of the pilot study for this research, 5 in depth semi-structured interviews were undertaken with top management from both the public and private sectors. The aims of the pilot study were as follows:

- To ensure that the PPP concept is readily understood during the interview by the selected respondents
- To study the degree of interest in the research topic
- To investigate whether enough adequate data can be gathered to make a substantial contribution to the area of study
- To test the practicality of the concepts identified in the literature review.

6.5.1 Timeline for the preliminary Study

Table 6.1 below illustrates the timeline for the preliminary study.

<table>
<thead>
<tr>
<th>Timeline of preliminary study</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Planning and preparation</td>
<td>Jun-Jul 2010</td>
</tr>
<tr>
<td>Conducting interviews</td>
<td>Aug-Sep 2010</td>
</tr>
<tr>
<td>Analysis</td>
<td>Sep-Oct 2010</td>
</tr>
</tbody>
</table>

6.5.2 Data collection for the preliminary study

A qualitative, open-ended, semi-structured interview questionnaire was used to evaluate the PPP experience in Kuwait. This approach allows for the collection of a
large amount of data under a set framework. The section below illustrates the questions posed and the rationale behind them.
### 6.5.3 Interview questionnaire and justifications for the questions posed – Preliminary study

Table 6.2 - Questions posed and their rationale

<table>
<thead>
<tr>
<th>Topic</th>
<th>Question posed</th>
<th>Rationale behind question</th>
</tr>
</thead>
<tbody>
<tr>
<td>Background to the interviews</td>
<td>1. Before we begin, please provide a brief description of yourself (job title and number of years' experience in this field)?</td>
<td>This opening question allows the researcher to place the responses of the various interviewees into context.</td>
</tr>
<tr>
<td>Health System Components:</td>
<td>2. Please describe the financial model used for the PPP experience in the Kuwaiti health sector (YADC)? What are the advantages and disadvantages of this model?</td>
<td>Questions 2 to 5 aim to examine how the PPP experience has affected the health care system components mentioned in the literature review: finance, organizational structure, resource allocation and service provision. They attempt to identify how such components have been implemented in the PPP experience, with reference to their advantages and disadvantages.</td>
</tr>
<tr>
<td>Financial model</td>
<td>3. Please describe the organizational structure of the PPP project (YADC)? What are the advantages and disadvantages of this structure?</td>
<td></td>
</tr>
<tr>
<td>Organizational structure</td>
<td>4. How have the resources such as staff, buildings and equipment been allocated in this project (YADC)? What are the advantages and disadvantages of this resource allocation?</td>
<td></td>
</tr>
<tr>
<td>Resources allocation</td>
<td>5. Has the service been delivered differently? What are the advantages and disadvantages of the service delivery?</td>
<td></td>
</tr>
<tr>
<td>Service delivery</td>
<td>6. If efficiency is defined as making good, thorough and/or careful use of resources, without over consuming, do you think the PPP experience in the Kuwaiti health sector (YADC) has enhanced health care system efficiency?</td>
<td>Questions 6 to 9 were posed to find out whether PPP has achieved the health care objectives and the process involved in this.</td>
</tr>
<tr>
<td>Evaluation of the intermediate health care system goals at YADC:</td>
<td>7. If equity is defined as a society’s requirement for justice and fairness, do you think the PPP experience in the Kuwaiti health sector (YADC) has enhanced health care system equity?</td>
<td></td>
</tr>
<tr>
<td>Efficiency</td>
<td>8. Do you think the PPP experience in the Kuwaiti health sector (YADC) has enhanced the health care system choice for patients?</td>
<td></td>
</tr>
<tr>
<td>Equity</td>
<td>9. If effectiveness is defined as the capability of producing an intended</td>
<td></td>
</tr>
<tr>
<td>Choice</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Effectiveness</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| Assessment of financial risk protection and customer satisfaction | 10. Do you think the PPP experience (YADC) has enhanced the financial risk protection of the health care system?  
11. Do you think the PPP experience (YADC) has enhanced customer satisfaction of the health care system? | Questions 10 and 11 aim to determine if the PPP has enhanced the achievement of the health care ultimate goals (customer satisfaction and financial risk protection). |
| Assessment of the success level of the centre | 12. In your opinion, has the PPP experience in the Kuwaiti health sector (YADC) been successful to date? | Question 12 is a direct question targeted at the respondents to identify whether overall they believed that the PPP experience in the Kuwaiti health care sector has been successful. |
| Evaluation of Socio-Economic Demographic, Economic, Legal, Political Epidemiological, Environmental and Technological Indicators | 13. Which of the following factors, in your opinion, have a positive effect on the PPP experience (YADC)?  
14. Which of the following factors, in your opinion, have a negative effect on the PPP experience (YADC)? | Questions 13 and 14 aim to distinguish which aspects the respondents believe have positive and negative effects on the PPP experience. Such questions will allow for the identification of which factor or factors have a greater bearing. |
| Evaluation of SWOT | 15. What, in your opinion, are the key weaknesses of the PPP experience in the Kuwaiti health sector (YADC)?  
16. What, in your opinion, are the key strengths of the PPP experience in the Kuwaiti health sector (YADC)?  
17. What, in your opinion, are the key opportunities of implementing a project such as YADC in Kuwait?  
18. What, in your opinion, are the key threats and barriers to implementing a project such as YADC in Kuwait? | Questions 15 to 18 aim to establish the SWOT of YADC to enable the undertaking of a SWOT Analysis for future implementation and development |
6.5.4 Research sampling strategy for the preliminary study

The realist evaluation method proposes that various stakeholders will have different information based on their role in the programme. Since this research is examining a PPP case in Kuwait, the sample consists of members from both the private and public sectors. Furthermore, an expert academic in the field was also part of the sample to provide an independent opinion. Thus, in total five interviews were conducted through quota sampling. The first two participants of the pilot study (one private and one public) were contacted directly by telephone to arrange appropriate times for the interviews. The following three participants were selected through a process of purposive sampling. The five interviews were conducted within a period of 6 weeks in Kuwait between May and June 2010.

6.5.5 Data analysis for preliminary study

The analysis of qualitative data included careful and systematic reading and coding. For the preliminary study thematic data analysis was selected to allow for the identification of prominent themes within various types of text (as described in section 5.7.1). A framework approach, which is founded on thematic analysis, was carried out to allow for deep systematic analysis. The framework approach consists of five main steps which include familiarisation, identifying a thematic framework, indexing, charting, and mapping and interpretation.

With regard to familiarisation, the researcher went through the interview audios recordings to gain a general understanding of the key topics. Of the five interviews carried out, two were in English and three were in Arabic. Following transcription of all the interviews from audio recordings to paper, the Arabic transcripts were translated into English.

A thematic framework was then created based on the research objectives and literature review. Data was categorised into themes based on PPP and health components, PPP and health care objectives, PPP and external factors such as demographics, political indicators, economic indicators etc, and future PPP implementation.
This was carried out to facilitate the next stage of indexing, which involved extracting key issues and main themes that are relevant to the research question. Extracted data were given a reference (index) or code.

The coded data was then charted in a table format across all respondents in relation to the corresponding theme.

Data were then interpreted in order to find associations between themes. Explanation of the findings was also done by referring the data to the literature review.

6.6 Research design for the main study

After conducting the preliminary study, it was found that there is a high degree of interest regarding the PPP experience in Kuwait, and that the PPP programme as a concept is well recognised. It was also found that there is an adequate amount of data available that could be extracted through further research. On this basis, data collection methods and the research sampling strategy for the main study were refined.

6.6.1 Timeline for the main study

Table 6.3 illustrates the timeline for the main study.

Table 6.3 - Timeline for the main study

<table>
<thead>
<tr>
<th>Timeline of main study</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Planning and preparation</td>
<td>Feb - Mar 2011</td>
</tr>
<tr>
<td>Conducting interviews</td>
<td>Mar - Apr - May 2011</td>
</tr>
<tr>
<td>Analysis of interviews</td>
<td>July - Aug 2011</td>
</tr>
<tr>
<td>Development and conducting of questionnaires</td>
<td>Mar - Apr 2011</td>
</tr>
<tr>
<td>Analysis of questionnaires</td>
<td>July - Aug 2011</td>
</tr>
<tr>
<td>Collecting and analysing documents</td>
<td>Feb - Sept 2011</td>
</tr>
</tbody>
</table>

6.6.2 Data collection for the main study

Given the broad scope of the evaluation and a desire to capture a holistic approach on the impacts of PPP on the health care objectives, a case study with
multiple methods (mainly qualitative) has been adopted. The research considers, at one level, the opinion of policy makers and managers from both the public and private sectors, and at another level, the opinions of individual staff and patients. Involvement of different stakeholders is a principle element in realistic evaluation. The multiple methods, including interviews, questionnaires and document review, are described below.

The main study consisted largely of semi-structured interviews with four key stakeholders (public, private, financial and regulatory/advisory bodies – as highlighted in the literature review) to explore their views regarding the implementation of PPP in the health care sector and its impact on health care objectives (efficiency, effectiveness, choice and equity) and its 4 levers (regulation, service provision, resource allocation and organisation). All interviews were carried out face-to-face and took place at the interviewees’ work place (office). Several issues were ensured with the interviewees prior to undertaking the interview. These include a verbal consent to take part in the research, notification of the proposed length of the interview (which was approximately 45 minutes) and that it will be recorded, as well as guaranteeing the anonymity of the interviewee. Interviewees were also given a brief introduction about the nature and purpose of this research, as well as provided with the option to seek clarification throughout the interview for any questions.

Due to the nature of the fifth stakeholder (the end-user), a customer experience questionnaire was also undertaken to determine the overall level of service provided at YADC. The author, with the help of two assistants, distributed the survey by hand to different patients at the end of their visit to the centre, asking them to complete it before leaving. All completed forms were placed in specially provided envelopes.

Furthermore, document review of relevant information is provided where appropriate to substantiate the findings. This data includes written materials such as certificates, newspaper clippings, photos and educational documents. These documents were collected throughout the study while undertaking interviews or visiting the facility. Documents which are relevant to the research topic were selected and reviewed and transferred to a template.

6.6.3 Interview questionnaire and justifications for the questions posed – Main study
After undertaking the preliminary study, a few changes were made to the interview questionnaire illustrated in section 6.9.2. These changes include:

- Two new opening question (Questions 1 and 2) were asked regarding the objectives of PPP and the interviewees' objectives in being part of a PPP project. These questions were asked as the pilot study questionnaire provided no clear evidence of the project's objectives or of what the participants' objectives were in being a part of this partnership.

- Questions 3 to 6 dealt with the health care system objectives, and correspond to Questions 6 to 9 from the pilot study questionnaire. Two changes were made to these questions. Firstly, in addition to asking the interviewees if they thought that PPP achieves health care objectives, participants were also asked 'how' this occurred and to 'explain their response further'. The purpose of this was to identify mechanisms brought about by the PPP experience. Secondly, such questions were brought forward earlier in the interview to increase clarity and avoid repetition.

- Questions 7 to 10 dealt with the health care levers, and correspond to Questions 2 to 5 from the pilot study questionnaire. Two changes were made to such questions. Firstly, the questions were rephrased; rather than asking the interviewees to describe how PPP has changed the health care levers as in the pilot study, the main study questionnaire sought to determine the 'impact' of PPP on the health care levers with reference to the health care objectives. Furthermore, participants were also asked to describe the mechanisms brought about by the PPP programme.

- Questions 11 and 12 sought to determine the factors that had a positive or negative effect on the PPP experience in an attempt to examine various contexts. On a general note such questions correspond to Questions 10 to 18 from the pilot study, the responses to which were believed to be overlapping and repetitive.

Appendix 3 gives the updated version of the main study questionnaire.

6.6.4 Customer satisfaction questionnaire and justifications for the questions posed – Main study

The customer satisfaction questionnaire has been adapted from one used by the Health Resource and Services Administration (HRSA), which is an agency of the U.S. Department of Health and Human Services. The sample questionnaire was selected from the HRSA questionnaire and was slightly modified to suit the YADC.
case study (providing various case-specific introductions to the questions) and was also translated into Arabic.

The questions asked were categorised into several sections. Respondents are first asked to rate their overall experience (based on their current visit) for the following: 1) health centre, 2) the quality of health care, 3) general facilities at the centre, and 4) reception and appointments. Respondents are then asked to rate their satisfaction on the ease of getting care (based on their current visit) for the following: 1) ability to get in to be seen, 2) working hours, 3) location of the centre, and 4) promptness in calling. Following on, respondents are asked to rate their satisfaction level on a set of attributes related to the time taken at the centre, including: 1) time taken in the waiting room, 2) time taken in the examination room, 3) time taken for testing, and 4) time taken for test results. After gauging the satisfaction level on waiting time, the respondents are asked to give their satisfaction level on staff related attributes such as 1) satisfaction with key staff (i.e. doctors), 2) satisfaction with assistant staff (nurse, assistant), 3) Satisfaction with other support staff. Thereafter, the respondents are asked to give their satisfaction level on payment related attributes: 1) satisfaction on overall charges (amount) paid, 2) satisfaction with the proper explanation of charges in the bill, and 3) satisfaction regarding collection of payment. The respondents are thereafter probed for their satisfaction level on the different facilities available at the centre such as: 1) neatness & cleanliness of the building, 2) ease of finding their way around the centre, 3) comfort and safety in the waiting room privacy. Finally, the respondents are probed on the centre for the following: 1) likelihood of referring the centre to friends/relatives, 2) considering the centre as their regular source of care, and 3) awareness of the centre being managed by the private sector, 4) likelihood of referring the center to friends/relatives.

6.6.5 Research sampling strategy for main study

As mentioned above, the realist evaluation method proposes that various stakeholders will have different information based on their role in the programme. Considering this, and based on the findings of the literature review and the preliminary study, the main study sought to obtain the opinions of 5 key stakeholders.
Therefore, semi-structured interviews were undertaken with 4 key stakeholders - public, private, financial and regulatory/advisory bodies. These included various professionals involved with the YADC PPP project such as policy makers, top and middle management, clinical and administrative staff. Such professionals were selected through a process of purposive sampling. A customer experience questionnaire with the 5th stakeholder (end-users) was also undertaken to determine the overall level of service provided at YADC. This 5th stakeholder group was selected through a process of stratified sampling. Random sampling was then carried out in the five main areas of the centre (reception, three diagnostic departments and the results waiting area). The population of Adan is about 700,000.

According to Saunder, Lewis and Thornhill (2009), researchers often seek 95% level of certainty; thus if a sample is selected 100 times, no less than 95 of such samples would represent a populations’ characteristics. Therefore, for a population size of 1,000,000, to ensure a confidence interval of 95% at least 384 questionnaires are required (Saunder, Lewis and Thornhill (2009). Therefore, to guarantee an adequate response rate a total of 600 questionnaires were distributed by the researcher and his assistant.

6.6.6 Data analysis for the main study

The analysis of the main study was conducted in three stages. The first stage involved analysing the qualitative data primarily through the framework approach taking into consideration the realist evaluation perspective (that aims to produce the CMO of such data). Such an approach requires data to be filtered, charted and organized in line with major themes, and consists primarily of five key stages which include familiarization, identifying a thematic framework, indexing, charting, and mapping and interpretation (as described in sections 5.7.1 and 6.5.5). See Appendix 5.

The second stage was analysing the findings from the customer satisfaction questionnaire using an Excel spreadsheet and SPSS. See section 9.3.

The third stage involved the use of various documents. These were analysed using a template generated by the author, and divided into six elements (type of document, characteristics of document, date of document, author of document, audience of the document and document information – see Appendix 6).
Finally all data (from the semi-structured interviews, customer satisfaction questionnaire and documents) was mapped and re-synthesised to produce mechanisms that help PPP achieve better the health care objectives. A process of pattern matching and explanation building was undertaken to determine the findings. The results that emerged were compiled within the CMOC to show how specific interventions caused what outcome, and in which context (see Table 9.3).

6.7 Ethical considerations

Since the research is conducted outside the UK, the work has reflected on the ethical practices in Kuwait. Approval was sought from the Kuwait MOH for this research. The data gathered through (verbal or written consent) from related organisations. Each participant was given information about the research before the interview and was informed that the interview will be recorded.

The research is carried out in line with the information provided in the thesis for collecting and analysing data in consultation with the university and the supervisors.

6.8 Evaluation of the quality of the research

To ensure the quality of the research, various criteria have been addressed by the researcher, which include construct validity, internal validity, external validity and reliability (such concepts are explained in section 5.6.3). Different tactics were applied for the application of such criteria.

Methodological triangulation was applied in this research to ensure that findings are derived from different sources (semi-structured interviews, questionnaires and document review) thus increasing the validity of the overall study.

According to Riege (2003), during the research phase, a researcher needs to eliminate any subjective judgement to enhance constructive validity. The researcher ensured construct validity of the semi-structured interview questionnaire by reviewing the preliminary review questions to enhance the flow of data, increase the focus of the questions and avoid overlap of information. Full transcriptions and translation of the interview data was also undertaken with the assistance of an expert bilingual translator to ensure data was not modified or lost. Furthermore, with regard to the
construct validity of the data, the researcher attempted to increase this by giving the themes extracted from the raw data to two experienced colleagues to cross-check. Modifications were made accordingly to eliminate subjective judgements.

According to Guba and Lincoln (1982) application of external validity (generisability) is limited in qualitative research (generalisations are impractical as occurrences are not time or context free). However, Patten and Applebourn (2003) suggest that the degree of generalisability of case studies can be established by the strength and quality of the content descriptions. This research has described the various steps and procedures taken in the design including data collection, research sampling and case description, along with their sequence and timeline, which facilitates the transferability of such methods to other settings within the healthcare sector.

With regard to internal validity, Pope et al (2002), suggest that such a form of validity can be achieved through a thorough description of real-life conditions. This was reflected in the research through detailed holistic descriptions of the case that involves various stakeholders and their relationship to the case study. The data of the research was related to the evidence in the literature review.

According to Robson (2002), measuring reliability in qualitative research can be difficult due to issues such as bias or observer error. For this research the author has undertaken various means to ensure a sound level of reliability. These include a detailed description of the method and procedure applied, as well as the sequence of the various stages of the research process. Another valuable step to ensure reliability is the accurate reproducibility of data achieved by tape-recording and professional transcripts and translations. Furthermore, the researcher explained his professional background to the interviewees and acknowledged potential biases. In addition, the preliminary study conducted in this research has added value by allowing the researcher to build a sound level of experience in the research setting and refocus questions for the main study.

6.9 Chapter summary

This chapter provided an overall review of the methodology of the study (Figure 6.6). Realist evaluation is the philosophical approach adopted to examine the
first PPP experience in the Kuwaiti health care system (YADC). To answer the research question, the selected strategy will be a case study with the use of qualitative multiple methods (primarily interviews, with the assistance of some observation, documents and a questionnaire). The interview questionnaire was created to serve the concept of the research and to facilitate relevant data collection and future thematic data analysis. A pilot study was also conducted to examine the quality and significance of the questions. Appropriate changes were then made to the interview questionnaire to adequately undertake the main study.
Chapter 7 - Pilot Study Findings and Analysis

7.1 Introduction

This chapter presents the findings of the pilot study. As previously mentioned, the aim of the pilot study was to ensure that the PPP concept is readily understood, to investigate whether adequate data can be gathered to make a significant contribution to the main area of study and to test the practicality of the concepts identified in the literature review. The pilot study analysis consists of two parts. The first part highlights various themes derived from the interviewees' direct responses. The second part briefly discusses these themes and the relationships between them, in relation to the findings of the literature review.

7.2 Preliminary study analysis - Part 1

This part of the analysis was undertaken in order to illustrate clearly all the different interviewees' responses to the questions posed, and the associated themes extracted. Section 7.3 goes on to summarise and discuss these responses and themes, making appropriate links to the literature review findings.

Table 0.1 - Preliminary data analysis - Part 1
### PPP in Kuwaiti health sector: is it successful?

<table>
<thead>
<tr>
<th>Question Posed</th>
<th>Theme extracted</th>
<th>Interviewee</th>
<th>Response 1</th>
<th>Response 2</th>
<th>Response 3</th>
<th>Response 4</th>
<th>Response 5</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Role</strong></td>
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<td></td>
<td><strong>Reduced costs</strong></td>
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<td></td>
<td><strong>Effective and efficient service delivery</strong></td>
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<tr>
<td></td>
<td><strong>No consideration of population growth, scientific development and modern technology</strong></td>
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<tr>
<td></td>
<td><strong>Confusion regarding non-citizen expenses</strong></td>
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<tr>
<td><strong>2. Financial model of YADC and the advantages and disadvantages of this</strong></td>
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</tbody>
</table>

**Interviewees:**
- **Respondent 1:** Worked as a legal consultant for the MOH (1975-2006) and is a witness of the growth and development of health in Kuwait.
- **Respondent 2:** Head of nuclear medicine in Farwaniya hospital. Nominated by the MOH to be a member of the supervising committee for YADC.
- **Respondent 3:** 50 years experience in the field of medicine and pharmacy and currently a consultant for the chairman of YADC.
- **Respondent 4:** Director of YADC and head of laboratory department at YADC.
- **Respondent 5:** Dean of the School of Business and the School of Allied Health Science in the University of Gujrat.

**Theme Extracted:**
- **Reduced costs:** The advantage of this model is the ease of handling and savings on the state budget. The advantage of this model is that it lowers cost, which is good for the Ministry’s budget.
- **Effective and efficient service delivery:** The advantage of PPP is that services can be performed relatively more affectively and more efficiently.
- **No consideration of population growth, scientific development and modern technology:** The main disadvantage of this model is that it does not account for a lot of issues such as population growth in the covered region, the development of services, and upgrading medical equipment. There are also many unexplained the contract in financial terms.
- **Confusion regarding non-citizen expenses:** The model has led to confusion about who should cover the expenses of non-citizens.

**Advantages:**
- Effective and efficient service delivery
- Reduced costs

**Disadvantages:**
- No consideration of population growth, scientific development and modern technology
- Confusion regarding non-citizen expenses
- Financial model of YADC scientific development does not account for a consideration the possibility of keeping and the advantages and modern lot of issues such as population increase, pace with scientific developments or the use of modem techniques.
- It determines the type of services provided without the possibility of keeping pace with scientific developments or the use of modern techniques. If so it will impose a financial burden on the company and make the project economically unfeasible.
### 3. Organisational structure of YADC and the advantages and disadvantages of this

<table>
<thead>
<tr>
<th>Monitoring mechanisms to identify errors and assess service quality.</th>
<th></th>
<th></th>
<th>The most important feature of this structure is a mechanism for monitoring and supervision to allow the Ministry to assess experience and identify errors.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Decentralisation enhances government supervisory role.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Potential mismanagement</td>
<td>Disadvantages of this structure are that the centre was managed by a technical team not administrative.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hostilities between private and public parties due to loss of power</td>
<td></td>
<td></td>
<td>The disadvantage is that the committees are not characterised by neutrality, and are always dealing with the status type of hostility since the centre has stripped them of many of the privileges and priorities which they had enjoyed in the past.</td>
</tr>
</tbody>
</table>
Several consultants were hired to determine the requirements of the MOH in equipment and manpower (allowing for development of work and efficiency).

No consideration of medical development and equipment. A disadvantage of this selection is that important aspects were neglected such as the possibility of development and improvement of equipment.

Predetermined model results in a failure to account for numerous diagnostic tests. Many diagnostic tests were not taken into consideration by this model.
<table>
<thead>
<tr>
<th>Enhanced customer satisfaction (reduced waiting times for patients)</th>
<th>YADC provides a distinguished service that has gained customer satisfaction. The advantage of this is to reduce the waiting times for services.</th>
<th>YADC has been organised to work better in terms of appointments and waiting periods. It has also added new services to keep pace with the evolution in the medical sector. The difference is concerned with handling services, such that all the services are located in a single building compared with the scattered centres of the MOH.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Efficient appointment system</td>
<td></td>
<td>Services are relatively more effective and efficient with timely disease detection</td>
</tr>
<tr>
<td>Timely disease detection</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No difference in service delivery from that delivered by the MOH</td>
<td>No, the centre tries to make the end-user not feel any difference in the quality of service provided</td>
<td>There was no value added to the service; it provided the same level as the standards of the MOH.</td>
</tr>
<tr>
<td>Efficient budget allocation</td>
<td>You will find that the budget here [YADC] is 25% of the budget there [other centres offering the same service], and I think that this gives an idea of the efficiency of the experience, especially as the level of service at YADC is better, provides time, and has greater productivity.</td>
<td>The project has achieved high efficiency, since the budget allocated for the project annually is a quarter of that of other areas in the health sector with the same components and specifications. The project therefore provides a better service at lower cost.</td>
</tr>
<tr>
<td>Reduced personnel without compromising service quality</td>
<td>Yes, efficiency was achieved and I'll give you an example: YADC centre could decrease the number of working teams without affecting the size or the level or quality of service.</td>
<td></td>
</tr>
<tr>
<td>6. Has the PPP experience enhanced health care system efficiency?</td>
<td>Reduced patient/customer complaints</td>
<td>YADC has taken advantage of earlier errors it has encountered in the improvement and development of services, thus raising efficiency. With the continuation of the contract between the Ministry and company, YADC shows an evolution in service and a high level of quality. The centre managed to reduce personnel without compromising service quality, reduce patient complaints, and reduce fines from the MOH (which were high at the beginning of the contract).</td>
</tr>
<tr>
<td>Reduced fines from MOH</td>
<td>Efficiency will definitely be more. Someone who is spending his or her own money always wants a better return for that money and this model the private sector is making an investment.</td>
<td></td>
</tr>
<tr>
<td>Continuous progress and improvement</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<p>| 7. Has the PPP experience enhanced health care system equity? | Abiding by rules and regulations of MOH (disregard to social status or personal relationships). | This concept was maintained well as a constitutional article that could not be touched. The process of achieving justice and equity is the responsibility of the MOH and not the company; however the company committed itself to maintaining what was in place earlier in this framework. |  |
|  | Yes, because YADC keeps the rules and regulations established by MOH in this regard | I believe that this experience has reinforced the concept of justice. Everyone gets the service to a manner appropriate to their needs and state of health without regard to social status or personal relationships |  |</p>
<table>
<thead>
<tr>
<th>7. Has the PPP experience enhanced health care system equity?</th>
<th>The queuing number system</th>
<th>The system follows the queuing number; there is no preference in patient treatment except in emergency situations. This system has greatly promoted the principle of equity.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-nationals have to pay additional fees for the service.</td>
<td>The centre is dedicated to serve the region’s population; other residents have to pay additional fees for the service.</td>
<td></td>
</tr>
<tr>
<td>A lack of choice in health care across the nation</td>
<td>No, this principle has not been enhanced because the principle does not exist in the health system in Kuwait. The patient has no right to choose the doctor or a convenient appointment.</td>
<td>No, this kind of choice does not exist in Kuwait</td>
</tr>
<tr>
<td>8. Has the PPP experience enhanced health care system choice for patients?</td>
<td>Inability to choose a preferred doctor or appointment.</td>
<td>The concept of choice is not clear in the health sector in Kuwait. I can say that the experience of this partnership has slightly strengthened this concept, giving the patient choice of a convenient date.</td>
</tr>
<tr>
<td>Operation during the evening (where the facility runs as a private facility) allows rapid access to services.</td>
<td></td>
<td>The work of the Centre as a private organisation in the afternoon and evening gives the patient access to services more quickly in the event of his willingness to pay additional fees.</td>
</tr>
<tr>
<td><strong>9. Has the PPP experience enhanced health care system effectiveness?</strong></td>
<td><strong>Continuous improvement of service</strong></td>
<td>Yes YADC has achieved the desired results, despite the obstacles faced in the beginning. The project is constantly evolving and achieves efficiency day after day. This has been achieved through the company's eagerness to maintain the standards, and not a radical change in the quality or services provided.</td>
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<tr>
<td><strong>Reduced costs, with a professional level of service</strong></td>
<td>No doubt. YADC has reduced costs on the Ministry's budget by treating patients in need without unnecessary diagnostic tests. It also reduced the number of personnel, and made better use of information technology while also providing patients with a professional level of service under the supervision and control of the MOH</td>
<td></td>
</tr>
<tr>
<td><strong>Numerous mistakes due to the project being the first of its kind.</strong></td>
<td>No, there have been many mistakes and problems because the experience was new. These kinds of mistakes negatively impact the effectiveness and prevent them achieving the desired results.</td>
<td></td>
</tr>
<tr>
<td>Question</td>
<td>Services Provided Free of Charge (With Exception of the Evening Hours)</td>
<td>Yes, YADC Centre Has Been Committed to Providing Services Free of Charge as Applicable in the MOH, Except in the Evening Working Hours.</td>
</tr>
<tr>
<td>12. Has the PPP experience in health been successful to date?</td>
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<tr>
<td>---------------------------------------------------------------</td>
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<tr>
<td>Irregular monitoring has led to an accumulation of errors</td>
<td></td>
<td></td>
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<tr>
<td>No significant change in quality and service</td>
<td></td>
<td></td>
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<tr>
<td>First of its kind model with numerous unclear issues</td>
<td></td>
<td></td>
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<tr>
<td>It was successful to some extent. Recent experience has created some gaps and errors that are not addressed on a regular basis which led to the accumulation.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No it was not successful, the experience did not add any additional value to the service in the MOH and there was no major change in the quality.</td>
<td></td>
<td></td>
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<tr>
<td>If we take into consideration that this is the first experience in this area, we can consider this experience successful even with the presence of many unclear points in the contract with the Ministry.</td>
<td></td>
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<tr>
<td>The answer is a guarded yes. The reason is you have only one model. There should be more participating with the private sector.</td>
<td></td>
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</tr>
<tr>
<td><strong>Technological factors due to the use of state-of-the-art equipment.</strong></td>
<td>All of the above factors have had a positive impact on the experience and because it was taken into consideration when preparing a contract of partnership, where care has been taken to take advantage of the above factors in the success of the experiment</td>
<td>The impact of technological development will provide a positive return on services for patients.</td>
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</tr>
<tr>
<td><strong>Economic</strong></td>
<td>No effect since the contract has a specific budget.</td>
<td>Positive because the 3 major principles of equity, efficiency and effectiveness are very promising in guarded generality.</td>
</tr>
<tr>
<td><strong>Epidemiological - increased efficiency from the PPP will reduce morbidity</strong></td>
<td></td>
<td>Positive because efficiency introduced by the partnership will reduce morbidity and increase control</td>
</tr>
<tr>
<td><strong>Political - less personal abuse of the services (‘wastah’ - a Kuwaiti term meaning connectedness)</strong></td>
<td></td>
<td>Negative for the government elite because they will lose some governing power, but this results in less abuse of services.</td>
</tr>
<tr>
<td><strong>Political</strong> because it encourages the trend towards privatisation in the state.</td>
<td></td>
<td>Positive political as the general trend is towards privatisation in the state.</td>
</tr>
<tr>
<td>Demographic the</td>
<td>Demographic is</td>
<td>Negative as the centre will</td>
</tr>
<tr>
<td>model does not cope</td>
<td>negative because of</td>
<td>not be able to cope with</td>
</tr>
<tr>
<td>with population growth in the local areas affecting efficiency in the long-term.</td>
<td>the neglect of population growth when signing the contract.</td>
<td>the increase of population in Al-Almedi Governorate [i.e. in the local region]</td>
</tr>
<tr>
<td>Economic – global recession and high prices of medical equipment have not been accounted for in the contract budget</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Epidemiological - increase in spread of disease and immeregence of new diseases will increase the pressure on services</td>
<td></td>
<td>Increased spread of disease and the imergergence of new diseases has increased pressure on the service which has added to the length of the waiting times.</td>
</tr>
<tr>
<td>Environmental - increased pollution in the local area of the centre puts increased pressure and demand on services</td>
<td></td>
<td>Environmental pollution in the area of Umm-Al-Hayman (covered by the centre) has a negative impact on the project causing increased pressure, demand, emergence of new diseases and symptoms of patients.</td>
</tr>
<tr>
<td>Weak management due to recent experience</td>
<td>Weak management due to recent experience</td>
<td>The key weak point in the project is not preparing the main contract, and failing to account for future needs and population increases</td>
</tr>
<tr>
<td>Deficiencies in the main contract due to failure to account for various functional and technical issues</td>
<td>Deficiencies in the main contract; not taking into consideration many functional and technical issues</td>
<td></td>
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14. Factors with a negative effect on the PPP experience in health

15. Key weaknesses of the PPP experience in Kuwaiti health sector
## 16. Key strengths of the PPP experience in Kuwaiti health sector

<table>
<thead>
<tr>
<th>Strengths</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Avoiding government bureaucracy</td>
<td>Staying away from government bureaucracy allows for more options in the performance.</td>
</tr>
<tr>
<td>Increased commitment by the company to meet requirements of MOH</td>
<td>The commitment of the company to meet the requirements and demands of the Ministry.</td>
</tr>
<tr>
<td>Reduced burden on MOH budget</td>
<td>Reduce the burden on the Ministry’s budget.</td>
</tr>
<tr>
<td>High quality service</td>
<td>High quality of service compared with what exists in the local market.</td>
</tr>
<tr>
<td>Use of latest scientific expertise and technology</td>
<td>Ability to develop and employ the latest scientific expertise in updated service.</td>
</tr>
</tbody>
</table>

## 17. Key opportunities of the PPP experience in Kuwaiti

<table>
<thead>
<tr>
<th>Opportunities</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Establishment of a partnership between public and private sectors</td>
<td>Opportunities are good to apply the experiment in other areas if they could avoid weakness points and establish a real partnership between government and the private sector.</td>
</tr>
<tr>
<td>Move towards privatisation by the government</td>
<td>The success of the experience enhances the opportunities to repeat it in other areas and other services.</td>
</tr>
<tr>
<td></td>
<td>The general trend of the government towards privatisation increases these opportunities.</td>
</tr>
<tr>
<td>health sector</td>
<td>Dissemination of experience between hospitals and centres in Kuwait</td>
</tr>
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<tr>
<td></td>
<td>Hostility between public and private sector affecting performance</td>
</tr>
<tr>
<td>18. Key threats of the PPP experience in Kuwaiti health sector.</td>
<td>Absence of debate between public and private parties</td>
</tr>
<tr>
<td></td>
<td>Conflict of opinion between committees overseeing the project</td>
</tr>
<tr>
<td></td>
<td>The remaining manpower in the Ministry and dealing with them, in the presence of the responsibility of the state towards its citizen’s recruitment.</td>
</tr>
</tbody>
</table>
7.3 Preliminary study analysis - Part 2

This part of the analysis was undertaken to analyse the themes extracted from Part 1 and to relate them to the findings of the literature review. It is divided into various sections based on Table 7.1, which include: health system components, intermediate health care system goals, the success level of the centre, socio-economic indicators, and strengths, weaknesses, opportunities and threats (SWOT) analysis of the centre.

7.3.1 Health system components

7.3.1.1 Financial model

The significance of the financial model (Figure 7.1), both as a major lever in the health system as a whole and in the PPP specifically, was emphasised on various occasions by the interviewees. Generally, interviewees explained that the financial model revolves around the implementation of a fixed amount, paid in monthly instalments. Additionally, there is a seizure of 10% of the total value of the contract as a deposit until the end of the contract. This model is highlighted in the diagram below (extracted from Chapter 2 of the literature review).

Figure 0.1 - Health care financial model
On the whole, the private sector respondents noted that the main advantage of the financial model is the reduction of costs on the MOH budget. With regard to the disadvantages, interviewees from both the public and private sectors were in agreement that the model provided no consideration of population growth, scientific development and modern technology despite its long term commitment. Respondent 3 from the private sector also highlighted that “the model has led to confusion about who should cover the expenses of non-citizens”. Such issues indicate that there is a deficiency in the drafting of the initial contract which require examination and perhaps a degree of flexibility needs to be added to accommodate such issues in future.

7.3.1.2 Organisational structure

The overall structure of the model fits within the MOH umbrella. It starts with a contractual agreement between the two parties. The MOH is responsible mainly for providing the finance through government channels and supervising the delivery of the services stated in the contract. The private party is responsible mainly for service delivery. The contract regulates the relationship and sets the specification of activities. The organisational structure fits in the middle of the diagram in Figure 7.2, below.

Figure 0.2 - Convergence between health system models

YADC itself has an organisational structure which consists of a director, assistant director and department heads (Figure 7.3). A committee was formed by the MOH to
monitor, supervise and submit periodic reports on the performance of the working groups (nurses & medical staff).

**Figure 0.3 - Organisational structure of YADC**

![Organisational structure of YADC](image)

Most of the interviewees described the organisational structure, without indicating much information about its advantages and disadvantages. The only advantage mentioned by the interviewees was from respondent 4 (private sector), who noted that "the most important feature of this structure is a mechanism for monitoring and supervision to allow the Ministry to assess experience and identify errors". Regarding the structure's disadvantages, respondent 4 also mentioned the hostilities between private and public parties due to loss of power, stating that "the committees are not characterised by neutrality, and are always dealing with the status type of hostility since the centre has stripped them of many of the privileges and priorities which they had enjoyed in the past". Furthermore, respondent 2 (public sector) noted that there is a potential for mismanagement as a result of the structure being managed by a technical team rather than an administrative one.

**7.3.1.3 Resource allocation**

Respondents clarified that resources (land, human resources, equipment) have been allocated depending on average resource consumption during the last three years and the predicted population increase within the next ten years. Resources for the project were identified initially by the MOH through the presentation of a tender highlighting certain requirements and conditions set by the Ministry. The capital development (land) was provided by the MOH. It should be noted that the price of land in Kuwait is one of the highest in the region. On the other hand, the construction cost of the building was provided by the private party. Respondent 3 (private sector) even noted the advantage that "several consultants were hired to determine the requirements of the MOH in equipment and manpower (allowing for development of work and efficiency)". Respondent 2 however noted
two key disadvantages which include no consideration of medical development and equipment, and a failure to account for numerous diagnostic tests.

7.3.1.4. Service delivery

The centre aims to deliver around 150 different diagnostic tests and procedures under a single roof. In the laboratory department, they offer tests in biochemistry, microbiology, haematology, cytology, histopathology and serology. Digital and computerised tests are also offered in the radiology and imaging department, including general radiography, fluoroscopy, doppler scan, ultrasound, computed tomography scans, bone densitometry, magnetic resonance imaging scan and angiography. Furthermore, YADC also offers a variety of diagnostic nuclear medicine tests such as bone scan, renal scan with GFR evaluation, myocardial perfusion scan, thallium/HMPAO brain scan, thyroid scan, MIBG whole body scan and haematology.

Both public sector respondents 1 and 2 noted that there is no difference in the type of tests and procedures from those delivered by the MOH. However, respondent 4 (private sector) noted that "the difference is mainly concerned with the handling of the service, such that all the services are located in one single building compared with the scattered centres of the MOH". Also, both respondents 3 and 4 (private sector) and respondent 5 (the independent academic) highlighted various key advantages of the centre relative to the services of the MOH, such as improved handling of results, enhanced customer satisfaction (reduced waiting times for patients), an efficient appointment system and timely disease detection.

7.3.2 Evaluation of the health care system objectives at YADC

Efficiency, effectiveness, equity and choice (experience) are some of the key elements evaluated in this study. These objectives are based on the literature review and are explained by Haisio (2003) and Atun and Menapde (2008). Each of these objectives was defined before the interview and each interviewee was made aware of this definition to unify the understanding of such terms.

7.3.2.1 Efficiency (making good, thorough, and/or careful use of resources, without over consuming)

The majority of respondents find YADC to be highly efficient. The private sector respondents both noted that it results in efficient budget allocation; respondent 4 even
indicated that “the project has achieved high efficiency, since the budget allocated for the project annually is a quarter of that of other areas in the health sector with the same components and specifications. The project therefore provides a better service at a lower cost”. Other respondents from the public sector, such as respondent 1, noted that “the centre managed to reduce personnel without compromising service quality, reduce patient complaints and reduce fines from the MOH”.

**7.3.2.2 Equity (society’s requirement for justice and fairness)**

Most respondents agreed that equity exists at the centre, as it is required to operate by the rules and regulations of the MOH (such that patients receive the treatment they require with disregard to social status or personal relationships). Respondent 5 (independent academic) in particular noted the importance of this issue, making reference to the term ‘wastah’ which he defines as “connectedness”. Respondent 5 explained that “wastah has disrupted the system causing inequity, with people in power working in management or in the hospital referring their friends or relatives before others. YADC has eliminated this power significantly”. Similarly, respondent 3 (private sector) even made reference to the queuing number system at the centre, which has promoted the principle of equity, stating that “there is no preference in patient treatment except in emergency situations”. However despite this, respondent 1 (public sector) mentioned the issue that although nationals do not have to pay for the service, non-nationals have to pay additional fees.

**7.3.2.3 Choice (enhancing the health care system choice for patients)**

The majority of respondents (respondent 1 and 2 from the public sector, and respondent 4 from the private sector) noted that there is a general lack of choice in health care across the nation, with an inability to choose a preferred doctor or appointment. However with regard to YADC, respondent 3 (private sector) noted that “operation during the evening (where the facility runs as a private facility) allows rapid access to services”, and thus increased choice.

**7.3.2.4 Effectiveness (capability of producing an intended result)**

Most respondents feel that YADC has achieved the desired result in terms of effectiveness (such as the shift from being a fully run service under a government hospital to a PPP centre, the ability to provide previous services to cover the entire Adan area, and building good connections with Adan Hospital departments). Respondent 1 noted that “the
project is constantly evolving and achieves efficiency day after day. This has been achieved through the company's eagerness to maintain standards, and not a radical change in the quality or services provided”. Similarly, respondent 3 (private sector) mentioned that YADC has reduced costs through implementing certain treatment protocols such as “treating patients in need without unnecessary diagnostic tests. It also reduced the number of personnel, and made better use of information technology while also providing patients with a professional level of service under the supervision and control of the MOH”.

Nonetheless, respondent 2 (public sector) observed that there are obstacles and mistakes faced, such as inadequate specification and lack of detail in the PPP contract in terms of work required and public and private relations.

7.3.3.1 Financial risk protection

The respondents all agreed that the YADC has enhanced the financial risk protection of the health care system because the centre works under the umbrella of the MOH’s regulations – a national service that gives citizens the right to use the service for free regardless of frequency of visits. It was noted by all respondents that the centre provided an increased option for patients who can pay additional fees.

7.3.3.2 Customer satisfaction

On the whole, the respondents all agreed that the centre provided a pleasant and comfortable environment with prompt services. Respondent 4 (private sector) noted that this is as a result of “the building layout, design, and extra services such as open plan and large reception area, coffee shops and TV screens in open areas” and “the punctuality and speed of completion of work required compared to other centres in MOI”. However, respondent 1 (public sector) did indicate that there is a difficulty in measuring customer satisfaction stressing that “this factor cannot be determined and the process of customer satisfaction cannot be measured accurately”.

7.3.3.3 Success level of the centre

Generally, the respondents provided mixed views regarding this question. Both respondents 3 and 4 from the private sector and respondent 5 (independent academic) noted that YADC was only successful to some extent. Respondent 3, for example, explained that is because this project, being the first of its kind, had “many unclear points in the contract with the Ministry”. Furthermore, respondent 4 mentioned that irregular monitoring has led to an accumulation of errors. On the other hand, respondent 2 from the public sector found that
there was no significant change in quality and service stating that "the experience did not add any additional value to the services of the MOH and there was no major change in the quality".

7.3.4 Evaluation of socio-economic indicators

Generally, respondents 3 and 4 (private sector) and respondent 5 (independent academic) felt that there have been negative effects on the centre resulting from demographic factors. They all felt that this is because the model did not account for population growth at the time of contract signing and will thus not be able to accommodate future population growth in the areas serviced by the centre. Respondent 4 stated that "the centre will not be able to cope with the increase of population to Al-Ahmedi Governorate", while respondent 5 added that "a high birth rate is negative for any partnership that has not accounted for population growth". This could have an impact on the efficiency of the project in the long run. Similarly, regarding economic factors, respondent 4 also felt that there had been a negative effect due to global factors, explaining that "the global economic crisis and soaring prices of medical equipment and materials are not in favour of the project, especially since the budget has not accounted for such factors".

7.3.5 Evaluation of the SWOT of YADC

Strengths

All the interviewees noted various strengths of the project. Both respondent 2 (public sector) and 4 (private sector) noted that a key strength was avoiding government bureaucracy, with respondent 2 explaining that "staying away from government bureaucracy allows for more options in performance". Furthermore, respondent 4 noted that "YADC provides a high quality service compared with what exists in the local market and has the ability to develop and employ the latest scientific expertise in updated services". Respondent 1 (public sector) and 4 (private sector) also mentioned that the private sector is passionate and keen to provide the service, with respondent 4 highlighting the "commitment of the company to meet the requirements and demands of the MOH". Furthermore, respondent 3 (private sector) stated that another strength is to "reduce the burden on the Ministry's budget".

Weaknesses

The project faced numerous challenges at the start as it is a new experience, although such challenges can be avoided in future. Respondent 2 (public sector), and respondents 3 and 4 (private sector) all noted that there are deficiencies in the main contract by not accounting
for functional and technical issues such as population growth and advancement in technology and research. Respondent 1 (public sector) highlighted that another issue is the "weak management [of the centre] due to it being a recent experience".

**Opportunities**

All the respondents noted various opportunities associated with the YADC project. Respondent 2 (public sector) and 3 (private sector) noted that such a project allows for the establishment of future partnerships between the government and the private sector. Respondent 3 stated that "the success of the experience enhances the opportunities to repeat it in other areas and for other services". Respondent 4 (private sector) also explained that "the general trend of the government towards privatisation increases these opportunities". Similarly, respondent 4 and respondent 1 (public sector) explained that the YADC project will allow for the dissemination of experience between other hospitals and centres in Kuwait.

**Threats**

Numerous threats were highlighted by the different respondents from both public and private sectors. Respondent 2 (public sector) explained that "negative competition between the government and the private sector creates hostility thus affecting performance". Respondent 4 (private sector) also made reference to the hostility between public and private sectors, highlighting that there is a "clinical literal absence of debate between the parties to the contract". He also noted the "conflict between the scientific views of the various committees overseeing the project". Similarly, respondent 1 (public sector) mentioned the issue of the existing manpower in the MOH and the responsibility of the state regarding their employment. He explained that "the remaining manpower in the Ministry and dealing with them in the presence of the reasonability of the state towards its citizen’s recruitment" is a potential threat.

**7.4 Chapter summary**

Finally it seems that PPP has been introduced into the Kuwaiti health sector with wide recognition. Respondents demonstrated a good understanding of the PPP model, with strong opinions on its implementation. It seems that the model has had a significant impact on the health service levers, which has a direct effect on the health care objectives. The results have shown there has been an overall positive effect of the PPP on the health care system in Kuwait. In addition the study has raised new issues that need to be looked at in the main
study. These include the regulatory framework and contract flexibility in terms of future considerations, the effect on the human resources policy, and the role of communication between public and private partners.
Chapter 8 — Pilot Study Discussion, Conclusion and Proposals for Further Research

8.1 Introduction

The following chapter begins by providing a discussion of the pilot study results and findings, making connections with the concepts, ideas and theories outlined in the literature review. A brief pilot study conclusion is then provided, after which proposals for further research are outlined.

8.2 Pilot study discussion

From the opinions of the five interviewees contacted and the findings of the literature review, several issues have been revealed regarding the role of PPPs in the Kuwaiti health sector. In section 4.8.1 of the literature review, it was discussed that among the strengths of PPP is the element of risk transfer between appropriate parties best able to manage them (Taylor, 2007). Quiggin (2005) also notes that PPPs yield improved VFM by achieving an optimal allocation of risk; thus the same service is provided by the private sector at a lower cost ensuring VFM (Nisar, 2007). Similarly, the World Bank (2007) also notes that PPP benefits include enhancing efficiency and innovation in project execution, improving implementation capacity, reducing public sector risk and organising financial resources by allowing public funds to be used for other purposes.

Many findings of the pilot study from Questions 2, 3, 4 and 5 that deal with the effect of PPP on the health care system levers (financial model, organisational arrangements, resource allocation and service provision) also support such arguments. On the whole, several respondents noted that YADC’s financial model resulted in the reduction of costs on the MOH budget. It was also suggested that the PPP model has led to a reduction of responsibility for work associated with service delivery for the MOH; the MOH’s role has shifted more towards monitoring and evaluating rather than service delivery thus reducing bureaucracy (by reducing the administration burden of many activities). Respondents therefore noted that the new organisational structure of YADC provided mechanisms for monitoring and supervision to allow the MOH to assess experience and identify errors better. Furthermore, regarding resource allocation, although respondents generally indicated that there is no difference in the type of tests and procedures from those delivered by the MOH, it
was suggested that the difference is mainly concerned with efficient handling of the service, and the fact that around 150 different diagnostic tests and procedures are provided under a single roof. It was thus indicated by four of the respondents that this resulted in enhanced customer satisfaction (reduced waiting times for patients), an efficient appointment system and timely disease detection.

Similarly, Taylor (2007) from the literature review argues that PPPs allow for increased expertise and asset operators. The findings of the pilot study from Questions 16 (strengths of YADC) and 17 (opportunities of YADC) also support such arguments. Respondents highlighted for both of these questions that this project (although the first of its kind in Kuwait) will increase the trend towards the involvement of the private sector in government projects and services, which will facilitate the dissemination of information and expertise across such sectors. Another advantage of involving the private sector in the delivery of such projects is that it will introduce competition among private sector partners.

Despite the above noted advantages, several authors from the literature review highlight that PPP arrangements have several disadvantages. For example, the OECD 2001 compares PPP to a ‘black box’ noting that while inputs and outputs in the system are visible, the procedures facilitating the transformation are not. Silva and Rodrigues (2004) make particular reference to ‘unknown parameters’ in the use of fund sources, the distribution of responsibility and accountability in PPP programme implementation, the role of local players and the extent of institutional involvement. Quiggin, (2005) also makes reference to the impact of long-term inflexible PPP contracts on public sector governments in particular. It is suggested that such contracts will cause the public sector to lose any benefits that can arise from the entry of new competitors, and to lose the ability to alter contract terms significantly in response to changing needs and conditions. Any contract variations must be negotiated with the private sector partner and this often entails additional and substantial costs and delays. Likewise, Ahmed and Ali (2006) also argue that research has not extensively considered the end-users’ perspective.

The findings from the pilot study, specifically Questions 2-5 (health care system levers), and Question 15 (YADC weaknesses) were largely in agreement with disadvantages noted in the literature review. Four of the interviewees from both the public and private sectors were in agreement that the model left many issues unclear, in that it provided no consideration of population growth, scientific development, modern technology and equipment despite its long-term commitment. It was also suggested that the model did not deal clearly with the position of non-citizens and their expenses. Such issues indicate that
there is a deficiency in the drafting of the initial contract, which requires examination and perhaps a degree of flexibility needs to be added to accommodate such issues in future.

The literature review also refers to other problems associated with partnership such as unclear goals and resource costs, as well as divergence in management practices and philosophies between public and private partners. McQuaid (2000) indicates that unclear goals are a main trigger for problems and partnership failures, as they can lead to misunderstandings and inadequate coordination among players. Such problems are enhanced especially if certain partners have hidden goals and agendas. Similarly, Stewart, (2003) notes that lack of transparency in numerous PPP arrangements is due to fragmentation and institutional complexity within the public sector. It is also noted that this results in lack of clarity regarding accountability structures (Hood, Fraser and McGarvey, 2006).

Such issues were also mentioned by respondents in the pilot study (Question 15), who highlighted that at YADC there is a lack of debate and communication between public and private parties, as well as a degree of hostility between such parties (due to loss of power and privileges for MOH employees, for example). This suggests that there could be a potential conflict of interest between parties. One respondent also made reference to the problem of mismanagement as a result of the centre being managed by a technical team rather than an administrative one.

In the pilot study, three of the respondents find YADC to be highly efficient in terms of budget allocation, human resources (by reducing the number of personnel required without compromising service quality), and reducing patient complaints. With regard to equity (society’s requirement for justice and fairness), most respondents agreed that equity exists at the centre, as it is required to operate by the rules and regulations of the MOH (such that patients receive the treatment they require with disregard to social status or personal relationships). At YADC a queuing number system is in place, which promotes equity, with patients being treated in turn (except in emergency situations). One respondent even noted that YADC reduced ‘wastah’ resulting in a more equitable and reliable system. However despite this, it was still noted that although nationals do not have to pay for the service, non-nationals have to pay additional fees. Regarding choice (enhancing the health care system choice for patients), it was noted by four of respondents from both public and private sectors that there is a general lack of choice in health care across the nation, with an inability to choose a preferred doctor or appointment. However, as YADC operates during the evening (where the facility runs as a private facility), services can be accessed rapidly, thus increasing choice for those willing to pay. Finally, with regard to effectiveness (capability of producing
an intended result), most respondents feel that YADC has achieved the desired result in terms of effectiveness (such as the shift from being a fully run service under a government hospital to a PPP centre, the ability to provide previous services to cover the entire Adan area, and building good connections with Adan Hospital departments). Nonetheless, one respondent did indicate that the centre faced and is facing obstacles and mistakes such as inadequate specification and lack of detail in the PPP contract in terms of the type and capacity of work required and public and private relations.

8.3 Pilot study conclusion

The respondents all agree that the proposed outcome of the PPP experience is to assist the health care system to achieve its goals better. It seems that PPP has been a good tool for introducing private sector investment and experience in a struggling public health care system in Kuwait. As a tool it has maintained public sector control and its supervisory role on the one hand, and on the other it has implemented private sector practices of efficiency and quality well without breaching the public interests of effectiveness and equity. However, numerous issues and concerns regarding the implementation of the PPP experience have been raised in the pilot study, which require further investigation in the main study.

In the main study, the research will conduct an examination to test the initial theory and find out what circumstances triggered what mechanisms that make PPP in the health care sector in Kuwait work and produce the proposed outcome. In the main study the interview questions will be rephrased to comply with the CMO configuration in an attempt to refine the initial hypothesis and identify patterns and enabling or constraining mechanisms that are triggered by different contexts. For example, the study will examine different issues such as operational concerns (recruitment and human resources, customer service), and policy concerns (misunderstanding of partnerships, contract flexibility, risk sharing).

Therefore, the main study will review and examine the implication of PPP on health care objectives in the Kuwaiti health care system. It will also evaluate what it is about PPP that enables the health care objectives to be achieved better. Finally, recommendations for future PPP implementation in the Kuwaiti health sector will be made.

The study will be in the form of 36 in-depth, semi-structured interviews with policy makers, top and middle management, and clinical and administrative staff. In addition, a questionnaire with end-user patients will be undertaken.
8.4 Chapter summary

Chapter 8 provided a discussion of the pilot study results and findings, making connections with the concepts and theories outlined in the literature review. A brief pilot study conclusion was provided, which highlighted appropriate changes required for the main study.
Chapter 9 – Main Study Findings and Analysis

9.1 Introduction

This chapter presents the findings of the main study. The main study consisted largely of semi-structured interviews with four key stakeholders (public, private, financial and regulatory/advisory bodies). These included various professionals involved with the YADC PPP project such as policy makers, top and middle management, and clinical and administrative staff. A customer experience questionnaire with the fifth stakeholder (end-users) was also undertaken to determine the overall level of service provided at YADC. Furthermore, document review is provided where appropriate to substantiate the findings.

Analysis of the data for this study was carried out through a framework approach. Such an approach requires the data to be filtered, charted and organised in line with major themes. It consists primarily of five key stages which include: 1) familiarisation, 2) identifying a thematic framework, 3) indexing, 4) charting, and 5) mapping and interpretation.

As different methods of data collection were undertaken, this chapter will analyse the data in two sections. The first section, semi-structured interview analysis, is divided into two parts. Part 1 identifies the numerous themes derived from the interview responses (stages 1-4 of the framework approach), while Part 2 discusses such themes and highlights their relative importance. The second section analyses the findings from the customer satisfaction questionnaire qualitatively through description. Both sections will draw correlations with findings from various documents collected for this research. Finally, all data (from both the semi-structured interviews and the customer satisfaction questionnaire) will be mapped and re-synthesised to produce mechanisms that help PPPs achieve the health care objectives better (mapping – stage 5 of the framework approach).
9.2 Qualitative data analysis – Interviews

Figure 9.1 illustrates a summary of the qualitative study, detailing the research method, target segment, survey period and sample size.

9.2.1 Interview analysis – Part 1

Themes have been extracted from the responses to questions posed during the various interviews. See Appendix 5. These themes are summarised and discussed in section 9.2.2, below.
9.2.2 Interview analysis – Part 2

The themes extracted are discussed below for each question posed, with particular emphasis given to their relative importance. To support the thematic finding, radar charts (content data) has been used to illustrate the number of respondents and their related group in each theme. Due to the nature of the qualitative data analysis the focus was on the significance and the interrelation of emerged themes. Exact figures of the source of each theme and its related group are shown in the related chart.

9.2.2.1 PPP objectives in the Kuwaiti health care system

Respondents noted various objectives of PPP in the Kuwaiti health care system as detailed further below. Generally, most respondents (and more prominently from the private sector) agreed that the main objective of PPP in the health care system is to improve the quality of services. Another key objective highlighted is cost optimisation for the government. Furthermore, several respondents mentioned that the private health care provider is more efficient in terms of quick service delivery and optimal allocation of resources, and more effective because of qualified, skilled, diligent employees being recruited. Figure 9.2, below, illustrates the occurrence of such themes in relation to the different stakeholders. These themes are interpreted and analysed further below.
**Improve the quality of health care services**

The PPP model is designed with the objective of improving the quality of health care services provided. This is primarily because the private health care provider is more efficient in terms of quick service delivery and more effective because of qualified, skilled, and diligent employees. A public stakeholder indicated that "the main objective of PPP is to develop the health care sector by raising the competition and improving the quality." Several other respondents explained that the involvement of the private sector also ensures stringent quality measures are in place and that there is an adherence to a customer centred approach. All in all, this results in better quality services compared to government-managed health care facilities.

**Assist government in reducing cost**

Traditionally, government health care facilities have operated with a high budget. Private health care providers, however, optimise use of their available budget through efficient and optimal usage of available resources. According to a private sector stakeholder the objective of PPP is "to increase the efficiency and reduce the cost of health care services provided." He explained that involving the private sector ensures timely service delivery to patients at a much lower cost. Furthermore, another respondent noted that the private sector
employs skilled staff at a fraction of the cost compared to the government sector and manages them to produce best quality results.

**Alleviate MOH's burden**

Provision of health care services requires immense financial, administrative and human resources. Several public and private stakeholders believe that the PPP model lessens the MOH's load of providing, managing and maintaining health care service delivery. A private stakeholder believes the objective of reducing the financial and administrative burden of the Ministry "increases the focus on providing better health care services". Thus with the PPP model, the MOH can benefit by delegating and decentralising some of its burdens to the private health care provider. Several respondents believe that the private sector, with its professional, well-trained staff and state-of-the-art equipment, is better able to manage such services competitively. The government can in turn focus more on supervising, leaving operational aspects of providing health care services to the private entities.

**Create competitive environment/eliminate government's monopoly**

Currently, the health care services market is monopolised by government entities, thus competition in the market is non-existent. Such lack of competition results in patients not necessarily receiving high quality services. With the introduction of the PPP model, the private health care provider is involved in managing and providing such services. Private parties are appointed based on renewable contracts for a set period of time. This creates competition amongst private entities, encouraging them to provide better services at an optimal cost, in order to win consequent contracts.

**Involve the private sector in health care provision**

Some respondents also noted the increasing involvement of the private sector, in partnership with the government, in executing and providing government services as a whole. A public stakeholder mentioned that "there is a global trend towards involvement of the private sector in provision of health care services", explaining that this in turn encourages local Kuwaiti authorities to follow such examples.
9.2.2.2 Objectives of stakeholders in being a part of a PPP project in the health care sector

When asked about their objectives in being part of a PPP project, most private sector respondents indicated that this project allows for the achievement of financial gains and has enhanced their company’s reputation, providing it with a distinct level of knowledge and know-how (especially as this project is the first PPP project in the health sector). Other respondents also indicated that this project allows for the establishment of a reference for future PPP projects in health care and allows for the achievement of a good level of experience. The majority of public sector stakeholders, however, maintained that their objective was to provide better services. Figure 9.3, below, illustrates the occurrence of such themes in relation to the different stakeholders. These themes are interpreted and analysed further below.

Figure 0.3 - Objectives of professionals in being a part of a PPP project in the health care sector
Establish a reference for future projects

Most respondents noted that the experiences gained through implementation and execution of this current project will be used as a base for future projects. A public stakeholder explained "the objective is to establish a successful experience of partnership in the health care field, which could be a used as a reference when there is a need to apply the PPP model in other fields." Thus the current project will help stakeholders in terms of lessons learnt and mistakes encountered.

Making financial profits

The majority of the private stakeholders have the objective of achieving financial profits for their company. A private stakeholder also mentioned their objective is to "build up a reputation in order to achieve superiority over competitors." Thus the private health care provider is more likely to utilise resources intelligently and optimally, and deliver quality services in order to gain more profits and set a competitive edge for future projects.

Enhance private company's reputation

Another objective for private stakeholders is to enhance the reputation of their organisation; a private stakeholder specifically emphasised that the objective is to "support the company's reputation in the health services sector". Being a part of the PPP gives the private health care provider more recognition and positive public opinion (due to better delivered services). The private health care provider is thus able to create a positive perception of the services they provide.

Provide better services

The majority of respondents believe that the key objective in implementing the PPP model is to provide better and higher quality health care services to patients by having more skilful and diligent staff, quick service delivery and shorter waiting times for patients. A public stakeholder emphasised that the objective is to "provide high-quality health care services that give priority to the patients."

Exchange of experiences and transfer of knowledge

The private service providers generally have extensive experience in providing professionalism in service delivery. As a private stakeholder mentioned, a private entity is part of the PPP to "provide the advantages of the private sector to the government hospitals."
They also have connections and collaborations with reputed international organisations which are experts in providing specialised health care services. Furthermore, a private stakeholder specifically mentioned that they are part of the PPP to “introduce new technologies through international agencies represented.” Thus with the help of the PPP model, government health care facilities are able to tap into these opportunities and introduce the latest technologies for their patients.

In addition to this, another key objective highlighted by several respondents is that the PPP model provides training to government employees. Private sector employees are relatively very competitive and highly skilled, demanding higher standards of work ethics and dedication. With the private and public sectors collaborating in a PPP project, public sector employees get trained on key aspects of providing and maintaining high quality services to their customers. Furthermore, Documents 3, 5 and 9 provide additional evidence to support this theme. Document 3 is correspondence between the Head of Medical Laboratory Department in the MOH to YIACO, officially acknowledging YIACO (the private sector partner in YADC) as a suitable training fieldwork centre for lab service students. It indicates that YIACO provides training to lab students, as well as evaluation and results for training different categories of students. Document 9 is also an officially stamped letter, from the General Manager of Forensic Medicine in the Ministry of Interior to the management of YADC, requiring the provision of training by YIACO to the Ministry of Interior Department of Criminal Evidence staff. This thus suggests that the private sector is also providing training services to other government bodies.

**Eliminate government bureaucracy**

The current health care services provided by the government are mired in bureaucracy. Many respondents thus believe that the PPP model can eliminate such government bureaucracy, enabling private entities to deliver the desired health care services expeditiously, at a lower cost, with better management and with increased patient satisfaction.

9.2.2.3 Efficiency (making good, thorough and/or careful use of resources without over consuming)
All stakeholders unanimously agree that the involvement of the private sector in the delivery of health care services has enhanced efficiency of the health care sector in Kuwait. Efficiency is increased mainly due to optimum usage of available resources and its management. This efficiency enhancement is believed to be a direct result of the introduction of private sector tools (corporate culture). Figure 9.4, below, illustrates the occurrence of such themes in relation to the different stakeholders. These themes are interpreted and analysed further below.

Figure 9.4 - Efficiency (making good, thorough and/or careful use of resources without over consuming)

PPP optimises the usage of resources (minimises wastage of resources)

The private entity in the PPP model has been able to optimise usage of its available resources (manpower, equipment), thus requiring fewer resources to perform a set task. A financial stakeholder mentioned that “the private company allocates resources based on the centre’s needs without any waste or excessive usage.” In terms of human resources, a private stakeholder specifically noted “efficiency has been enhanced as we provide services with less
Thus skilled staff are employed who are able to deliver quality services in a shorter time.

Furthermore, in terms of equipment, several respondents mentioned that although government health care facilities have been deploying much advanced equipment, often this has not been utilised to its full potential due to lack of qualified, professional and skilled staff. In the PPP model, however, the private health care provider ensures that they have highly skilled professionals able to operate equipment at its full capacity and maximise its usage. A private stakeholder supported this, explaining that “PPP introduced modern technologies and used innovative mechanisms which ultimately led to enhanced efficiency.”

It is thus clear that, due to the aim of generating profits through minimal use of resources, private health care providers have become extremely efficient in managing resources within stipulated limits. In contrast to government facilities, where resources (medicines etc) are often wasted due to improper accountability structures and usage, the private health care provider has efficient accountability structures to ensure minimum wastage of resources. Supporting this view, a public stakeholder said that “the private sector optimises resources and reduces the wastage without affecting the quality of service.” This is essential for the private sector as it allows for an increase in profits (compared to government health care providers which are generally not concerned about generating profits).

Furthermore, Document 8, a study by the paediatric consultant in Adan Hospital presented to the management and clinical staff, supports this theme. This study provides an example of how YADC has achieved efficiency. The study shows a decrease in paediatric emergency admissions within the last four years due to the introduction of YADC and its efficiency in using more urgent imaging studies, including ultra sound and CT scans, as well as improved coordination with the emergency department, thus enabling physicians and clinical staff to take prompt clinical decisions.

Adaptation of latest technology and continuous training

Use of the latest technology by private health care providers is a key factor in delivering efficient services to patients. A private stakeholder emphasised that “the partnership has introduced modern technologies and used innovative mechanisms which led ultimately to enhanced efficiency.” Such technology helps the work team perform tests and deliver accurate results in less time.

It was also mentioned by numerous respondents that to maintain high standards of service delivery, the private health care providers continuously train their employees. A
A private stakeholder explained that “the ongoing training provided to the work team and good organisation and technical follow-up have increased the efficiency.” Such regular training helps employees become aware of the latest technological advancements and ultimately provide better services to patients.

Documents 3 and 9, that deal with the training offered by YADC (mentioned above), also support this theme.

There is sufficient and good utilisation of time (streamlined operations)

Due to the population growth and increasing demand for specialised health care services, it has become essential to screen patients, conduct tests and deliver results in a swift manner. Some respondents explained that patients requiring specialised tests in government health care facilities generally encounter long waiting lists, whereas the PPP model has largely reduced such waiting periods. A private sector stakeholder indicated that “the centre has shortened the required time to deliver results and minimised waiting lists.” Numerous respondents explained that the private health care providers are efficient in delivering faster services with the help of organised and well-defined processes, skilled professionals, latest technologies and a solid commitment to work ethics.

Furthermore, according to some respondents, the private health care providers have benchmarked processes in place. This helps organise operations and deliver quality services and results to patients. One private stakeholder noted “appointments have especially become more organised.”

Increased accountability

In the PPP model, there is a supervisory body that ensures the private health care provider is adhering to the contractual obligations and delivering desired services and results. According to a private stakeholder, “the work team has become more accountable and more efficient.” Thus professionals are held accountable for their work and consequent results. In the case of sub-standard service delivery, the supervisory body has the right to question the private party and request explanations. A public stakeholder explains “this is measured through periodic supervision by the MOH,” which in turn increases the accountability factor of running a health care facility.
9.2.2.4 Equity (society’s requirement for justice and fairness)

Most respondents agreed that equity exists at the centre. It was noted by most that the PPP project has succeeded in treating patients at the same level regardless of social or personal considerations. It was even emphasised by most that examination appointments are based on medical considerations only. It was also mentioned by a few respondents that PPP has not enhanced equity but has simply maintained this objective, which already exists, to a large extent, in the current MOH system. However, several respondents did mention that there is a degree of ‘wastah’ (connectedness) in which some patients are given priority over others due to a certain social network. Figure 9.5, below, illustrates the occurrence of such themes in relation to the different stakeholders. These themes are interpreted and analysed further below.

Figure 0.5 - Equity (society’s requirement for justice and fairness)

Patients treated at the same level (elimination of ‘wastah’, prejudice or preference)

Several respondents explained that traditionally, there have been instances in government-managed health care facilities in which there has been unequal delivery of services and dissatisfied customers on the receiving end. However under the PPP model, a large majority noted that all patients are treated equally and fairly, in terms of waiting time, treatment and result delivery. Consequently, no one patient feels ignored or neglected.
According to a public stakeholder “equity has been strengthened and patients are treated at the same level without any social or personal considerations.” All patients have to go through the process of obtaining necessary appointments, after which they are diagnosed, have tests performed on them and receive results. Furthermore, a private stakeholder explained that “the system the centre has created does not allow any personal or social factors to take a place; in the process patients are serviced at the same level and there is no preference.”

The priority is based on medical situation (condition)

Prior to private sector involvement, appointments were not well organised, with many patients being unfairly disadvantaged. Patients not requiring urgent medical attention had to wait a long time for appointments. A private stakeholder mentioned that in this project, “equity has been enhanced and patients are served according to medical priority only.” Thus the appointments are given based on a patient’s medical condition and priority is given only to patients requiring immediate medical attention.

Better organisation and adaptation of regulation (traceability system) improves client satisfaction

Numerous respondents mentioned that in a system where there is no proper structure for appointments, patients demand to be preferred over others, leaving a great scope for ‘wastah’ (favouritism and connectedness). However, with the introduction of more sophisticated systems in which appointments are generated based on the inputs to the system (leaving no options for alteration), ‘wastah’ is eliminated.

Overall, the PPP model is able to enhance equity amongst its patients due to well-organised processes, which were implemented as a traceability system. One respondent explained that introducing the traceability system “makes the staff more committed to applying the concept of equity”. This system ensures that appointments are generated based on pre-defined criteria and no special preference is given to any patient based on social status or personal relationships. Such systems are paramount in maintaining equal treatment to all patients.

Furthermore, Document 6, a quality control worksheet (YADC in-house document drafted by the Quality Assurance Officer in YAICO to the management and staff of the centre) supports the above theme. This document shows that the system at YADC identifies through a template (define, measure, analyse, improve and control) various phases associated
with potential problems encountered by the centre such as patient complaints. It identifies the exact nature of any problem encountered within the centre’s field of work; defines its boundaries; measures its impact on the centre’s work; analyses the problem by breaking down and determining the relationship of the issues identified; improves the problem by identifying solutions and problem solving mechanisms; and controls the problem to ensure that the problem is under supervision to prevent reoccurrence. This document indicates that the centre is implementing good procedures to control issues and problems raised. This template is assigned for a team that includes the Quality Assurance Officer, Senior Tech Histopathology, Head of Unit Histopathology and the Director of YADC.

PPP experience has maintained the equity

A few respondents also mentioned that the PPP experience simply maintained equity in the health care system; they believe equity exists to a large extent under the current system as the MOH, as a national system, guarantees health care for all.
9.2.2.5 Choice (enhancing the health care system choice for patients)

The majority of respondents believe that the concept of choice for patients has increased with the implementation of the PPP project. Several noted that the PPP experience has given patients more importance, putting them at the centre of the process. Some respondents said that this has manifested itself in the flexibility of appointments (allowing patients to change or select appointments more easily). Also numerous respondents noted that the centre has strengthened the link between end-user and management (through an efficient feedback and complaint system – Action Request – to deal with various situations). Figure 9.6, below, illustrates the occurrence of such themes in relation to the different stakeholders. These themes are interpreted and analysed further below.

**Figure 0.6 - Choice (enhancing the health care system choice for patients)**

![Diagram showing themes related to choice and patient focus]

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**The patient was put at the centre of interest**

A large number of respondents noted that the PPP model gives priority to the patients. Processes and operations are designed to keep patients at the forefront of care, with their requirements and needs considered. A financing stakeholder concurred by mentioning that "the patient becomes at the centre of attention in any procedure."

Furthermore, several respondents noted that, unlike government-managed health care facilities where patient feedback or opinions are not consulted, the private health care
provider has implemented a system that encourages patients to provide suggestions or note complaints. A private sector respondent explained that "patients are able to lodge a complaint or provide a suggestion; we have introduced a complaint system (Action Request) to deal with all such situations."

**Increased flexibility of appointments**

Traditionally, government health care facilities operate for limited hours resulting in fewer patients being treated. A number of respondents, however, noted that the private health care provider operates in two shifts: in the mornings they operate as part of the PPP and in the evenings they operate as an autonomous private entity. This gives patients willing to pay an additional cost the option to avoid the morning rush and receive faster services. A public stakeholder also mentioned "patients have become more important and are given the right to suggest, complain or change their appointments easily."

**Easy client to management access**

Several respondents highlighted that the private health care provider has processes in place to allow professionals and support staff to communicate better with patients. Improved communication in turn reduces incidences of patient grievances and attends promptly to patients' suggestions and problems. A private stakeholder explained that "communication with patients has become better than before and patients themselves feel more comfortable in contacting physicians and technicians." Patients are thus able to express their opinions and requirements with minimum effort and discomfort.

Furthermore, a number of respondents made note of the availability of customer satisfaction surveys, explaining that these are carried out to gauge patient feedback and identify any complaints and/or improvement areas. A private stakeholder explained that "we try to listen to patients and get their feedback and measure their satisfaction regularly."

**The concept of choice is not available or was not affected**

On the other hand, a third of respondents (both public and private sector) did not provide a direct response as to whether PPP has increased the level of choice for patients. Such respondents, however, stressed that the concept of choice is not available in the current health care system as a whole.

**Giving the option to choose public or private**
Two of the respondents indicated that the concept of choice has increased with the implementation of the PPP model, especially as the centre provides the customer with the option to choose public or private care. One respondent explained that "patients could choose to get the service in the evening shift when the centre is working as a private facility if they need to get faster results".

9.2.2.6 Effectiveness (capability of producing an intended result)

It seems there is a consensus amongst several stakeholders that YADC has successfully managed a smooth transfer of two of its departments, radiology and the diagnostic laboratory, and has opened up a new nuclear diagnostic unit and seamlessly integrated them to function as a single diagnostic centre.

A large majority agreed that the centre has enhanced effectiveness noting that it is using international quality control systems to assure the accuracy of results and processes. A number even noted that the centre has been keen to be accredited with ISO. It was also indicated that the centre is able to meet increasing demands on services by increasing working hours and operating equipment at the maximum capacity. Overall, it is clear that the private health care provider brings with it high service delivery standards, optimum usage of available equipment and resources, and increased customer satisfaction. Figure 9.7, below, illustrates the occurrence of such themes in relation to the different stakeholders. These themes are interpreted and analysed further below.

Figure 9.7 - Effectiveness (capability of producing an intended result)
Application of international standards and professional affiliation

The MOH in Kuwait has set certain quality standards that need to be met by the private health care provider in the PPP partnership model. Meeting such quality standards enables the private health care provider to operate effectively and meets patients' needs. A private stakeholder commented that "the good regulation of daily work and following local and global standards have all enhanced the effectiveness."

In addition to meeting the stipulated local standards of the MOH, the private health care services provider has obtained accreditation from internationally renowned quality standard organisations. A public stakeholder cited that "the centre has ISO accreditation and is committed to following international standards." Such accreditation ensures the private health care provider maintains its quality standards.

This theme is further supported by Document 4, an award from the College of American Pathologists, acknowledging YADC for participation in surveys and anatomic pathology education programmes. It is thus clear that YADC has been scientifically active and up to date with international professional standards.

Accurate and speedy delivery of results

One of the key aspects in measuring the effectiveness of any operation is its ability to deliver professional and timely services. A financing stakeholder specifically mentioned "the centre delivers accurate results to the clients." The private health care services provider, with the help of latest technology, highly skilled professionals, better processes and well-organised operations, is able to deliver timely and accurate results of the tests conducted on patients. The increased satisfaction of patients is a testimony to this.

Customer satisfaction on the provided service

Several respondents noted that an increase in customer satisfaction is a testimony to the enhanced effectiveness of the PPP model. There are options available to the patients to lodge their complaints against any discomfort or issues faced at the facility, or provide any suggestions that can improve the services. A private stakeholder explained that "customers' satisfaction with the services provided has been recorded periodically by surveys." The private health care provider can thus act immediately to address patients' complaints or
suggestions. Active participation of patients has made the overall process more effective. A private stakeholder stressed "the centre is responding well to any complaint or suggestion that could lead to improvement in the level of services being provided."

**Meeting the increasing demands on services**

Effectiveness of the PPP model can be gauged by its ability to treat all patients well despite an increase in population and growing demand for specialised health care services. A public stakeholder said that "the private company centre has managed to meet patients' needs and growing demand for health care services in the region." Generally, although an increase in number of patients to be treated may cause services to falter, this PPP facility has been able to maintain its standards.

Furthermore, in government hospital facilities there are only limited hours for patients to have tests carried out or receive results. The PPP model however operates for long hours; as well as regular morning shifts, it operates as a private stand-alone entity in the evening. This enables access for patients who require urgent tests and faster results. A private stakeholder mentioned that "the centre is keen to enhance effectiveness as much as possible and deal with work requirements wisely to meet the client needs by increasing the working hours."

In addition to this, it was also mentioned that proper and optimum use of equipment by skilled staff at the PPP centre has led to faster and more accurate delivery of results and tests.

**Reducing the penalties applied by the government**

Several respondents mentioned the issue that government facilities are under immense pressure to see a large number of patients due to limited services offered and relatively unorganised operational processes in place. A public stakeholder thus explained that "the centre helps reduce the burden on the hospital." The partnership with the private sector enabled the government to lessen some of the burden on its facilities and assign some of its operations to the private health care provider (which is able to provide faster services to patients).

Furthermore, to minimise errors, the MOH has implemented a system that imposes penalties on the private health care provider in the event of any mistakes on the part of the private entity. A few respondents mentioned that the private health care provider has shown a
reduction in penalties imposed over the period of time, proving their effectiveness at operating the centre. A private stakeholder, among others, specifically explained that "effectiveness has been enhanced as demonstrated by the reduced number of penalties applied by the Ministry on the centre."

**The effectiveness has not been enhanced**

Three key government representatives (Head of the Financial Department in Ahamidi Health District, Head of the Lab Department in Al Adan Hospital and an MOH family medicine doctor) noted that effectiveness has not been enhanced as the capability of producing the intended result existed in the current system (governed by rules and regulations and current standards of the MOH) to which the PPP did not add extra value. The Head of the Lab Department specifically noted, "the PPP experience has not added anything to this objective, as errors or faults still exist".

**9.2.2.7 Effect of the financial model on the health care objectives**

Overall the respondents noted that the existing financial model has numerous flaws. Most of the stakeholders are of the opinion that the financial model is fraught with serious issues as it does not account for changing conditions. The majority of respondents noted that there is no flexibility in the allocated budget to meet changing demands due to rising population, workload, prices and need of equipment. Furthermore, numerous physicians indicated that the financial model is lacking in terms of financial incentives and bonuses to the staff. It was mentioned that the private company does not have the authority to allocate additional incentives to staff. Taking into account its regulatory process, it should include encouragement of employees throughout the organisation. All in all, most respondents recommended that the financial model requires attention and should be reviewed and amended for future contracts and projects. Figure 9.8, below, illustrates the occurrence of such themes in relation to the different stakeholders. These themes are interpreted and analysed further below.
No flexibility in the allocated budget to meet changing demands

In the existing PPP model, a fixed budget is allocated to the private health care provider for a 10-year period (set when the contract was signed). This budgeted amount is paid to the private entity in monthly instalments. Several respondents view this fixed budget as limiting to the private sector provider, which is likely to face changing demands and business environments over the contract period. A private stakeholder stressed, "The financial model of the centre is a fixed budget allocated even before the centre had opened. I believe this model does not support the health care services objective." This is especially a concern as the health care sector is continuously changing due to external factors such as demographic changes, customer demands and technological advancements.

The financial model has several faults and defects

Due to various financial constraints imposed on the current financial model — in the form of having a fixed budget for 10 years, no scope for review or increasing the budget based on higher demand as a result of the growing population, limited options for updating the facility with new equipment — the overall effect on the PPP model has been generally perceived as negative. Most of the stakeholders of the current PPP project believe that there is
a need for incorporating certain amendments into the way the financial model has been designed and executed. Such issues are elaborated further below.

It was recommended by several respondents that during the formation of the contract, an option should be set for annual review of the allocated financial budget. After the review, the financial budget should be modified/amended accordingly, to take into account the changes occurring due especially to increasing populations and requirements for new, advanced technologies and equipment.

The demographic structure of Kuwait is a particular concern as there has been substantial population growth since the beginning of the existing PPP contract, resulting in increasing demand for health care services. A private stakeholder noted that the financial model has a negative effect, stressing that “the budget was determined based on statistics existing when the contract was signed”, highlighting that “many facts have changed since then such as population, medical tests and prices”.

Similarly, with the constant detection of new ailments and diseases, the medical science industry constantly discovers new methods of treatment as well as more accurate and effective devices and equipment. With the limited budget availability, the private health care provider is incapable of adding new services, which require additional capital and budget. A public stakeholder also indicated that “the current financial model does not allow for the addition of new services and tests.”

**More incentives are required**

The financial constraints (due to the fixed budget) have created a situation whereby to reduce costs the private health care provider is obliged to offer lower salaries to their employees. A private sector respondent explained that “the limitation of budget leads the company to pay lower salaries for the staff than the MOH”. Thus employees in the government health care sector tend to receive larger salary packages than in the private sector. In the long run this could result in an inability to recruit and maintain qualified staff and hence degradation of the service delivery standards.

**Financial incentives have a positive effect**

On the other hand, a few respondents noted that the financial model does have a slight positive effect on the health objectives. A respondent from the government sector indicated that “the incentives for employees are acceptable so the work team is mostly satisfied and working better.” Similarly, a private sector business consultant mentioned that “the financial
model is good because it is fixed, feasible, reasonable and effective. It gives the Ministry less liability and ensures that the work team will deal carefully with resources’.

**Capitation is good for efficiency**

Several respondents noted that a fixed budget is particularly beneficial for the financier (MOH) as it ensures regulation of strict policy and clinical protocol for providing services to patients that truly require treatment. It thus limits wastage and abuse of the service. A business consultant from the private sector explained this, noting that “the financial model is good because it is fixed, feasible, reasonable and effective; it gives the Ministry less liability and ensures that the work team will deal carefully with resources”.

Document 10, a report published by the MOH, provides further evidence to support this. This report shows the financial operating costs of the diagnostic services of different health governances and their hospitals. It provides a comparison in the operating costs of different types of radiology services at Adan diagnostic centre with other similar diagnostic services in Kuwait and highlights the efficiency of YADC’s systems.

**Figure 0.9 - A comparison between Kuwaiti health districts: radio and lab services**

<table>
<thead>
<tr>
<th>Health District</th>
<th>Population 2008</th>
<th>Average Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Al Sabah</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Capital</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jahra</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hawalli</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Farwania</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ahmadi &amp; Mubarak Al Kabeer</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: Data collected by the author from the MOH whilst undertaking the research

Financial evidence taken from the MOH’s finance and statistical department shows a comparison between Kuwait’s six main hospitals comparing the population and the cost of
diagnostic services in each hospital. These figures were recorded three years after the launch of the case study. It shows that YADC has significantly and substantially reduced the cost of diagnostics as compared to the cost in other areas.

Figure 0.10 - Cost comparison between Kuwaiti health districts: radio and lab services

Cost comparisons between Kuwait health districts: radio & lab services

<table>
<thead>
<tr>
<th>District</th>
<th>Average Cost (KD/person)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Al Sabah</td>
<td>5</td>
</tr>
<tr>
<td>Capital</td>
<td>30</td>
</tr>
<tr>
<td>Jahra</td>
<td>25</td>
</tr>
<tr>
<td>Hawalli</td>
<td>20</td>
</tr>
<tr>
<td>Farwania</td>
<td>15</td>
</tr>
<tr>
<td>Ahmadi &amp; Mubarak Al Kabeer</td>
<td>10</td>
</tr>
</tbody>
</table>

Source: Data collected by the author from the MOH whilst undertaking the research

Figure 9.10, above, illustrates that with regard to the average cost spend per person, YADC (Ahmadi & Mubarak Al Kabeer) has the lowest diagnostic cost, considering that this is the only PPP-operated diagnostic centre in Kuwait.
Table 0.1 - A comparison between YADC and other government hospitals concerning radiology services (2010)

<table>
<thead>
<tr>
<th>Category</th>
<th>YAIICO-Adan</th>
<th>Mubarak</th>
<th>Farwaniya</th>
</tr>
</thead>
<tbody>
<tr>
<td>CT cases</td>
<td>23,349</td>
<td>11,623</td>
<td>7,171</td>
</tr>
<tr>
<td>MRI cases</td>
<td>3,959</td>
<td>6,113</td>
<td>5,146</td>
</tr>
<tr>
<td>X-Ray cases</td>
<td>311,958</td>
<td>263,129</td>
<td>242,344</td>
</tr>
<tr>
<td>U/S cases</td>
<td>18,915</td>
<td>14,623</td>
<td>19,436</td>
</tr>
<tr>
<td>Total cost</td>
<td>956,964</td>
<td>3,391,757</td>
<td>4,352,866</td>
</tr>
</tbody>
</table>

Table 9.1, above, provides data that has been collected by the author to provide a comparison between Adan, Mubarak and Farwaniya hospitals in 2010. These hospitals were chosen due to close similarities in population size. The data suggests that despite the similarity of input resources i.e. diagnostic equipment in the radiology department, YADC has produced a much higher output. This demonstrates the higher efficiency of the PPP model.

The financial model has no effect

Finally the Strategy Implementation Officer of YADC believes that the financial model has no effect, noting that “there was no significant impact on the health objectives, as the company has isolated the financial issues from medical issues that could affect patients”.

9.2.2.8 Effect of the organisational structure on the health care objectives

There are two types of organisational structure: internal and external. The internal organisation structure is within the health care services facility, which consists of the
facility's director, top management, department heads and other staff. The external organisational structure consists of the supervisory committee and the link between government and the private health care provider. Although there is wide acceptance within the public sector about the concept and performance of YADC, there still appears to be a lack of motive and willingness within the external structure to support a real partnership for the model. Figure 9.11, below, illustrates the occurrence of such themes in relation to the different stakeholders. These themes are interpreted and analysed further below.

**Figure 9.11 - Effect of the organisational structure on the health care objectives**

![Diagram](image)

*The internal structure is good, cooperative and open*

Numerous respondents (primarily physicians) highlighted the robustness of the internal structure (between management and staff) noting that it is well-defined, with effective and direct communication between staff and management. Respondent 4 (Quality Assurance Officer) highlighted that "periodic meetings are held at several levels to discuss the daily performance and the way to enhance it" and respondent 34 (consultant HOD laboratory) stated that "the relationship between management and the staff is good and the working policies are supportive". Several respondents added that such a structure allows each member to be fully aware of roles, relationships and responsibilities, and thus contributes to increased staff satisfaction. A private stakeholder explained this by mentioning "the internal organisational structure of the centre is excellent and straightforward, which makes members fully aware of their duties and rights." Such a clear structure with direct access for
communication assists in the quick identification of problems and immediate consideration of improvement opportunities.

**Good communication and follow up**

Several private sector stakeholders also specifically mentioned that the PPP has enhanced communication and logging systems. Respondent 30, the Secretary of Radiology, mentioned that "modern techniques have been enforced, such as internal mail systems" which facilitate communication. Similarly, respondent 33, the senior technician of histopathology, among others, mentioned the accessibility between staff and management, noting that "staff have direct access to management in case of complaints or suggestions".

**There is a lack of cooperation between public and private partners**

The stakeholders believe that the external structure (link between government and the private health care provider) is not properly defined. Numerous respondents from both public and private sectors noted that there is a lack of cooperation as well as a conflict of interest between public and private partners. Respondent 22, administrative and financial affairs supervisor, Alahmadi district, stated that "the mechanism of cooperation between the MOH and the company is not clear". Respondent 19, strategy implementation officer, YAICO, clarified that "the organisational structure is very complicated and does not help in achieving goals because of the different priorities among the various levels." Another respondent even mentioned that there is no collaboration with the supervisory committee, whose role is to ensure effective execution of the PPP project, stressing that "there is no cooperation between the centre and the supervisory committee".

Furthermore, several respondents noted that the organisational structure with many committees could hinder the performance of the centre. It was explained that the existence of many committees for different purposes of controlling the private health care provider could lead to bureaucracy, as this might result in prejudice and bias against the private health care provider. Members from different committees might have different and conflicting agendas, which could hinder the overall performance of the PPP project.

**Set up a neutral/independent committee**

While a number of respondents believe that appointing a supervisory committee has positive effects on health objectives, the business and financial consultant for the private...
sector added that the structure of the supervisory committee needs to be "neutral and independent". Several stakeholders — particularly private stakeholders — consider the supervisory committee to be unfair in its treatment, claiming that it enforces unnecessary pressure and unreasonable penalties on the private health care provider. Currently, the government has formed the supervisory committee giving it full responsibility for monitoring performance of the private health care provider. Numerous private sector respondents have indicated that the committee as a whole lacks independence and can often be biased. A public stakeholder also noted that the government-appointed supervisory committee could "negatively impact the private party, especially if the committee tries to give a bad impression of the centre."

Thus several respondents have recommended setting up a committee that consists of neutral and independent members from different areas. The selection of appropriate members for this committee, although maybe challenging, is essential. Such independent members (not biased against the private party) can therefore effectively judge, monitor, and suggest recommendations. A public sector respondent also explained that "a neutral committee to be set up by the Ministry to discuss the grievances or complaints and to adjudicate any dispute between the parties" is essential.

The importance of supervising and monitoring the performance

Most of the stakeholders, both public and private, agree that a competent monitoring and regulatory body is required to control the operations of the private health care provider and ensure that it operates as per the contractual obligations and regulations. However, several respondents maintained that the supervisory committee should not negatively prevent the private entity executing day-to-day operations smoothly and efficiently. The supervisory committee should work and cooperate with (not against) the private health care services provider.
9.2.2.9 Effect of the allocated resources on the health care objectives

Various stakeholders highlighted that YADC has addressed the need for, and showed awareness towards, the importance of proper resource allocation processes. A large number of respondents believe that the private health care provider is efficient at using available resources optimally (both human resources and technical equipment). Most private sector respondents noted that the resource allocation, however, was largely affected by the financial model. Several respondents shared the concern that financial resources are both improperly allocated and insufficient (for the health care facility to keep up with rising demands for new, advanced equipment). Figure 9.12, below, illustrates the occurrence of such themes in relation to the different stakeholders. These themes are interpreted and analysed further below.

Figure 0.12 - Effect of resource allocation on the health care objectives

Resource allocation is fair and acceptable

Resources have increased to meet growing demand (without increase in the budget)

Require a transparent and clear guideline for resource allocation to meet growing demand

Terms of the contract regulate all the aspects of resource allocation

Resource allocation affected by the financial model

Human resource allocation is based on local terms and conditions

Public

Private

Financing

Supervisory

Resource allocation is fair and acceptable

Despite financial constraints on resource allocation (mentioned above), a large number of respondents believe that the private health care provider has implemented effective means to guarantee that all essential resources – equipment and infrastructural resources – are of the highest quality and used optimally, and to ensure effective service delivery procedures. A public sector respondent indicated this, explaining that “the centre is keen to provide various resources within the available budget set by the Ministry”, while a private sector
respondent similarly mentioned that "the company does their best to provide the most advanced resources within their financial capability." In addition to this, another private stakeholder explained that "a preventive maintenance programme" is in place to ensure equipment and facilities are "working at the maximum capacity." This has in turn enhanced overall efficiency of the health care facility, allowing it to cater for more patients, as well as reducing waiting periods and result delivery time. Furthermore, as the private party ensures continuous training of its employees, professionals become well equipped to operate technically advanced equipment at the maximum capacity.

Resource allocation affected by the financial model

Several respondents highlighted the negative effect of improper and inflexible financial resource allocation, noting that this impacts the facility's ability to operate optimally. Financial resource allocation (thorough budgeting) was carried out at the start of the contract period, at which time no consideration was given to future growth in demand for health care services, or to the need to upgrade existing equipment, or add new equipment to perform new tests. Thus budget constraints have limited the addition of resources (despite higher requirements). A private stakeholder stressed that "financial resources need to be developed as they do not cover all the requirements", while another private sector respondent mentioned that "although the allocation of resources was good at the beginning, now there is no way to add new services or update our systems and equipment because of the budget limitations." Furthermore, a supervisory stakeholder indicated that "there are resources that might help to raise the efficiency but unfortunately the centre could not provide them because of the limitation in the allocated budget."

Human resource allocation is based on local terms and conditions

A number of respondents, both public and private, noted that a key benefit of involving the private sector in delivering health care services has been access to qualified, skilled and professional human resources. The private health care provider hires qualified staff as and when the need arises. A private sector respondent explains that "human resources are hired based on certain requirements and qualifications." Other respondents mentioned that, to maintain high quality standards, the private health care provider ensures regular training of its employees, allowing them to deal with patients professionally and operate equipment appropriately, while simultaneously increasing their satisfaction. In the public
sector recruitment is very centralised; it is difficult to recruit or dismiss any employee in the system.

The terms of the contract regulate all the aspects of resource allocation

A few respondents referred to the terms regarding resources that were set in the initial PPP contract. A public stakeholder said that "In the main partnership contract all these things [resource allocation matters] were carefully clarified. I think such clarification at the beginning has a positive effect on the achievement of objectives." The MOH has obliged the private health care provider to use resources most effectively in order to carry out its operation as per the desired standards and quality. A supervisory stakeholder also confirmed this, saying that "the company has a commitment to provide high standard resources within the available capabilities." Several respondents noted that the private health care services provider has ensured that it can maintain such resource allocation standards. The financial resources to be allocated to the private health care services provider were also stipulated right in the beginning in the contract.

Require a transparent and clear guideline for resource allocation to meet growing demand

The private health care services provider is adept at utilising the available resources at the optimum level. As the allocated financial resources proved to be insufficient and did not allow for growth in demand (due to increasing population and technological advancements), the private health care provider has consistently added new resources and has tried to manage them within the available budget. A private stakeholder mentioned that the "resources that were allocated to the project were initially similar to what was provided to MOH, but the annual increase in demand for the diagnostic services has forced the company to increase the resources to meet this growing demand without getting any financial coverage against the increase."

Despite the private health care services provider's ability to maximise utilisation of the available resources, it would be desirable to have a transparent structure where the private health care provider sets clear guidelines for the effective usage of the allocated resources. A financing stakeholder said that "I believe that determination of clear guidelines will solve any issue that the project could face." Increased clarity will instil more confidence in the system.
9.2.2.10 Effect of the way the service has been delivered on the health care objectives

For the most part, the stakeholders are satisfied with the health care services being provided to patients. It is believed that the capable and experienced health care service provider, with better technology, highly skilled employees and assurance of international quality standards, has helped the PPP model to deliver up-to-standard services in a shorter time. Figure 9.13, below, illustrates the occurrence of such themes in relation to the different stakeholders. These themes are interpreted and analysed further below.

Figure 9.13 - Effect of the way the service has been delivered on the health care objectives

Adapting technology and mechanisms improves service delivery

A large number of respondents mentioned the automated work processes and procedures implemented by the private party. The private health care provider has introduced a number of new techniques, such as a pneumatic tube system, a queuing system, an action centre, a call centre, etc. A private sector respondent mentioned that “the company is using modern technology in all departments such as registration, services delivery and archiving records and samples, all of which has reflected positively on performance.” Similarly, a supervisory stakeholder explained that “adding new automated techniques to provide health care services enables delivery of better results.” The automated work processes have increased the quality of the health care services delivered while simultaneously reducing the
time required for conducting tests, analysing samples and preparing results. The automated work processes have also increased the accuracy of delivered results.

**The patient has been put at the centre of the process (satisfied customers)**

Several respondents indicated that the private health care provider has improved the services with better technology, advanced equipment and highly skilled, professional staff to adequately serve their patients. The positive effect of the services is perceived by patients’ responses captured through regular customer satisfaction surveys carried out by the private sector. A private stakeholder said that “the services delivery has become more organised and good results are provided in a shorter time which has a positive impact on client satisfaction."

**Implementation of clinical protocol with international affiliation**

To ensure high quality health care services, PPP stakeholders have set policies and regulations that require the private health care provider to adhere to local and global quality standards. To ensure such policies are followed, a supervisory monitoring committee has been appointed. Any deviation from such policies puts the private health care provider at risk of penalties (which vary in accordance with the severity of lapse).

Overall, numerous respondents indicated that the standard of health care services at the facility has increased with the implementation of such policies and standards (especially international quality standards, such as ISO, which mandates the use of certain processes to ensure quality services are being provided to patients). These international standards are designed to ensure that the processes to be implemented are well-organised, follow pre-defined criteria and meet requisite quality standards. Several respondents indicated that the implementation of such standards in addition to the use of advanced equipment and deployment of skilled staff, has led to more accurate and prompt result delivery. For example Respondent 14, the head of the IT department, among others, noted that “The centre is accredited by ISO which has enhanced the quality of the centre’s processes”

Furthermore, periodic evaluations of services are undertaken to maintain high quality, up-to-date health care services, and identify problem areas or relapses on the part of the private health care provider. A public stakeholder explains that “specific standards are set up and a periodic evaluation takes place to assure and maintain the quality level.” Thus prompt detection of any issues faced enables immediate corrective measures to be taken.
Furthermore, Document 2, a national award (Jaber Liljawda) for provision of quality service, supports the above theme. This further shows that the case study (YADC) has maintained a national quality standard of service.

Creates a competitive environment with implementation of clear administration policies

Previously, in government health care facilities, the process for giving appointments to patients was not organised, resulting in long waiting lists, use of ‘wastah’, dissatisfied customers, etc. In the PPP model, however, several respondents noted that the private health care provider has introduced a more organised and technically advanced appointment system, whereby appointments are fixed through an automated and regulated system which obviates any chance of prejudice or ‘wastah’. A private stakeholder explained that “we have implemented several policies to regulate and organise the whole work process in the centre, including the services delivery.” This helps them regulate allocation of appointments to patients effectively and obviates scope for any unethical means being used by patients, as before. This has resulted in increased customer satisfaction and reduced waiting periods for all patients.

Furthermore, several respondents mentioned that a key benefit of the PPP model has been the significantly shortened waiting period for patients. A public stakeholder agreed and said “the centre has helped to reduce the waiting time.” Previously, due to unreasonable burdens on the government health care facilities and ineffective work procedures, patients had to endure long waiting lists before receiving the required treatment. The private health care services provider has implemented a number of work processes based on international quality standards that have helped them use methods that deliver quicker services to patients, resulting in reduced waiting time.

In addition to this, the use of advanced equipment, coupled with the skilled, professional staff, has enabled the private health care provider to reduce the time required to conduct tests and deliver results to the patients significantly. A private stakeholder believes that “shortened result delivery time is the most important value added by the centre and this has affected the health care objectives positively.” Furthermore, the actual workforce required (to complete a similar task in government health care facilities) has been minimised in this PPP project. This is due to increased efficiency as a result of the well-organised delivery processes, use of advanced technical equipment and skilled, professional, staff.
Furthermore, Documents 4, 6, and 7 support the above mentioned theme. Document 4, is an officially stamped certificate, from The College of American Pathologists, awarded to YADC for participation in surveys and anatomic pathology education programmes. This indicates that YADC is scientifically active and up to date with the international professional standards. Similarly, Document 6 is a quality control worksheet (YADC in-house document drafted by the Quality Assurance Officer in YAICO to the management and staff of the centre), that identifies a template of various phases associated with potential problems encountered by the centre (define, measure, analyse, improve and control). It identifies the exact nature of any problem encountered within the centre’s field of work; defines its boundaries; measures its impact on the centre’s work; analyses the problem by breaking down and determining the relationship of the issues identified; improves the problem by identifying solutions and problem solving mechanisms; and controls the problem to ensure that the problem is under supervision to prevent reoccurrence. This document indicates that the centre is implementing good procedures to control issues and problems raised. Also the document indicates that there is proper teamwork to tackle the issues raised by the document (Quality Assurance Officer, Senior Tech Histopathology, Head of Unit Histopathology and the Director of YADC).

Service delivery has exceeded the partnership requirements

The services offered, along with their specifications, were laid out and explained in the initial PPP contract. The private health care services provider follows those stipulated conditions and requisite quality standards. A public stakeholder emphasised that “the way services are delivered is based on the provisions and rules of the partnership.”

All in all, with the high standards of services being delivered, the private health care provider has raised the bar for future competitors for the PPP contract. There are also distinct auxiliary services and facilities such as attractive reception areas and a café. A financing stakeholder mentioned that “the involvement of the private sector in the partnership will improve the way services are delivered and make it competitive for other private players.” The improved health care service delivery would create a competitive environment which in turn would benefit the patients. Competitors would have to exceed the current services level, which has already improved significantly in comparison to the earlier government-managed health care facilities.
The means of service delivery has no effect

A small number of professionals simply noted that the means of service delivery has no significant impact on the health care objectives, giving no further explanation.

9.2.2.11 Factors, conditions, platforms or circumstances with a positive effect on the PPP experience

Respondents highlighted similar factors that they believe had a positive effect on the PPP project. One of the significant factors is the cooperation between both the public and private parties, which was mentioned by most of the PPP stakeholders. Figure 9.14, below, illustrates the occurrence of such themes in relation to the different stakeholders. These themes are interpreted and analysed further below.

Figure 9.14 - Factors, conditions, platforms or circumstances with a positive effect on the PPP experience
Build up a real partnership based on cooperation

In the PPP model, both the private and public parties have joined hands and are working cohesively towards the same goal of providing high quality, professional health care services to the patients. Such cooperation brings out the best in both parties which invariably benefits the patients. A private stakeholder concurred with this, noting that the PPP model is positively affected by the "compatibility of the work mechanism in the centre and the hospital".

Furthermore, several respondents mentioned the benefit of utilising government facilities as a positive factor. Combining the private health care provider’s qualities (such as efficiency and employment of professional, skilled staff) with the high quality infrastructure of the government has allowed the benefits of the PPP model to be realised. A public stakeholder explains that "the use of government facilities" contributed positively to the objectives of the PPP.

PR & marketing (public awareness)

The community has also now come to know about the government’s initiative of involving the private sector in delivering health care services. A private stakeholder pointed out "community awareness of the PPP concept" has a positive effect. With the better services that are being delivered by the health care facility under the PPP model, patients have also accepted this in a positive light.

Human resource policy

The team managing the PPP project is very professional and skilled. The private health care services provider has top quality management that supervises and operates the health care services facility under the PPP model. A private stakeholder said the private health care facility has "recruited professional and efficient teams". Because of the professional management team, the private health care services facility has been able to deliver better services in a timely manner, enabling them to cater to more patients and reduce waiting periods.

Review all terms and conditions of the contract (financial, legal, etc)

A few respondents noted that the contract was designed in detail, covering all requisite and necessary aspects of the PPP model that would ensure a high quality,
impeccable health care service to patients. A supervisory stakeholder said “clarity of mechanism” has a positive effect on the PPP project. Such contractual clarity is required to obviate any future ambiguities and enforce duties on all responsible parties, without letting them have an excuse to get away with mediocre health care services.

9.2.2.12 Factors, conditions, platforms or circumstances with a negative effect on the PPP experience

Predominantly, many of the respondents believe that the complicated legal issues and various laws and regulations are the key issues that negatively affect the progress of the PPP project. Additionally, having limited financial resources and financial constraints strangles the growth of the private health care facility. Figure 9.15, below, illustrates the occurrence of such themes in relation to the different stakeholders. These themes are interpreted and analysed further below.

Figure 0.15 - Factors, conditions, platforms or circumstances with a negative effect on the PPP experience

Social and political circumstances

The private health care services provider is believed to pay lower salaries to their employees than what is being paid by the government health care provider. Primarily, the private health care provider has a limited budget within which to
operate the health care facility efficiently. Some respondents noted that this results in lower salaries paid to employees, which might negatively affect the PPP project, as it could lead to less satisfied employees delivering substandard services. A public stakeholder believes "lower salaries" results in compromised service delivery.

Furthermore, several respondents noted that with the involvement of the public sector (in the PPP model) there are numerous political aspects that need to be measured and balanced. A private stakeholder said that "political issues" drag the performance of PPP projects down. Due to this, there are some political barriers that exist and a degree of corruption also becomes pervasive. Some individuals, worried about losing their authority over government health care service systems, try to create obstacles for the PPP project.

A few respondents also noted that the government sector is somewhat unclear about their administrative responsibilities and duties. Such ambiguities within the government sector obstruct the smooth operation of the private health care services facility. A financing stakeholder clearly stated that "administrative confusion in the government sector" has impeded the smooth operation of the PPP project, and this needs to be resolved for future projects.

**Legal issues such as contract drafting (flexibility of terms and conditions)**

Document 1, the YADC contract signed between the financial affairs and services purchasing department of the MOH and its private sector partner (YADC), explains the legal aspect of the project. This contract was written as part of the legal process to specify each party's roles, rights and obligations. It clarifies details of the project such as the requirement to construct, equip and operate a building at Adan Hospital for the services of radiology, nuclear medicine and laboratories. The contract duration is 12 years as of the date of receiving the site by the second party. This contract details such as dates, tender specifications, roles, relationships and responsibilities of the parties involved.

With regard to the interviews, however, several respondents noted that the progress of the PPP project is hampered by various legal entanglements and complications. A financing stakeholder explained "lack of clarity in the legal aspects prevents progress". There are several laws and regulations to be followed by the parties involved in the PPP project, which are believed to be unclearly set in the contract, leading to confusion and ambiguity. An inability to understand clearly and
follow some of these legal issues has negatively affected the PPP model. One of the private stakeholders highlighted this, stating that "the weakness of the contract" has negatively affected the PPP project. These loopholes in the contractual framework have resulted in evasiveness by both parties and negatively affected the overall project.

**Lack of confidence between parties**

A number of respondents also mentioned the lack of cooperation and trust between parties and its negative impact on the PPP project. The government and private sector need to work together towards the success of the project. One respondent noted that "losing the spirit of partnership" is a key negative issue, explaining that the PPP concept can flourish further only with better understanding and communication between both the parties.

**Resistance to change by management and staff**

Various respondents mentioned the issue of resistance to change, explaining that the existing system of providing health care services has been in place for decades, and the introduction of the PPP concept required various changes at different levels. Consequently, people working within the current system find it difficult to accept changes. A supervisory stakeholder emphasised that "resistance to change" is a major hindrance to the PPP project's success. It may require some time for the existing system to adapt to the new processes and procedures used by the private sector.

It was even suggested by some respondents that some government representatives (old management system) interfere with the day-to-day activities of the private health care provider's facility as they are worried about losing their power over the system and/or having their influence diluted in terms of their decision-making authority. Such interference drags the performance of the health care services facility down. A public stakeholder agreed, stressing that "government interfering with the operations of the private health care services provider will limit the progress of the PPP project."
Demographic changes

Several respondents made note of demographical changes, the impact of which is worsened by the limited financial resources. With the rise in population, the demand for health care services also increases substantially, while available resources are set. Many respondents noted that this has adversely affected the performance of the PPP. A private stakeholder emphasised this, noting that "limited financial resources" limit the growth of the PPP project. There is an increase in demand for health care services and new technology, and having limited financial resources is considered as a constraint for providing even better services.

Ineffectual process for hiring the supervisory committee

Some respondents noted that the supervisory committee is inefficient and believed to create a hindrance to the PPP project's progress. Conflict with the supervisory committee was further emphasised by a private stakeholder, who stated that "the unprofessional hiring of the supervisory team" is a blockage for the success of the PPP project. The stakeholders want to have a professional process for appointing appropriate members for the supervisory committee. These members should contribute positively towards the performance of the private health care services provider and act as an unbiased monitoring entity.

9.3 Quantitative data analysis – customer satisfaction survey

This section describes the quantitative data collected from the fifth stakeholder (patients). It is mainly focused on descriptive analysis that reflects patients' experience and satisfaction in an attempt to achieve a different perspective on the evaluation of the case being studied.

The following customer satisfaction survey consisted of customer satisfaction questionnaires distributed in different areas of YADC. The survey targeted the fifth stakeholder in the research – the end-users. Patients include Kuwaitis as well as Arab and non-Arab expatriates visiting the centre during the survey period (March/April 2011). A total of 489 customer satisfaction surveys were completed and are analysed below.
9.3.1 Response rate

The population of Adan District is approximately 700,000 (see Figure 9.15, above). A total of 600 questionnaires were distributed in an attempt to ensure a 95% confidence level in the findings. 600 questionnaires were distributed, and 489 completed. The response rate was 81.5%. As this was a personally administered questionnaire, a relatively high response rate was achieved. Respondents were motivated to participate and any doubts they had were clarified.

9.3.2 Sample profile

The survey considers mainly gender and age groups for socio-demographic profiling. As illustrated below (Figure 9.17), the sample is represented mainly by middle-aged females.
9.3.2 Overall satisfaction

The respondents were probed on their 'overall satisfaction' (based on their current visit) for the following:

- Health centre
- Quality of health care
- General facilities at the centre
- Reception and appointments

Overall, the respondents were satisfied with the 'health centre', the 'quality of health care', the 'general facilities', and 'reception and appointments', with the majority rating such factors as either good or very good. The health centre as a whole received the highest rating. However, there were slightly more patients relatively less satisfied with the 'general facilities' of the centre and 'reception and appointments'. Similarly, considering satisfaction level across gender, it is observed that females are more satisfied than males on all the above-mentioned touch points.
9.3.3 Ease of getting care

Initially, the respondents were probed for their satisfaction on the ‘ease of getting care’ at the centre by asking for their rating on the following attributes:

- Ability to get in to be seen
- Working hours
- Location of the centre
- Promptness in calling
- Ease of taking the appointment on the phone

On a general note, most respondents found all the above-mentioned attributes of the centre to be mostly good or very good. The ‘ability to get in to be seen’ scored higher than most other attributes, as more than half of the respondents (56%) noted that this was either very good (37%) or excellent (19%). On the other hand, the ‘promptness in calling’ and ‘ease of taking appointments’ were the two attributes
where respondents showed a relatively lower level of satisfaction, with more respondents noting that such aspects were fair or even poor.

Figure 0.19 - Ease of getting care

9.3.4 Waiting time

Respondents were asked to rate their satisfaction level on a set of attributes related to time taken at the centre. The attributes asked were as follows:

- Time taken in the waiting room
- Time taken in the examination room
- Time taken for testing
- Time taken for test results

At least one third of respondents gave a rating of ‘good’ for all the above-mentioned attributes. Furthermore, it is observed that most respondents are relatively better satisfied (close to half) with ‘time taken for testing’ and ‘time taken for test results’ implying that lab services are quicker than other services at the centre.
9.3.5 Staff related attributes

After gauging the satisfaction level on waiting times, the respondents were asked to give their satisfaction level on staff related attributes regarding:

- Satisfaction with key staff (doctors)
- Satisfaction with assistant staff (nurses, assistants)
- Satisfaction with other support staff

Overall, most respondents were largely satisfied with the attributes asked (see below) for key staff such as doctors. A large majority (55%) particularly found the advice given by doctors for treatment to be good, very good or excellent. With regard to assistant staff such as nurses, the majority of respondents were also relatively satisfied with their friendliness and helpfulness. It is observed that the satisfaction level is more or less similar for both the attributes. Subsequently, for other support staff, it is found that although in general most respondents are satisfied, there were a larger number of respondents less satisfied with such staff in comparison with key and assistant staff. This is also reflected in the average rating noted below.
Figure 0.21 - Staff related attributes

- Listen to you: Excellent 16%, Very Good 34%, Good 34%, Fair 10%, Poor 6%
  Average: 3.4

- Taken enough time with you: Excellent 13%, Very Good 30%, Good 42%, Fair 12%, Poor 3%
  Average: 3.4

- Explain what you want to know: Excellent 14%, Very Good 34%, Good 36%, Fair 13%, Poor 3%
  Average: 3.4

- Gives good advice and treatment: Excellent 21%, Very Good 34%, Good 29%, Fair 14%, Poor 2%
  Average: 3.6

- Friendly and helpful to you: Excellent 18%, Very Good 38%, Good 32%, Fair 8%, Poor 4%
  Average: 3.6

- Answer your questions: Excellent 21%, Very Good 30%, Good 36%, Fair 9%, Poor 3%
  Average: 3.6
9.3.6 Payment related attributes

Next, the respondents were asked to give their satisfaction level on payment related attributes:

- Satisfaction on overall charges (amount) paid
- Satisfaction with the proper explanation of charges in the bill
- Satisfaction regarding collection of payment

As expected, the respondents gave lower satisfaction scores for all the three attributes in comparison to ratings given for other features of the centre. Half of the respondents rated the three mentioned attributes (overall charges paid, the explanation of the charges in the bill and collection of payment) to be good, and there were no significant differences between the genders.
9.3.7 Facility related attributes

The respondents were then probed for their satisfaction level on the different facilities available at the centre. The attributes they were asked to rate were the following:

- Neatness and cleanliness of the building
- Ease of finding their way around the centre
- Comfort and safety in the waiting room
- Privacy

It is evident that respondents are most satisfied with privacy during checkup and the comfort level in the waiting room (63% and 61% respectively). Furthermore, the average for both these attributes is higher compared to the other attributes of
neatness and cleanliness of the building, and ease of finding one’s way around the building.

Lower satisfaction was observed for neatness and cleanliness and for ease of access around the building (47% and 43% respectively), the average being 3.3 and 3.2 respectively for both the attributes.

Figure 0.23 - Facility related

9.3.8 About the centre

Lastly, the respondents were probed on the centre for the following:

- Likelihood to refer the centre to friends/relatives
- Considering the centre as their regular source of care
- Awareness of the centre being managed by the private sector.
- Likelihood of referring the centre to friends/relatives was shown by close to half of respondents (46%). This likeliness to refer is observed to be slightly higher among females compared to males.
Slightly more than half (57%) of the respondents consider this center as their regular source of care. Surprisingly, however, only (23%) of respondents are aware that the center is managed by the private sector.

Figure 0.24 - About the centre
9.3.10 A Summary of the satisfaction scores

Table 0.2 - A summary of the satisfaction scores

<table>
<thead>
<tr>
<th>Ease of getting care</th>
<th>Mean</th>
<th>Poor</th>
<th>Fair</th>
<th>Good</th>
<th>Very Good</th>
<th>Excellent</th>
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<tbody>
<tr>
<td>Ability to get in to be seen</td>
<td>3.5</td>
<td>6%</td>
<td>13%</td>
<td>24%</td>
<td>37%</td>
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<tr>
<td>Hours centre is open</td>
<td>3.4</td>
<td>2%</td>
<td>12%</td>
<td>30%</td>
<td>33%</td>
<td>13%</td>
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<td>Convenience of centre’s location</td>
<td>3.3</td>
<td>3%</td>
<td>13%</td>
<td>44%</td>
<td>27%</td>
<td>13%</td>
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<tr>
<td>Prompt return on calls</td>
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<td>4%</td>
<td>17%</td>
<td>44%</td>
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<td>Ease of making your appointment by telephone</td>
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<td>9%</td>
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<th>Fair</th>
<th>Good</th>
<th>Very Good</th>
<th>Excellent</th>
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<td>8%</td>
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<td>Time in exam room</td>
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<td>43%</td>
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<td>36%</td>
<td>32%</td>
<td>17%</td>
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<tr>
<td>Waiting for test results</td>
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<td>15%</td>
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<th>Fair</th>
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<th>Very Good</th>
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<td>Explanation of charges</td>
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<td>51%</td>
<td>25%</td>
<td>8%</td>
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<td>52%</td>
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<th>Mean</th>
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<th>Fair</th>
<th>Good</th>
<th>Very Good</th>
<th>Excellent</th>
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</thead>
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<td>Neat and clean building</td>
<td>3.3</td>
<td>8%</td>
<td>17%</td>
<td>28%</td>
<td>32%</td>
<td>16%</td>
</tr>
<tr>
<td>Ease of finding where to go</td>
<td>3.2</td>
<td>8%</td>
<td>19%</td>
<td>29%</td>
<td>29%</td>
<td>14%</td>
</tr>
<tr>
<td>Comfort and safety while waiting</td>
<td>3.7</td>
<td>3%</td>
<td>6%</td>
<td>30%</td>
<td>41%</td>
<td>20%</td>
</tr>
<tr>
<td>Privacy</td>
<td>3.7</td>
<td>3%</td>
<td>7%</td>
<td>28%</td>
<td>46%</td>
<td>17%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Confidentiality</th>
<th>Mean</th>
<th>Poor</th>
<th>Fair</th>
<th>Good</th>
<th>Very Good</th>
<th>Excellent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Keeping my personal information private</td>
<td>3.6</td>
<td>3%</td>
<td>8%</td>
<td>34%</td>
<td>34%</td>
<td>21%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Overall Satisfaction</th>
<th>Mean</th>
<th>Poor</th>
<th>Fair</th>
<th>Good</th>
<th>Very Good</th>
<th>Excellent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health centre</td>
<td>3.5</td>
<td>3%</td>
<td>10%</td>
<td>38%</td>
<td>33%</td>
<td>16%</td>
</tr>
<tr>
<td>Quality of health care received</td>
<td>3.4</td>
<td>3%</td>
<td>13%</td>
<td>37%</td>
<td>33%</td>
<td>13%</td>
</tr>
<tr>
<td>General facilities</td>
<td>3.1</td>
<td>4%</td>
<td>25%</td>
<td>35%</td>
<td>25%</td>
<td>11%</td>
</tr>
<tr>
<td>Reception &amp; appointments</td>
<td>3.2</td>
<td>4%</td>
<td>20%</td>
<td>40%</td>
<td>24%</td>
<td>12%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Staff related -- providers</th>
<th>Mean</th>
<th>Poor</th>
<th>Fair</th>
<th>Good</th>
<th>Very Good</th>
<th>Excellent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Listen to you</td>
<td>3.4</td>
<td>6%</td>
<td>10%</td>
<td>34%</td>
<td>34%</td>
<td>16%</td>
</tr>
<tr>
<td>Takes enough time with you</td>
<td>3.4</td>
<td>3%</td>
<td>12%</td>
<td>42%</td>
<td>30%</td>
<td>13%</td>
</tr>
<tr>
<td>Explains what you want to know</td>
<td>3.4</td>
<td>3%</td>
<td>13%</td>
<td>36%</td>
<td>34%</td>
<td>14%</td>
</tr>
<tr>
<td>Gives you good advice and treatment</td>
<td>3.6</td>
<td>2%</td>
<td>14%</td>
<td>29%</td>
<td>34%</td>
<td>21%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Staff related -- nurse &amp; assistants</th>
<th>Mean</th>
<th>Poor</th>
<th>Fair</th>
<th>Good</th>
<th>Very Good</th>
<th>Excellent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Friendly and helpful to you</td>
<td>3.6</td>
<td>4%</td>
<td>8%</td>
<td>32%</td>
<td>38%</td>
<td>18%</td>
</tr>
<tr>
<td>Answers your questions</td>
<td>3.6</td>
<td>3%</td>
<td>9%</td>
<td>36%</td>
<td>30%</td>
<td>21%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other supporting staff</th>
<th>Mean</th>
<th>Poor</th>
<th>Fair</th>
<th>Good</th>
<th>Very Good</th>
<th>Excellent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Friendly and helpful to you</td>
<td>3.3</td>
<td>5%</td>
<td>20%</td>
<td>31%</td>
<td>30%</td>
<td>14%</td>
</tr>
<tr>
<td>Answers your questions</td>
<td>3.2</td>
<td>5%</td>
<td>22%</td>
<td>36%</td>
<td>26%</td>
<td>12%</td>
</tr>
</tbody>
</table>
9.4 Mapping and interpretation of the main study findings

Data from both the semi-structured interviews and the customer satisfaction questionnaire is mapped and re-synthesised below to produce mechanisms that help PPPs achieve the health care objectives better (mapping – stage 5 of the framework approach). This process of mapping consisted first of extracting key ideas from the various data (which includes themes, questionnaire data and document support – see Figure 9.25, below). The extracted key ideas were in turn grouped together to generate mechanisms that were used as a part of the context-mechanism-outcome configuration.

Figure 9.25 - Data Interpretation, extraction and mechanism generation

<table>
<thead>
<tr>
<th>35 Interviews</th>
<th>Thematic analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>489 Questionnaires for customer satisfaction</td>
<td></td>
</tr>
<tr>
<td>8 Supportive documents</td>
<td></td>
</tr>
</tbody>
</table>

Interpretation → Key ideas

Table 9.3 - Context, Mechanism and Outcome Configuration

Below
<table>
<thead>
<tr>
<th>Lever</th>
<th>Context</th>
<th>Mechanism</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resource Generation and Allocation</td>
<td>• Need • Awareness</td>
<td>Corporate culture (importance of resources)</td>
<td>Periodic maintenance (system &amp; process)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Participation in market challenge</td>
<td>Up-to-date technology</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Quality control indicators</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Elimination of unneeded tests</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Result documentation</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Comparative analysis</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Client satisfaction surveys</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Strengthen the relationship with the government and gain their confidence</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Flexibility (meeting the increasing demands for services)</td>
<td>Negotiate with the government to increase the budget</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Upgrade equipment to reduce the procedures time</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Rescheduling options for appointments</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Transparency</td>
<td>Create opportunity for private sector</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Clear bidding process</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Sharing responsibility and reducing opportunism (corruption)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Ability to adopt new technology</td>
<td>Queuing system</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Full system automation</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Pneumatic system</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Internal mail</td>
</tr>
<tr>
<td>Organisation</td>
<td>• Motivation • Political Support</td>
<td>Team work spirit and the achievement of targets as a group</td>
<td>Internal (open) mail communication</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Action Center system</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Periodic meetings (documented follow up)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Social activities</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Autonomy and Independency</td>
<td>Good distribution of power</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Clear relationship between stakeholders</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Accountability and direct recruitment</td>
<td>Selection of qualified employees</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Staff training &amp; development</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Incentives</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Standardised operation policy</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Professionalism &amp; commitment</td>
<td>Eliminating of ‘wastah’</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Applying penalties</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Periodic reporting</td>
</tr>
<tr>
<td>Service Provision</td>
<td>• Competence • Community Involvement</td>
<td>Introduction of PPP concept to the society</td>
<td>Enhancing of public relations</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Media and marketing</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Elimination of ‘wastah’</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Encouraging people to respect rules and regulations</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Introducing the company’s achievements and international experiments</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>International accreditation</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Assurance of competence and competitiveness</td>
<td>Standard operation policy</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Introducing the PPP guidelines</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Enhance the reputation</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Build international partnership</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Attractive internal design</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Attention to details (enhance the augmented services)</td>
<td>Easy access to facilities and services</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Hospitality (attractive internal design, spacious waiting area, café, restaurants etc)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Diagnostic results deliver to patients</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Strict safety measures</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Customer oriented approach (client is priority)</td>
<td>Complaint system (Action Centre system)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Call center</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Client satisfaction survey</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Open door policy</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Flexible appointments</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Optimal utilisation of resources</td>
</tr>
<tr>
<td>Finance</td>
<td>• Regulation • Incentives</td>
<td>Financial Feasibility Assurance</td>
<td>Operation with maximum capacity</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Optimal utilisation of resources</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Incentives</td>
<td>Reward according to performance</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Risk sharing</td>
<td>Confidence in project feasibility</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Reduce liability</td>
</tr>
</tbody>
</table>
9.4.1 The impact of PPP on the health care levers

This section looks at the impact of PPP on each health care lever. It explains each mechanism that has been enabled by the PPP and the supporting context required for such mechanisms to function better.

9.4.1.1 Resource allocation

PPP has changed the way resources are allocated from a time-based budget usually derived from historical estimations to a population based block contract. Resources such as human resources and equipment have been managed differently under the PPP.

Two key aspects (contexts) are required to ensure effective resource allocation and management: need and awareness. To ensure both good consumption and production of resources in health planning, public demand should be promoted and prioritised after careful assessment. Furthermore, to ensure good utilisation and management of resources and to minimise unnecessary wastage of them, awareness among stakeholders is key. This requires collaborative effort from all stakeholders, from the public, private, financial and regulatory/advisory bodies, as well as the end-users, to promote such issues through appropriate channels.

Resource allocation mechanisms:

Corporate culture (importance of resources)

The PPP model has introduced a corporate culture of valuing resources. Processes and protocols have been well implemented to ensure proper utilisation of such resources. The use of an inventory system, streamlining operations and strict maintenance of equipment all reflect a tendency towards proper resource utilisation and reduced wastage in the system.

Participation in market challenges

The YADC model has positioned itself differently from the conventional diagnostic centres of the MOH. It has involved the community and addressed their essential needs. It has also participated in free market challenges with other diagnostic centres to attract private patient treatments outside the MOH working hours. This has ensured optimum utilisation of time. Furthermore, competing for private patients in the evening hours has encouraged the centre to maintain competitive standards.
Flexibility (meeting the demand for services)

The PPP model has been able to cope with and adapt to different situations (rising population and advancements in technology) despite the contract being fixed in terms of budget allocation. The population that is eligible for the service of YADC has been increasing since the opening of the centre; this is an issue which was not accounted for in the initial contract. Nonetheless, YADC has coped with this by increasing operating hours and applying more efficiency measures (streamlining many of the operations such as appointments and diagnostic procedures). In addition to the issue of increasing population, the contract has not addressed the advancement in medical technology and the need to upgrade equipment due to rapid developments in diagnostic procedures. However, the centre has been flexible in its upgrade to the latest equipment to fulfil the best interests of PPP objectives.

Although YADC has been negotiating with the government to increase the centre's budget (no increase has been granted and negotiations are ongoing to date), the centre has still managed to maintain its efficient operations and ensure a sound reputation among its patients.

Transparency

The PPP model has created transparency in resource allocation in various areas, from selecting the private sector partner to specifying human and equipment resource specifications. Project resources have been assembled on business cases to ensure their value for money, and there has been an overall reduction in bureaucracy and the abuse of power within the old system.

Ability to adopt new technology

The PPP model has made proper use of new technology, automating many of its operations and procedures. This has in turn resulted in a reduced number of staff to perform a set task and improved overall efficiency of operations. Such adoption of technology is often difficult to promote under the existing system.
9.4.1.2 PPP and organisation

Introducing PPP into the health care system has impacted on the way the system has been organised. It has separated the regulation and finance from health care delivery. This separation has enabled the introduction of mechanisms (key market tools) within the system. As shown in Figure 9.26, PPP has shifted the health care system from a unified public model into a public contract model and is moving it more towards a structured pluralism model.
The research has found that two key contexts are required in order to trigger and maintain the mechanisms mentioned further below: motivation and political support. For the PPP model to work, motivation and willingness from the public sector management is essential. Cooperation between different levels of public sector management is key to facilitating the transition and implementation of PPP projects. Proper understanding and mutual agreements among different stakeholders, with regard to PPP practices and procedures, will support improved performance of the health care system. Political support for the PPP concept will lift pressure from top management of both public and private sectors. Advocacy to promote the PPP concept in the health sector would create a better platform for the PPP organisation to accomplish its objectives.

**Organisational mechanisms:**

*Teamwork spirit and the achievement of targets as a group:*

The PPP experience has led to the creation of teams focused on functioning collectively as a unit with a results-oriented approach. This has been reflected through a number of activities to improve communication within YADC, such as periodic
official meetings that are well documented and followed through, as well as prompt usage of internal emails between departments.

**Autonomy and independence (in making decisions and adopting new technology):**

The decentralisation of service provision through YADC has given autonomy and independence to the management, which has enabled YADC to exceed performance standards. This allows the centre’s management to set their own targets and monitor protocols away from the bureaucracy and rigid structures of the MOH. It has also made people more accountable for their roles and responsibilities.

**Accountability and central or direct recruitment:**

The PPP experience has given the health care sector a major advantage in comparison to the conventional model where employees are recruited centrally (in order to meet job quotas) for all MOH departments, with no consideration to job specific criteria or skills.

**Professionalism and enhanced regulations:**

In addition to this, the separation of service delivery from regulation and finance has empowered the centre’s staff and enhanced their professionalism and commitment to the organisation’s protocol and policies. This has enhanced YADC’s service delivery reputation, and has significantly reduced social abuses of the system such as ‘wastah’.

### 9.4.1.3 PPP and service provision

The PPP experience has enhanced overall service provision by primarily providing patient-centred care, putting the patient at the centre of its operations and activities. Two key aspects (contexts) are required to create the appropriate environment for such care: competence and community involvement. Competencies within the private sector are very important in ensuring the success of the PPP model. Core business practices, such as innovation and efficiency in service provision, are key. Community involvement in health care is very important for health care system development. In the current PPP project, community involvement has significantly
influenced service provision standards, making services more responsive to local needs. The PPP model has also proved that better communication with the community will ensure a better platform for service provision assessment.

**Service provision mechanisms:**

**Customer oriented approach (the client is the priority)**

The PPP model has increased the focus towards the end-users of the health service, ensuring that patients are always a priority. This is evident through the well-established open door policy that eliminates communication barriers among staff, physicians and the management of the centre. The centre has also provided a call centre to handle care services and facilitate communication, and has set up a complaint reporting system to ensure complaints are addressed. Furthermore, customer satisfaction and experiences are well documented through regular satisfaction surveys. In line with this approach, the centre has also set up a service for delivering diagnostic results for certain patients outside the centre.

**The introduction of the PPP concept to the society**

The centre has implemented a good public relations policy to ensure ongoing connection with the public. They have used the media to market and promote their services and publicise their achievements and affiliations, thus enhancing their image and gaining further support (a practice rarely seen in the public model).

**Assurance of capability and competitiveness**

To ensure that operational policies and quality standards are up to date, the centre has set up a special quality control department and has appointed a qualified manager to oversee this. Such standards have enhanced the centre's reputation and increased its competitiveness in the market.

**Attention to detail (enhance the auxiliary services)**

Various measures have been taken by the centre to ensure a relaxed and safe atmosphere for visitors and patients. These include good hospitality services, such as aesthetically pleasing spacious waiting areas, coffee shops and beverage serving counters, surrounded by state-of-the-art internal design features. In addition to this,
the centre has provided easy access to facilities and services like signage for guidance, well kept reception areas and wide corridors.

9.4.1.4 PPP and finance

The PPP model has changed the way the health system is financed from the conventional budget allocation (government revenue going directly to government organisations), where financial budgets are based on historical data, to a new means of finance, involving the allocation of a fixed budget directly to the health centre. Two key contexts are required for this: regulation and incentives. Official financial regulation will both facilitate the PPP project and maintain the best public interest in the health sector. Financial regulations will also encourage private firms to be more involved in future PPP deals with greater confidence. Furthermore, providing incentives is essential to the overall success of the PPP model. The chosen incentives should be clear among all stakeholders before initiating the PPP project. This will guarantee better alignment of the PPP objectives between the public and private sectors.

Financial mechanisms:
Financial feasibility and assurance

The PPP has taken revenue from the government through a capitation system (fixed amount) to deliver health through a non-governmental organisation aiming to make a profit while improving and maintaining service standards. It has allowed the centre to operate with maximum capacity with an improved utilisation of resources. This method of funding has also reduced costs without compromising the quality of services and, at times, has even raised standards.

Rewards according to performance
Due to greater financial independence, the centre has been able to use financial means to incentivise their employees, offering rewards according to their performance, and even providing over-time payments. This has created greater employee satisfaction and flexible working hours, and has enhanced the centre’s overall performance.
**Risk sharing**

The PPP model spreads project risks among the appropriate stakeholders best able to manage them, while providing reasonable expected returns. This has enhanced the private company’s confidence while simultaneously reducing government risk and liability. There are various kinds of risk, including financial, operational and technical risk.

![Health care financial model](image)

*Source: Atun (2008)*

### 9.4.2 Barriers (disabling mechanisms)

The following section discusses the numerous barriers that hinder the implementation of PPP.

The MOH has undergone numerous difficulties in placing its priorities and struggled in setting a long-term strategy of implementation and governance. Unstable government, with various changes within the MOH’s cabinet over the past seven to eight years, has aggravated this issue. Furthermore, data has shown that the clear lack of a structured legal and financial framework has hindered the PPP’s progress and performance.
Another obstacle facing the Kuwaiti health care system is a shortage of competent professional health leaders and managers, which affects the smooth development of PPP programmes in the country. In addition, the data has shown that there has been resistance to change in the YADC PPP model, which seems to be caused largely by the impact of the PPP programme on the organisational structure. As this study has shown, there was insufficient engagement during the PPP transition process of managers and physicians who managed various diagnostic departments (e.g. imaging department and medical labs) under the old structure. After the introduction of the PPP, a number of them were appointed as advisors or members of the supervisory committee responsible for overseeing the work of YADC on behalf of the MOH. Many of those managers felt this was a passive change, which has negatively influenced their involvement with the direct management of the hospital. This in turn created unease, managerial friction and a major bias among the supervisory committee's approach to YADC.

It has also been evident that the partnership concept was not well digested by various stakeholders. Issues such as PPP missions and objectives should be better communicated. There is a need to create a real partnership that has pre-defined objectives and is governed by joint policies that balance the power and guarantee implementation. Furthermore, another key barrier is that despite the availability of data and resources, evaluation is relatively neglected.

9.4.3 Findings of the quantitative study (patient/end-user experience)

The quantitative study has supported the findings by approaching the end-users (patients), who are the fifth stakeholder in the PPP programme, through a survey. By asking patients about numerous aspects of the centre, the questionnaire aimed to gauge an accurate impression of patients' overall satisfaction with the centre's facilities. This is especially important considering that such services are far from being satisfactory within the current facilities run by the MOH.

Patients were probed on numerous aspects of the centre, such as their overall satisfaction with the health centre, its quality of care, general facilities, and reception and appointments. More specifically, they were asked about the ease of getting care (such as the ability to be seen, working hours, centre location, and ease of making an
appointment on the phone), waiting times (such as in waiting rooms, and examination rooms), staff related issues (such as satisfaction with doctors, nurses and support staff), payment related issues (such as overall charges and explanation of such charges), and facility related issues (such as the centre’s neatness and cleanliness, ease of finding one’s way around the centre, comfort, safety and privacy).

It was found that overall, patients are very satisfied with the different aspects of the centre (especially considering their previous experiences with other government facilities). Many patients noted that they would refer friends or relatives to the centre, and would consider it as their regular source of care. Surprisingly, however, only a quarter of respondents were aware that the centre is managed by the private sector, which could perhaps indicate that there has been proper integration of the private facility within the current structure of government facilities.

All in all, such findings reflect the commitment of YADC in addressing end-user experiences and putting patients at the heart of its operations.

9.5 Chapter summary

This chapter presented the findings of the main study, which consisted largely of semi-structured interviews with four key stakeholders (public, private, financial and regulatory/advisory bodies) and a customer experience questionnaire with the fifth stakeholder (end-users). Furthermore, document review is provided where appropriate to substantiate the findings.

As different methods of data collection were undertaken, the chapter presented the data analysis in two key sections. The first section, semi-structured interview analysis, was carried out through a framework approach and was in turn divided into two parts. Part 1 identified numerous themes derived from the interview responses (stage 1-4 of the framework approach), while Part 2 discussed these themes. The second section, analysed the findings from the customer satisfaction questionnaire qualitatively through description. Both sections drew correlations with findings from different documents collected for this research. Finally all data (from both the semi-structured interviews and the customer satisfaction questionnaire) were mapped to produce mechanisms that help PPP achieve the health care objectives better (mapping – stage 5 of the framework approach).
10.1 Introduction

The main study assessed the PPP experience in the Kuwaiti health care sector in relation to the health care system objectives. The study revealed that the PPP experience has had a significant impact on the health care levers of resource allocation, organisation, service provision and finance (introducing various market tools such as incentives, competition, profitability and innovation). This impact changed the way the health care system operates and introduced numerous enabling mechanisms (processes) that facilitate improved achievement of health care system objectives (outcomes of equity, effectiveness, efficiency and choice). The research also identified various contexts (platforms) for these mechanisms to operate optimally within and be leveraged, as a synchronized process.

In order to provide a thorough discussion of the findings, the chapter is divided into various sections. It begins by discussing the principal findings of the main study, highlighting the various contexts required and mechanisms triggered by the PPP experience. This is followed by a discussion of the impact of such findings for the health care sector and policy makers. Connections between such findings and the ideas and theories outlined in the literature review are then highlighted. Finally, the chapter concludes with a discussion of the limitations of the research and provides recommendations for further research.

10.2 Principal findings

The research findings have shown that the recent PPP experience in the Kuwaiti health sector has a significant impact on the health care levers of resource allocation, organization, service provision and finance by introducing various mechanisms (processes) that facilitate improved achievement of health care system objectives.
In terms of resource allocation, PPP has introduced various mechanisms (corporate culture, market challenges, flexibility, transparency and the ability to adopt new technology) that have facilitated the streamlining of many operations. Examples of such streamlining include periodic maintenance of systems and processes, quality control indicators, comparative analysis procedures and an overall reduction in opportunism through enforcing a clear bidding process for resources. Furthermore, the centre has further streamlined operations and maximised resource utilisation through the enforcement of a queuing system and the elimination of unneeded tests.

On an organisation level, the PPP model has decentralised the provision of services from the centre of the MOH. This has given YADC more autonomy and accountability with regard to operations and overall performance. The centre has thus been able to take decisions on various aspects of its operation such as recruitment, quality standards and other policies. YADC has been able to directly recruit and select employees who qualify for specific jobs. Such a shift in power has also enabled the centre to eliminate ‘wastah’.

With regard to the financial structure, the PPP model has activated various mechanisms (such as rewards according to performance, feasibility assurance and risk sharing) which have created a strong level of incentives. Such incentives have allowed the PPP model to optimise its operation and utilisation of resources, and have also resulted in more motivated employees.

Finally, in terms of service provision, the PPP model has introduced mechanisms (such as the introduction of PPP to the society, competitiveness, customer-oriented approach and attention to detail that enhanced auxiliary services), which reflect a strong, patient-centred approach. This patient-centred approach has encouraged staff and patients to respect rules and regulations. It has also led to the formation of a flexible appointment system, the provision of complaint systems, a call centre and satisfaction surveys.

The findings have also shown that the PPP model in health care has the potential to achieve the health care system objectives better and create better value if implemented well and in the right context.

All in all, the impact of PPP on health care system functions has enabled the health care system to maintain its effectiveness and equity (public sector values) while significantly introducing efficiency and choice (private sector values), as illustrated in Figure 10.1 below. PPP thus seems to have the potential to modernise
the health care system and address its various challenges by introducing market tools into the public health care sector. It is able to do this while still maintaining significant government intervention and supervision to ensure equity and effectiveness.

0.1 - PPP and health care objectives

Nonetheless, the findings have also shown that there are numerous barriers that hinder positive implementation of PPP in the Kuwaiti health care sector. The MOH has faced difficulties in setting out its priorities and struggled to have a clear long-term strategy of implementation and governance. This is mainly due to an unstable government with constant changes within the MOH's cabinet setup over the past seven to eight years. Political stability is key and policy makers should seriously consider creating a new organisation that looks after the formulation of long term policies and strategies for the health sector which is able to work as an independent body (such as a health authority), unaffected by the main political tensions. Institutions with definite roles and functions can set their own functional boundaries and priorities. This step seems to be crucial as Kuwait is a small country with political tensions having a strong impact on almost all government functions.

The obvious lack of a structured legal and financial framework has rendered the overall success of the case study sluggish. Hence, taking away the ambiguity and overcoming the weaknesses of the legal and financial framework are crucial regulatory steps to ensuring smooth operation of PPP projects. A comprehensive PPP contract that is implemented within a regulatory system which protects the various stakeholders is essential for partnership success. A specific PPP law for the health
care system would certainly indicate the political willingness to pursue such a PPP programme and could trigger more PPP projects in the future.

Lack of competent professional health leaders and managers in the health care system in Kuwait is a major challenge for the health sector, creating barriers for the smooth development of PPP programmes in the country. This implies that more attention and practical measures need to be taken to attract talented health executives and leaders to the health system arena. Individuals with the ability and insights, who can adapt to various situations and apply adequate skills in different settings, will shape the overall picture of the health care system better. These individuals can capture knowledge and good opportunities by assessing and understanding the health system to strengthen the PPP model.

Resistance to change has been evident in the PPP YADC model, and this seems to be caused by the impact made by the PPP model on the organisational structure. In changing the way a health system is managed, the resistance to change will run parallel to the level of change. Therefore, such changes should engage the various professions that might be affected by the change and manage their expectations appropriately. It is very important when the PPP model is initiated to address the various individuals involved and to ensure their direction within the change process. Support and training needs to be provided to ensure development of necessary skills required by the change.

As this study has shown, there was insufficient engagement during the PPP transition process of managers and physicians who managed various diagnostic departments (e.g. imaging department and medical labs) under the old structure. After the introduction of the PPP, a number of those were appointed as advisors or members of the supervisory committee responsible for overlooking the work of YADC on behalf of the MOH. Many of those managers felt this was a passive change that has negatively influenced their involvement with the direct management of the hospital. This has thus created unease, managerial frictions and major bias among the supervisory committee’s approach towards YADC.

A better approach to managing this type of change and transition of duties and responsibilities is by committing the private sector to retain the existing more progressive professionals through a series of evaluations, feedbacks and interviews. This will also help in preventing the sudden shift within the hospital management structure that could in most cases result in a management void that is difficult to
occupy quickly and will reduce the burden on the public sector of accommodating the surplus staff and allow their transition into other roles more smoothly. It has also been evident that the partnership concept was not well digested among various stakeholders. Issues such as PPP missions and objectives should be better communicated. There is a need to create a real partnership that has pre-defined objectives and joint policies that balance the power and guarantee implementation.

Despite the availability of data and resources, evaluation is relatively neglected. Frequent systematic evaluation would provide a clear picture of the ongoing progress and its limitations and so empower the decision makers.

10.3 Implications of the findings

The following section discusses the importance of the findings for Kuwaiti health care policymaking and management. Mechanisms identified in this research will provide a valuable platform for health managers to exploit in PPP practice. Such mechanisms will also highlight important issues to be considered by policy makers. These findings will be discussed in relation to the numerous obstacles faced by the Kuwaiti health care system.

At present, there are various issues facing the health care system of Kuwait, which pose a continuing challenge for policy makers, and which may affect the health system operations, public usage of the services and the overall health of the population if not addressed. Such challenges are complex and often overlapping, thus putting strong pressure on the government. Addressing these challenges while ensuring the integrity of the health care objectives is a key task that policy makers need to address.

Bureaucracy and inadequate management are a key challenge. It is believed that the lack of leadership and professional management within the health system has caused the lack of long term strategic planning that has left the health care sector in Kuwait without proper health reform. The Kuwaiti government largely lacks the essential management skills required to run care facilities effectively (McKinsey, 2007). The country suffers from an ageing health care infrastructure and facilities, with the latest hospital being built in 1981. This has led to an accumulation of serious
service issues (rising patient waiting times, surgical backlogs and a decline in patient-to-hospital-bed ratio), and patients seeking immediate care are increasingly turning to private practices or medical tourism (Al Mutairi, 2007; State Audit Bureau of Kuwait, 2004). Lack of constructive regulations together with the absence of long term policy making is a prime cause of such issues. Policies dating back to the 1980s need to be replaced through strategic policy reviews, fresh insights into organisational structure, advanced health informatics and modern skills, and a set of researchers and policy makers to boost overall health management standards (Kuwait Medical Association, 2009). Furthermore, Kuwait's recent budget surplus (KD 9.3 Billion for 2009/08) suggests that more could be spent on areas of planning and strengthening central governance, with lines of communication channelling across local authorities to understand their immediate needs and future demands (Kuwait Medical Association, 2009).

Demographical and epidemiological changes are other key issues facing the existing health care system. Kuwait's population is growing rapidly due to high birth rates, a large number of expatriates and rising life expectancies. Currently the vast majority of the population in Kuwait are younger than 30 and more than half of these are younger than 20 (Business Monitor International, 2011). Thus by 2030, 8% of Kuwaitis will be over 60 years old, and by 2050 this figure will rise to 25%. An ageing population will see increases in chronic diseases such as cardiac and pulmonary complications, mental disorders and cancers. Furthermore, chronic heart disease and accidents are already leading causes of death in Kuwaiti society. According to the WHO, this represents 60% of the overall burden of chronic diseases in the region (Kuwait Medical Association, 2009; WHO, 2006). Despite the large financial resources stabilising the economy and the situation being masked by high oil revenue, the implications of such demographic changes could be devastating (Business Monitor International, 2011). This is especially because the vast majority of the population still rely on the government's free health services.

Furthermore, Kuwait, despite being a wealthy economy, faces the key challenge of cost. This rise is mainly due to increase in demand for services, high costs of professional work force, cost of medication (pharmaceuticals) and equipment, in addition to the cost associated with infrastructure and facilities.

Rising public expectations for health services and developments is another challenge facing government. This has led to increasing demands for high end
medical services with better quality and facilities (Oxford Business Group, 2007; Business Monitor International, 2011). As service quality has struggled over the past decade, Kuwait’s health care system has seen a strong decrease in patient satisfaction and confidence within the health system. According to the Kuwait Economic Society Public Opinion Survey in 2007, health care in Kuwait came third in terms of urgency to be improved by national government (Business Monitor International, 2011). Furthermore, in addition to the above challenges, ‘wastah’ (a Kuwaiti term, meaning ‘connectedness’) is also a major and escalating concern effecting health services. This term refers to the situation in which people with no medical priority bypass the waiting time and create major unfairness to eligible people (Al Mutairi, 2007). Currently, there is no central body that governs and constitutes ethical or regulatory guidelines (medical law) to minimise this.

The section below discusses the implications of the research findings in relation to the above-mentioned challenges.

10.3.1 Organisational implications

For PPPs to work in the organisational context it is important that the organisation is highly motivated and politically supported in effectively introducing potential mechanisms that will, in turn, aid the organisation in the achievement of its targets. Organisational mechanisms (team work, autonomy, accountability and professionalism) are thus the processes that can enable a health care organisation. Although these processes could work in the public or private sectors independently, this research has shown that such processes are triggering a positive effect when brought under the PPP model.

As the health system has three main functions (finance, regulation and service provision), the PPP model, in separating the service provision (delivery) from the finance and regulation while decentralising power and authority, has increased the range of choice for better decision making. This decentralisation has moved the institutional function from one central body (monopolistic) to peripheral agencies. Consequently, mechanisms such as teamwork, autonomy, accountability and professionalism have been enabled and have enhanced the overall performance.

However, for organisational decentralisation, policy makers and health managers should review the organisational structure of the MOH to ensure proper
planning for various functions within the organisation (finance, human resource, supply chain etc). Another key issue to consider is the importance of power distribution within the MOH and its entities (such as YADC), and their ability and capacity to cooperate. Various stakeholders have to be involved in a proper monitoring process to ensure that such PPP policy remains on course. Furthermore, policy makers and the government also have to review their HR policies and regulations, which currently incentivise people to work under the government sector due to the ease of work and time, thus discouraging people from working under the private element of the PPP, which is more competitive. Dealing with such issues will in turn avoid conflicts between private and public employees, which could potentially arise due to power shifts from government to private entities resulting in tension and a general resistance to change.

The effect of PPP decentralising the service provision of the health care system may be hard to capture. Despite seeing a good effect through the mechanisms introduced under the PPP model, the decentralisation process has to be further addressed to ensure proper planning and implementation in the health care system. This might involve operational, managerial, political and financial collaboration for further development of the process.

10.3.2 Financial implications

Health care finance in Kuwait, including purchasing and staff salaries, and covering all medical and non-medical services etc, is mostly managed by the government through its central department at the MOH,. While the MOH has a fairly good health care system, it also shows waste of resources and inefficiencies characterised by duplication of services, long bureaucratic procedures and misuses that unnecessarily inflate the health budget. It has been evident that the way the health care system is financed could determine the level of health care performance. Therefore, policy makers and health care managers should continuously revise and evaluate such issues or systems.

The PPP model’s payment method has introduced a financial mechanism which has managed to determine the service delivery and in turn affect the behaviour of professionals. YADC has created incentives to reduce unnecessary services and streamline operations. However, despite the capitation system’s benefit on the public
finance, the financial clauses were not flexible enough to adjust to and take account of the changes in demographics (increase in population) and adoption of new technologies. Further effort needs to be made to examine the existing payment method to address the current problems within the system.

Issues that need to be taken into account when redesigning the financial system for future projects include addressing how payment strategies affect the recruitment process, how payment methods affect employees’ overall performance, how payment methods can be used to encourage the adoption of new technology and capacity development, and how financial policies influence health service provider behaviour.

As Kuwait’s government continues to adopt PPP within its health care system, we can see the emergence of a new type of organisational structure. An understanding of the interactions of different participants (providers, health planners and purchasers) involved in such a structure must be made, along with an assessment of the impact on the resulting performance and its associated cost. The government needs also to take important steps in the MOH to ensure smooth transition, avoiding negative consequences. People in charge of designing and setting up the PPP need evidence not only of financial mechanisms and organisational structure affecting the cost and overall performance of the health care system, but also of policy features that are aligned with the context of the health care system.

10.3.3 Resource implications

Resource allocation and management are vital to any health care system, and it is necessary for such systems to set priorities within their limited resources. Government obligations are to decide the scope of spending on its health system, and this is governed by various determinants including financial, political and technical. The PPP model has shown various mechanisms that enhanced the resource allocation function. Kuwaiti policy makers and health sector leaders have to assess the need of the entire population in order to review and understand the health issues and ensure the enabling of these mechanisms. Collaborative effort from various stakeholders, including government, managers, facilitators and health practitioners, needs to be assembled and coordinated in view of making the whole practice of resource allocation embedded successfully in the entire health system.
As resources can be better managed under the PPP model, the MOH needs to introduce good practices on this PPP initiative. Effective resource management is greatly needed to achieve long-term health outcomes. YADC has opened a window of opportunity for proper practice in efficient resource allocation, which the MOH can benefit from. These resource allocations, opportunities and mechanisms introduced in the system require focus when strategically planning for their contribution towards achieving enhanced levels of health care objectives. The corporate culture mechanism of valuing resources needs to be supported and empowered by the health care system.

YADC has positioned itself in the market place and become part of the current health system. This enabling mechanism has improved and optimized the utilization of resources, hence policy makers ought to get prepared to identify the trends and issues relating to the PPP practice and their evolution in the market. This can be done for example by benchmarking YADC against similar services from both the public and private sectors and establishing a national programme that acknowledges the need for PPP and other public and private competitors to develop and maintain databases that help to evaluate the standard of various entities. This will allow governments to develop sector specific PPP programmes and maintain a continuous flow of PPP data which will enable them to secure the necessary resources and identify the various skills required. Creating such tables or rankings will act in the best interests of the community or end-user (patients) and the overall quality of the health care system.

The new model that YADC has been part of has created better manoeuvrability for decision-making and resource allocation. Kuwait’s MOH, as part of the government, has always suffered from rigidity and bureaucracy in decision-making. This has blinded the health sector to great improvement opportunities and the over use of resources. Health care sector leaders and policy makers should appreciate the importance of flexibility. The policy makers and managers should understand and address this challenge in order to appreciate the benefit that flexibility could bring. This flexibility will eventually lead to improved communication and make stakeholders actively listen to each other’s advice and so implement their tasks more progressively. Getting government and all the other stakeholders within the health care system to incorporate flexibility as one of the most important criteria when dealing with each other will eventually cause the whole system to realize better utilization of resources through consensus among all the stakeholders, brought about by flexible policies and negotiations.
As the MOH has suffered from highly centralised decision making and a lack of professional long term strategic planning, transparency is becoming increasingly important. Transparency has always been a cornerstone for any government competitiveness because of its direct effect on the society's wellbeing. The transparency process has been enabled through the PPP model, thus making a transparent and more open (accountable) environment which will expose inefficient systems and processes and so allow policy makers and managers to shift or direct their attention to address these issues. By doing so, more efficient use of resources can be directed to improve these areas and the resulting improvement in the systems and processes will lead to a positive knock-on effect on the entire health system.

Despite growing interest in adopting technology to improve health care system performance, there is still limited response towards such adoption. This limitation seems to occur despite the availability of such technological resources. The current bureaucratic system does not facilitate proactive adoption of these new technologies for use within the Kuwaiti health care system. A key reason for this is poor management that is due to a lack of understanding of the importance of adopting new technologies to create opportunities and improve the overall system. The PPP model has enabled technology adoption as part of a good resource allocation process by removing various barriers through the use of financial solutions, skilled staff, training and better communication etc. Governments need to address and capitalise on adoption of technology and realise the effect on the health system. As development of medical technology has recently been accelerating, proper steps are required to sustain and motivate such processes. PPPs could therefore be an excellent tool to ensure such adoption and diffusion of technology within the system.

10.3.4 Service provision implications

Due to the reasons discussed above (challenges in health care), it is apparent that the Kuwaiti MOH, despite an availability of resources, has failed to create excellence in health care. The low quality of service resulting in low patient satisfaction stems directly from political and managerial deficiencies.

On the other hand, YADC has demonstrated enhanced service provision through its strong and competent private sector partner. The government needs to promote, facilitate and support the private sector nationally and open up more
channels for involvement of international expertise and affiliations; doing so will stimulate the growth of a strong private sector. Furthermore, community involvement in the mainstream health care system is a key part of a PPP model that influences its overall success. The acknowledgement of community groups, advocates and figures through involvement in PPP programmes through consultation committees, creates a stronger platform to overcome the above mentioned barriers. Furthermore, the enhanced outcome of service provision has been enabled through a strong customer-oriented process that puts the patient at the centre of its activities and operations. Thus policy makers should consider the adoption of such mechanisms of good communication channels and strategies to deal with the community in order to achieve the health care objectives better.

Overall, as part of service provision, the PPP model has shown strong competitive mechanisms that have raised quality standards and enabled the centre to achieve many of its overall objectives. The achievement of organisational competitiveness allows the MOH to be more dynamic, scalable, renewable and more responsive to the open market. More collaborative effort is needed to put together and emphasise the importance of such mechanisms and processes in order to ensure such competitiveness. The people behind health care policy formulation should draw up criteria that can encompass all the relevant attributes of scaling, replicating and integrating the existing PPP model to improve future partnerships.

It is evident from the steps taken by the PPP model that to build services which pay attention to detail enables the health care programme to improve and achieve overall satisfaction for the end-users. Hence, such practices need to be applied and encouraged as an underlying principle to strengthen the overall service provided.

10.3.5 Implications for the patient/end-user experience

It is clear that the PPP model has raised satisfaction levels among the end-users of the service, especially relative to the existing facilities being managed by the MOH. The centre has been able to deliver the appropriate standard of service, treating patients fairly and resolving any arising obstacles, thus gaining patient satisfaction and trust. Fulfilling patient needs and requirements and engaging the patient at the centre of service delivery aids in the creation of optimum end-user satisfaction and
builds better experiences that facilitate the promotion of health. Hence, it is important to acknowledge the importance of patients’ experience and account for this in any health care planning.

10.3.6 Theoretical implications

Overall this research has contributed to several areas including health care system management literature, public policy and research methodology.

According to health care system management literature, PPPs have long been established in other sectors and nations, but the PPP concept is still a relatively new phenomenon in the Kuwaiti health care sector. Furthermore, the Kuwaiti health care system lacks substantial research data to provide a solid and scientific platform for health care researchers. This thesis has thus provided a holistic review of the Kuwaiti health care system, in addition to examining thoroughly the first PPP case in the country.

In addition to this, the research has highlighted specific issues for health care policy makers to address to improve future PPP implementation. Furthermore, the study has contributed to research methodology by assessing the PPP case study from a realist evaluation perspective, i.e. examining what within the PPP works in what circumstances.

10.4 Comparison with the literature

The following section discusses the findings of the main study by making connections with the ideas and theories outlined in the literature review. Based on the opinions of the different respondents interviewed and the end-users consulted, as well as the findings of the literature review, several issues can be identified regarding health care levers, mechanisms, contexts and outcomes, and the overall role of PPPs in the Kuwaiti health sector.

10.4.1 PPP objectives
The overall PPP experience seems to fulfil the theoretical objective of PPP, which according to the Higher Education Funding Council for England, (1997) includes the use of private sector funds, technologies, managerial skills and operational efficiency, the transfer of design, construction, and operational risks, as well as revenue stream risks and technological deterioration risks to the private sector, and better value for money, achieved by providing improved services at lower costs than can be obtained by traditional public procurement routes. The research has shown that YADC reflects proper use of private sector experience and know-how, as well as an ability to deliver infrastructure, while sharing operational and financial risk with the government. In addition to this, the PPP experience has also shown significant efficiency in utilizing health care resources.

Furthermore, in the literature (section 4.3.1), the five core aspects that represent the underlying philosophy of the NPM theory (Hays and Kearney, 1997), include downsizing (reducing the size of government), managerialism (using business protocols in government), decentralisation (moving decision making closer to the service recipients), debureaucratisation (restructuring government to emphasise results rather than processes) and privatisation (directing the allocation of government goods and services to outside firms). These aspects have been shown in the research findings (table 9.3).

10.4.1.1 PPP and streamlining (utilisation of resources)

Section 4.8.1 in the literature review explains that the private sector can provide better streamlining in the use of operations and greater innovation when it comes to utilisation of resources, in comparison to the public sector. Resource allocation refers to the allocation of funds and accessible resources such as human resources, capital investment or equipment, and the payment mechanisms for health service providers (section 2.4.3). In Europe, capitation is the means through which resources are allocated by calculating purchasers’ budgets. However, political negotiations, historical trends and lowest bids still rule across various other health systems (Elk, Mot, and Franses, 2009).

The PPP experience in the Kuwaiti health sector has changed the way resources are allocated from a time-based budget, usually based on historical estimations, to a population based block contract. This shift in power (decentralization) has resulted in the allocation of resources according to local
population needs and in allowing YADC to make its own decisions regarding different resources, recruitment, buildings, equipment etc.

The research has found that proper utilisation of resources requires the presence of two key aspects, need and awareness. It is maintained that, to ensure both good consumption and production of resource allocation in health planning, public demand should be promoted and prioritized through careful assessment. The importance of public consultation has indeed been supported by the literature (section 2.4.3 – Table 2.2): Mills AJ and Ranson MK (2006) identify nine key stages of purchasing health services, two of which include assessing the needs of a population and consulting public, patients and professionals on their values and priorities. In addition to assessing population needs, this research has found that to ensure good resource utilization and waste management, awareness among health care system stakeholders regarding such issues is key. Collaborative effort from all stakeholders and appropriate promotion of such issues are essential.

Furthermore according to the WHO (1990), decentralization in health occurs for many reasons including technical, political and financial (section 2.4.4). From a technical perspective, decentralization improves administrative and service delivery provisions (WHO, 1990). In agreement with this, the research has found that resources such as human resources and equipment have indeed been managed differently through the PPP. Overall, the PPP project has enhanced the adoption of new technology thus increasing efficiency in both administrative areas and service provision (which is often difficult under the existing public health system). Similarly, the automation of many of YADC’s operations and procedures has increased efficiency by reducing the number of staff required to perform a set task.

The PPP model has also shown a high degree of flexibility in meeting the demand for services. YADC has been able to cope with and adapt to different situations despite the contract being fixed in terms of budget allocation. For example, the initial PPP contract provided no consideration of population growth, scientific development, modern technology and equipment despite its long-term commitment. The eligible population for the services of YADC has been increasing since the opening of the centre; nonetheless, YADC has coped well with this by increasing operating hours and applying more efficiency measures. Furthermore, although the initial contract did not address the advancement in medical technology and the upgrade of equipment, the centre has been flexible in its upgrade to the latest
equipment to meet the interests of the PPP. Despite the fixed budget, YADC has negotiated with the government to increase the budget to meet rising demand.

Furthermore, on a financial note, the WHO (1990) mentions that decentralization seeks to increase cost efficiency by providing control of local resources to local owners, and increasing self-accountability. Likewise Taylor (2007), as mentioned in section 4.5 of the literature review, highlights that among the reasons that PPP’s use and support grew in the UK in 1992 are to ensure greater efficiency and transparency in the assignment of public money. He emphasizes that the fundamental objective of such partnerships is the delivery of enhanced services with increased efficiency and savings (hence more VFM).

In support of the literature, the research has found that PPP has indeed increased transparency in the allocation of public money, and has reduced the abuse of power within the MOH; resources have been assembled according to business cases to ensure their value for money. Similarly, the PPP model has also introduced a corporate culture of valuing resources by implementing processes and protocols to ensure good utilization of such resources (an issue that is critical in private sector profitable organizations). The use of an inventory system, streamlining operations and strict maintenance of equipment all reflect a tendency towards proper resource utilization and reduced wastage in the system.

YADC has also participated in free market competition with other diagnostic centres in attracting private patients for treatment outside the MOH’s working hours. This has ensured optimum utilization of time through operating longer hours. Secondly, competing for private patients has enhanced the centre’s competitive standards.

10.4.1.2 PPP and decentralisation

As explained in the literature review (section 2.4.1), regulation refers to the use of power by government to ensure the right actions are undertaken by health system actors (health reform right). This vital role for any government involves rules, policies and penalties. Regulation involves frameworks to create policies that govern the entire health system, in which interactive exchange occurs between institutional and non-institutional players (Mills and Ranson 2006).
This research has found that introducing PPP into the health care system has impacted on the way the system has been organized. It has separated regulation and finance from health care delivery, resulting in decentralisation. On a general note, in section 2.4.4 of the literature review, decentralization is defined as the shift or diffusion of power in public planning, management and decision making from the national to the sub-national level or from higher to lower levels of government (WHO, 1990). Philosophical interpretation of decentralization states that, at a pragmatic level, it is often suggested as a means of overcoming the administrative constraints exerted by institutions by transferring the development role from the centre to the periphery (WHO, 1990). This decentralisation requires that motivation and political supports are present.

For the PPP model to work effectively in the Kuwaiti health sector, both motivation and willingness towards cooperation from the public sector are essential. Cooperation from different levels of management in the public sector is especially key to facilitating the transition and implementation of PPP projects. Proper understanding and mutual agreement are vital and will improve PPP practices and procedures and create a better platform for the PPP organisation to accomplish its objectives. The research has found that political support for the PPP concept will also elevate pressure from top management of both the public and private sector entities, thus allowing them to perform in better circumstances.

The importance of public and private sector cooperation is greatly supported by the literature (section 4.3.5); the Institute of World Economy demonstrate in their analysis of NPM's strengths and weaknesses that disincentivization goes in parallel with incentivisation in their significance for policies success (Oehler-Sincai, 2008). It is emphasized that PPPs will not last without mutual trust between the partners and competent civil servants and officials. Hence, in order to avoid potential failure, the supervising and monitoring of government's activities by authorized third parties (who should control through disincentivization and incentivization) is crucial (Oehler-Sincai, 2008; Kolthoff, et al., 2007). Furthermore, in support of this, Roberts, et al., (2008) note that effective regulation has a significant role in achieving health system goals especially when it is associated with clear incentives, behaviour alteration and innovative organisational structure. They highlight that for health policy actors to make a significant change they need to consider their capability of enforcing processes, ensuring political assistance with good use of information monitoring.
This research has also found that the PPP model has given autonomy and independence to the management of YADC, and has thus enabled the centre to exceed performance standards. This has allowed them to set their own targets and monitoring protocols away from the bureaucracy and rigid structure of MOH. It has also resulted in more precise accountability structures (making people more accountable for their roles and responsibilities). Similarly, the research has found that the PPP experience enhanced the teamwork spirit and the drive to achieve targets as a group within the YADC. The centre has been functioning collectively as a unit with a results-oriented approach. A number of activities have facilitated this such as periodic official meetings (well documented and followed through) and the efficient use of internal emails between departments.

Such findings are in agreement with the literature (section 2.4.3); Elk, et al (2009) mention that the decentralization process also provides government with a clear distinction between the purchase of health services and the provision of health services, thus enhancing the service provider’s ability to manage its operations better. It is also noted in section 2.4.4 that decentralization motivates local bodies and gives greater local ownership, shifting power from a central structure and decreasing ethnic and/or regional tensions (WHO, 1990).

In addition to the above findings, it should be mentioned that YADC’s organisational structure has resulted in direct recruitment, which is a major advantage to the health sector in comparison to the conventional model where employees are recruited centrally for all MOH departments with no consideration to job specific criteria or skills. The separation of YADC has thus empowered the staff and enhanced their professionalism and commitment to the organisation’s protocols and policies. This consequently has improved the centre’s service delivery reputation, and significantly reduced social abuses of the system (such as ‘wastah’, discussed further below).

10.4.1.3 PPP and patient-centred care

The literature (section 2.4.4) clarifies that service provision describes the services or substances provided by the health sector. In other words, service provision is concerned with organisations that provide the service, the activities and tasks within such organisations, and the interactions between them. This research has found that the PPP model enhanced service provision by putting the patient at the centre of
health care (promoting patient-centred care). This is primarily due to the competencies of the private sector and increased community involvement (through surveys, consultations, public relations work etc.).

Private sector competencies are key to ensuring the success of the PPP model; core business practices such as innovation and efficiency in providing services are vital in the partnership model. YADC has set up a special department with a professional manager specializing in quality control studies, to ensure that the centre is up to date with the latest operational policies and quality standards. Such aspects have enhanced YADC’s competitiveness and reputation within its market. Pessoa, (2006) from the literature (section 4.2.2) mentions such competencies, noting that in comparison to the public sector, the private sector is often associated with strengths such as improved efficiency, innovation, quality and customer care, that ultimately stem from their aim to maximise profits and from increased competition among different players. Pessoa (2006) also mentions that private sector organisations are recognised for their improved management standards with better paid and motivated staff, and for their investment in research and development being sufficient to initiate new and innovative techniques. Similarly, Corry et al (1997) argue that public provision often suffers from lack of competition and constraints on investment, which can result in reduced innovations and quality (section 4.2.2).

In addition to the above, YADC has also promoted patient-centred care through ensuring that patients are always a priority, widely involving the community and making its services more responsive to local needs. It is found that better communication with the community will ensure a better platform for service provision assessment. For example, YADC has ensured significant attention to detail in its services, especially through its auxiliary services. A relaxed and safe atmosphere for the patients is promoted through services such as aesthetically pleasing spacious waiting areas, coffee shops and beverage serving counters, with state of the art internal design features. The centre has also improved access to facilities and services through appropriate and clear signage, welcoming reception areas and wide corridors. This is reflected through well-established open door policies, with no barriers to communication with staff, physicians and the management of the centre. A call centre has been established to handle care enquiries and facilitate communication. A complaints reporting system has also been set up to ensure that complaints involving the end-user are addressed within the system. Also, patient experiences are
documented through regular patient satisfaction surveys. The centre also provides a service for delivering diagnostic results to certain patients outside the centre.

The importance of community involvement has also been supported in the literature (section 2.4.3 – Table 2.2) by Mills AJ and Ranson MK (2006), who highlight that consultation with the public, patients and professionals on their values and priorities is key.

Furthermore, YADC has implemented a very strong PR policy to ensure a strong connection with the public, marketing and promoting their services, achievements, affiliations and activities through various media channels. Such practices have enhanced the centre's image, and are rarely seen under the public model.

10.4.1.4 PPP and financial incentives

Financial resources comprise investment costs of buildings and equipment, health care staff and consumables. As mentioned in the literature (section 2.4.2), the way in which these financial resources are being generated and managed poses key questions to policy makers and financial planners (Gottret, et al 2008). Health care financing fulfils 3 key tasks: collecting revenues, pooling revenues (risks) and purchasing services. Such functions can be integrated into one organisational body or divided between various institutions adopting the decentralization scheme.

The PPP experience in the Kuwaiti health care sector has changed the way the health care system is financed from a conventional budget allocation model, where financial budgets are made on historical data and government revenue goes directly to government organisations, to a way of financing that is allocated as a fixed budget directly to the health centre. In other words, the PPP has taken revenue from the government through a capitation system (fixed amount) to deliver health through non-government organisations aiming to make a profit while improving and maintaining service standards. To maintain such a model the research has found that both regulation and incentives are required.

Regarding incentives, it is noted in the literature that NPM theory highlights the importance of incentives to be more sensitive to the growing needs and demands of society (Walsh, 1995, in section 4.3.2). This research has also found that the provision of incentives is essential to the overall success of the PPP model. Prior to initiating any work on a PPP project, incentives need to be clear among all
stakeholders to ensure better alignment of PPP objectives between the public and private sectors. For example, as risks of cost overruns and delays under the PPP model rest with the private sector, they are incentivised to operate the centre optimally and maximize utilization of resources. As noted in section (4.6.1) of the literature review, the importance of incentives in this perspective has been highlighted by the Office of Federal Procurement Policy (1998), which sets out four key factors of performance based contracts, one of which includes compensation coupled with incentives/disincentives. Although the PPP contract in the Kuwaiti health sector is not a performance based one, perhaps such a contract would further incentivise the private sector to perform better. Furthermore, due to financial independence, YADC has been able to use financial means to incentivise their own employees and offer them rewards according to their performance or provide overtime payments. This has increased employee satisfaction, resulted in flexible working hours and has enhanced overall performance of the centre.

In addition to the above, the PPP model has also balanced the level of risk among stakeholders and provided them with reasonable expected returns. This has increased the confidence level of private firms to join such a large project while simultaneously reducing government liabilities. This is in agreement with the literature (section 4.8.1) where several authors note that among the strengths of PPP is the element of risk transfer between appropriate parties best able to manage them (Taylor, 2007;). Nisar, (2006) also mentions numerous types of risks emerging during the lifecycle of a PPP project, related often to design, construction and development, performance, operating cost, revenue variability and termination (section 4.8.1). Furthermore, Quiggin (2005) mentions that PPPs yield improved VFM by achieving an optimal allocation of risk. It is assumed that the private sector can provide services more efficiently and with greater innovation than the public sector (Nisar, 2007); the same service is provided at a lower cost thus ensuring VFM. The research has found that this model has also significantly reduced costs (on the public sector overall health care budget) without compromising the quality of service, and at times has raised its standards (see findings, Chapter 9).

With regard to regulation, it is found that to ensure success and eliminate failure, official financial regulations are required to facilitate both the PPP project and maintain the public interest in the health sector. Financial regulations will also increase private firms' confidence to join future PPPs in health care. Similarly, in
section 4.6.1 of the literature review, a study by Skietrys, Raipa and Bartkus, (2008), identifies 3 key prerequisites for efficient partnerships: 1) need, 2) the political, legislative and administrative environment, and 3) communication. The second prerequisite (the political, legislative and administrative environment) supports this finding of the research. Skietrys, et al. (2008) note that actions/strategies are in turn bound by the political, legal and administrative environment, and so suggest that the environment must have a dependable and stable policy and contract regulations that set down requirements and allow for international best practices in common types of PPP contracts. Thus ensuring these factors are present will allow for the establishment of partnerships with enhanced synergy.

10.4.2 PPP and health care objectives:

10.4.2.1 Equity

Equity as an objective of health systems can be explained as a universal equal access to health care (section 2.5 in the literature review). It is the fair allocation of resources or treatments among different individuals or groups. The WHO (1990) argues that decentralisation facilitates equity by bridging the gap of unmet demands and local empowerment, thus boosting efficient health performance (section 2.4.4).

Overall, the PPP model in the Kuwaiti health sector has maintained the high equity standards that already exist within the MOH, meeting society's requirement for justice. As mentioned in the literature and the fieldwork however, among the challenges affecting most public departments is 'wastah' (a Kuwaiti term, meaning 'connectedness'). Al Mutairi 2007 from the literature review (section 3.7.5), defines this as a syndrome which has a very dangerous effect on health services as people without medical priority bypass the waiting time and create major unfairness to eligible people. However, the research has found that YADC has largely eliminated the culture of 'wastah'. Various respondents from both the pilot study and the main study indicated that YADC has helped eliminate this issue, highlighting features such as the queuing number system at the centre, which has promoted the principle of equity. Thus, the introduction of PPP has proved a major stepping stone towards eradicating this problem mainly because of its independent management and the culture of accountability and profitability.
10.4.2.2 Efficiency

Efficiency as an objective of health care can be explained as making good, thorough and careful use of resources, without over consuming. It is measured on the basis of the best utilization of resources. Efficiency relates to resource inputs (i.e. cost, in the form of labour, capital and equipment) or intermediate outputs (numbers treated and waiting time) and the final health outcome (quality of life improved, life years gained). In other words, it refers to the amount of resources getting used (inputs) and the extent to which they are being utilised to produce services (outputs).

YADC has shown significant efficiency in resource input and output. As discussed, the input (yearly budget) has been fixed and is comparatively lower than other hospitals around Kuwait while having similar variables i.e. population, equipment and patients. The centre has shown higher output in dealing with a number of tests. This higher efficiency reflects the various mechanisms enabled by the PPP model such as quality accreditation, adopting new technology and measurable outcomes etc, as discussed above.

10.4.2.3 Effectiveness

Effectiveness in health care can be described as the extent to which an intended result is produced or the extent to which a health care target can be achieved (section 2.5). If service targets are not met then resources utilized will be lost and any resulting process will be considered inefficient. As mentioned in the literature (section 2.5), the public's demand for health systems to do more than just improve health has put pressure on policy makers to increase the effectiveness and scope of the health system (Hurst, 2002). Nowadays, quality of care, patient satisfaction and system responsiveness are vital. Kuwaiti public expectation for health service standards has been increasing in the last few years, in parallel with the economic boom seen in different sectors in Kuwait and in surrounding GCC countries (Oxford Business Group, 2007; Business Monitor International, 2011), as mentioned in section 3.6.

Overall the PPP model has resulted in enhanced effectiveness at YADC. The centre is able to deliver intended results at good standards through various mechanisms discussed above such as supervision procedures, standardised operations, policy implementation, training and education. The centre has also managed to reduce admissions of certain paediatric cases (document 8).
10.4.2.4 Choice

Today, patients are seeking greater engagement in health care choices, increasing the demand for high-quality information about clinical options. Thus, governments have become more concerned about knowing how patients perceive the quality and type of care they receive and the settings in which they receive this care. Therefore, reliance on surveys to measure these perceptions has greatly increased.

The PPP model has strongly enhanced the achievement of choice and responsiveness through a patient-centred approach. To support this, the centre has thoroughly monitored patient satisfaction, measuring and incorporating patients' experiences in all aspects of the organisation. This is reflected through various mechanisms introduced by the model such as a call centre, complaints system, practice of hospitality services etc. Surveys conducted provide information on patient perceptions related to treatment ethics, communication transparency, perceived barriers to provision of services and other forms of care.

In support of this, Corry et al (1997), cited in section 4.2.1, suggests that a public service (such as YADC) must have three main features: accessibility (which affects the price at which it can be offered); quality (to meet user needs and wants); and efficient delivery (efficient use of resources such as land, labour and capital). Similarly, Pessoa (2006) in section 42.1 mentions that the public sector, in providing public services, must have the means for ensuring equity and geographical availability, for controlling price, for being responsive to users' needs to improve quality, and for ensuring efficiency and technological innovation in delivery.

10.4.3 Overall achievement of the objectives

The PPP model represented through YADC seems to have significantly improved health care services by improving achievement of the health care objectives. PPP appears to have taken the strength of the public sector (equity and effectiveness) and managed to merge them successfully with the attributes of the private sector (efficiency and choice).

The fieldwork has demonstrated that, regarding efficiency, YADC is highly efficient in terms of budget allocation, human resources (by reducing the number of personnel required without compromising service quality) and reducing patient complaints. With regard to equity, the research has found that equity does indeed exist.
at the centre, as the centre is required to operate by the rules and regulations of the MOH, such that patients receive the treatment they require irrespective of social status or personal relationships. At YADC the queuing number system has especially promoted equity (patients are treated in turn, except in emergency situations), and ‘wastah’ (in which people in power working in management or in the hospital refer their friends or relatives before others) has been largely reduced resulting in a more equitable and reliable system. However despite this, it should be noted that although nationals do not have to pay for services, non-nationals have to pay additional fees.

Regarding effectiveness, YADC has achieved the desired result in terms of effectiveness, being able to provide services to cover the entire Adan area, and building good connections with Adan hospital departments. Finally, with regard to choice, the majority of respondents consulted were in agreement that there is a general lack of choice across the Kuwaiti public health system, with an inability to choose a preferred doctor or appointment. However as YADC operates during the evening (when it runs as a private facility), services can be accessed rapidly, thus increasing choice for those willing to pay. Similarly, customer satisfaction surveys undertaken at YADC are an example of the centre’s attempt to understand patient requirements, complaints, and demands better so as to address and account for these.

Nonetheless, despite the achievement of the health care objectives to some extent, there are a number of barriers and obstacles that have impinged upon and compromised the PPP process.

An unstable political environment is a key obstacle hindering the PPP’s progress. To effectively implement the PPP model in health care, public policy and governance needs to remain consistent. This will enable the setting of a long-term vision for prioritizing health policy relative to other government plans for health care. The beliefs, views and attitudes of government agencies regarding health care challenges are not clearly set and prioritized. Widespread political hyperactivity within the evolving democratic process also indicates the importance of prioritizing the issues and addressing them accordingly. The effect of such an obstacle was also mentioned under the literature review (section 4.9.2), where it is noted that inefficient public procurement frameworks are due to public clients failing to incorporate PPP projects in their development plans (Zhang, 2005).

YADC has encountered difficulties in its practices due also to insufficient legal and financial frameworks. The current legislative system for introducing new
legal frameworks for the health care sector has been overlooked for many years. Regulation of PPPs for the health sector lacks clarity in terms of the legal and financial duties of various stakeholders (regulator, financier, service provider and the supervisory committees). Although new regulations to govern PPP projects in Kuwait have recently emerged, (such as Law-7/2008– www.ptb.gov.kw and the Partnership Technical Bureau - PTB), at the time this PPP project was initiated no measures were taken to oversee the legal parameters or relationships governing this partnership and there was a general reliance on non-PPP specific laws to govern the project. It should also be noted that even after the PTB was created, there is still, to date, no clear relationship or channel between the PTB and its associated MOH office (for sharing knowledge and information regarding activities and progress of PPP’s). Zhang (2005) from the literature review (section 4.9.2) has also identified that a poor legal framework with unenforceable contracts increases government restrictions and public resistance to PPP.

Furthermore, inexperienced government bodies with limited knowledge of the PPP concept have prevented the progress and promotion of PPP practices in the health sector. The MOH has suffered from a lack of professional health care managers and leaders. There is insufficient skill and ability within the MOH to analyze, identify and capitalize on PPP opportunities. Consequently, various PPP functions and milestones are not adequately monitored by the public sector. This is in turn compromising the confidence of private sector participants towards partnerships with the government.

It is also apparent from the research findings that there has been a noticeable resistance to change from public sector employees, managers and physicians towards PPPs. Scepticism (regarding the soundness of PPPs), hidden agendas, threat to position and loss of status and privileges are key reasons for this. A number of managers, staff and physicians, responsible for different diagnostic departments under the original setting of Adan Hospital, lost their positions after the formation of YADC. Some of these individuals have been recruited in the supervisory committee for PPP in the MOH, resulting in what appears to be lobbies challenging the PPP idea. At YADC there is indeed a degree of hostility and divergence in management practices and philosophies between public and private partners.

In addition to the above obstacles, another key issue is ambiguity in understanding the concept of ‘partnerships’. The degree of cooperation and the influence each
sector's institution has on the project is critical to understanding. Clear, open and transparent communication channels and sufficient information exchange is required.

Furthermore, unclear goals and lack of specification and detail in the PPP contract, in terms of the type and capacity of work required and public and private relations, has negative effects throughout the course of the project. Interviewees from both the public and private sectors were in agreement that the model left many issues unclear, in that it provided no consideration of population growth, scientific development, modern technology and equipment despite its long-term commitment. Such issues indicate that there is a deficiency in the drafting of the initial contract, which requires examination and perhaps a degree of flexibility to accommodate such future issues.

Many of these issues have also been highlighted by several authors from the literature review. McQuaid (2000) in section 4.8.1 indicates that unclear goals are a main trigger for problems and partnership failures as they can lead to misunderstandings and inadequate coordination among players. Such problems are enhanced especially if certain partners have hidden goals and agendas. Similarly, Stewart, (2003) in section 4.8.1 notes that lack of transparency in numerous PPP arrangements is due to fragmentation and institutional complexity within the public sector. It is also mentioned in section 4.8.1 that this results in lack of clarity regarding accountability structures (Hood, Fraser, and McGarvey, 2006). Furthermore, Quiggin, (2005) has also made reference to the impact of long-term inflexible PPP contracts on public sector government in particular. It is suggested that such contracts cause the public sector to lose any benefits that can arise from the entry of new competitors, and to lose the ability to alter contract terms significantly in response to changing needs and conditions (section 4.8.1). Any contract variations must be negotiated with the private sector partner and this often entails additional and substantial costs and delays.

Finally, lack of proper evaluation has been a key barrier to the progress of the PPP project. Although six years have passed since the initiation of the PPP model, this current research forms the only evaluation study undertaken examining the project from the start. This PPP model (YADC) seems to lack systematic and independent methods from the MOH (apart from routine data collection) for collecting and analyzing data to highlight performance indicators about the project and its policies.
10.5 Limitations of the method

This section discusses the limitations of the research and the issues that were encountered while undertaking the literature review, the research design and questionnaires.

While undertaking the literature review, it was found that there are a limited number of studies regarding PPPs in health care services worldwide. In most cases, to overcome this, the author had to refer to the literature of PPP implementation in other sectors. It was also found that there was a significant lack of good academic literature about Kuwait's health care sector in particular. To compensate for this, the author went on numerous field visits to places such as Kuwait's House of Parliament and other institutions to gather appropriate information.

With regard to the research design, the author found that the realist evaluation approach adopted for this research requires no specific or practical guidelines for data collection and analysis. Therefore, this study has applied best practice in its qualitative design to justify this shortcoming. Data was collected through semi-structured interviews, questionnaires and document review so as to achieve the CMO framework. Thus many of the mechanisms identified were a result of interpretations of various themes that have emerged through this approach.

Furthermore, although the health care objectives of efficiency, effectiveness, equity and choice can be measured specifically through indicators, in this study data has been collected and interpreted qualitatively in line with the aim of this research. Specific indicators would require a longer time frame along with substantial amounts of quantitative data, which is not readily available in the Kuwaiti health sector, and is thus outside the scope of this research.

In accordance with the realist point of view of evaluating a situation from various perspectives, the opinions of the fifth stakeholder (end-user patients) were gathered. Due to the nature of the fifth stakeholder, a quantitative study was undertaken to ensure a representative sample and non-biased opinion. However, despite achieving a good response rate, the data was analyzed descriptively to support the qualitative finding. Statistical analysis was not undertaken as this did not serve the aim of this study. Nevertheless statistical analysis would be beneficial and can be used for future publications on areas dealing with patient experiences.
Furthermore, it should be noted that this research contains a degree of researcher bias (where the author’s profession may have influenced the opinions of interviewees consulted). The author in addition to being a researcher is a physician and part of the Kuwaiti MOH organisation. This may have caused some degree of bias or variation in the interviewees’ expressed views (for example, trying to be over-polite thus concealing some aspects of the reality, or being suspicious and diplomatic). This may have in turn led to important themes or mechanisms being overlooked. Nonetheless, the author clarified to all interviews the neutrality of his position, and the purpose of the research at hand.

Finally, as this research is context-specific to the Kuwaiti health sector, there is some degree of restriction in the applicability of its findings to other domains or public sectors.
10.6 Call for further research

This thesis has highlighted various areas that could require further investigation. Future research should consider the following:

1. **PPP and health care organisation:**

   Further research is needed to investigate how PPPs could reshape the health care organisation’s structure and the impact of such reshaping on various organisational functions and cultures.

2. **PPP and human resource policy**

   The impact of PPPs on national HR policy could be further investigated. This research has brought to light various concerns which require further study, particularly because the Kuwaiti government operates a national policy of recruitment within its ministries, while the recruitment process in a PPP is independent from the direct control of the government. As the PPP model evolves, a burden could be left on the government, as many of the job posts will be under the control of the private sector, especially because the private sector has a tendency to recruit more expatriates on lower salaries. This situation can also create potential wage gaps between public and the private sector employees.

3. **PPP and health finance**

   Further research could be undertaken on the impact of potential financial models within the PPP (prepaid or reimbursed fixed budget, capitation or service based models) on the private sector partner behaviour and on the various stages and functions of the PPP.

4. **Legal**

   As the PPP model evolves, various gaps in the existing legal structure can create uncertainty for both public and private stakeholders, thus impeding the growth of PPPs. Further research might be needed to develop specific health sector PPP laws that can govern and clarify various aspects within PPP practice. Such areas can include procurement practice, provision of public infrastructure, conflict resolution, and end-user rights and obligations.
10.7 Conclusion

As health care directly affects people’s wellbeing, it has always been, and will continue to be, a unique and fundamental part of any government’s planning and strategy. Health care systems worldwide, whether private or public, face numerous ongoing challenges. PPP has been investigated as an evolving tool to address such challenges and provide long-standing solutions to benefit both the public and private sectors. This research has found that a PPP is able to deliver far more than infrastructure in health care settings.

Kuwait’s health care system is primarily a public system combined with recent strong and growing contributions from the private sector. The numerous challenges faced by the Kuwaiti health care system indicate strong warnings, which need to be addressed by policy makers. This research has thus looked at NPM theory, and thoroughly examined whether the introduction of market tools within the Kuwaiti health care system enhanced health system outcomes (of efficiency, equity, effectiveness and choice). It was found that the recent PPP experience in the Kuwaiti health sector has introduced market tools (incentives, competition, profitability, innovation etc) that have a significant impact on the four health care system levers (resource allocation, organisation, service provision and finance). This impact has introduced and activated various mechanisms (processes) that facilitate improved achievement of health care system objectives (outcomes). Furthermore, this thesis identifies various contexts (platforms) for these mechanisms to operate as a synchronized process. Thus the PPP experience in the Kuwaiti health sector has brought about enabling mechanisms that have enhanced the overall achievement of health care outcomes. In addition, PPP objectives (such as reduced cost, elimination of bureaucracy, private sector involvement and profitability etc) in the health care system itself have not shown any contradiction with the health care system objectives, if implemented in the right context.

Various stakeholders consulted in this research have agreed that the PPP experience (YADC) has demonstrated an improvement in the performance of health services and ensured the best interest of the community. Furthermore, the thesis has shown that the PPP experience has resulted in appropriate risk sharing arrangements, which have in turn improved overall performance of YADC. Assigning risks and responsibilities to parties best able to manage them has created added value, which
was lacking in the previous public sector model. YADC has also assisted the government in reducing costs and delivering its service economically. In addition to this, the involvement of the private sector has created a competitive environment and has assisted in the elimination of government bureaucracy and monopoly.

Nonetheless, despite the advantages of the PPP experience, the research has highlighted various obstacles that have impinged upon and compromised the PPP process. These include unstable political environment, with no long-term vision for prioritizing health policy, as well as insufficient legal and financial frameworks. Inexperienced government bodies with limited knowledge of the PPP concept is another obstacle that has prevented the progress and promotion of PPP practices and has reduced confidence of private sector participants towards such partnerships. In addition, other key issues that had negative effects throughout the course of the project include ambiguity in understanding the concept of partnerships among health care managers, as well as unclearly documented goals and lack of detail in the PPP contract in terms of the type and capacity of work required and public and private relations. The research has found that the PPP model left many issues unclear, providing no consideration of population growth, scientific development, modern technology and equipment, despite its long-term commitment. This indicates that there is a fundamental deficiency in the drafting of the initial contract, which requires examination and perhaps a degree of flexibility to accommodate such future issues.

Nevertheless, to ensure that PPP objectives (reduced cost, elimination of bureaucracy, private sector involvement and profitability) are maintained, while protecting the ultimate health care system objectives, various recommendations for health care policy makers and managers are suggested below. Through the implementation of such recommendations, PPP models in health care can evolve into more consolidated and refined versions.
10.8 Recommendations

Based on the findings of this research, the following recommendations for health care managers and policy makers are suggested:

For policy makers:
Legal framework – Regulatory changes are required with specific clarification of the processes and good practices of PPP in health (such as project approval processes) in order to encourage greater confidence and further private sector investment. Such regulatory changes should also ensure proper due diligence to evaluate the credentials of the private sector and the management of the project (to ensure commitment and capability). Furthermore, a comprehensive PPP contract that is implemented within a regulatory system which protects various stakeholders is essential for partnership success. A specific PPP law for the health care system will certainly indicate the political willingness to pursue PPP programmes and could trigger more PPP projects in the future.

Financial framework – A financial framework is required that can demonstrate the value for money and the economic advantage of PPP to the MOH. Such a framework should also identify the financial scope of a PPP project during various project stages (design, build, operation and maintenance), as well as allow for changes or uncertainties that may occur throughout the course of the project. Such a framework should be reviewed regularly to avoid future disputes and to keep pace with changes in health care.

Independent authority – The creation of an independent health care authority with a special PPP unit is recommended. Such a health authority needs to provide the PPP with support (assisting in the alignment of private-public objectives) and regulation, as well as set appropriate standards for members from a non-biased perspective.

For health care managers:
Management training and development – Adequate training needs to be provided to both public and private management to ensure proper understanding of the importance and value of PPP. This can include the introduction of professional development programmes that help to understand better various elements of a partnership, as well as the importance of
communication and service delivery standards. Furthermore, effective resource management is greatly needed to achieve long-term health outcomes, and the corporate culture mechanism of valuing resources needs to be supported and empowered by the health care system. In addition to this, improved communication among all health care stakeholders, and especially between the PPP bureau in Kuwait and the MOH’s top management, is recommended.

Appropriate human resource and recruitment policy – Management has to ensure a good HR and recruitment policy. Competency frameworks should be designed to identify and select suitable professionals, and create incentives to attract and retain talent. This is essential especially to overcome the human resource challenges mentioned in the research, such as the resistance to the PPP model by staff that lost their previous power/position after the creation of YADC. Furthermore a system needs to be implemented to align strategically the health organisations recruitment and performance assessment with the perceived patient experience.

Independent Evaluation – An independent supervisory committee is needed as opposed to the current committee, which is under the MOH. These processes should encompass proper transparency measures that ensure fair assessment towards various stakeholders.

Best practice guidelines – Best practice guidelines for PPP projects in health care (from design through to operation and maintenance) are required to ensure better implementation, execution and evaluation of projects.
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WHO, World Health Organisation. (2009), Kuwait profile, *Demographic and health indicators*, WHO


Appendix 1 - Pilot study research sample profile

Government Partner representatives:
1. Name: Dr. Eaman Al Shammari
   • Designation: Head of Nuclear Medicine in Farwaniya Hospital
   • Qualifications & Recognitions:
     o Received the American Board of Nuclear Medicine in Kuwait 1993: Consultant at the Ministry of Health
     o Has 20 years of experience in nuclear medicine
     o Nominated by the Ministry of Health to be a member of the supervising committee for project YAICO Diagnostic Centre

2. Name: Yahya Abol Fotooh
   • Designation: Worked as a legal consultant for the Minister of health in Kuwait 1975-2006
   • Qualifications & Recognitions:
     o Bachelor’s of Law, Cairo University 1962
     o Masters of Administrative Law
     o A witness on the growth and development of the Kuwaiti health sector

Private Partners representative
3. Name: Dr. Arfaat
   • Designation(s): Head of the Laboratory Department & Director of the YAICO Diagnostic Centre. He is also the head of the Biochemistry department in Adan Hospital
   • Qualifications & Recognitions:
     o Bachelor’s of Medicine, Kuwait University 1986
     o Fellowship of the Royal College.

4. Name: Mohammed Afifi
   • Designation(s): Consultant for the Chairman of YAICO Company
   • Qualifications & Recognitions:
     o Bachelor’s of Pharmacy, Cairo University 1958
     o Post Grad. Diploma in Management, Kuwait University, 1973
     o Over 50 years of experience in the field of medicine and pharmacy
Independent Academic

5. Name: Dr. Maktoum Ali Shah

- Designation: Dean of the School of Business and the School of Allied Health Science in the University of Gujrat

- Qualifications & Recognitions:
  - John Hopkins School of Hygiene & Public Health Graduate, 1975
  - Fellowship of the American School of Allied Health Professions
  - Chairman of the Federal Bureau of the Public Health in the Kuwait Institute of Medical Specialization
  - Consultant to the Ministry of Health in areas of Program Planning & Implementation Evaluation.
Appendix 2 - Pilot study interview questionnaire

1. Before we begin, please provide a brief description of yourself (job title and number of years experience in this field)?

2. Please describe the financial model used for the PUBLIC PRIVATE PARTNERSHIP experience in the Kuwaiti health sector (YIACO DIAGNOSTIC CENTER)? What are the advantages and disadvantages of this model?

3. Please describe the organisational structure of the PUBLIC PRIVATE PARTNERSHIP project (YIACO DIAGNOSTIC CENTER)? What are the advantages and disadvantages of this structure?

4. How have the resources such as staff, buildings, and equipment been allocated in this project (YIACO DIAGNOSTIC CENTER)? What are the advantages and disadvantages of this resource allocation?

5. Has the service been delivered differently? What are the advantages and disadvantages of the service delivery?

6. If efficiency is defined as making good, thorough, and/or careful use of resources, without over consuming, do you think the PUBLIC PRIVATE PARTNERSHIP experience in the Kuwait health sector (YIACO DIAGNOSTIC CENTER) has enhanced health care system efficiency? If yes, how. If no, why

7. If equity is defined as a societies requirement for justice and fairness, do think the PUBLIC PRIVATE PARTNERSHIP experience in the Kuwait health sector (YIACO DIAGNOSTIC CENTER) has enhanced health care system equity? If yes, how. If no, why

8. Do you think the PUBLIC PRIVATE PARTNERSHIP experience in the Kuwait health sector (YIACO DIAGNOSTIC CENTER) has enhanced the health care system choice for patients? If yes, how. If no, why

9. If effectiveness is defines as the capability of producing an intended result, do you think the PUBLIC PRIVATE PARTNERSHIP experience in the Kuwait health sector (YIACO DIAGNOSTIC CENTER) has enhanced health care system effectiveness? If yes, how. If no, why

10. Do you think the PUBLIC PRIVATE PARTNERSHIP experience (YIACO DIAGNOSTIC CENTER) has enhanced the financial risk protection of the health care system? If yes, how. If no, why
11. Do you think the PUBLIC PRIVATE PARTNERSHIP experience (YIACO DIAGNOSTIC CENTER) has enhanced customer satisfaction of the health care system?
   If yes, how
   If no, why

12. In your opinion, has the PUBLIC PRIVATE PARTNERSHIP experience in the Kuwaiti health sector (YIACO DIAGNOSTIC CENTER) been successful to date?
   If no, why
   If yes, how

13. Which of the following factors, in your opinion, have a positive effect on the PUBLIC PRIVATE PARTNERSHIP experience (YIACO DIAGNOSTIC CENTER)?
   Demographic
   Economic
   Legal
   Political
   Epidemiological
   Environmental
   Technological

14. Which of the following factors, in your opinion, have a negative effect on the PUBLIC PRIVATE PARTNERSHIP experience (YIACO DIAGNOSTIC CENTER)?
   Demographic
   Economic
   Legal
   Political
   Epidemiological
   Environmental
   Technological

15. What, in your opinion, are the key weaknesses of the PUBLIC PRIVATE PARTNERSHIP experience in the Kuwait health sector (YIACO DIAGNOSTIC CENTER)?

16. What, in your opinion, are the key strengths of the PUBLIC PRIVATE PARTNERSHIP experience in the Kuwait health sector (YIACO DIAGNOSTIC CENTER)?

17. What, in your opinion, are the key opportunities to implementing a project such as YIACO DIAGNOSTIC CENTER in Kuwait?

18. What, in your opinion, are the key threats and barriers to implementing a project such as YIACO DIAGNOSTIC CENTER in Kuwait?
Appendix 3 - Main study interview questionnaire

Before we begin, please provide a brief description of yourself (job title and number of years experience in this field)

1. What are the objectives of PPP’s in the Kuwait health care system?

2. What are your objectives in being a part of a PPP in the health care system?

3. Do you think the PPP experience in the Kuwait health sector has enhanced health care system efficiency (by making good, thorough, and/or careful use of resources; without consuming extra)?
   If yes
   If no

4. Do you think the PPP experience in the Kuwait health sector has enhanced health care system equity? (Equity is the concept or idea of fairness)
   If yes how
   If no why

5. Do you think the PPP experience in the Kuwait health sector has enhanced health care system choice for patients?
   If yes how
   If no why

6. Do you think the PPP experience in the Kuwait health sector has enhanced health care system effectiveness (by producing or being capable of producing an intended result)?
   If yes how
   If no why

7. What effect has the financial model used for the PPP in the Kuwaiti health sector had on the health care objectives (efficiency, equity, choice, effectiveness)?
   How? Please describe the mechanism?

8. What effect has the organisational structure of the PPP project had on the health care objectives (efficiency, equity, choice, effectiveness)?
   How? Please describe the mechanism?

9. What effect have the resources (such as human capital, equipments, building) that have been allocated to the project had on the health care objectives (efficiency, equity, choice, effectiveness)?
   How? Please describe the mechanism?

10. What effect has the way the service is being delivered in the PPP project had on the health care objectives (efficiency, equity, choice, effectiveness)?
    How? Please describe the mechanism?

11. What factors, conditions, platforms, or circumstances, in your opinion, had a positive effect on the PPP experience?

12. What factors, conditions, platforms, or circumstances, in your opinion, had a negative effect on the PPP experience?
Appendix 4 - Customer Satisfaction Questionnaire

We are pleased to have been of service to you during your recent visit to the YIACO Diagnostic center.

The following questions concern the quality of the facility and health care rendered.

Your responses will be given individual attention and serve as input as we continually work to improve services at our center.

<table>
<thead>
<tr>
<th></th>
<th>Excellent</th>
<th>4</th>
<th>Very Good</th>
<th>3</th>
<th>Good</th>
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<th>Poor</th>
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For each item identified below, circle the number to the right that best fits your judgment of the quality of our service.

Use the scale above to select the quality number.

<table>
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<tr>
<th>Service</th>
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<tr>
<td>1 Ease of making your appointment by telephone</td>
<td>5 4 3 2 1</td>
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<tr>
<td>2 Waiting time at reception area</td>
<td>5 4 3 2 1</td>
</tr>
<tr>
<td>3 Friendliness and courtesy of the staff</td>
<td>5 4 3 2 1</td>
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<tr>
<td>4 Correct diagnosis and treatment was provided</td>
<td>5 4 3 2 1</td>
</tr>
<tr>
<td>5 Related health services were prompt and courteous</td>
<td>5 4 3 2 1</td>
</tr>
<tr>
<td>6 Hours of operation convenient for you</td>
<td>5 4 3 2 1</td>
</tr>
<tr>
<td>7 Overall cleanliness and comfort</td>
<td>5 4 3 2 1</td>
</tr>
<tr>
<td>8 Standard of equipment/service</td>
<td>5 4 3 2 1</td>
</tr>
<tr>
<td>9 Health care information/education was provided</td>
<td>5 4 3 2 1</td>
</tr>
<tr>
<td>10 Follow up care was prompt and efficient</td>
<td>5 4 3 2 1</td>
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<tr>
<td>Rate Your Overall Satisfaction with:</td>
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</tr>
<tr>
<td>11 The Health Center</td>
<td>5 4 3 2 1</td>
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<tr>
<td>12 The quality of health care received at</td>
<td>5 4 3 2 1</td>
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<tr>
<td>13 General facilities</td>
<td>5 4 3 2 1</td>
</tr>
<tr>
<td>14 Reception and appointments</td>
<td>5 4 3 2 1</td>
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Suggestions (if any):

__________________________________________________________________________

__________________________________________________________________________

Name (optional): __________________________________________________________

ID # (optional): __________________________________________________________

□ Male □ Female
## Appendix 5 – Framework Analysis

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<td><strong>1. What are the objectives of PPPs in the Kuwait health care system?</strong></td>
<td><strong>To raise the quality of health care services</strong></td>
<td>Business &amp; financial consultant - Private sector</td>
<td>Assistant Undersecretary for Financial Affairs - MOH</td>
<td>Biomedical Engineer</td>
<td>Quality assurance officer</td>
<td>Consultant, HOD - Radiology</td>
<td>Consultant, HOD - Nuclear Medicine</td>
<td>Corporate Planning Manager - Private Sector</td>
</tr>
<tr>
<td><strong>How will you measure their success?</strong></td>
<td><strong>To provide better services</strong></td>
<td><strong>To make the health care system more efficient and more accountable</strong></td>
<td><strong>Improving the level of service</strong></td>
<td><strong>To provide services in high quality, To develop the health services and adding new services</strong></td>
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<td><strong>Assist government in reducing cost</strong></td>
<td><strong>Reduce the cost and budget</strong></td>
<td><strong>To reduce the administrative and financial burden on the MOH</strong></td>
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<td><strong>Alleviate MoH’s burden</strong></td>
<td><strong>To eliminate the government monopoly</strong></td>
<td><strong>Facilitate the work procedures by elimination of government bureaucracy</strong></td>
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<td><strong>Eliminate beurucracy &amp; centralization</strong></td>
<td><strong>The global trend towards involve private sector in provision of health services</strong></td>
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<tr>
<td><strong>Involve the private sector in health care provision (create competitive environment / eliminate government’s monopoly)</strong></td>
<td><strong>Optimal allocation of resources (financial and human, Support the local economy</strong></td>
<td><strong>To reduce the cost</strong></td>
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<tr>
<td>Improve the quality of health care services</td>
<td>To deliver health care services in most efficient way. The main objective of PPP is to develop the health care sector by raising the competition and improving the quality.</td>
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<td>Assist government in reducing cost</td>
<td>Reduce the cost of the diagnostic services For government it save the allocated budget for health care and minimize their responsibility.</td>
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<td>Alleviate MoH's burden</td>
<td>Help the ministry to provide better health care services To reduce the administrative burden for the ministry</td>
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<tr>
<td>Eliminate beucracy &amp; centralization</td>
<td>To enhance transparency, commitment and quality. My objectives will be avoiding bureaucracy To Shift towards decentralization in decision-making</td>
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<td>Involve the private sector in health care provision (create competitive environment / eliminate government's monopoly)</td>
<td>Reduce the cost of the diagnostic services</td>
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1. What are the objectives of PPPs in the Kuwait health care system? How will you measure their success?
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<td>Improve the quality of health care services</td>
<td>Improve the level of service, Developing the health care services, Recruiting the professional staff</td>
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<td>Improve the quality</td>
<td>Improve the level of service, Developing the health care services, Recruiting the professional staff</td>
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<td>Improve the level of service</td>
<td>Improving human resources, Improving the quality level of services</td>
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<td>Developing the health care services, Recruiting the professional staff</td>
<td>Establish a new experience to improve the quality of health services</td>
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<td>Respondent 22</td>
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<td>Improving human resources, Improving the quality level of services</td>
<td>Development of health services provided to patients</td>
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<td>Respondent 23</td>
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<td>Establish a new experience to improve the quality of health services</td>
<td>Improving the level of service</td>
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<td>Development of health services provided to patients</td>
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<td>Improving the level of service</td>
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<td>Respondent 26</td>
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<td>Improving the level of service</td>
<td>Raise the level of services provided to clients</td>
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1. What are the objectives of PPPs in the Kuwait health care system? How will you measure their success?

- Improve the quality of health care services
- Improve the level of service
- Developing the health care services, Recruiting the professional staff
- Improving human resources, Improving the quality level of services
- Establish a new experience to improve the quality of health services
- Development of health services provided to patients
- Improving the level of service
- Reduce the cost of the provided services
- Reduce the financial burden

- Reduce the allocated budget
- Save the government budget
- Reduce costs
- Alleviate MoH's burden
- Eleminate beurucracy & centralization
- Involve the private sector in health care provision (create competitive environment / eliminate government's monopoly)
- Proof of the ability of the private sector to manage projects of health services

MOH Family medicine Doctor
Head of lab department in Al Adan Hospital
Head of Financial department in Al Ahmadi Health District
Chief Tech - Radiology
Admin. & financial affairs supervisor - Al Ahmadi District
MOH Financial
Public Supervisory
Private
Supervisory
Private
Public

Head of Business Strategy - YAICO Co.
Private Officer - YAICO
Reception Medicine supervisor
Organizer Ahmadi Sector Co.
Doctor Al Ahmadi Health Hospital
District
Doctor
Private
Consultant - Implementation - Radiology
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<td>Financing</td>
<td>Sr. Microbiology Doctor</td>
<td>Business &amp; financial consultant - Private sector</td>
<td>Secretary - Radiology</td>
<td>Sr. Consultant, HOU - Microbiology</td>
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<tr>
<td>Improve the quality of health care services</td>
<td>Improve the level of service</td>
<td>Provide better services to citizens similar to what are available in the private sector</td>
<td>Improve the quality and level of services</td>
<td>To raise the quality of the health care services.</td>
<td>To increase the efficiency.</td>
<td>To deliver high quality diagnostic services to the public.</td>
<td>To enhance the quality of provided services</td>
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<td>Reduce the cost and the financial burden for the ministry</td>
<td>To increase the efficiency and reduce the cost of health care services provided.</td>
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<td>Alleviate MoH's burden</td>
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<td>Reduce the financial burden</td>
<td>To reduce the responsibility and the accountability of the government.</td>
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<td>Business &amp; financial consultant - Private sector</td>
<td>Assistant Undersecretary for Financial Affairs - MOH</td>
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<td>Corporate Planning Manager - Private Sector</td>
<td>Director of YAICO-ADAN center</td>
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**Question Posted**

2. What are your objectives in being a part of a PPP in the health care system?

**Theme extracted**

- **Enhance private company's reputation**
  
  - The objective is to establish a successful experience of partnership in the health care field, which could be used as a reference when there is a need to apply PPP model in other fields.
  
  - To achieve the precedence in the partnership experience and open the way for further experiments depending on the success of the current.
  
  - Get variable mileage in health care sector and strength the company profile.

- **Establish a reference for upcoming projects**
  
  - To establish a reference for the concept of PPP

- **Provide better services**
  
  - To achieve an excellent level in the medical field

- **Eliminate government bureaucracy**
  
  - Provide high-quality health care service that gives the priority to patients

- **Making financial profits**
  
  - Facilitate work procedures (elimination of government bureaucracy)

- **Exchange of experiences and transfer of knowledge**
  
  - Achieving financial profits

- **Get several benefits (experience, financial, etc)**
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<td>Consultant, HOU - Histopathology</td>
<td>MOH GP</td>
<td>Director</td>
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<td>Sr. Accountant</td>
<td>Head of IT department</td>
<td>Lab Operation Coordinator</td>
<td>Chief Tech - Radiology</td>
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**Question Posted**

1. **Enhance private company's reputation**
   - **Theme extracted**: To enhance the reputation of the company
   - **Objective**: Build up a reputation in order to achieve superiority over competitors

2. **Establish a reference for upcoming projects**
   - **Theme extracted**: To enhance the mechanism of control

3. **Provide better services**
   - **Theme extracted**: To provide better services to the clients and get their satisfaction
   - **Objective**: Help the ministry to provide better health care services

4. **Eliminate government bureaucracy**
   - **Theme extracted**: To improve the experience and make profits
   - **Objective**: To make profits

5. **Making financial profits**
   - **Theme extracted**: To achieve financial profits
   - **Objective**: Achieve financial profits for the company

6. **Exchange of experiences and transfer of knowledge**
   - **Theme extracted**: To gain experience in this field

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<td>Radiology Reception Organizer</td>
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<td>Admin. &amp; financial affairs supervisor - Al Ahmadi District</td>
<td>Chief Tech - Radiology</td>
<td>Head of Financial department in Al Ahmadi Health District</td>
<td>Head of lab department in Al Adan Hospital</td>
<td>MOH Family medicine Doctor</td>
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<td>Enhance private company's reputation</td>
<td>Support the company's reputation in the health services sector</td>
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<td>Provide better services</td>
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<td>Eliminate government bureaucracy</td>
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<td>Making financial profits</td>
<td>Make profits, To achieve financial profits for the company, Make profits and get advantages</td>
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<tr>
<td>Exchange of experiences and transfer of knowledge</td>
<td>We are introducing new technologies through international agencies that we represent,</td>
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2. What are your objectives in being a part of a PPP in the health care system?

- Improve the work performance
- Implement the recommendations of the World Bank
- Improve the income
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<td>Chief Tech - Nuclear Medicine</td>
<td>Business &amp; financial consultant - Private sector</td>
<td>Secretary - Radiology</td>
<td>Sr. Consultant, HOU - Microbiology</td>
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<td>Sr. Tech - Histopathology</td>
<td>Consultant, HOD Laboratory</td>
<td>CFO - YAOO-ADAN Center</td>
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</tbody>
</table>

**Question Posted**

2. What are your objectives in being a part of a PPP in the health care system?

- **Theme extracted**
  - Enhance private company's reputation
  - To build a good reputation
  - Improve the company's reputation in the market
  - build reputation
  - Enhance the reputation and the management experience
  - To build good reputation
  - To achieve financial profitability
  - To make profits
  - To exchange work and experience
  - To get into the challenge of managing and providing healthcare services, and therefore gain experience in this field
<table>
<thead>
<tr>
<th>Interviewee</th>
<th>Respondent 1</th>
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<td>Director of YAICO-ADAN center</td>
</tr>
<tr>
<td>Question Posted</td>
<td>Theme extracted</td>
<td>PPP optimises the usage of resources (minimizes wastage of resources)</td>
<td>the private sector normally would increase the efficiency through his commitment to rationalize the consumption</td>
<td>that the private sector is using the resources in the optimum way to avoid waste</td>
<td>The centre is delivering better service with lower cost and through lower time</td>
<td>there an optimal utilization of manpower, equipment, consumable - there is a minimization of wastage</td>
<td>Dispose of surplus labour. (From approximately 200 to 115 professional technicians)</td>
<td>The partnership experience has reduced the wastage of resources through optimal use of such resources</td>
</tr>
</tbody>
</table>

3. Do you think the PPP experience in the Kuwait health sector has enhanced health care system efficiency (by making good, thorough, and/or careful use of resources; without consuming extra)?

- PPP optimises the usage of resources (minimizes wastage of resources)
- There is sufficient and good utilization of time
- Increased accountability
- Adaptation of latest technology and continuous training

| Increased accountability | Adaptation of latest technology and continuous training | There is sufficient and good utilization of time | The centre is delivering better service with lower cost and through lower time | there an optimal utilization of time | Reduced the waiting period for the patient to do tests and get results | use the time optimally | Add new technology as required | the partnership introduced modern technologies and used innovative mechanisms which ultimately led to enhanced efficiency |
|------------|--------------|---------------|---------------|---------------|---------------|---------------|---------------|---------------|---------------|
| Role       | Private      | Public        | Private       | Private       | Financing     | Private       | Supervisory   | Supervisory   | Private       |
|            | Consultant, HOU - Histopathology | MOH GP | Director Secretary | Engineering Officer | Sr. Accountant | Head of IT department | Head of Al Ahmadi Health District | Lab Operation Coordinator | Chief Tech - Radiology |
| Question Posted | Theme extracted | | | | | | | | |
| 3. Do you think the PPP experience in the Kuwait health sector has enhanced health care system efficiency (by making good, thorough, and/or careful use of resources; without consuming extra)? | PPP optimises the usage of resources (minimizes wastage of resources) | Reducing the cost with maintaining the quality is the most important objective that PPP could achieved | I think the centre has succeeded to optimize the resources and use them in the right manner | we have succeeded to optimize resources without affecting the quality | increase the capability of the centre to receive more clients through the working hours | the private partner is naturally trying hard not to overdo in consumption because it means a financial loss for him. | the optimal use of resources and time | |
| Increased accountability | the work team has become more accountable and more efficient | | | | | | | | |
| Adaptation of latest technology and continuous training | | | | | | | | | |
### Question Posted

**3. Do you think the PPP experience in the Kuwait health sector has enhanced health care system efficiency (by making good, thorough, and/or careful use of resources: without consuming extra)?**

### Theme extracted

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**PPP optimises the usage of resources (minimizes wastage of resources)**
- I think the experience has reduced the budget without affecting the quality or going under the normal rate of tests and visits.
- Through the exclusion of unnecessary tests in order to save time and resources.
- Resources were optimally used without wasting.
- Reduce the wastage without affecting the quality of service.
- Optimal utilization of resources and time.
- The company is still able to cope with increased demand for health services coming from population growth and allocate the required resources.
- Accounts of resources at max capacity.
- The company is accountable and able to cope with increased demand.
- This is measured through periodic supervision by the MOH.
<table>
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<td>3. Do you think the PPP experience in the Kuwait health sector has enhanced health care system efficiency (by making good, thorough, and/or careful use of resources; w/o wasting extra)?</td>
<td>The concept of partnership, of course, would support the optimum use of resources. The partnership has a good accountability with an optimized usage of resources. The wastage of resources become less. We provide services within waiting lists in all departments. The results delivery has especially become faster. The company allocates resources based on the centre's need without waste or excessive.</td>
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- Good organization and technical follow-up have increased accountability
- the work team is accountable to acceptance or rejection of any case
- Increased accountability
- Adaptation of latest technology and continuous training
- the ongoing training provided to the work team and good organization and technical follow-up have increased the efficiency
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4. Do you think the PPP experience in the Kuwait health sector has enhanced health care system equity? *(Equity is the concept or idea of fairness)*

- Patients treated at the same level (elimination of WASTAH, prejudice or preference) PPP experience has eliminated WASTAH

- The priority is based on medical situation (condition)

- PPP experience has maintained the equity

- Better organization and adaptation of regulation (traceability system) improves client satisfaction
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<td>The priority is based on medical situation (condition)</td>
<td>PPP experience has maintained the equity</td>
<td>we treat all our clients at the same level</td>
<td>I believe that PPP maintain this objective</td>
<td>Of course, the experience has eliminated WASTAH</td>
<td>Elimination of WASTAH</td>
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<tr>
<td><strong>Theme extracted</strong></td>
<td>the centre has enhanced the equity by eliminating WASTAH</td>
<td>We deal with clients equally based on their medical condition</td>
<td>we deal with clients equally according to their medical situation</td>
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4. Do you think the PPP experience in the Kuwait health sector has enhanced health care system equity? (Equity is the concept or idea of fairness)

- There is no preference for any patient according to his relations and all clients are equally been serviced.
- Of course, the experience has eliminated WASTAH
- Elimination of WASTAH

- This objective has been enhanced, but not significantly.
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**Question Posted**: Patients treated at the same level (elimination of WASTAH, prejudice or preference) PPP experience has eliminated WASTAH. They deal with clients equally without any ethnic, social or personal considerations. The previous system was encouraging the WASTAH, there is no effect except reducing wastah. The concept of WASTAH has been minimized significantly. The WASTAH was significantly reduced. As well as the elimination of WASTAH, the WASTAH may be eliminated through the minimizing of WASTAH.

4. Do you think the PPP experience in the Kuwait health sector has enhanced health care system equity? (Equity is the concept or idea of fairness)

The priority is based on medical situation (condition) equity has been enhanced and patients are served according to medical priority only. The centre has created a system to deal with everyone at the same level without any intervention of social or personal factors. The equity may be enhanced through the minimizing of WASTAH. Only the medical priority is controlling the work system.

PPP experience has maintained the equity. There was nothing to add but it has been maintained. The process receiving patients was organized according to the region of residence.

Better organization and adaptation of regulation (traceability system) improves client satisfaction new technical systems such as RIS system help to regulate appointment. The region of residence.

<table>
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<td>Patients treated at the same level (elimination of WASTAH, prejudice or preference) PPP experience has eliminated WASTAH</td>
<td>The centre is not subject to any external pressures or personal relationships to give a preference for any patient</td>
<td>the system the centre has created does not allow any personal or social factors to take a place. In the process patients are serviced at the same level and there is no preference</td>
<td>we do not favour any patient on other according to personal or social connections</td>
<td>there no preference for any one under any circumstance.</td>
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<tr>
<td>PPP experience has maintained the equity</td>
<td>only the medical priority is controlling the work system.</td>
<td>the standards of receive cases based on medical priority</td>
<td>except if there is a medical need to give the priority for certain client</td>
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<td>Better organization and adaptation of regulation (traceability system) improves client satisfaction</td>
<td>This objective has not been enhanced but it has been maintained.</td>
<td>Introducing the Traceability System that make the staff more committed to apply the concept of equity</td>
<td>the good regulation of daily work</td>
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<tr>
<td>The patient was put at the center of interest</td>
<td>Yes it enhanced the choice for patients, and put the patient at the centre of care</td>
<td>Respondent 1</td>
<td>Business &amp; financial consultant - Private sector</td>
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<td>Increased flexibility of appointments</td>
<td>or change his appointment easily.</td>
<td>Respondent 2</td>
<td>Assistant Undersecretary for Financial Affairs - MOH</td>
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<td>Easy client to management access</td>
<td>the patient become more important by giving him the right to suggest, complain</td>
<td>Respondent 3</td>
<td>Biomedical Engineer</td>
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<td>Giving the choice to choose public or private</td>
<td>We have been promoting this aspect and give the patient the ability to choose the system that suits him as the center works in the evening as a private sector.</td>
<td>Respondent 4</td>
<td>Consultant, HOD - Nuclear Medicine</td>
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<td>The concept of choice was not affected</td>
<td>I do not think so, as the health care system in Kuwait does not give choices for the patients.</td>
<td>Respondent 5</td>
<td>Corporate Planning Manager - Private Sector</td>
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<td>Patients are able to lodge a complaint or provide a suggestion; we have introduced a complaint system (Action Request) to deal with all such situations</td>
<td>Respondent 6</td>
<td>Director of YAICO-ADAN center</td>
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5. Do you think the PPP experience in the Kuwait health sector has enhanced health care system choice for patients?
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<tr>
<td>5. Do you think the PPP experience in the Kuwait health sector has enhanced health care system choice for patients?</td>
<td>The patient was put at the center of interest</td>
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<td></td>
<td></td>
<td>Yes we try to put the client at the centre of care.</td>
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<td></td>
<td>Increased flexibility of appointments</td>
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<tr>
<td></td>
<td>Easy client to management access</td>
<td>Communication with patients has become better than before and patients themselves feel more comfortable in contacting physicians and technicians</td>
<td>We try to listen to patients and get their feedback and measure their satisfaction regularly</td>
<td>activating the action request system to deal with clients' feedback or complaints professionally</td>
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<tr>
<td></td>
<td>Giving the choice to choose public or private</td>
<td>Yes, PPP gives more options for the patients. These options are limited in the public sector</td>
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<td></td>
<td>The concept of choice was not affected</td>
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The value was added in this side is the improving of way to dealing with clients as they have been given some advantages and facilities to get or change appointments.
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5. Do you think the PPP experience in the Kuwait health sector has enhanced health-care system choice for patients?

- Easy client to management access
  - Yes there is a significant interaction between patients and the work team

- Giving the choice to choose public or private
  - The concept of choice was not affected
  - I think there are several regulations and conditions do not support this objective.

- The centre considers the clients as a financial burden and there is not benefit of providing additional values
  - This objective has not been enhanced
  - PPP experience has not added any value to this objective

- The importance of the patient and give him the priority and advantages, such as flexible appointments
  - complaint system has also become more efficient and accessible
  - The centre considers the clients as a financial burden and there is not benefit of providing additional values
  - PPP experience has not added any value to this objective

- MOH Family medicine Doctor
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<tr>
<td>The patient was put at the center of interest</td>
<td>the patient will become at the centre of attention in any procedure</td>
</tr>
<tr>
<td>Increased flexibility of appointments</td>
<td>The patient was put in the centre</td>
</tr>
<tr>
<td>Easy client to management access</td>
<td>has been given some features and flexibility in appointments</td>
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<tr>
<td>Giving the choice to choose public or private</td>
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<tr>
<td>The concept of choice was not affected</td>
<td>Not significantly as this object is not exist in the local health sector</td>
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</table>

5. Do you think the PPP experience in the Kuwait health sector has enhanced health care system choice for patients?

Patients could choose to get the service in the evening shift as the centre is working as a private entity if they need to get faster results.

I do not think the current health care system support this objective.

This objective is not available in the current system.

I think that patient become more important and have limited choices.

This system is adding value to the patient and put him in centre.

Increased flexibility of the system is adding value to the patient and put him in centre.

The patient will become at the centre of attention in any procedure.

The patient was put in the centre.
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<td>The centre has been accredited by ISO and has a commitment to go international standards and I think it is a good example to show how this objective has been enhanced.</td>
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6. Do you think the PPP experience in the Kuwait health sector has enhanced health care system effectiveness (by producing or being capable of producing an intended result)?

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<td>It could be shown through good results of the Centre and customer satisfaction on the level of service.</td>
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<tr>
<td>Meeting the increasing demands on services</td>
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<td>The effectiveness has not been enhanced</td>
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<td>Consultant, HOU - Histopathology</td>
<td>MOH GP</td>
<td>Director Secretary</td>
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<td>the centre uses quality control system to assure the accuracy of results and the process and matches the global and local standards.</td>
<td>some elements have improved such as accreditation from famous organizations</td>
<td>Our tests are accurate, quality controlled and accredited.</td>
<td>the centre is accredited by ISO</td>
<td>works according to international quality standards such as CAP. The centre has got international accreditation (ISO)</td>
<td>this was proved clearly by getting the international accreditation (ISO)</td>
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<td>Customer satisfaction on the provided service</td>
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6. Do you think the PPP experience in the Kuwait health sector has enhanced health care system effectiveness (by producing or being capable of producing an intended result)?

- Application of international standards and professional affiliation
  - the centre uses quality control system to assure the accuracy of results and the process and matches the global and local standards.
  - some elements have improved such as accreditation from famous organizations
  - Our tests are accurate, quality controlled and accredited.
  - the centre is accredited by ISO

- Customer satisfaction on the provided service
  - The customer satisfaction surveys could show you how we have enhanced the effectiveness.

- Accurate and speed delivery of results
  - we try our best to shorten the required time for delivering results
  - the system was implemented to meet the hospital requirements
  - the centre, with the help of latest technology, skilled professionals, better processes and well-organized operations, is able to deliver timely and accurate results of the tests conducted on patients
  - this was reflected through the speed delivery of tests results.
  - these elements make the results that provided by the Centre significantly more reliable.

- Meeting the increasing demands on services

- The effectiveness has not been enhanced

- Reducing the Penalties applied by the government
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<td>affairs</td>
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<td>department in</td>
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**Question Posted**

**Theme extracted**

- **Application of international standards and professional affiliation**
- centre applies CAP (college of American pathology) as a quality control indicator in all labs.
- The intended result for the company was the high customer satisfaction on the provided services. this has been recorded periodically surveys. The centre responding well with any complaint or suggestion that could lead to improvement in the level of services being provided.

- **Customer satisfaction on the provided service**
- Accurate and speed delivery of results
- Meeting the increasing demands on services
- The effectiveness has not been enhanced
- Reducing the Penalties applied by the govt.

- **6. Do you think the PPP experience in the Kuwait health sector has enhanced health care system effectiveness (by producing or being capable of producing an intended result)?**
- what can be improved significantly is the speed of delivery
- Effectiveness has not been enhanced, the capability of producing an intended result was exist in the past and the PPP experience did not add any value to it.
- The PPP experience has not added anything to this objective, errors or defaults is still exist and the centre is incapable to avoid it.
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<tr>
<td><strong>Application of international standards and professional affiliation</strong></td>
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<td>The center is able to provide good results conducted especially with quality control indicators that been applied.</td>
</tr>
<tr>
<td><strong>Customer satisfaction on the provided service</strong></td>
<td>Customer satisfaction on the provided service</td>
<td>The center is keen to enhance the effectiveness as much as possible and deal with work requirements wisely to meet the client needs by increasing the working hours and operating the equipments at the maximum capacity.</td>
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<td><strong>Reducing the Penalties applied by the government</strong></td>
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<td>the center helps reduce the burden on the hospital. It has also reduced the penalties that was applied by the supervisory committee.</td>
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<td>No flexibility in the allocated budget to meet changing demands</td>
<td>but has to be flexible and takes into account the natural growth of population in the region</td>
<td>it needs to be developed to keep pace with the annual population growth and the consequent increase in demand for services.</td>
<td>The current financial model is limited budget</td>
<td>it doesn't help us to add more tests or services or update our equipment or facilities</td>
<td>it doesn't take into account several factors such as increasing demands for diagnostic services</td>
<td>it does not take into account the population growth or technical development of systems and equipments</td>
</tr>
<tr>
<td>7. What effect has the financial model used for the PPP in the Kuwaiti health sector had on the health care objectives (efficiency, equity, choice, effectiveness)</td>
<td>More incentives are required</td>
<td>Financial model has several defaults and defects</td>
<td>the current financial model does not allow for the addition of new services and tests</td>
<td>Financial incentives have a positive effect</td>
<td>Capitation is good for efficiency</td>
<td>The financial model has no effect</td>
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7. What effect has the financial model used for the PPP in the Kuwaiti health sector had on the health care objectives (efficiency, equity, choice, effectiveness)
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<td>No flexibility in the allocated budget to meet changing demands</td>
<td>the financial model of the centre is a fixed budget and was allocated even before the centre had opened. I believe this model does not support the health care services objective. It doesn't allow any upgrading in the equipment and technology.</td>
</tr>
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<td>More incentives are required</td>
<td>This has affected us directly as we haven't got enough incentives and bonuses.</td>
</tr>
<tr>
<td>Financial model has several defaults and defects</td>
<td>I believe this model does not support the health care objectives as there were several changes in many fields (Geography, population Growth, Rising prices, etc). This system has to be evaluated periodically and modified as required.</td>
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<td>Financial incentives have a positive effect</td>
<td>the incentives for employees are acceptable so the work team is almost satisfied and working better.</td>
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More incentives are required

Financial model has several defaults and defects

7. What effect has the financial model used for the PPP in the Kuwaiti health sector had on the health care objectives (efficiency, equity, choice, effectiveness)
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<td>No flexibility in the allocated budget to meet changing demands</td>
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<tr>
<td>Sr. Tech - Histopathology</td>
<td>Private</td>
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<tr>
<td>Consultant, HOD Laboratory</td>
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<tr>
<td>CFO - YAICO-ADAN Center</td>
<td>Financing</td>
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- **Question Posted**
  7. What effect has the financial model used for the PPP in the Kuwaiti health sector had on the health care objectives (efficiency, equity, choice, effectiveness)

- **Theme extracted**
  - No flexibility in the allocated budget to meet changing demands
  - More incentives are required
  - Financial model has several defaults and defects
  - Financial incentives have a positive effect
  - Capitation is good for efficiency
  - The financial model has no effect
<table>
<thead>
<tr>
<th>Role</th>
<th>Respondent 1</th>
<th>Respondent 2</th>
<th>Respondent 3</th>
<th>Respondent 4</th>
<th>Respondent 5</th>
<th>Respondent 6</th>
<th>Respondent 7</th>
<th>Respondent 8</th>
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<td>Public</td>
<td>Public</td>
<td>Supervisory</td>
<td>Public</td>
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<tr>
<td></td>
<td>Business &amp; financial consultant - Private sector</td>
<td>Assistant Undersecretary for Financial Affairs - MOH</td>
<td>Biomedical Engineer</td>
<td>Quality assurance officer</td>
<td>Consultant, HOD Radlogy</td>
<td>Consultant, HOD - Nuclear Medicine</td>
<td>Corporate Planning Manager - Private Sector</td>
<td>Director of YAICO-ADAN center</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Question Posted</th>
<th>Theme extracted</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>The internal structure is cooperative and open</td>
</tr>
<tr>
<td></td>
<td>The internal administrative structure of the centre is good and well-defined, set up a clear relationship between the work team members</td>
</tr>
<tr>
<td></td>
<td>The organizational structure is clearly defined and it works well quite efficiently in the sense of actions are been taken</td>
</tr>
<tr>
<td></td>
<td>The internal organizational structure of the centre is excellent and straightforward, which makes each member fully aware of his rights and duties</td>
</tr>
<tr>
<td></td>
<td>this structure is clearly defined and every member is fully conscious of his responsibilities</td>
</tr>
<tr>
<td>8. What effect has the organisational structure of the PPP project had on the health care objectives (efficiency, equity, choice, effectiveness)? How? Please describe the mechanism?</td>
<td></td>
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<tr>
<td></td>
<td>There is a lack of cooperation between public &amp; private partners</td>
</tr>
<tr>
<td></td>
<td>many committees could lead to keep bureaucracy of the government</td>
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<tr>
<td></td>
<td>Organizational structure established for the project has no differences from the organizational structure of government, and in my opinion this is one of the weaknesses in the project</td>
</tr>
<tr>
<td></td>
<td>The importance of supervising and monitoring performance</td>
</tr>
<tr>
<td></td>
<td>it has developed a regulatory mechanism to monitor the performance of the company</td>
</tr>
<tr>
<td></td>
<td>The need to set up a neutral/independent committee</td>
</tr>
<tr>
<td></td>
<td>I suggest a neutral committee to be set up by the ministry to discuss the grievances or complaints and to adjudicate any dispute between the parties</td>
</tr>
<tr>
<td></td>
<td>We use internal mail to contact each other and we hold periodic meetings at several levels to discuss the daily performance and the way to enhance it</td>
</tr>
<tr>
<td></td>
<td>Good communication &amp; follow up</td>
</tr>
<tr>
<td></td>
<td>It gives a better way to communicate</td>
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<tr>
<td>Role</td>
<td>Private</td>
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<td></td>
<td>Consultant,</td>
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<td></td>
<td>HOU -</td>
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<td></td>
<td>Histopathology</td>
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<td>Question Posted</td>
<td>Theme extracted</td>
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<tr>
<td>8. What effect has the organisational structure of the PPP project had on the health care objectives (efficiency, equity, choice, effectiveness)? How? Please describe the mechanism?</td>
<td>The internal structure is cooperative and open</td>
</tr>
<tr>
<td>The importance of supervising and monitoring performance</td>
<td></td>
</tr>
<tr>
<td>The need to set up a neutral/independent committee</td>
<td></td>
</tr>
<tr>
<td>Good communication &amp; follow up</td>
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</table>

**Note:** The table represents the roles and responses of different respondents to the question posed.
<table>
<thead>
<tr>
<th>Question Posted</th>
<th>Theme extracted</th>
</tr>
</thead>
<tbody>
<tr>
<td>The internal structure is cooperative and open</td>
<td>The current organizational structure is good and a good hierarchy is available in a professional manner and gives each member an important role</td>
</tr>
<tr>
<td>There is a lack of cooperation between public &amp; private partners</td>
<td>The mechanism of cooperation between the ministry and the company is not clear</td>
</tr>
<tr>
<td>The importance of supervising and monitoring performance</td>
<td>Organizational structure was not identified in the main contract as well as the relationship between the ministry and the company</td>
</tr>
<tr>
<td>The need to set up a neutral/independent committee</td>
<td>If there is any failure from the company the supervisory committee will make a penalty on the company</td>
</tr>
</tbody>
</table>

8. What effect has the organisational structure of the PPP project had on the health care objectives (efficiency, equity, choice, effectiveness)? How? Please describe the mechanism?
<table>
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<tr>
<td>Role</td>
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<td>Supervisory</td>
<td>Financing</td>
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<td>Private</td>
<td>Private</td>
<td>Private</td>
<td>Private</td>
<td>CFO - YAICO-ADAN Center</td>
</tr>
</tbody>
</table>

**Question Posted**

**Theme Extracted**

8. What effect has the organisational structure of the PPP project had on the health care objectives (efficiency, equity, choice, effectiveness)? How? Please describe the mechanism?

| The internal structure is cooperative and open | The organisational structure is highly responsible and cooperative | The internal organisational structure is a distinguished, professional | The organisational structure is good and cooperative | There is a nice cooperation between management and staff |

The organisational structure of the centre is efficient and cooperative. The relationship between management and the stuff is good and the working policies are supportive.

8. VV hate eff the organisational structure that the centre is not well organized. The relationship between the public & private partners is not effective. How? Please describe the mechanism?

| There is a lack of cooperation between public & private partners | The external organisational structure that organizes the relationship between the centre management and the ministry is fixed and could not be developed |

The importance of supervising and monitoring performance

| The importance of supervising and monitoring performance | The current organisational structure needs to be developed by forming a neutral supervisory committee |

Unfortunately there is lack of neutrality and professionalism in the current supervisory committee.

8. How can the PPP project be improved to meet the health care objectives? Please describe the mechanism?

<table>
<thead>
<tr>
<th>The need to set up a neutral/independent committee</th>
<th>Good communication &amp; follow up</th>
</tr>
</thead>
<tbody>
<tr>
<td>it enhances communication between staff or with the senior management</td>
<td>modern mechanisms such as the Internal Mail system</td>
</tr>
</tbody>
</table>

Good organization and regular meetings with the staff

Staff has a direct access to the management if they have any suggestion or complain

The relationship between management and the stuff is good and the working policies are supportive.
<table>
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<tr>
<th>Question Posted</th>
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</tr>
</thead>
<tbody>
<tr>
<td>9. What effect have the resources (such as human capital, equipments, building) that have been allocated to the project had on the health care objectives (efficiency, equity, choice, effectivenees)? How? Please describe the mechanism?</td>
<td>The annual increase in demand for the diagnostic services has forced the company to increase the resources to meet this growing demand without getting any financial coverage against this increase.</td>
</tr>
<tr>
<td>Resource allocation affected by the financial model</td>
<td>There is a resources crunch due to what I mentioned before about weakness of the contract and the way that centre is financed.</td>
</tr>
<tr>
<td>Human resource allocation is based on local terms and conditions</td>
<td>The company was given full authority to allocate human resources due administrative requirements and technical needs.</td>
</tr>
<tr>
<td>Resource allocation is fair and acceptable</td>
<td>Centre is keen to provide various resources within the available budget that were set by the ministry.</td>
</tr>
<tr>
<td>Require a transparent and clear guideline for resource allocation to meet growing demand</td>
<td>The centre provides the basic needs inaccordanc e with the available capabilities.</td>
</tr>
<tr>
<td>Resources have increased to meet growing demand (without increase in the budget)</td>
<td>Resources that were allocated for the project were initially similar to what MOH had required.</td>
</tr>
<tr>
<td>The terms of the contract regulate all the aspects of resource allocation</td>
<td>Resources that were allocated to the project were initially similar to what was provided to MOH, but the annual increase in demand for the diagnostic services has forced the company to increase the resources to meet this growing demand without getting any financial coverage against the increase.</td>
</tr>
<tr>
<td>Role</td>
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</tr>
<tr>
<td>Consultant, HOU - Histopathology</td>
<td>MOH GP</td>
</tr>
</tbody>
</table>

**Question Posted**

**Theme extracted**

| Resource allocation affected by the financial model | There is no way to add new services or update our systems and equipment because of the budget limitation. | The terms of the contract should be updated every year due to a comprehensive evaluation of the whole process | Resources have increased to meet growing demand (without increase in the budget) |
| Resource allocation is based on local terms and conditions | I think the allocation of resources was good at the beginning | The resources allocation was professionally managed by the company to make everybody satisfied | Require a transparent and clear guideline for resource allocation to meet growing demand |

9. What effect have the resources (such as human capital, equipments, building) that have been allocated to the project had on the health care objectives (efficiency, equity, choice, effectiveness)? How? Please describe the mechanism?

- Resources have increased to meet growing demand (without increase in the budget)
- The terms of the contract regulate all the aspects of resource allocation
<table>
<thead>
<tr>
<th>Role</th>
<th>Interviewee</th>
<th>Question Posted</th>
<th>Theme Extracted</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financing</td>
<td>Business Consultant - Private Sector</td>
<td>Resource allocation affected by the financial model</td>
<td>Lack of financial incentives for employees is leading them to be indifferent when they use the different resources.</td>
</tr>
<tr>
<td>Private</td>
<td>Strategy Implementation Officer - YAICO Co.</td>
<td>Human resource allocation is based on local terms and conditions</td>
<td>Human resources have a positive effect due to right selection and training programs.</td>
</tr>
<tr>
<td>Public</td>
<td>Radiology Reception Organizer</td>
<td>Resource allocation is fair and acceptable</td>
<td>The company is committed to allocate the required resources that could support the objectives.</td>
</tr>
<tr>
<td>Supervisory</td>
<td>MOH Family Medicine Doctor</td>
<td>Require a transparent and clear guideline for resource allocation to meet growing demand</td>
<td>The company has a commitment to provide high standard resources within the available capabilities.</td>
</tr>
<tr>
<td>Private</td>
<td>Admin. &amp; financial affairs supervisor - Al Ahmadi District</td>
<td>Resources have increased to meet growing demand (without increase in the budget)</td>
<td>The company has a commitment to provide high standard resources within the available capabilities.</td>
</tr>
<tr>
<td>Supervisory</td>
<td>Chief Tech - Radiology</td>
<td>The terms of the contract regulate all the aspects of resource allocation</td>
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</tr>
<tr>
<td>Private</td>
<td>Head of Financial department Al Ahmadi Health District</td>
<td></td>
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</tr>
<tr>
<td>Public</td>
<td>Head of lab department in Al Adan Hospital</td>
<td></td>
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<tr>
<td>MOH</td>
<td>Family Medicine Doctor</td>
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<td>Question Posted</td>
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<tr>
<td>Resource allocation affected by the financial model</td>
<td>The allocation of the required resources was a priority for the company, but the financial resources did not help this. The financial resources need to be developed as it does not cover all the requirements.</td>
<td></td>
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<tr>
<td>Human resource allocation is based on local terms and conditions</td>
<td>Human resources are allocated according to the requirements of the MOH. Human resources are fair, efficient and could support the objectives.</td>
<td></td>
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</tr>
<tr>
<td>Resource allocation is fair and acceptable</td>
<td>Equipments are subject to periodic maintenance and the Quality Control, and Safety Check list. The company was committed to provide the required within the available financial resources. Think the resources allocation is fair and meet the requirement.s</td>
<td></td>
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<tr>
<td>Require a transparent and clear guideline for resource allocation to meet growing demand</td>
<td>The financial resources need to be developed (based on guidelines).</td>
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<tr>
<td>Resources have increased to meet growing demand (without increase in the budget)</td>
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<tr>
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9. What effect have the resources (such as human capital, equipments, building) that have been allocated to the project had on the health care objectives (efficiency, equity, choice, effectiveness)? How? Please describe the mechanism?

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<tr>
<td></td>
<td>Sr. Microbiology Doctor</td>
<td>Chief Tech - Nuclear Medicine</td>
<td>Business &amp; financial consultant - Private sector</td>
<td>Secretary - Radiology</td>
<td>Sr. Consultant, HOU - Microbiology</td>
<td>Sr. Tech - Microbiology</td>
<td>Sr. Tech - Histopathology</td>
<td>Consultant, HOD Laboratory</td>
<td>CFO - YAICO-ADAN Center</td>
</tr>
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</table>

| Resource allocation affected by the financial model | The allocation of the required resources was a priority for the company, but the financial resources did not help this. The financial resources need to be developed as it does not cover all the requirements. |
| Human resource allocation is based on local terms and conditions | Human resources are allocated according to the requirements of the MOH. Human resources are fair, efficient and could support the objectives. |
| Resource allocation is fair and acceptable | Equipments are subject to periodic maintenance and the Quality Control, and Safety Check list. The company was committed to provide the required within the available financial resources. Think the resources allocation is fair and meet the requirement.s |
| Require a transparent and clear guideline for resource allocation to meet growing demand | The financial resources need to be developed (based on guidelines). |
| Resources have increased to meet growing demand (without increase in the budget) | |
| The terms of the contract regulate all the aspects of resource allocation | |

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<table>
<thead>
<tr>
<th>Interviewee</th>
<th>Respondent 1</th>
<th>Respondent 2</th>
<th>Respondent 3</th>
<th>Respondent 4</th>
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<td>Business &amp; financial consultant - Private sector</td>
<td>Assistant Undersecretary for Financial Affairs - MOH</td>
<td>Biomedical Engineer</td>
<td>Quality assurance officer</td>
<td>Consultant, HOD Radiology</td>
<td>Consultant, HOD - Nuclear Medicine</td>
<td>Corporate Planning Manager - Private Sector</td>
<td>Director of YAICO-ADAN center</td>
</tr>
<tr>
<td>Question Posted</td>
<td>Theme extracted</td>
<td>The means of service delivery has no effect</td>
<td>Adding new services or techniques to the main services (i.e. pneumatic tube, queuing system, action centre system, call centre, etc) makes good result in service delivery</td>
<td>It does not have a significant impact</td>
<td>We tried to establish an integrated and automated work system to control the whole process</td>
<td>to enter service a new model for service delivery and create an atmosphere of competition between similar services.</td>
<td></td>
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<tr>
<td>10. What effect has the way the service is being delivered in the PPP project had on the health care objectives (efficiency, equity, choice, effectiveness)? How? Please describe the mechanism?</td>
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<tr>
<td>Implement protocol with international affiliation</td>
<td>Specific standards are set up and a periodic evaluation takes place to assure and maintain the quality level</td>
<td>The centre has helped to reduce the waiting time and regulate the appointments</td>
<td></td>
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<tr>
<td>The patient has been put at the center of the process (satisfied customers)</td>
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<td></td>
<td>Better quality and faster service increased client satisfaction</td>
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<td>Supervisory</td>
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<td></td>
<td>Consultant, HOU - Histopathology</td>
<td>MOH GP</td>
<td>Director</td>
<td>Engineerining Officer</td>
<td>Sr. Accountant</td>
<td>Head of IT department</td>
<td>Head of Al Ahmadi Health District</td>
<td>Lab Operation Coordinator</td>
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<tr>
<td>The means of service delivery has no effect</td>
<td>I think this factor has no effect as it will be the same current way.</td>
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<tr>
<td>Adapting technology and mechanisms improves service delivery</td>
<td>The service become more quality and been delivered within shorter time</td>
<td>Automation, pneumatic system, quality control and other mechanisms have made the service delivery more efficient</td>
<td></td>
<td></td>
<td>The centre has automated most of services so they shortened the required time to deliver</td>
<td>this has reflected positively on the way to deliver services, it become higher quality and save time and efforts</td>
<td>apply the international protocols to improve the performance</td>
<td>Reduce the waiting time is the most important value that was added by the Centre</td>
</tr>
<tr>
<td>Service delivery has exceeded the partnership requirements</td>
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<tr>
<td>Creates competitive environment with implementation of clear administration policies</td>
<td>I think we have implemented several policies to regulate and organize the whole work in the centre including the service delivery</td>
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<tr>
<td>Implementation of clinical protocol with international affiliation</td>
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<td>The center is accredited by ISO which has enhanced the quality of the center's processes</td>
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<tr>
<td>The patient has been put at the center of the process (satisfied customers)</td>
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<td>Financing</td>
<td>Theme extracted</td>
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<td>Respondent 18</td>
<td>Business Consultant - Private Sector</td>
<td>Private</td>
<td>The means of service delivery has no effect</td>
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<tr>
<td>Respondent 19</td>
<td>Startegy Implementation Officer - YAICO Co.</td>
<td>Private</td>
<td>Adapting technology and mechanisms improves service delivery</td>
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<td>Radiology Reception Organizer</td>
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<td>Service delivery has exceeded the partnership requirements</td>
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<td>Respondent 21</td>
<td>MOH Family Medicine Doctor</td>
<td>Supervisory</td>
<td>Creates competitive environment with implementation of clear administration policies</td>
<td></td>
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<tr>
<td>Respondent 22</td>
<td>Admin. &amp; financial affairs supervisor - Al Ahmadi District</td>
<td>Private</td>
<td>Implementation of clinical protocol with international affiliation</td>
<td></td>
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<tr>
<td>Respondent 23</td>
<td>Chief Tech - Radiology</td>
<td>Supervisory</td>
<td>The patient has been put at the center of the process (satisfied customers)</td>
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<tr>
<td>Respondent 24</td>
<td>Head of Financial department in al Ahmadi Health District</td>
<td>Private</td>
<td>The way of service delivery and the speed of getting final results</td>
<td></td>
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<tr>
<td>Respondent 25</td>
<td>Head of lab department in Adan Hospital</td>
<td>Public</td>
<td>The way of service delivery is highly organized</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Respondent 26</td>
<td>MOH Family medicine Doctor</td>
<td>Private</td>
<td>Reducing the waiting time for test and results is the most important value that was added by the Centre</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Question Posted:** The company is using modern technology in all departments which have reflected positively on the performance. The private sector will try to improve the level of service and add new services.

10. What effect has the way the service is being delivered in the PPP project had on the health care objectives (efficiency, equity, choice, effectiveness)? How? Please describe the mechanism?

**Theme extracted:**
- The means of service delivery has no effect.
- Adapting technology and mechanisms improves service delivery.
- Service delivery has exceeded the partnership requirements.
- Creates competitive environment with implementation of clear administration policies.
- Implementation of clinical protocol with international affiliation.
- The patient has been put at the center of the process (satisfied customers).
<table>
<thead>
<tr>
<th>Question Posted</th>
<th>Theme extracted</th>
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</thead>
<tbody>
<tr>
<td>10. What effect has the way the service is being delivered in the PPP project had on the health care objectives (efficiency, equity, choice, effectiveness)? How? Please describe the mechanism?</td>
<td>The means of service delivery has no effect</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Question Posted</th>
<th>Theme extracted</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adapting technology and mechanisms improves service delivery</td>
<td>Service delivery has exceeded the partnership requirements</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Question Posted</th>
<th>Theme extracted</th>
</tr>
</thead>
<tbody>
<tr>
<td>Creates competitive environment with implementation of clear administration policies</td>
<td>The way of service delivery has become more professional and higher level</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Question Posted</th>
<th>Theme extracted</th>
</tr>
</thead>
<tbody>
<tr>
<td>Implementation of clinical protocol with international affiliation</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Question Posted</th>
<th>Theme extracted</th>
</tr>
</thead>
<tbody>
<tr>
<td>The patient has been put at the center of the process (satisfied customers)</td>
<td></td>
</tr>
<tr>
<td>Role</td>
<td>Public</td>
</tr>
<tr>
<td>------</td>
<td>--------</td>
</tr>
<tr>
<td>Interviewee</td>
<td>Respondent 1</td>
</tr>
<tr>
<td>Business &amp; financial consultant - Private sector</td>
<td>Assistant Undersecretary for Financial Affairs - MOH</td>
</tr>
</tbody>
</table>

**Question Posted**

**Theme extracted**

11. **What factors, conditions, platforms, or circumstances, in your opinion, had a positive effect on the PPP experience?**

<table>
<thead>
<tr>
<th>Question</th>
<th>Theme</th>
</tr>
</thead>
<tbody>
<tr>
<td>Build up a real partnership based on cooperation</td>
<td>Good intentions and the power of decision</td>
</tr>
<tr>
<td>Review all terms &amp; conditions of the contract (financial, legal, etc)</td>
<td>The clarity of all financial, administrative and legal aspects</td>
</tr>
<tr>
<td>Public relations and increasing community awareness</td>
<td>Marketing the concept of partnership to the community</td>
</tr>
<tr>
<td>Human resource policy</td>
<td></td>
</tr>
<tr>
<td>Legal issues such as contract drafting (flexibility of terms and conditions)</td>
<td></td>
</tr>
<tr>
<td>Social and political circumstances</td>
<td></td>
</tr>
<tr>
<td>Resistance to change by management and staff</td>
<td>Resistance to change</td>
</tr>
<tr>
<td>Lack of confidence and trust between parties</td>
<td>The weakness of the potential private partner</td>
</tr>
<tr>
<td>Ineffectual process for hiring supervisory committee</td>
<td></td>
</tr>
<tr>
<td>Demographic changes resulting in increased demands for health services</td>
<td>Increased demand for health services</td>
</tr>
</tbody>
</table>

12. **What factors, conditions, platforms, or circumstances, in your opinion, had a negative effect on the PPP experience?**

<table>
<thead>
<tr>
<th>Question</th>
<th>Theme</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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<tr>
<td>Question Posted</td>
<td>Theme extracted</td>
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<tr>
<td>----------------</td>
<td>----------------</td>
</tr>
<tr>
<td>11. What factors, conditions, platforms, or circumstances, in your opinion, had a positive effect on the PPP experience?</td>
<td>Build up a real partnership based on cooperation</td>
</tr>
<tr>
<td></td>
<td>Review all terms &amp; conditions of the contract (financial, legal, etc)</td>
</tr>
<tr>
<td></td>
<td>Public relations and increasing community awareness</td>
</tr>
<tr>
<td></td>
<td>Human resource policy</td>
</tr>
<tr>
<td></td>
<td>Legal issues such as contract drafting (flexibility of terms and conditions)</td>
</tr>
<tr>
<td></td>
<td>Social and political circumstances</td>
</tr>
<tr>
<td></td>
<td>Resistance to change by management and staff</td>
</tr>
<tr>
<td></td>
<td>Lack of confidence and trust between parties</td>
</tr>
<tr>
<td></td>
<td>Ineffectual process for hiring supervisory committee</td>
</tr>
<tr>
<td></td>
<td>Demographic changes resulting in increased demands for health services</td>
</tr>
<tr>
<td>-------------</td>
<td>---------------</td>
</tr>
<tr>
<td>Role</td>
<td>Private</td>
</tr>
<tr>
<td></td>
<td>Sr. Microbiology Doctor</td>
</tr>
</tbody>
</table>

Question Posted | Theme Extracted

11. What factors, conditions, platforms, or circumstances, in your opinion, had a positive effect on the PPP experience?

- Build up a real partnership based on cooperation
- Review all terms & conditions of the contract (financial, legal, etc)
- Public relations and increasing community awareness
- Human resource policy

- The independence when make decisions.
- Availability of financial resources and incentives
- Improving public relations
- Lack of clarity of laws and regulations

- The good communication between public and private partners.
- The independence of regulatory and supervisory
- Showing the centre success and achievement
- Possible corruption

- Building of a real partnership between public and private centre.
- Enhancing the financial resources
- Enhancing the human resources
- Legal Factors

12. What factors, conditions, platforms, or circumstances, in your opinion, had a negative effect on the PPP experience?

- Resistance to change by management and staff
- Lack of confidence and trust between parties
- Infrequent process for hiring supervisory committees
- Demographic changes resulting in increased demands for health services

- Resistance to change.
- The attempt to fail the Partnership.
- Putting barriers from the government
- Demographic changes

- Instability of the government partner
- Legal issues
- Political issues
- administrative confusion in the government sector

| 320 |
Appendix 6 – Document Review Template

1. DOCUMENT TYPE
   Newspaper
   Advertisement
   Letter
   Press Release
   Report
   Contract
   Certificate

2. DOCUMENT CHARACTERISTICS
   Interesting Letterhead
   Notations
   Handwritten
   Officially stamped
   Typed

2. DOCUMENT DATE(S)

4. DOCUMENT AUTHOR
   POSITION (TITLE)

5. DOCUMENT AUDIENCE

6. DOCUMENT INFORMATION
   A. Important issues raised by the document
   B. Reasons for creating the document
   C. What the document indicates about the case study at the time it was written
   D. Other relevant issues not raised by the document
Appendix 7- Document 1: PPP Contract

To construct, equip and operate a building at Al Adan Hospital for the Services of Radiology, Nuclear Medicine and Laboratories

On the Monday 27 of Rabii' II 1423 AH corresponding to 8 July 2003 at the headquarters of the Ministry of Health of Kuwait

This contract is made between the parties below:

1- Ministry of Health represented by H.H. Minister of Health

The first party

2- Ylaco Medical Company

The second party

Represented by Mr. / Yousef Ibrahim Al-Ghanim

Nationality: Kuwaiti

Address: Al Shamiyah - No. 99 - Plot (5)- Al-Mamoun St. Civil ID No.: 257050500111

The address and the data of the second party as written in the tender's documents:

Shuwaikh Industrial Area, No. 99, St. No.8

P.O. Box: 435 Safat Postal Code: 13005

Tel. 4814358- 4842322- 4832600 /1/2/3/ Fax:4833612/ 4844954

License No. M/ 898 /1977 Civil ID No: 611971

Duration of the contract: 12 years as of the date of receiving the site by the second party without any obstacles.

The value of the contract: -KD 22,500,000 (only twenty-two million and five hundred thousand Kuwaiti Dinars)

Statements of the guarantee of implementation:
Arwa Translation Services

The value: KD 2,250,000

Guarantee No.: 44828

The bank: Kuwait Finance House

Starting Date: 6/7/2002

Expiry Date: 5/8/2014

First Party
Muhammad Ahmad Al-Jarallah

Second Party
Yiaco Medical Co.

Starting Date:

Expiry Date:
The two parties agreed the following:

I- Under the approval of the Department of Fatwa and Legislation by its two letters No. 4/198/99 – 864 dated 20/4/1999 and No. 4/198/99-1466 and under the letter of the Central Tenders Committee No. WXX/19/3/1705 dated 5/2/2002, the tender No. XGR/2/98/99 To construct, equip and operate a building at Al Adan Hospital for the Services of Radiology, Nuclear Medicine and Laboratories, was awarded to the second party for an amount of -/KD 22,500,000 (only twenty-two million and five hundred thousand Kuwaiti Dinars) and based on the approval of the State Audit Bureau by its letter No. 18/5/812- 1817 / T dated 15/6/2002, so the second party pledges to implement the tender in question according to the its offer of 29/2/2000.

II- Duration of the contract:

a- The total period of the contract is (12) twelve years as of the date of receiving the site by the second party without any obstacles.

b- The second party pledges to construct the building according to the specifications illustrated in the technical engineering terms and in accordance with detailed layouts of it and its services, that should be approved by the competent staff of the first party (engineers and doctors) within (18) months as of the date of receiving the site.

c- The second party commits to equip the building with all the equipments, devices, tools and furniture and all the necessary installations to operate it according to the specifications determined by the first party and with the latest products of the world markets, on the date when the construction of the building completed, from any source that is approved by the first party and within (6) six month as of the date of completion of construction of the building, and it commits to renew the equipments and devices in question after the first five years passed from the date of building operation according to the technological developments and the approval of the first party.

d- The second party commits to provide a schedule for the stages of execution of the construction works within two weeks as of the date of signing the contact by the Engineering Affairs Dept. of the first party.
e- The second party commits to provide the contracted services (radiology, nuclear medicine and labs) within ten years as of the date of completion of the building equipping, and any delay in the construction or equipping of the building, according to the above mentioned, is not calculated of this period.

III- The first party pays the dues of this contract to the second party on monthly payments – the value of each is – KD/187500 (only one hundred and eighty thousand and five hundred Kuwaiti Dinars) under the request of the second party and a letter and reports ratified by the Ahmadi Health District which show that work completed by the second party according to the specification – any amount for contraventions, fines, compensation or a value of any work implemented at his expense because of default during this period are deducted from them- taking into account that the payment of these payments starts at the end of the first month of the ten years when the contracted services are being provided (radiology, nuclear medicine and labs) within this period. These payments are for the obligation of the second party to provide the required services to any number of in-patients and out-patients of the Ahmadi Health District without any min. or max. limitation.

IV- The second party undertakes, before signing the contract, to deposit an amount of 10% (ten percent) of the total value of the contract under a guarantee letter, that is free of conditions or preservations, from an authorized bank in the State of Kuwait and which is valid as long as the valid period of contract and for thirty days after this period to be as an insurance to guarantee the implementation of the contract. No interests are paid for this contract and it kept with the first party until all the works of the contract are accomplished, and from this guarantee the first party can deduct the amounts of fines and compensations that may be deserved from the second party, and if such a deduction has occurred, the second party, within seven days from taking note, must complete the insurance, and if he defaulted to do so, the first party has the right to complete the insurance amount from his dues of any other amounts, and if he does not have due payments and he defaulted to complete the insurance within the mentioned respite period, the first party has the right to terminate the contract with the terms of item Z of.
Arwa Translation Services

this contract with a recommended letter without the need to take any judiciary procedures with the reservation of the first party's right to take due compensations from the second party.

V- The second party undertakes to train the national staff on all the works of the contract according to item (24) of the special terms of the tender and he undertakes to pay the rent of the ground on which the required building will be constructed, in accordance with item (9) of the same conditions and for annual value of KD 250 (only two hundred and fifty Kuwaiti Dinars) as of the date of actual operation of the building and until the end of the contract’s implementation (ten years). This amount is paid on two payments, on the first of January and the first of July every year.

VI- The second party must supply the devices and equipments and execute the contracted works in the agreed place and in accordance with the way stipulated in the special conditions and in the definite period as of the date of receiving the site, and if the second party defaulted or delayed to implement the required works or a part of them within the limited time defined in (II) item of this contract, the first party has the right to impose the fines that are clarified in item (47) of the tender’s special conditions, and the first party may create any fine for contravention and to estimate any suitable amount for this fine within the period of implementation without any right to the second party to make an objection.

VII- As well as any other rights for the first party due for this contract or the conditions of the tender, he has the right to terminate the contract for any of the following reasons:

a- If the second party violates any of the contract’s terms

b- If he or his representative makes any kind of cheating.

c- If he bribed or tried to bribe any of the first party's staff (directly or indirectly)

d- If he bankrupted or he applied for bankruptcy.

e- If he was slow or negligent to implement his obligations of the contract and the first party clearly sees that he cannot continue to implement the contract according to its terms.
In these cases, the contract is terminated under a recommended letter without the need to make any judiciary procedures, and the termination of the contract will result the following:

1- The final insurance will be a full right to the first party without the need to take any judiciary procedures.

2- The first party completes the implementation of the remained works of the contract in his suitable way and he takes all the due expenses and compensations from the second party.

VIII- The second party undertakes to freight the goods and materials, that he imports for the implementation of the contract, on the ships of the United Arab Shipping Co. if they pass the port of export, and in case of air-freight and travel of his staff, he undertakes to use the planes of the Kuwait Airways or the planes of the companies that have the right of direct flight between Kuwait and the countries from employees and goods are brought in from according to the bilateral agreements concluded by the State of Kuwait according to the disciplines stipulated in the resolution No. 21 of 1985 of the Council of Ministers and its amendments of the resolution taken in the session No. 18/87 held on 13/4/1987.

IX- The second party undertakes to procure the needed materials or tools of the national products or the products of national origin in accordance with the resolution of the Ministry Of Commerce and Industry No (6) of 1987 and which amended by the resolution No. (22) of 1987 and resolution No. (282) of 2000, and the rules of these resolutions are an integrated part of this contract and any contravention to them causes a fine of 20% (twenty percent of the purchases' value as well as the other penalties imposed on the second party for any contraventions to his contract obligations, considering the resolution No. 412 of the Council of Ministers issued in the meeting held on 13/6/1999 concerning the support of the local products and commodities and the national contractors.

X- The first party reserves his right to alter the quantities of the contract (increase or decrease) within the limit of 25% (twenty-five percent) of the total value of the contract. In case of increase, the second party undertakes to increase the final guarantee with the
same percentage of the increase, and he undertakes to implement the works according to the same conditions and prices of his offer.

XI- The second party undertakes to report the first party on any commission, gift or a grant or the similar, whatever the name is, according to the law No. 25 of 1995 regarding the reveal the commissions offered for contracts made by the State in the light of State Audit Bureau's circular no. (1) of 1995 in this regard.

XII- The general and special conditions, the tender's annex, the technical specifications, the prices tables and all the documents of the offer of the second party and all the minutes signed with him and the contracts that he offers as well as the rules of the law of public tenders no. (37) of 1964 and its amendments, all are considered as a complement to the items of this contract. In case of contradiction, the items of this contract should be applied.

XIII- The second party undertakes to enable any other contractor assigned by the first party to perform works out of this contract and at the same site and offer facilities that enable him to achieve his task without gaining any right to claim any amounts for this.

XIV- The second party may not waive this contract or a part of it to others without a prior written approval of the first party, and in this case the second party is still cooperatively responsible with the assignee on the implementation of all the contract's obligations properly.

XV- This contract is made in the State of Kuwait which the Kuwaiti rules of laws and regulations are applied on it.

XVI- This contract is made on two copies, one copy handed over to each party.

First Party
Muhammad Ahmad Al-Jarallah

Second Party
Yiaco medical Co.
3. DOCUMENT TYPE
Contract

2. DOCUMENT CHARACTERISTICS
Interesting Letterhead
Notations
Handwritten
Officially stamped
Typed

3. DOCUMENT DATE(S): 8/6/2002

4. DOCUMENT AUTHOR: Ministry of Health Kuwait
POSITION (TITLE): Financial affair and services purchasing department

5. DOCUMENT AUDIENCE: For the Ministry of Health and its Private sector partner

6. DOCUMENT INFORMATION

B. Important issues raised by the document
   1. A contract to construct, equip, and operate a building at Adan hospital for the service of radiology, nuclear medicine and laboratories.
   2. The contract is signed between the first party (Ministry of Health) represented by his highness Minister of Health, and the second party (private sector – YIACO Medical Company) represented by Yousef Alganim
   3. The contract duration is 12 years as of the date of receiving the site by the second party.

B. Reasons for creating the document
This document was written as part of the legal process to specify each parties roles, rights and obligations

C. What the document indicates about the case study at the time it was written
This contract shows that this case study was a bid from the Ministry of Health, and provides details such as dates, tender specifications, roles, relationships and responsibilities of the parties involved.

D. Other relevant issues not raised by the document
Detailed justification of the sum of money has not been provided (a breakdown of the sum)
تكريم الفائزين من القطاعين الحكومي والخاص

«ياكو وموارد العمل» يحصد جائزة جابر للإبداع

المكرمون

الإدارة العامة لجامعة عمان السبع، تحت رعاية رئيس الوزراء، وحمدان بن محمد بن ناصر آل مبارك، رئيس الدولة، batching. 1

الشكر

John Smith

330
Document Review 2

1. DOCUMENT TYPE
Newspaper

2. DOCUMENT CHARACTERISTICS
Interesting Letterhead
Notations
Handwritten
Officially stamped
Typed with picture
Other

3. DOCUMENT DATE(S): 19/11/2009

4. DOCUMENT AUTHOR: Hassan Malak
POSITION (TITLE): Reporter

5. DOCUMENT AUDIENCE: For the public

6. DOCUMENT INFORMATION
A. Important issues raised by the document
Award winning – YIACO has won a national award for quality service (Jaber liljawda)

B. Reasons for creating the document
To announce the winners of the award of quality

C. What the document indicates about the case study at the time it was written
Winning an award provides evidence that the case study has maintained a national quality standard of service.

D. Other relevant issues not raised by the document
The criteria of the award has not been specified
ن. السير

مدير مركز يابو الطبي

الحالة الطبية وعندما

الموضوع : التدريب المهني لدورة في السردم

في إطار التعاون بين إدارة خدمات المختبرات الطبية والهيئة العامة للتعليم الطبي، والتدريب في مجال التدريب المهني لدورة في النظافة في الفترة من 2010/9/19 حتى 2010/9/27.

للتدريب بالنعمان، من مثالي، وفني، ودورة في الفترة من 9/2010، وفقاً لطلبكم.

يرجى التوجه إلى النتائج المذكورة في التقرير المؤقت ومنذ انتهائه.

شكرًا لدعمكم و maçعم مهنيكم.

مدير إدارة خدمات المختبرات الطبية

Cables : HEALTH KUWAIT
Addr. : Financial Affairs
P.O.Box : 1519
Zip Code : 13001

E-Mail : health @moh.gov.kw

7540 HA 0006423
Document Review 3

4. DOCUMENT TYPE
Letter

2. DOCUMENT CHARACTERISTICS
Interesting Letterhead
Notations
Handwritten
Officially stamped
Typed
Other

3. DOCUMENT DATE(S): 27/04/2010

4. DOCUMENT AUTHOR: Ibrahim Almuzary
POSITION (TITLE): Head of Medical Laboratory Department in the Ministry of Health

5. DOCUMENT AUDIENCE: To the YIACO Medical Company centre

6. DOCUMENT INFORMATION
A. Important issues raised by the document
   a. YIACO provides training to lab students
   b. YIACO provides evaluation and results for training different categories of students

B. Reasons for creating the document
To acknowledge the training of YIACO and to follow up their progress in the training education process

C. What the document indicates about the case study at the time it was written
The Ministry of Health has officially acknowledged YIACO (the private sector) as a suitable training fieldwork centre of lab service students.

D. Other relevant issues not raised by the document
What other types of training does YIACO provide
Appendix 10 - Document 4

The College of American Pathologists

Awards this Certificate of Participation
to

Radiology Nuclear Medicine and Lab Center
71971-14-01
For participation in the 2006 Surveys and Anatomic Pathology Education Programs

Jude N. Schuen, M.D., Ph.D., FCAP
President

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Document Review 4

1. DOCUMENT TYPE
Certificate

2. DOCUMENT CHARACTERISTICS
Interesting Letterhead
Notations
Handwritten
Officially stamped
Typed
Other

3. DOCUMENT DATE(S): 2008

4. DOCUMENT AUTHOR: The College of American Pathologist
POSITION (TITLE): President Jard N.Schwartz

5. DOCUMENT AUDIENCE: For the public

6. DOCUMENT INFORMATION
A. Important issues raised by the document
Award

B. Reasons for creating the document
To award YIACO a certificate of participation in the surveys and anatomic pathology education programs

C. What the document indicates about the case study at the time it was written
YIACO are scientifically active and keeping up to date with the international professional standard

D. Other relevant issues not raised by the document
Document Review 5

1. DOCUMENT TYPE
Training manual for YIACO

2. DOCUMENT CHARACTERISTICS
Interesting Letterhead
Notations
Handwritten
Officially stamped
Typed
Other

3. DOCUMENT DATE(S): 21/10/2008

4. DOCUMENT AUTHOR: Dr. Joseph Paul
POSITION (TITLE):

5. DOCUMENT AUDIENCE New employees, trainees and students coming into the YIACO centre

6. DOCUMENT INFORMATION
A. Important issues raised by the document
   a. Document provides a brief background about the centre,
   b. Highlights the training objectives and provides orientation information about the centre

B. Reasons for creating the document
To give a full orientation for new employees, students and trainees about the centre facilities.

C. What the document indicates about the case study at the time it was written
The case study has a very thorough training programme which covers all different departments.
YIACO participates in external quality control programs from the College of American Pathologists (CAP). The centre also implements internal quality control systems and quality management systems practiced in accordance with the requirements of the ISO 9001:2000 standard.

D. Other relevant issues not raised by the document

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### DMAIC Case Study Worksheet

**Tracking Number:** -

**Date Initiated:** 11/04/2010  
**Date Closed:** 19/04/2010

<table>
<thead>
<tr>
<th>Phase</th>
<th>0</th>
<th>D</th>
<th>M</th>
<th>A</th>
<th>I</th>
<th>C</th>
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</thead>
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<tr>
<td>Identify the Problem</td>
<td>Define</td>
<td>Measure</td>
<td>Analyze</td>
<td>Improve</td>
<td>Control</td>
<td></td>
</tr>
</tbody>
</table>

**O: Identify the Problem**

Delay in collection of reports by Dept. of Surgery, Adan hospital.

**D: Define**

Study of the delay in receiving Histopathology reports at Surgery Dept Adan Hospital was based on:

1. **Turn around time (TAT):**
   - The time taken by RNLCH Histopathology unit to report the cases received from Ward 10, Ward 12 and Surgical OPD.
   - TAT is calculated as the number of working days between the date of receiving the specimen and the date of reporting. [Total days - (Fridays & Saturdays + Holidays)]

2. **Time taken by the Surgery Dept. to collect the report, when it is ready.**

**M: Measure**

The below histograms represents the key metrics used in the study of the delay in receiving Histopathology reports at Surgery Dept Adan Hospital.

1. **Turn around time (TAT):** Out of the 347 specimen received from Surgery Dept. (SOPD, Ward 10 and Ward 12) in the first quarter of 2010, 94% were reported within TAT.
2. To study the delay in collecting reports:

A) Days taken to collect reports of cases sent from Surgery Dept.

<table>
<thead>
<tr>
<th>No. of days</th>
<th>No. of reports collected</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>9</td>
<td>2.62</td>
</tr>
<tr>
<td>1</td>
<td>36</td>
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<td>45</td>
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<td>41</td>
<td>11.92</td>
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<td>17</td>
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<td>5</td>
<td>12</td>
<td>3.49</td>
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<td>6-10</td>
<td>59</td>
<td>17.15</td>
</tr>
<tr>
<td>11-15</td>
<td>45</td>
<td>13.08</td>
</tr>
<tr>
<td>16-20</td>
<td>20</td>
<td>6.81</td>
</tr>
<tr>
<td>21-25</td>
<td>15</td>
<td>4.36</td>
</tr>
<tr>
<td>26-30</td>
<td>20</td>
<td>6.81</td>
</tr>
<tr>
<td>30-50</td>
<td>25</td>
<td>7.27</td>
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</table>

B) Days taken to collect Surgical OPD reports

<table>
<thead>
<tr>
<th>No. of days</th>
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<th>Percent</th>
</tr>
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<tbody>
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<td>0</td>
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<td>6.49</td>
</tr>
<tr>
<td>1</td>
<td>16</td>
<td>20.78</td>
</tr>
<tr>
<td>2</td>
<td>20</td>
<td>25.97</td>
</tr>
<tr>
<td>3</td>
<td>17</td>
<td>22.08</td>
</tr>
<tr>
<td>4</td>
<td>7</td>
<td>9.09</td>
</tr>
<tr>
<td>5</td>
<td>1</td>
<td>13.0</td>
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<tr>
<td>6-10</td>
<td>8</td>
<td>10.39</td>
</tr>
<tr>
<td>11-15</td>
<td>3</td>
<td>3.90</td>
</tr>
</tbody>
</table>
c) Days taken to collect Ward 10 reports

![Days taken to collect Ward 10 reports (Jan - Mar 2010)](chart)

<table>
<thead>
<tr>
<th>No. of days</th>
<th>No. of reports collected</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-5</td>
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<td>14.0</td>
</tr>
<tr>
<td>6-10</td>
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<td>62.9</td>
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<tr>
<td>11-15</td>
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<td>3.50</td>
</tr>
<tr>
<td>16-20</td>
<td>4</td>
<td>2.80</td>
</tr>
<tr>
<td>21-30</td>
<td>4</td>
<td>2.80</td>
</tr>
<tr>
<td>31-40</td>
<td>2</td>
<td>1.40</td>
</tr>
<tr>
<td>40+</td>
<td>2</td>
<td>1.40</td>
</tr>
</tbody>
</table>

D) Days taken to collect Ward 12 reports

![Days taken to collect Ward 12 reports (Jan - Mar 2010)](chart)

<table>
<thead>
<tr>
<th>No. of days</th>
<th>No. of reports collected</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-5</td>
<td>2</td>
<td>14.7</td>
</tr>
<tr>
<td>6-10</td>
<td>11</td>
<td>8.09</td>
</tr>
<tr>
<td>11-15</td>
<td>20</td>
<td>14.71</td>
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<tr>
<td>16-20</td>
<td>20</td>
<td>14.71</td>
</tr>
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<td>21-25</td>
<td>6</td>
<td>4.41</td>
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<tr>
<td>26-30</td>
<td>9</td>
<td>6.62</td>
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<td>31-40</td>
<td>18</td>
<td>13.24</td>
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<tr>
<td>40+</td>
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<td>9.56</td>
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<td>5-10</td>
<td>8</td>
<td>5.88</td>
</tr>
<tr>
<td>11-15</td>
<td>3</td>
<td>2.21</td>
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<td>16-20</td>
<td>12</td>
<td>8.82</td>
</tr>
<tr>
<td>21-25</td>
<td>5</td>
<td>3.68</td>
</tr>
<tr>
<td>26-30</td>
<td>9</td>
<td>6.62</td>
</tr>
</tbody>
</table>
A: Analyze

From this study of the delay in receiving Histopathology reports at Surgery Dept Adan Hospital, the following was concluded:

1. 94% of the cases sent from Surgery Dept. were reported within TAT.
2. 66% of the cases were reported within 3 days.
3. As shown in the histograms more than 60% of the reports were collected after 6 days, and reaching to a maximum of 25-50 days to collect 13% of the cases, from the date, they were ready.
4. Lack of a system for timely collection of the reports. When we request the wards to send the porters to collect the report, we often receive the reply that “the patient is discharged and now we are not responsible for the collection/filing of the reports”.

I: Improve

Measures to reduce the delay in collection of reports:

1. The concerned ward /OPD shall send the porters daily to collect the report.
2. Patient details like ward /OPD, Correct Civil I D & Hospital Number will help in the proper identification of the patient and timely release of the report.

C: Control

Better control of the collection of reports can be achieved by:

1. Maintaining a log book by the wards / OPD both for specimen and reports as followed by Dermatology Dept., Al- Adan Hospital.
2. Generation of quarterly reports on TAT, a key performance indicator (KPI) of Histopathology Unit.

Conducted by: Ms. Abeer Al Anazi
Quality Assurance Officer

Approved by: Dr. Arafat Al-Sulaiman
Director

Mr. Sanil C S
Sr. Tech. Histopathology.

Dr. Munish Joneja
HOU/ Histopathology
Document Review 6

1. DOCUMENT TYPE
DMAIC – Define, measure, analyse, improve and control- case study worksheet

2. DOCUMENT CHARACTERISTICS
Interesting Letterhead
Notations
Handwritten
Officially stamped
Typed
Other (in-house quality control document)

3. DOCUMENT DATE(S): 19/04/2010

4. DOCUMENT AUTHOR: Abeer Al Anezi
POSITION (TITLE): Quality Assurance Officer in YAICO

5. DOCUMENT AUDIENCE: Management and staff of the centre

6. DOCUMENT INFORMATION
A. Important issues raised by the document
   a. The document identifies a template of various phases associated with potential problems encountered by the centre (define, measure, analyse, improve and control)
   b. It identifies the exact nature of any problem encountered within the centres field of work; defines its boundaries; measures its impact on the centres work; analyses the problem by breaking down and determining the relationship of the issues identified; improves the problem by identifying solutions and problem solving mechanisms; and control the problem to ensure that the problem is under supervision to prevent reoccurrence

B. Reasons for creating the document
As part of the quality assurance procedure implemented within the centre

C. What the document indicates about the case study at the time it was written
The centre is implementing good procedures to control issues and problems raised. Also there is proper team work to tackle the issues raised by the document (Quality Assurance Officer, Senior Tech Histopathology, Head of Unit Histopathology and the Director of YIACO)

D. Other relevant issues not raised by the document
No indication of whether the public sector (Main Adan Hospital Building) has been involved in this quality control procedures)
Certificate of Registration

This certificate has been awarded to

Radiology, Nuclear Medicine & Laboratory Center
P.O. Box 435, Safat, 13005, Kuwait

in recognition of the organization’s Quality System which complies with

ISO 9001:2008

The scope of activities covered by this certificate is defined below

Radiology, Nuclear Medicine, Clinical Laboratory and Blood Bank Services Required for Hospitals & Walk-in Patients

Certificate Number: 26395/A/0001/UK/En
Date of Issue: 25 July 2007
(Original Certificate)
Date of Issue: 25 August 2009
Expiry Date: 24 July 2010
Issued by: On Behalf of the Schemes Manager
Document Review 7

1. DOCUMENT TYPE
Certificate

2. DOCUMENT CHARACTERISTICS
Interesting Letterhead
Notations
Handwritten
Officially stamped
Typed
Other

3. DOCUMENT DATE(S): 25/08/2009

4. DOCUMENT AUTHOR: URS (United Registrar of Systems) Quality Control Management
POSITION (TITLE): URS Quality Control Management

5. DOCUMENT AUDIENCE: YADC Management and the Public

6. DOCUMENT INFORMATION
A. Important issues raised by the document
   a. Radiology, nuclear medicine and laboratory centre has been awarded a certificate in recognition of the organization's quality system which complies with ISO 9001:2008.
   b. The scope of activities includes radiology, nuclear medicine, clinical laboratory and blood bank services required for hospitals and walk in patients

B. Reasons for creating the document
The certificate was written to award the centre with the ISO standard it has achieved

C. What the document indicates about the case study at the time it was written
The centre is keeping up with ISO international standard that reflect the centre's good performance

D. Other relevant issues not raised by the document
Appendix 14 - Document 8

Graph shows reduction in admission for paediatrics emergency in Adan hospital.
1. DOCUMENT TYPE
Study

2. DOCUMENT CHARACTERISTICS
Interesting Letterhead
Notations
Handwritten
Officially stamped
Typed
Other

3. DOCUMENT DATE(S): 2009

4. DOCUMENT AUTHOR: Dr. Marzok Alazmy
POSITION (TITLE): Paediatric consultant in Adan hospital

5. DOCUMENT AUDIENCE: Management and clinical staff

6. DOCUMENT INFORMATION
A. Important issues raised by the document
Study showing decrease in paediatric emergency admission within the last four years

B. Reasons for creating the document

C. What the document indicates about the case study at the time it was written
The reduction in admission was partly due to the introduction of YIACO diagnostic centre and its efficiency in enhancing the urgent imaging studies including ultra sound and CT scans, and its enhanced coordination with the emergency department. Also introduction of important blood investigation in the emergency department with cooperation of the YIACO lab.

D. Other relevant issues not raised by the document
الموضوع زيارة خاصة لموظفات قسم البيطولوجي

رغبنا من تطوير الأداء الوظيفي للفني مختبر البيطولوجي وإطلاعيهم على أحدث التقنيات العلمية والعملية في مجال التحضير البيطولوجي.

يرجى من سيداتكم التفضل بالموافقة على تنظيم زيارة إلى المختبر الخاص للشركوك (مختبر الهيستو البيطولوجي الموجود في مختبر مستشفى العدان) ، وذلك للإطلاع على برنامج الصبغات الخاصة.

SPECIAL STAINS ( ready made kit )

علما بأن المرشحتين لهذه الزيارة هما:

1. أ.آلاء سليمان سعد
2. فاطمة إسماعيل محمد

وتفضلا بقبول فائق الاحترام والتقدير.

مدير إدارة الطب الشرعي
ال العلي / معاون مدير عام

ك.ح.ع.

To: HOU - Histopathology

Thank you kind care

[Signature]

19/11/2016

Tel: 24346888 / 24346583 - Fax: 24334221 - Kuwait
web site: www.moi.gov.kw
1. DOCUMENT TYPE
Letter

2. DOCUMENT CHARACTERISTICS
Interesting Letterhead
Notations
Handwritten
Officially stamped
Typed
Other

3. DOCUMENT DATE(S): 14/12/2010

4. DOCUMENT AUTHOR: Colonel Hamad Alanizy
POSITION (TITLE): General Manager of Forensic Medicine in Ministry of Interior - Department of Criminal Evidence

5. DOCUMENT AUDIENCE: YADC Management

6. DOCUMENT INFORMATION
A. Important issues raised by the document
Provision of training by YIACO to the Ministry of Interior Department of Criminal Evidence staff

B. Reasons for creating the document

C. What the document indicates about the case study at the time it was written
The private sector is also providing services to other government bodies (training)

D. Other relevant issues not raised by the document
Comparison between YIACO-Adan Hospital and other governmental hospital concerning Radiology Services

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Total # of CT Cases</th>
<th>Total # of MRI Cases</th>
<th>Total # of X-Ray Cases</th>
<th>Total # of U/S Cases</th>
<th>Total Cost of Radiology Services (KD)</th>
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</thead>
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1. DOCUMENT TYPE
Financial report

2. DOCUMENT CHARACTERISTICS
Interesting Letterhead
Notations
Handwritten
Officially stamped
Typed
Other

3. DOCUMENT DATE(S): 4/10/2010

4. AUTHOR (OR CREATOR) OF THE DOCUMENT: Kuwait Ministry of Health
POSITION (TITLE): Finance Department

5. DOCUMENT AUDIENCE: Government and the public

6. DOCUMENT INFORMATION
A. Important issues raised by the document
   1. The document provides financial information regarding the financial operating costs of the diagnostic services of different health governances and its hospitals.

   2. It provides a comparison of different types of radiology services carried out in different diagnostic services in Kuwait

B. Reasons for creating the document
It was written as part of the mandatory financial account report

C. What the document indicates about the case study at the time it was written
It provides a comparison of Adan diagnostic centre operating cost and other hospitals in Kuwait.

D. Other relevant issues not raised by the document
Detailed breakdown of the operating cost is not available.