

Collaborations in Reproductive Health Care Sector and Meta Organizational Challenges

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Abstract This study was done to explore the dynamics of conflict of interests among various organizations in reproductive health sector. This study is based upon in-depth interviews of DKT India officials, Government officials, its partners and clients. Along with interviews, observations of various operations of DKT India have been made. Findings indicate that the issue is not public private partnership per se, but collaboration amongst various stake holders including the clients. It is multi-level partnership paradigm. It gets well reflected in the argument that such collaboration between organizations and communities is likely to provide the genesis for meta-organizations. It is inferred from findings that genesis of meta organization creates the complex cultural challenges which could be used for innovations strategically.

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Introduction

In India, there is clear cut reproductive health care usage differentials in favour of private sector with respect to quality of care in clinical services (International Institute for Population Sciences (IIPS) and John Hopkins University, 2005). It implies very clearly that reproductive health care can not be seen as only public health service but needs partnerships with private sector. While discussing public-private partnerships in health care Hasio refers to marketisation as “the illusory magic pill”. It is concluded that neither pure centrally planned nor free market health systems can achieve maximum efficiency. A complex mixed system seems to be the way out. This necessitates the understanding of the complexity of public private partnerships in the context of reproductive health care (Barr, 2007). PPPs can be broadly defined as financial arrangements between governments and the private sector where the private sector provides financial and other forms of capital to fund the construction and maintenance of government services, including schools, hospitals, water supplies and road and rail networks (Blake N 2004). There is substantive literature available that throws light upon public and private health care differentials. The differences can be categorized in three broad manner (Palmer at al, 2003). In one view, private sector is argued to be more efficient than public sector. Second perspective argues that private sectors are often not superior in quality or efficiency; contracts are not straightforward to design and implement. Thirdly, neither public nor private providers have uniform characteristics. The analysis of South Africa cases show that there has been difference in nature of services sought by clients (Palmer at al, 2003). Usage of private sector is driven there by inaccessibility of

public services, perception of greater privacy, speed of service, quality of diagnosis, prescribing and counselling (Tran Tuan et al 2005). Result of a study in Northern Cyprus show that on all the dimensions of quality of health care in hospitals i.e. giving priority to patients' needs, professionalism of staff, providing patients with high-quality services and opportunities, relationships, equipment, medicine, facilities and other provisions, hygiene, environment and design; private hospitals perform better than public hospitals (Arasali H et al. 2004). Valery Ridde (2005) argues that the overall monitoring and evaluation of services provided by subcontractors have been problematic. It was observed that the contracts were not sufficiently clear in setting out the expected results, there was inadequate information, a lack of interest in monitoring. In Canada federal government provides about 30% of the funds from corporate and personal income taxes. The provincial governments' contribution varies from 38-50 percent. Private sources provide 20-30% of the funding. Supplementary insurance plans from insurance industry provide upgraded hospital room coverage, prescription plans, vision care or hearing care (Isbister 1991). In 1940, there was introduction of National Health Service in Britain (Shaw E 2003). Around same time, India also had Bhore Committee report in 1946, The Chopra committee report on Indian systems of Medicines in 1946 and The Sokhey committee report in 1948 (Duggal R et al 2005). The recommendations of these three committees acted as guide for formulating health services plans in India. In India, there has always been utilization of private health services along with Public health services. Private interest is not restricted to provisioning alone but has penetrated financing, technology and drugs, medical and paramedical education as well (Baru, R 2005). The interaction between private and public providers in health care revolves around form of partnership (joint venture, providing subsidies and various fiscal incentives, having informal understanding about the provision of services, 100% privatization),

focus (Clinical or non-clinical services, other provisions such as handling management aspect etc.) and flexibility (in terms of having their own structure). (Bhat, R; 2000). For the last 10 years, Janani has been working in Bihar. Janani is engaged in discussions on establishing a systemic way to forge public-private partnership (website <http://www.janani.org> last accessed on August 23, 2006). However, the partnership is not limited to the service provider only. It may include families in the decision making like a case of designing a service plan for young child with special health care needs (Feinberg E, 1999). In the context of these facts, it can be inferred that it is not a public-private partnership but public-private partnership(S). Janani also collaborates with many other private players. In such scenario it becomes an issue of care and regulation. As on one hand, it has to be ensured that health care services are being provided. At the same time, clients need to be protected against negligence and exploitation. That requires efforts of regulation from the government. Partnership(S) also reflects upon the culture of organizations e.g. in this case Janani and its associates and Policy of DKT International. Therefore, the issue is not partnership per se, but collaboration amongst various stake holders including the clients. So, we seem to referring to multi-level partnership paradigm. It gets well reflected in the argument that such collaboration between organisations and communities is likely to provide the genesis for meta-organisations (Anand, S, 2006). Genesis of meta-organizations is also based upon need and therefore partnerships.

However, *“high level PPP (Public Private Partnership) interactions are in fact instruments of elite governance which advance the corporate-led neoliberal restructuring of the world”*. (Richter, 2003 as quoted in Buse and Harmer, 2004). According to critics, partnership is dominated by corporate elites and it will inevitably subvert the public service of international organizations such as UN or the WHO (Karliner, 1999 as quoted in Buse and Harmer, 2004;

Utting 2001). Against this, pluralist argue that there is no one single dominant partner. Many interest groups participate in the process and decisions are often taken by consensus (Held 1996 as quoted in Buse and Harmer, 2004; Walt 1994). Further, neo-pluralist though agree with participation of multiple pressure groups, but they argue that the agenda is, or is in danger of becoming, biased towards corporate players (Held 1996 as quoted in Buse and Harmer, 2004).

Public private partnership seems to be requiring evolution of detailed norm for use of non-profit insurance schemes. It also requires deliver and services norms. Malpractices as evident through literature in Indian private health hospitals can have two interpretations. First, regulatory systems are not properly evolved and government need to play much more active role in that. Secondly, liberalization does not imply shirking off to private service providers. It is not a question of either NHS or Insurance (Naylor et al. 1999). In the given context, it can be argued that partnership is not to reduce the role of public-health services but to create alternatives for service recipients at various levels. A study of interindustry mergers and acquisitions among U.S. public companies in the period 1985-2000 has indicated that while mutual dependence is a key driver of mergers and acquisitions, power imbalance acts as an obstacle to their formation (Casciaro, T. and Piskorski M, J. 2005). Power imbalance acts as a negative force in the process of collaboration. It is likely to act as a barrier in the formation of meta organization.

Methodology

This study was done to explore the dynamics of conflict of interests among various organizations in the reproductive health sector. This study is based upon in-depth interviews of 10 DKT India (better known as Janani in India) officials, 5 government officials, its 5 partners and 10 clients. Along with interviews, observations of various operations of DKT India have been made. Interviews of officials in health secretariat, directorate of health services and population bureau

have been conducted. To understand the conflict of interests, semiotic analysis of observation study and interviews have been done.

Findings and Discussion

Findings confirm the hypothesis that today it is not a public-private partnership but public-private partnership(S). DKT International, a reproductive health care organization, working in many countries, also collaborates with many other players apart from government. In such scenario, the quality issues revolve around conflict of interests, care and regulation. As on one hand, it has to be ensured that health care services are being properly provided. At the same time, clients need to be protected against negligence and exploitation. That requires efforts of regulation not only from the government, but self regulation. Partnership(S) also reflects upon the culture of organizations e.g. in this case DKT India, its associates and policy of DKT International. Therefore, the issue is not partnership per se, but collaboration amongst various stake holders including the clients. So, we seem to be referring to multi-level partnership paradigm. It gets well reflected in the argument that such collaborations among organizations and communities are likely to provide the genesis for meta-organizations. The findings show that there are conflicts at various levels within DKT India, among various departments of government and partners. Due to lack of openness & trust, conflict of interest prevails. There is clear lack of a policy which could integrate various players in meta organization. It is indicated that power play rules the decision making and do not allow any structure to emerge which does not fit into its power game. The “zero sum game” cognition not only promotes the culture of violence within meta-organization but also creates problem in delivery of quality for reproductive health services in India. Findings indicate that at DKT, organizational system is there to ensure the productivity. Employees have well defined targets and rules and regulation. They have clear targets in terms of

sales, visits to the centres etc. Office timings are very strict. If one reaches late in office for more than 3 days in a month, the employee's salary is reduced for that particular month. Some amount is deducted from his salary. Though, the exact compensation is not known, however employees feel that it is comparable with the private sector. There is a sense of pride in comparing the organization with private corporations. As per response of one official *"We are getting more or less same salary as one gets in a good company. We are at par"*. It can be inferred here that the reference group is 'corporations'. Corporations as reference group, indicate certain set of values which are reflected in day to day activities of organization as well as in goals of organization. One of the desired values is to expand its size. One official mentions that DKT also plans to enter into activities for HIV/AIDS in the state of Bihar. The official mentions that Gates foundation is approaching them for it. The official feels if it happens, it shall be very good for them as lot more funds they will get. The official feels that in this manner DKT will also become large. So, though DKT is an NGO, it aspires to become a large visible corporation in India. So, it is found that NGOs are making an attempt to become corporations. There are also global aspirations reflected in the dialogue. On the other side, there seems to be complete collapse of reproductive government/public health system. Even basic needs of employees are not being met. As per head, population bureau, government of Bihar, there is minimum amount which a contractual employee is supposed to receive. He says that as per government rules, even for an employee working on contract basis, minimum salary needs to be protected. Even, they need to be given certain allowances. However, according to government official, in case where it has to be paid approximately around Rs¹. 7800/- per month, there the payment given is around Rs. 3900/- per month. So it is indicated that in multi-level partnership, the challenge is to manage the conflicting demands. Medical practitioners feel that it is too early to talk about public-private

¹ Indian currency in Rupees.

partnerships in Bihar. The system is not ready for that. The findings are indicative of the dynamics of prevalent conflict of interests. Conflicts are indicated between government (public player)& NGO (private player), NGO & its collaborators and among various departments of these organizations. These conflicts necessitate the creation of a meta structure. Meta structure can handle the various conflicting demands emanating from various stakeholders (Anand, S. 2006; Anand et al 2007). Semiotic analysis has indicated that all these conflicts reflect upon the symbolism of power which is well grounded in culture of India. The discussion leads to the following framework which provides the perspective for justice for clients seeking reproductive health care.

The **communities** in Bihar seeking reproductive health care have been putting their demands in different forms. Interviews with clients show that they have really become clients from beneficiaries. They are no longer beneficiaries of programme offerings. Now they have expectations from the services being offered by both public and private players. The expression of voice from communities has started compelling corporations to emphasize about ethical behaviour, where duties and obligations are being redefined. We can not avoid that. Today, in this way, 'socialization of corporations' is happening. (Anand S. 2007).

Privacy emerges as the most important predictor of treatment effectiveness perceptions. This leads to investigation of the relationship between privacy and perceived effectiveness of the treatment. In fact "privacy as issue is increasingly becoming important in the public space. This has happened due to claimed death of distance due to IT (Information Technology) revolution and increasing surveillance. Infact, organized activities from bodies like privacy international clearly demonstrate the importance of it. Though the issue of privacy is well captured in the personal space literature, however recent past has given new meaning to it (Seshadri M and

Singhi S 2007). Today core of reproductive health care services need to have privacy and dignity at its core. However, the privacy and dignity can not be seen only at the individual level. Both individual and collective right to privacy and dignity need to be created (Heredia R.C., 2007). Collective right to privacy needs to be created as the privacy can not be denied because of one's belongingness to certain caste or tribe.

Communities are demanding right to **dignity**. The language used by the clients might not be 'right to dignity' language, but the underlying theme is very clear in their responses '*we want dignified treatment irrespective of the hospital we visit*'. Verdict is obvious , the voice is very clear. Clients do not want to face any interaction with any health service provider where they feel that treatment given to them is below their dignity. They put all of their efforts where they could avoid any situation endangering their dignity. Dignity has become core to the services being received by individuals. All service providers irrespective of their origin need to meet the minimum requirement of dignity.

Literature in the field of sociology has identified 5 meanings of **alienation**: powerlessness, meaninglessness, normlessness, isolation, and self-estrangement.(Seeman, M, 1959). The technological changes and forces of globalization seem to have created sense of conflict among the client whether they find themselves distant from the traditional value system, belief system and practices. For e.g the client may have belief that more pain one has during pregnancy better it is for one' reproductive health. However, cognitive dissonance is likely to be created when she finds herself amidst conflict where doctors' advice is contrary to the one's earlier belief system.

It is indicated in the responses of various officials who feel that people want to get everything without paying for that , though they can afford that. They also feel the government needs to

clearly decide what is good or what is not good for them. When they say that the government can think best in favour of them, it implies that the government is the best judge for collective good. They feel that it happens as government do not decide on ad hoc basis, but decisions are institutional in nature. They feel that many a times decision making in corporate houses is in hurry and takes lesser time than what is required for a wise decision. When asked if decision making takes longer time, then it is likely to result into a wise decision, they respond by saying that no it is not like that. They say that the process of decision making requires optimization of time. They feel when we have decided to go for public private partnership, it becomes critical that decision making process is optimized in its real sense. However, when public sector is compared with the private sector, in public sector delay may be there but the decisions are more going to be collective in nature and thereby meeting the requirements of larger good. This kind of logic as given by senior government officials/bureaucrats strengthens the argument in favour of state. By strengthening the power of state, these officials want to exercise control on the communities to which they serving through their role in health department. The attempt to exercise control is not unexpected. It has been associated with the process of corporatization of public sector undertakings. The system faces the problems when 'stickiness of identity' is observed (Josserand, E, Teo, S and Clegg, S 2006). The process becomes further complicated in the context of meta organization, where different kind of stakeholders at different level are involved.

The term **corporate structure** refers to power structure created by organizations. It also refers to conditions created by organizations under which clients or communities receive services from various organizations. The impact of organizational characteristics on the services provided by health organization is clearly indicated in earlier studies (Kochevar, Laura K., Yano, Elizabeth

M. 2006). Increasingly, the studies indicate that corporate structure is being forced to become transparent and can not ignore issues which are wider in nature.

Analysis indicates that the laissez-faire benefit model has failed in United States of America. It is argued that without government defining some basic standards for health care and pension benefits, the number of Americans without health insurance will continue to rise and retiring Americans will be without the needed resources to have basic dignity at the end of their working lives (Kochan, T and Shulman, B).

A analysis of health insurance in reproductive health care and broadly in public health indicate that health insurance markets always fail because of three inherent features of healthcare. It fails because of adverse selection, inadequate monitoring and moral hazard. Adverse selection takes place when sickest people buy policies and drive up the price for everyone else. It is difficult to monitor whether treatments given are necessary. It may create moral hazard if the insurance leads people to take fewer precautions to prevent illness than they would if they had to bear the cost of the treatment (Hammer J, Aiyar Y and Samji, S, 2007)

The **governance** is not only to be reflected in the meta structure and policies of public – private partnerships. E.g. dignity needs not only to be integrated in policies of various stakeholders but also to be communicated to the client. A study done in Netherland shows that empathetic touch either by doctor or from nurses or paramedical staff establishes a clinical relation of inter subjectivity. This relationship of inter subjectivity indicates and affirms in patients the dignity and worth that morally distinguish persons from objects (Gadow, S, 1984).

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Framework for ‘Reproductive Health Justice Model’ (Borrowed from Anand, S, Patra, B. and Kumar I 2007 framework and modified)

