

# Exploring the Feasibility of Public Private Partnerships in the Healthcare Sector in Zimbabwe

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## Abstract

Governments today face a broad range of complex healthcare challenges prompted by changing demographics, a growing burden of chronic diseases, escalating healthcare costs and rapidly changing healthcare technologies. Due to these challenges healthcare delivery systems are increasingly strained and are struggling to expand access and deliver high-quality healthcare services in line the implementation of Universal Health Coverage (UHC) and the overarching objective of achieving Sustainable Development Goal 3, which seeks to ensure healthy lives and promote wellbeing for all at all ages by 2030. Additional investment in health is, thus, needed in many countries, particularly in developing countries where healthcare infrastructure remains inadequate, and facilities lack the necessary management skills and patient care personnel to address the growing demands of caring for their populations. Faced with such a situation, and the imperative to stretch their healthcare funding and produce better results, many countries are increasingly turning to PPPs (World Bank, 2013). Zimbabwe, a developing country, situated in Southern Africa is faced with the same situation. A protracted debilitating economic crises has severely undermined the capacity to healthcare delivery to the populace. Against this backdrop, there is an increasing realisation within the country that provision of health services through several Public-Private Partnership initiatives could be of help to alleviate the challenges.

**Key Words:** public-private-partnerships; healthcare, universal health coverage, sustainable development goals, Zimbabwe

## I. INTRODUCTION

As Asogwa and Odoziobodo (2016) point out, governments and the private sector have historically worked together on a broad range of issues, including setting regulatory frameworks, implementing development programmes, and other public policy decisions that affect the economy and society. Governments all over the world are, thus, turning to public-private partnerships (PPPs) as means of improving the delivery of public services and meeting the investment challenges that they face. In the health sector PPPs have particularly gained importance due to fiscal limitations. Zimbabwe has scope for PPPs in health care financing as it is a country faced numerous challenges including limited fiscal space, inadequate infrastructure, lack of technical capacity and skills flight.

## II. GLOBAL CHALLENGES WITHIN THE CONTEXT OF UNIVERSAL HEALTH CARE COVERAGE

Governments today face a broad range of complex healthcare challenges prompted by changing demographics, a growing burden of chronic diseases, escalating healthcare costs and rapidly changing healthcare technologies (Abuzaineh, Brashers, Foong, Feachem, Da Rita (2018). Owing to these challenges healthcare systems are increasingly strained and are struggling to expand access and deliver high-quality healthcare services in line the implementation of Universal Health Coverage (UHC) and the overarching objective of achieving Sustainable Development Goal 3, which seeks to ensure healthy lives and promote wellbeing for all at all ages by 2030. As noted by Abuzaineh et al. (2018), additional investment in health is, thus, needed in many countries, particularly in developing countries where healthcare infrastructure remains inadequate, and facilities lack the necessary management skills and patient care personnel to address the growing demands of caring for their populations. Faced with such a situation, and the imperative to stretch their healthcare funding and produce better results, many countries are increasingly turning to PPPs (World Bank, 2013). USAID and Pakistan Initiative for Mothers and Newborns (2006) maintains that the underlying logic for partnerships is that both the public sector and the private sector have unique characteristics that provide them with advantages in specific aspects of service or project delivery. Furthermore, they submit that the most successful partnerships draw on the strengths of both the public and private sectors for complementarity, although roles and responsibilities of the partners may vary from project to project. In a similar vein, Jomo, Chowdhury, Sharma, Platz (2016) posit that from a public policy perspective, the prime objective of a PPP is improvement in the quality and efficiency of a given service to the citizen. They further argue that at the same time, PPPs have the benefit of attracting private resources into public services, thereby allowing public money to be diverted into other critical areas and alleviating long-term fiscal pressures.

The World Bank (2013) identifies four key factors driving governments worldwide to the PPP model for health sector improvements, namely, the desire to improve the operation of public health services and facilities and expand access to high quality services, the opportunity to leverage private investment or the benefit of public services, the desire to formalise

arrangements with non-profit partners, who deliver an important share of public services and more potential partners for governments as the private health care sector matures. While acknowledging the potential benefits of public funding and private delivery of health facilities and services, the World Bank (2013), however, notes that the path from publicly-run hospitals to privately-provided hospital services is not so well-known and can be challenging.

Relatedly, USAID and Pakistan Initiative for Mothers and Newborns (2006) notes that although a public-private partnership is one of a number of ways of delivering public infrastructure, including health services, it is not in any way a substitute for strong and effective governance and decision making by government. In the final analysis, government remains responsible and accountable for delivering public services, like health services and projects in a way that protects and advances the public interest.

The World Health Organization and World Bank (2017) asserts that the goal of universal health coverage (UHC) is ensuring that every community and individual accesses healthcare services. In the past few years, calls for the stepping up of efforts to attain UHC have grown considerably. Ghebreyesus (2017) puts it aptly by stating that all roads lead to universal health coverage (UHC). This underlines the centrality of global efforts to attain universal health coverage. According to Collaborative Africa Budget Reform Initiative (2015) UHC has been defined by the World Health Organisation (WHO) as ensuring that all people obtain the health services they need without suffering financial hardship when paying for them. For Ghebreyesus (2017), the key question of universal health coverage is an ethical one since it is a human right. He points out that at least 400 million people have no access to essential health services, and 40% of the world's population lack social security. Progress towards UHC means that more people, especially the poor, who are presently at greatest risk of not receiving needed services, receive the services they need. In addition, progress towards UHC implies lowering of barriers to seeking and receiving required medical care such as out-of-pocket payments, distance, poorly trained health workers and poorly equipped facilities (World Health Organization and World Bank, 2017). Importantly, UHC also entails that getting needed healthcare services is associated less and less with financial hardship and that people receiving health care services are still able to afford food and other necessities, and do not put their families at risk of poverty by accessing the care they need. World Health Organization and World Bank (2017) notes that in several less developed countries, lack of physical access to even basic services remains a colossal problem. Against this backdrop, health systems have a fundamental role to play in making strides towards UHC. Health systems strengthening through the enhancement financing, strengthening of governance of the system, improving health-care workforce, improving service delivery, improving health information systems and improving the provision of medicines and other health products is critical to progressing towards UHC. In this regard PPPs in the health care sector could also make a significant contribution as they allow the tapping of financial resources and expertise from the private sector.

### III. THE SUSTAINABLE DEVELOPMENT GOALS FRAMEWORK

According to World Health Organisation (WHO) and the World Bank (2017) a number of the 17 Sustainable Development Goals (SDGs) adopted by the United Nations General Assembly in 2015 have targets related to health, with one goal SDG 3 focusing specifically on ensuring healthy lives and promoting well-being for all at all ages. Sustainable Development Goal 3.8 sets the following target to be attained by 2030:

Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality, and affordable essential medicines and vaccines for all (Ghebreyesus, 2017).

Bhuwanea (2017) submits that there are compelling arguments that investments in health need to focus, not only on direct service delivery, but also on overall health-systems strengthening, as strong health systems will be pivotal to the achievement of SDG 3. Furthermore, he points out that many countries need substantial additional investments in health to achieve SDG 3. Evidently, the noble goal of achieving universal health coverage requires considerable fiscal space. Relatedly, Asogwa and Odoziobodo (2016) posit that there are challenges pertaining to finding mechanisms to harness the resources of the private sector to support public sector effort to promote national health. Against this backdrop, PPPs could be an alternative for bridging this gap. Relatedly, Shah and Thakur (2018), researching in India, assert that achieving Universal Health Coverage is not just the responsibility of the government, but cooperation from the private sector is imperative. Additionally, they note that the Indian private healthcare sector has grown rapidly in recent years and continues to contribute significantly to the provision of health services. They also submit that governments can improve private sector participation in health by improving transparency, reducing bureaucracy and allowing flexibility in post-contract negotiations. Some examples of successful healthcare PPPs that have contributed to improving the coverage and access to health services were also noted as well as the need to increase the level of private sector involvement in healthcare (Shah and Thakur, 2018).

### IV. THE ZIMBABWEAN CONTEXT

According to the *National Health Strategy for Zimbabwe 2016-2020*, there are prospects that the economy will remain sluggish in the short to medium term, and total tax revenues will generally remain at about 27% of GDP. These fiscal trends and projections indicate that the government's capacity to allocate financial resources to the health sector is limited. This macro-economic environment calls for innovation and effective partnerships between government and other stakeholders in both funding and provision of health services to the population.

Zimbabwe is among those countries that are faced with limited fiscal space and consequently deteriorating public utilities and service provisions (Mutandwa and Zinyama, 2015). The Zimbabwean government is struggling to keep the

Healthcare sector afloat due to the ever-increasing costs and demand for healthcare as the population grows. The nation of Zimbabwe, among many other African countries is currently faced with severe staff shortages, low work motivation, high rates of absenteeism and a general inefficiency of the health sector.

Despite having embarked on economic reforms such as the Economic Structural Adjustment Programme (ESAP) in 1990, which were meant to improve the serious economic crisis that Zimbabwe was in, the situation in the health delivery system has drastically deteriorated (Mutizwa, 1998). The economic hardships in the country have further aggravated the situation due to budgetary constraints to meet the requirements of the public health institutions. Corruption and malpractice has also been cited at the public institutions and this worsens the situation.

Focus has been gradually shifting towards the role of Public-Private Partnerships (PPPs) to alleviate the situation. Public Private Partnerships are increasingly being adopted internationally and public-private collaboration has been used to deliver health services in systems performing excellently around the globe (World Bank, 2013). PPPs have been proven for their ability to harness the efficiencies and expertise of the private sector to service delivery (Abuzaineh et al., 2018). This leads to the improvement of public health services and facilities to increase the access to services of higher quality (Sarmah, 2009; Abuzaineh et al., 2018). The private sector also brings in the benefits of more capital investment and sharing of risk (USAID and Pakistan Initiative for Mothers and Newborns, 2006; Kosycarz, Nowakowska and Mikołajczyk, 2018). In direct contrast to privatization, the public accountability is maintained with PPPs.

According to the Ministry of Health and Child Care E-Health document, (2012-2017) there is an increase in government efforts to increase the collaboration as well as provision of health services through several Public-Private Partnership initiatives. These initiatives are meant to strengthen health systems by covering the gaps identified in the six pillars for efficient delivery of health services, which were identified by the National Health Strategy of 2009-2013. The gaps included the presence of obsolete and non-functional medical equipment, reduced access to essential drugs and supplies, weakening of the health management and high human resource health vacancy level. The health sector is unacceptably underfunded with a budget allocation of US\$7 per capita against the recommended US\$34 per capita per annum. The result of these gaps is loss of life and untold suffering of the poor who are not able to access the services of the private sector.

## V. PPPS- DEFINITIONS

The World Bank (2013) defines PPPs as initiatives that establish a contract between a public agency and a private entity for the provision of services, facilities or equipment. It further points out that a PPP exists when members of the public sector partner with private sector players in pursuit of a common vision and goals. Elaborating further, the World Bank posits that in a situation of equal partnership, all the partners bring resources together, contribute to the

development and implementation of the project, and benefit from its results.

For the World Bank (2017), a PPP denotes a long-term contract between a private party and a government entity, for providing a public asset or service, in which the private party bears significant risk and management responsibility, and remuneration is linked to performance.

Likewise, the USAID and Pakistan Initiative for Mothers and Newborns (2006) posit that public-private partnerships (PPPs) denote arrangements between government and private sector entities for the purpose of providing public infrastructure, community facilities and health services. It adds that such partnerships are typified by the sharing of investment, responsibility, risk, responsibility and reward between or among the partners. They also point out that the reasons for establishing such partnerships vary but generally involve the financing, design, construction, operation and maintenance of public infrastructure and services.

Kosycarz, Nowakowska and Mikołajczyk (2018) a PPP is an agreement between one or more public and private entities, typically of a long-term nature, reflecting mutual responsibilities in the furtherance of shared interests. Importantly, this definition implies that PPPs work only when both parties benefit from the relationship, and the expected benefits are clarified in advance.

For Hellowell (2019), PPPs denote long-term contracts between a public and a private entity in which the latter is responsible for delivering new healthcare facilities and services. He further elucidates that in PPPs of this kind, the private entity earns an income stream from a performance-adjusted unitary fee, paid by the public entity, together with user fees.

As Mutandwa and Zinyama (2015) note, a commonality in the definitions of PPPs is that the concept is largely discussed as a gap-filler towards infrastructural development by government. They hasten to stress that the impact of PPPs mainly depends on the extent to which the government effectively controls the private partners, sufficiently providing for the operational autonomy for private partners.

## VI. HISTORY OF PPPS

Jomo et al (2016) submit that public-private partnerships are not new, asserting that concessions, the most common form of PPPs, where the private sector players exclusively operates, maintains and carries out the development of infrastructure or provide services of general economic interest, date back thousands of years. They point out that during the time of the Roman Empire, concessions served as legal instruments for road construction, public baths and the operation of markets. The authors cite an example of medieval Europe, where as early as 1438, a French nobleman named Luis de Bernam was granted a river concession to charge the fees for goods transported on the Rhine. They however, point out that, while the practice has been around for millennia, the term "Private-Public Partnership" or PPP was coined and popularized in the 1970s, when neo-liberalism began questioning the hitherto dominant Keynesian paradigm and the



role of the state in the context of poor economic performance. This view is corroborated by Mutandwa and Zinyama (2015) who posit that the evolution of PPPs can be traced back to the 1970s during which a macro-economic dislocation ensued. They further point out that the trajectory of PPPs is found in the New Public Administration (NPM) body of reforms in which there was a retreat of government frontiers in the provision of public goods and services, noting that in that context, PPPs were seen as the gap-filler of the recurrent government failure.

Similarly, Abuzaineh et al. (2018) notes that historically, governments have engaged the private sector to deliver services through healthcare PPPs to achieve one or more of the following six functions: financing, design, building, maintenance, operation and delivery of services.

In Zimbabwe, as Dube and Chigumira (2011) asserts, the idea of PPPs was mooted in 1998 and significant attempts to craft a PPP framework were made in 2004. Nonetheless, to date the legal and regulatory frameworks for PPPs are yet to be established although some PPP projects have been implemented in the country, such as the Beitbridge-Bulawayo Railway (BBR), the New Limpopo Bridge (NLB) and the Newlands Bypass (Dube and Chigumira, 2010).

## VII. PPPs MODELS

There are several of models which can be adopted depending on the requirements of the Healthcare system. These include Build and transfer scheme (BT), Build and operate and transfer Scheme (BOT), Build own operate and transfer scheme (BOOT), Build lease and transfer (BLT), Build transfer and operate (BTO), Rehabilitate operate and transfer (ROT) and the Lease develop and operate scheme (LDO) (Savas 2000). Private Perspective

According to Dube and Chigumira (2010) under the Build-and-Transfer scheme (BT), the private sector player sources the requisite finance and constructs the facility. After completion, the company hands over the infrastructure to government, which then takes over all the roles. The government pays the firm an agreed amount of money, along with negotiated reasonable returns.

Confederation of Indian Industries and HOSMAC (2016) asserts that under the Build – Operate – Transfer (BOT) arrangement, the private sector builds an infrastructure project, operates it, and eventually transfers ownership of the project, or a major part of it, to the government. Usually in that arrangement the government becomes the company's only customer and promises to purchase at a predetermined amount of the project's output. This is meant to ensure that the private player recovers its initial investment in a reasonable duration. At the end of the contract, the public sector assumes ownership but can elect to assume operating responsibility, contract the operation responsibility to the developer, or award a new contract to a new partner (Confederation of Indian Industries and HOSMAC, 2016).

Build–Transfer–Operate (BTO) is a variation of Build – Operate – Transfer (BOT). Under this arrangement public sector contracts with the private player to design, construct and operate a facility (Confederation of Indian Industries and HOSMAC, 2016; Mutandwa and Zinyama, 2015). After

completion, the private player transfers ownership of the facility back to the public sector. The public sector then leases the facility back to the private partner under a long term contract.

The Confederation of Indian Industries and HOSMAC (2016) asserts that the other model is the Build–Own–Operate (BOOT) model. In this kind of arrangement the public sector either transfers ownership and responsibility for an existing facility or contracts with a private firm to build, own and operate a new facility permanently. The private partner usually provides the financing. The facility is then handed to the government or government department after the agreed term (Mutandwa and Zinyama, 2015).

The Design–Build–Operate (DBO) model is another common PPP model. Under this model the public sector contracts with a private player to design, construct and operate a facility, but ownership of the facility remains with the public sector (Dube and Chigumira, 2010; Mutandwa and Zinyama, 2015; Confederation of Indian Industries and HOSMAC, 2016).

Another common PPP model is the Design–Build–Finance–Operate (DBFO) arrangement. In this model the private player is responsible for designing, building, financing and operating the facility. The arrangements vary significantly in terms of the degree of financial responsibility that is transferred to the private player.

The Private Finance Initiative (PFI) is another PPP model. It entails an arrangement where a private sector consortium finances, builds and maintains a project in return for an annual fee from the government for a period of 25-30 years, throughout the life span of the project (Dube and Chigumira, 2010; Confederation of Indian Industries and HOSMAC, 2016).

According to Dube and Chigumira (2010) the Rehabilitate-operate and transfer (ROT) models involves a system where the infrastructure that is in existence but in a bad state is handed over to a private sector partner for refurbishment, reconditioning and maintenance. The private player is allowed to operate the infrastructure for a period, recover investment costs and get a reasonable return, after which the facility is handed back to the government.

Under the Build-lease-and-transfer (BLT) the private sector constructs infrastructure and once complete, it hands the operation issue to the government on a lease basis, where the government pays for the lease (Dube and Chigumira, 2010; Mutandwa and Zinyama, 2015). The lease payments give the firm an opportunity to recover its costs, and after an agreed term, the government stops paying the lease and assumes ownership and control over of facility.

On the other hand the Lease, develop and operate (LDO) arrangement is whereby a private sector actor leases an existing facility from the public sector, renovates, modernises or expands it before assuming operation rights for a fixed term. That way, the company gets an opportunity to recover costs, with the public sector benefiting from the lease payments (Dube and Chigumira, 2010; Mutandwa and Zinyama, 2015).

For Abuzaineh et al., (2018), in health care there are three basic PPPs models, namely, the infrastructure-based model, for to build or refurbish public healthcare infrastructure, the discrete clinical services model, for adding or expanding service delivery capacity, and the integrated PPP model, for providing a comprehensive package of infrastructure and service delivery.

### VIII. PPPS IN ZIMBABWE

The Zimbabwean government introduced the Public-Private Partnerships as early as 1998 whereby the private sector could partner with the government to improve service delivery. The government took this policy position due to the underperformance of the State-Owned Enterprises. These entities were making losses and becoming a liability to the nation's finances. PPPs were then proposed as a solution to improve the public infrastructure and other service delivery. This was done to complement the Public-Sector Reforms (PSR) under the Economic Structural Adjustment Programme (ESAP) where commercialisation and privatisation strategies were employed to improve the delivery of services and were quite successful in some sectors (Massimo, 2014).

The proposed PPP strategy in 1998, however, failed to take off since there was no framework to support the policy implementation. It was only in 2004 that the government was able to craft a framework on PPP investment. The 2004 Public-Private Partnership in Zimbabwe Policy and Guidelines were put in place to provide the parameters for developing an appropriate legal and regulatory framework which should protect the investors and consumer interests. However, the guidelines were not further developed into a legal and regulatory framework though some PPP projects have been implemented successfully in the nation (Dube and Chigumira, 2010). These projects include the Beitbridge-Bulawayo Railway (BBR), the New Limpopo Bridge (NLB) and the Newlands By-Pass (NBP) Zimbabwe National Chamber of Commerce (ZNCC, 2009).

The BBR was executed under the Build-Operate-and-Transfer scheme (BOT) by the Beitbridge Bulawayo Railway (Pvt) Limited, a subsidiary of NLPI Ltd which was established to implement the project (Dube and Chigumira, 2010). The construction phase was executed in a record eighteen month. The BBR is a 350km railway line from Beitbridge to Bulawayo which is an essential link for the fuel transportation to the southern parts of Zimbabwe.

The New Limpopo Bridge (NLB) was the first BOT of that nature in Africa whereby a private company, New Limpopo Bridge (Pvt) Ltd also a subsidiary of NLPI Ltd was awarded to finance and build a toll bridge over the Limpopo River in 1993 by the governments of Zimbabwe and South Africa. The bridge was completed in a record time of thirteen months and the company is still operating the bridge. The company has also been able to upgrade its systems to ease border crossing procedures and promote trade.

The NBP was completed in 2007 having been implemented under the Build and Transfer scheme (BT) and the constructor handed to the government at completion. The NBP is a four-lane highway bypassing the Newlands shopping centre in Harare.

The Zimbabwe Investment Authority (ZIA) has also adopted some BOT PPP model and investors are getting some incentives because of getting into the PPP scheme which include five-year tax holiday and reduced rate of tax for five years after. This arrangement is regularised and made legal by the Income Tax Act. However, regardless of some success stories the uptake of PPPs has been depressingly low (Zinyama and Nhema, 2015). Dube and Chigumira (2010) cited the uncertain political environment and the absence of a sound legal framework for guiding the PPP project implementation as the main factors affecting the PPP uptake in Zimbabwe.

There has been an increase in cooperation between the public and private sectors in recent years for development and delivery of infrastructure. These PPP arrangements were because of the need for investment cover as well as to improve the quality of the public service in general.

In 2009, the Short-Term Emergency Recovery Programme document (STERP) invited private sector players in areas such as air and rail services, power generation, dam construction and national highways. There was a follow up document the Three Year Macroeconomic Policy and budget Framework (STERP II) which further confirmed the government position on the need to make use of PPPs. In 2009 and 2010 several documents were drafted after a series of workshops on PPPs to form the basis of PPP structuring, but they are yet to be adopted by the government.

The Draft PPP Policy Document the government had identified the transport sector, education sector, health facilities and power infrastructure as the primary candidates for early PPP (Dube and Chigumira, 2010). However, up to now Zimbabwe still has unclear legislative and regulative framework for PPPs.

A study conducted by Mugwagwa, Chinyadza and Banda (2017) revealed the need for collaboration between government and private sector in health delivery in view of the shrinking resource base for health delivery which has weakened an already strained health system faced with manifold economic, social and political difficulties. The study acknowledges that the government has established the National Health Strategy and several programmes for the direction and institutionalisation stakeholder participation in health care delivery, the maintenance of the momentum of public-private cooperation and creation an enabling environment. Mugwagwa et al. (2017) also note that the monitoring of alignment of the motivations, procedures and impacts of private sector participation in health delivery is impeded by the added constraints of human resources, funding and time. They concluded that while broadened participation by the private sector results in some favourable intermediate outcomes in terms of access and equity, there is need for systematic documentation and standardisation of the various approaches and procedures employed by the different actors, in order for their motivations to be aligned with the government's health care delivery goals and for more predictable, scalable, measurable and sustainable impact from these interventions to be realised. This, they contend, will not only help to avoid possible deleterious links like wastage of much needed resources through overlaps and duplications between private sector participation and health system performance in the country, but will also ensure timely decision-making, curation and deployment of required institutionalisms and identification

of synergies that are appropriate for government, health facilities and patients.

#### IX. RATIONALE FOR PPPS IN HEALTH SECTOR

Kosycarz, Nowakowska and Mikołajczyk (2018) submit that all governments globally struggle with rising health care expenditures and public budget constraints. This factor has led governments to look for various approaches to limit their costs and increase investment in the health sector through PPPs. PPPs are increasingly seen as improving the performance of healthcare systems worldwide, by bringing and mixing the best characteristics of the public and private sectors to improve efficiency, innovation and quality. In the same vein, Hellowell (2019) posits that the economic case for using the PPP model over a conventional public system resides in its ability to transfer the risks of infrastructure and service delivery to the private sector, give rise to a lower risk-adjusted cost to the state, that is, better value for money. He further asserts that theoretically, this transfer is achieved in three ways. First, the payment to the private sector is made as, when and to the extent that facilities and services are available to users and failure to achieve these outcomes results in reduced payments to the private sector. Second, the private sector's profits are determined by its ability to minimise costs, for instance, by exploiting economies of scope across the range of activities under its control (Hellowell, 2019). Hellowell (2019) further elaborates that governments often prefer the use of PPPs over public procurement because they provide access to private capital, thereby allowing the impact on public budgets of any related up-front expenditures to be deferred. He, however, hastens to point out that, ironically, the result is a long-term financial commitment to repay the private capital with interest, and pay service costs and the expected profits of the private firms involved. This seems to suggest that PPPs may not always be cost-effective to the public sector so caution should be exercised in adopting them.

Hellowell (2019) notes that around the world, hospitals are in disrepair, and facilities and services are managed poorly, as most governments lack the capital budgets to finance new constructions on a large scale, and are constrained by national policies and hiring norms that inhibit their ability to implement reforms. Through partnering with the private sector players by means of PPP arrangements, governments access more flexible and innovative practices—such as the introduction of comprehensive computer systems and performance-based human resource management practices, thereby expanding capacity and improving service delivery (Hellowell, 2019). In addition, governments gain access to new sources of financing and are able to share risks with the private sector. The private sector also reaps benefits from PPPs, including an opportunity to access new markets at a lower risk profile, while contributing to a public good (Hellowell, 2019).

Sarmah (2009) suggests that apart from general considerations of quality, cost and efficiency, PPPs have been viewed as a vehicle of attaining equity in public health. Equity is crucial as it one of the guiding tenets of UHC and SDG 3.

In a similar vein, USAID and Pakistan Initiative for Mothers and Newborns (2006) points out that although PPPs are not necessarily the solution for the delivery of all services, they

can yield benefits such as cost saving, risk sharing, improved level of services, enhancement of services, and increased economic growth. It however, points out that PPPs have potential risks such as loss of control by government, increased costs, political risks, unreliable services, inability to benefit from competition, reduced quality of service, bias in the selection process and labour issues.

Whyle (2015) asserts that PPP initiatives have made a significant impact in the fight against diseases that disproportionately affect the poor, noting that non-state actors, including for-profit and not-for-profit organisations, as well as individuals are usually the principal providers of primary health services in the majority of low and middle income countries. Whyle (2015) submits that private sector involvement in health is given, but there is debate as regards how public-private cooperation can enhance the efficacy and efficiency of health systems. In particular, there are legitimate concerns vis-à-vis the difficulties of imposing consistent regulation and quality control on a sector as diverse and fragmented as the private health sector. In the context of sub-Saharan Africa, the difficulties of regulation lead to inconsistent quality and allow an unscrupulous minority of service providers to prevail (Whyle, 2015). However, Whyle (2015) concludes that while these concerns are legitimate, it is crucial to note that PPPs, when correctly implemented, present an opportunity to control the actions of the private sector in the best public interest. There is, therefore, need for an improved understanding of PPPs as mechanisms for ensuring that the private health care sector acts in accordance with national priorities, and the effective implementation of PPPs.

Taylor, Nalamada and Perez (2017) submit that the underlying causes of morbidity and mortality must be addressed to achieve long-term improvements in health. Furthermore, they contend that these underlying causes, or determinants of health, cut across all areas of development, such as education, gender equality and employment and, as such, effectively addressing them requires multi-sectoral collaboration, hence the need for PPPs. In a similar vein, Whyle and Olivier (2016) asserts that while the delivery and financing of healthcare is commonly considered to be the sole responsibility of the state, despite the fact that in low- and middle-income countries a lack of resources hampers governments' capacity to fulfil this role, the health systems of many low and middle income countries are mixed health systems in which public health systems operate alongside a non-state health sector, with market systems often playing a dominant role. They argue that in such arrangements, inadequate government funding and under-regulation of the private sector combine to undermine the efficiency and equity of the system as a whole. They further note that in most Southern African countries, insufficient public health infrastructure, shortages of medical drugs, and inadequate financial and human resources undermine the state's capacity to meet population health needs, and low quality of care characterises public sector provision. Although historically the state was seen as the appropriate sole provider of health care, and interaction and collaborations between the public and private sectors was limited, structural adjustment programmes driven by the World Bank and International Monetary Fund in the 1980s and 1990s, together with international concern



about the government's capacity to deliver adequate health services, and economic theory regarding the increased efficiency of the private sector, saw reductions in public spending which undermined public sector health care provision, resulting in an increased role for the private sector in health care (Whyle and Olivier, 2016).

Likewise, Languille (2017) posits that in middle and low income countries, the involvement of private actors in the provision of health is not a recent phenomenon, pointing out that literature on PPPs in both sectors acknowledges the historical role of private actors in this field. She argues that what is new in the rise of PPPs, both as policy and practical provision arrangements, is the scale of the phenomenon, and its significance for the on-going reconfiguration of the relation between the public and private sectors. For Languille (2017), there are general factors that explain the expansion of PPPs in both sectors. These factors include neoliberal globalisation and the attendant ideological shift. During the first phase of the neoliberal era, in the 1980s, the dominant discourse advocated a retreat of the state and its drastic downsizing by means of outright privatisation. Languille (2017) contends that emergence of PPPs particularly coincided with the next stage of neoliberalism, beginning in the late 1990s, when the role of the state was rehabilitated to correcting market failures and enabling the private sector to thrive. The second factor which has contributed to the emergence of PPPs as an acceptable policy model for health provision was power shift among international organisations (Languille, 2017).

Confederation of Indian Industries and HOSMAC (2016) points out that PPPs provide a vehicle for coordinating with private actors to undertake integrated and comprehensive efforts to meet community needs. They seek to take advantage of the expertise of each partner, to ensure that resources, risks and rewards can be allocated in a way that best meets defined public needs. In the healthcare sector, PPPs are an approach for addressing public health problems through the combined efforts of public, private, and development organizations. Each partner makes a contribution in its area of special competence, bringing in expertise that is usually not available in development projects. The partners in a PPP rally around a common cause, while at the same time pursuing some of their own organizational objectives. Through the correct use of PPP mechanisms, public sector organizations such as the ministries of health may achieve their objectives faster, and with smaller investments. Through PPPs, private sector entities are able to expand their markets, develop new marketing techniques, and contribute to the communities in which they operate. Development organizations achieve their strategic objectives in collaboration with others, leverage new resources for public health, and gain experience with a highly feasible and sustainable approach to public health promotion.

According to Abuzaineh et al (2018) PPPs in healthcare provide opportunities for governments to leverage private sector resources and expertise, to enable investment in large-scale projects that advance national and local public health goals, such as improving quality of service delivery, and expanding access to care.

Kosycarz, Nowakowska and Mikołajczyk (2018) observe that two of the most crucial benefits of PPPs are reducing the financial burden on the public sector for infrastructure development, and risk sharing between partners. The authors contend that PPPs are considered more as an instrument to improve value for money than an additional source of financing and they have been used in several countries to reform the healthcare sector constructively. They posit that in undeveloped and developing countries public-private partnerships have been commonly used to drive and facilitate innovations in healthcare activities, with the most common activities relating to research, vaccines and discovery of drugs for the treatment of communicable diseases, development of personalized medicines, management and infrastructure growth.

For Jomo, Chowdhury, Sharma, Platz (2016), the principal objective of a PPP is improvement in the quality and efficiency of a given service to the citizens, while at the same time having the benefit of attracting private resources into public services, thereby allowing public money to be directed into other critical areas, thus alleviating long-term pressures on public finances. They maintain that the gains of PPPs have in many cases not been realized and the performance and viability of PPPs varies significantly across activities and sectors, asserting that for PPPs to be an effective instrument of delivery of important services, such as infrastructure, countries should have the institutional capacity to create, manage and evaluate PPPs, in relation to other alternative sources of funding. Jomo et al. (2016) argue that in order for PPP to be justifiable, it must provide what they term value for money. By this they mean the cost of a PPP, as well as the quality of service, would need to compare favourably with how public sector provision would have performed on these criteria. They contend that the cost of a PPP project would need to be assessed over its lifetime, taking into consideration the entire range of expenses linked to financing, construction and transactions related to tendering, negotiations and monitoring projects. They further posit that in this respect, the evidence provided by several researchers and international organisations indicates that PPPs have frequently tended to be more expensive than the alternative of public projects, citing the example of Lesotho where a hospital constructed through a PPP arrangement turned out to be very expensive.

Jomo et al. (2016) contend that the much-discussed case of recently built hospital in Lesotho provides an illustrative example of how a seemingly successful PPP may have negative impacts on the country's fiscal liabilities, and hence on overall social development. They point out that a recent quantitative study of the project using measures that reflected capacity utilization, clinical quality and patient outcomes describes the project as successful project and generally concludes that health care PPPs may improve hospital performance in less developed countries and that changes in leadership and management might account for differences in clinical outcomes.

Jomo et al. (2016), however, note that referring to the same project, an Oxfam study (2014) asserts that the hospital threatens to bankrupt the impoverished African country's national health budget, since more than half the country's health budget (51%) is being spent on payments to the private

consortium that built and administers the hospital. They further point out that PPPs cost US\$67 million per year, at least three times what the public hospital would have cost today, and it consumed more than half of the total government health budget. The Lesotho hospital case highlights the complexity of the costs of PPPs and the consequent need to improve their impact assessment on long term sustainable development. It also highlights the need for caution when replicating apparently successful PPPs in other contexts. Overall, the research evidence indicated that PPPs have tended to be more expensive than the alternative public projects. In several instances they have failed to deliver the envisaged gains in quality of service delivery, including efficiency, coverage and development impact, with their impact varying across sectors.

Hellowell (2019) observes that the Lesotho public-private partnership (PPP) is an ambitious attempt to outsource new healthcare facilities and a broad range of clinical services. He, however, notes that quality of services delivered is relatively high, but the cost to government has been greater than had been projected.

As Mutandwa and Zinyama (2015) note, the constant failure of African governments to provide adequate services to their people is well documented and can only be remedied through PPPs. Zimbabwe is one of the countries that have resorted to PPPs due to lack of resources to provide basic services to the citizenry.

According to the Zimbabwe's E-Health Strategy document, the country is making efforts to increase collaboration and health service provision through numerous PPP initiatives. This has been necessitated by the gaps identified by the National Health Strategy (2009-2013). These gaps were identified in the six pillars of health systems for efficient delivery of health services. These included the Public Sector Human Resource Health vacancy which lies at an unacceptable levels, weakened health management, great reduction in access to essential drugs and supplies, obsolete medical equipment and shortage of infrastructure. Above all, the health system is grossly underfunded and the budgetary allocation was then standing at US\$7 per capita per annum compared with the WHO recommendation of at least US\$34 and this has long since gone even further down.

The Public Health System has virtually broken-down thus causing the private health sector to expand and dominate. This has caused untold suffering as the poor patients are forced to seek services from the expensive service providers in the private sector. This has led to the thought that there is need for collaboration of the private and the public sector since neither of the two can stand alone in providing the best interests of the health system (Venkat Raman & Bjorkman, 2009).

Dube and Chigumira (2010) note that in Zimbabwe, the public healthcare system has been traditionally the largest provider of health-care services, with Mission hospitals and non-governmental organisations (NGOs) playing a complementary role. The infrastructure in the public health institution was also well managed and maintained. However, years of economic decline, have almost resulted in a reversal of this pattern, with the public sector failing to perform its leading role. The health infrastructure in Zimbabwe is in a sorry state as a result of underfunding and a lack of maintenance. As result, the period

2008-2009 saw public hospitals more or less closing doors to patients as lack of supplies took its toll, with those who could not afford private medical facilities being left vulnerable. Lack of supplies for health facilities also extended to laboratory equipment and laboratory reagents. In the meantime, the privately run health institutions managed to persevere, and they more or less managed to carry the burden placed upon them by the public sector failure, but only for patients who could afford their comparatively high service charges. This shows the critical role that a combination of the public and private sector can play in bringing back normalcy in the sector, which is where PPPs become relevant.

Mutandwa and Zinyama (2015) submit that Zimbabwe harbours high hopes of turning around poorly performing public utilities by bringing the new expertise, financial resources and a more commercial orientation through PPPs. They further point out that the Zimbabwe Agenda for Socio-Economic Transformation, the country's economic blueprint for the period 2013 to 2018, also gives an impetus to the use of PPPs in water infrastructural development and service provision.

Zinyama and Nhema (2015) also point out that during the Government of National Unity in Zimbabwe, under the Short-Term Emergency Recovery Programme document (STERP), PPPs were provided for under private sector invitation in areas such as air and rail services, power generation, dam construction and national highways. This was also reconfirmed under the Three Year Macroeconomic Policy and budget Framework (STERP II) which also envisaged the use of PPP in infrastructure development.

#### X. CONDITIONS FOR THE SUCCESSFUL IMPLEMENTATION OF PPPS

For PPPs to be an effective instrument through improvements in service delivery, efficiency and development impact, it is important that the public sector is able to correctly identify and select projects where PPPs would be viable, structure contracts to ensure an appropriate pricing and transfer of risks to private partners, establish a comprehensive and transparent fiscal accounting and reporting standard for PPPs, and establish legal, regulatory and monitoring frameworks that ensure appropriate pricing and quality of service. In sum, it is necessary that countries have in place the institutional capacity to create, manage, evaluate and monitor PPPs.

Taken together, an institutional framework that provides countries with the above four interrelated capacities would have the benefit of ensuring that PPPs are established for the right reason, that is ensuring an improvement in the quality and cost efficiency of a given service to the citizen and not as a vehicle for undertaking off budget activities. They are also essential for making sure that efficiency improvements are measurable and monitored and facilitating good governance in the administration of the PPP.

A study by Mutandwa and Zinyama (2015) indicated that although Zimbabwe has already engaged PPPs it is generally failing to achieve the desired results due to lack of a legal framework and an institutional framework. The two authors also argued that corruption continues to hinder PPP uptake



through underhand deals and inflation of prices in the absence of proper legal framework.

Mutandwa and Zinyama (2015) also cited lack of political will, especially to involve the Western countries of which the political leadership declared western countries enemies, as one of the hindrances to the uptake of PPPs in Zimbabwe.

Zinyama and Nhema (2015) maintain that despite some successful PPPs cases in Zimbabwe, the uptake of PPPs has been depressingly low, due to an uncertain political environment and the absence of legal framework to guide the implementation of PPP projects. The two authors summarized the reasons for the low uptake of PPPs in Zimbabwe as investor perceptions of high political risk, lack of political commitment, lack of clear legal and policy frameworks, lack of financial resources with the government, currency risks, lack of expertise and capacity within the government and lack of policy consistency.

Zinyama and Nhema (2015) conclude that case studies evidence demonstrates that regulatory, legal and institutional frameworks are critical for PPPs to be successful in Zimbabwe, submitting that Zimbabwe should move with haste to finalise the PPP policy development. Furthermore, they recommended the establishment of a standalone PPP unit as is the case in Australia, United Kingdom, several European countries and in South Africa. They also suggested that Zimbabwe should simplify regulations, procedures and rules to remove bottle-necks for smooth functioning of the government, noting that this is only attainable through policy predictability and consistency to enhance confidence in investors. In the same vein, Mutandwa and Zinyama (2015) assert that requisites for the successful adoption of PPPs the world over successful PPPs largely depends on conditions which serve as benchmarks for proper implementation, without which implementation of PPPs becomes problematic. They point out that pre-conditions for PPPs are relatively similar in context but vary from one country to another. In some countries such as those in the European Union preconditions are well-articulated. They further submit that chief among the preconditions for successful implementation of PPPs are legal and institutional framework, political will, government commitment, economic stability, financial support, technical expertise, public acceptance, and respect of property rights. Relatedly, Zinyama and Nhema (2015) assert that in planning the execution of PPP projects there are a number of issues that need to be addressed. These include international best practices, legal and institutional policy in place.

Apparently, Legal, regulatory and policy frameworks particularly play an enabling role for establishing PPPs. Such a framework helps in establishing the legal reforms needed to reduce impediments to improved or expanded service such as assignments of responsibility for development, control lines, financing, regulating and managing infrastructure and services. It is also important to note that legal reforms are required to overcome potential constraints to PPPs including hindering asset management or ownership, repatriation of resources and impediments to cost recovery.

Dube and Chigumira (2010) maintain that PPPs involve complex technical issues and their success is dependent on the

friendly interaction of multiple stakeholders. A study by Mutandwa and Zinyama (2015) indicated that corruption continues to hinder PPP uptake through underhand deals and inflation of prices in the absence of proper legal framework for PPPs. The study also indicated that there were no clear rules and regulations in place and there was also lack of political will to involve the Western countries, having declared them enemies. It was also revealed that the problem was exacerbated by the fact that Zimbabwe is under sanctions from the western powers, hence private players from those countries are forbidden through instruments such as Zimbabwe Economic Recovery Act (ZIDERA). The study also revealed that there was no legislation, policy or institutional framework that pertains to PPPs specifically in Zimbabwe. In addition, the study indicated that the concept of PPP legislation is shrouded in confusion. The study, thus, concluded that Zimbabwe was not ready for PPPs in the infrastructure development sector because it lacked political commitment, legal framework, finance, and monitoring and evaluation.

Sajani and Aktaruzzaman (2014) argue solid commitment at all levels of government, smooth flow of resources, active involvement of local government, raining, strong supervision and monitoring by all the partners, communication among the partners are critical to the success of PPPs as they engender a strong sense of ownership, mutual trust and respect are significant concerns for the success of partnership.

Relatedly, Torchia, Calabrò and Morner (2013) submit that while PPPs can provide mechanisms for achieving the comparative advantages of public and private sectors in mutually supportive ways, numerous issues are essential so they need to be carefully considered when implementing PPPs. Importantly, these authors note that despite the involvement of the private sector in PPP projects, the government needs to play the role of regulator, especially in sectors like health care where accountability is critical and the public interest is crucial. Particularly, they argue, the public sector should set standards and monitor product safety, efficacy, and quality, and ensure that citizenry has sufficient access to the products and services they require. Torchia et al. (2013) strongly contend that PPPs do not imply less government but a different governmental role. Through a review of PPPs in the health care sector, the authors further suggest that partnerships between the public and the private sector contribute to the improvement of the health of the poor by combining the different skills and resources of various entities, public and private, in innovative ways. Furthermore, they contend that in order for PPPs to be beneficial, the public sector should fund fundamental research; set standards for product safety, efficacy, and quality; establish a system whereby the citizenry has sufficient access to health product and services; use public resources efficiently; and create an atmosphere in which business enterprises are properly motivated to meet the needs of the whole population.

Studying results based financing (RBF) of health care in Zimbabwe, Mutupo (2017), concluded that as regards equity and inclusiveness there is a trade-off between achieving allocative efficiency and equity, especially when scaling up health programmes, and that under RBF, private partners assumed an active role in health finance outside government with a view to improving equity, sustainability, transparency,

governance, effectiveness and allocative efficiency in financing health care. She recommended that the government upholds the spirit of partnership under the PPPs initiative. Such PPP arrangements, she contended, ensures mutual accountability, donor coordination, harmonisation of efforts to ensure positive health outcomes and ownership of the initiative through the active involvement of the state and communities. The study also concluded that PPPs ease the allocation of resources, enhance equity in health care provision and are a good governance mechanism that ensures that the health delivery system is operating well in line with the dictates of the RBF philosophy. This conclusion seems to suggest that PPPs are appropriate for the resource-constrained health care system in Zimbabwe, although further research would be required to determine the nitty-gritties of their implementation.

Languille (2017) identifies three factors that make a literature review on health PPPs a challenging exercise, namely, the absence of a consensual definition of PPPs within and across sectors, the extreme heterogeneity of the category and the underlying ideological confrontation between proponents of the public sector and advocates of the private system. She further points out that the design and management of practical PPPs are source of high transaction costs, which require important contractual and administrative capacities in sector ministries. She also expressed scepticism as regards the impact of PPPs, arguing that the key predictions of the PPP doctrine, that is, cost-efficiency and improved service delivery to the poor, are barely fulfilled in practice. Furthermore, she contends that PPPs, both as policy model and practical arrangements, are underpinned by a narrow conception of health, which denies its fundamental embeddedness within the society and the economy. In addition, she argues that in both PPPs schemes are in practice onerous for the public purse and generates an administrative burden for highly strained health systems. However, she acknowledges that in view of the worldwide currency of the partnerships mantra and the private sector's quest for new sources of profit, PPPs are likely to gain prominence as ingredients of social policies in developing and emerging countries.

Looking at the case of Lesotho, Byiers, Große-Puppenthal, Huysse, Rosengren and Vaes (2016), observed that a key factor in determining the course of a PPP is the capacity of the public partner to sufficiently negotiate, manage and monitor the deal throughout its entire contract term. Further, they noted that Lesotho was lacking in this particular regard. The Lesotho case, they contended, suggested that a manifest lack of capacity of a public actor involved in a PPP arrangement may result in a power imbalance that is detrimental to the public interest purportedly served by the PPP. Thus, this risk should be considered when weighing the pros and cons of a PPP and in comparison to other options.

Researching in the Nigerian context, Asogwa and Odoziobodon (2016) posits that public-private partnership as financing model for physical and socio-economic development has been in vogue for more than two decades in developed countries and in South Africa. They note that PPPs have been used by developed countries as a financing strategy or option for public sector projects since the 1990s, but it was only in the last few years that Nigeria started creating an enabling atmosphere for PPPs as part of its socio-economic and political reform programmes. Furthermore, they point out that there are

challenges relating to finding mechanisms of harnessing the resources of the private sector to support public sector effort towards the promotion of the national health objective, especially, the health-related targets of SDGs. They, however, suggest that accelerated progress should be contingent on partnerships that are established on mutual trust, joint planning, policy formulation, sharing of information, implementation and evaluation, as well as joint financing of activities and programmes. In addition, they submit that there is also need for collaboration to improve quality by supporting innovation, improving information for quality monitoring, enhancing clinical and administrative management capacities, and reviewing national programmes and project support on SDGs as well as to enact appropriate consumer protection laws aimed at protecting consumers from monopolistic and unfair business practices that are consequences of market deregulation or privatization. Łakomy-Zinowik and Horváthová (2016) conclude that PPPs were created as a remedy for inadequate funds that were intended for providing public services by the public sector and as a form of increasing the efficiency in the delivery of public services. Citing the example of the United Kingdom, the authors maintain that PPPs have contributed to the development and modernisation of medical infrastructure as well as to the inclusion of private actors in the provision of medical services, thus significantly contributing to the increase in the availability of medical clinics. They also submitted that resulted in shortening the time that patients spent waiting for medical examination.

With regard to Poland, Łakomy-Zinowik and Horváthová (2016) conclude that in spite of the fact that implementation of PPP in Poland is comparatively recent, Polish local authorities are slowly swaying in favour of transferring part of their rights to private subject, underscoring that lack of trust in PPPs can be engendered by failure to adjust the laws to possibilities offered by public private partnerships.

## XI. CONCLUSION

Owing to increasingly shrinking fiscal space most countries are turning to PPPs in various sectors as well as the health care sector. PPPs in the health sector are quite common virtually across the globe, notably in Poland, Pakistan, Nigeria, South Africa and Lesotho. PPPs enable the harnessing of private sector resources, thereby helping to address fiscal challenges and the cost of health care provision. They can also drive innovation and improve service quality.

However, ironically PPPs can be costly to the government as it may be required to repay private sector partners for protracted periods of time. As such, individual PPPs ventures need to be carefully analysed and considered before they are adopted.

It increasingly came to the fore in the foregoing discussion that the conduciveness of the broader operating environment is critical for the success of PPPs. In particular, the legal and regulatory environment should be sufficient and appropriate for the establishment of PPPs. It also came out clearly that political will as well as a conducive political environment is a crucial success factor for PPPs. It is evident that currently Zimbabwe does not have an adequate legal and legislative framework for PPPs. This implies that for the effective implementation of PPPs to be effected, the country should develop an appropriate legislative and regulatory framework. The reviewed literature did not shed enough light as regards

the political environment and political will relative to PPPs in the Zimbabwean context. However, it is common knowledge that there is political polarisation in the country and private players who venture in projects that are meant for the common good, like healthcare programmes, are usually regarded with suspicion and have their political motives questioned by the government. As such, this is an area which needs to be critically considered before large scale PPPs can be ventured into.

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