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Aladino José Manhiça

INSTITUTIONAL ANALYSIS ON PUBLIC-PRIVATE PARTNERSHIPS IN SUB-SAHARAN AFRICA'S HEALTHCARE SYSTEMS AND POLICY IMPLICATIONS

ABSTRACT

Many people in developing countries are exposed to a greater risk to access essential healthcare services. The World Health Organization (WHO) and the World Bank estimate that more than half of the world's 7.3 billion people do not obtain all of the essential needed healthcare services. To minimize this burden, Sub-Saharan African (SSA) countries have embraced the private sector through public-private partnership (PPP) as a mean to achieve Universal Healthcare Coverage (UHC). A number of publications have raised the importance of institutional setting for effectiveness of the PPP in the region. However, very few have outstretched persuasive requirements to examine the effectiveness of PPP considering SSA's socio-economic context. This paper examines the applicable environment for PPP in healthcare systems in SSA and has observed a trend of decrease in resources allocated by developing countries to healthcare services; increasing participation of private sector in healthcare delivery; the effectiveness of PPP is determined, but not limited to, by the quality of institutions and additional variables such as cultural characteristics, community attributes, and physical or material conditions.

Key Words: Public-private partnership; private sector, institutions, healthcare services

Aladino José Manhiça
Ministry of Health of Mozambique, Department of Planning and Cooperation, Mozambique

Correspondence: Aladino José Manhiça
E-mail: alamanyissa@gmail.com

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INTRODUCTION

Government failure to provide some public goods and services has resulted in increasing private sector participation to support the Government's gap. This collaboration is broadly known as Public-Private Partnerships (PPP), in which both parties share responsibilities and principles. In fact, the integration of the private sector is seen as a macroeconomic solution to promote socio-economic growth, while enhancement of institutional quality is required to boost the private sector's comparative advantage (Todaro and Smith, 2003).

A research conducted by the United Nations Economic Commission for Europe (UNECE, 2018) goes further by proposing that Good Governance matters in PPP if Governments are to climb the maturity curve. Yet, it endorses the need to put into place empowering institutions, procedures, and processes surrounding PPP in order to achieve its comparative advantages. The Third International Conference on Financing for Development, mostly known as The Addis Ababa Action Agenda, held in 2015, pointed out that both public and private investment have key roles to play through PPP (United Nations, 2015, para. 48).

A number of theories on PPP advise for harmonization of a set of conditions, namely: regulatory framework, institutional framework, operational maturity, investment climate, financing, and subnational adjustment to achieve social outcomes, including in healthcare services (EIU, 2015). Thus, global support and advocacy for PPP in infrastructure including in healthcare services seems stronger than ever before and has been transformational (Leigland, 2018).

Many people in developing countries are exposed to a greater risk to access essential healthcare services. More than 7.3 billion people in the world do not have all of the essential healthcare services they need and it seems that PPP in healthcare is the solution, especially for developing countries (World Health Organization and World Bank, 2017; Meier et al., 2013) because households do not have sufficient income to pay for healthcare services and Governments are challenging to achieve UHC goals (Sachs, 2012). Many SSA countries have been choosing PPP as a solution for their healthcare systems. The most fundamental and clear importance of PPP in healthcare services came out to be mentioned by the 2030 Agenda on Sustainable Development Goals (SDG) 2015, specifically by SDG 17, that stressed the importance of cooperation between private and public sectors to meet the health-related indicators as a mechanism to target the UHC.

Notwithstanding the aforementioned rationality behind PPP in general and in particular on healthcare systems, this paper has found that PPP appears to be more sensitive between theory and practice in the field. Whereas many Governments in SSA have been betting in collaboration with the private sector for the betterment of respective healthcare systems, the evidence shows that its effectiveness varies from country to country. For that reason, unlike the general assumptions linking the effectiveness of PPP arrangements to an institutional setting, this paper has observed that SSA's healthcare systems are determined not only by the quality of institutions but also additional variables such as cultural characteristics, community attributes, and physical or material conditions.

The final goal of this paper is to contribute to the improvement of policy formulation on PPP arrangements on socio-economic projects particularly in healthcare systems in SSA.

This research is founded in healthcare PPP literature by focusing on selected cases in SSA: South Africa, the Democratic Republic of Congo (DRC), Tanzania, and Rwanda. The criteria of case studies selection were as follows: (1) current trend suggests that most of PPP projects have been implemented in developing countries; (2) selected countries share many issues including: (i) historical path and almost institutional profile; (ii) socio-economic conditions; (iii) similar disease burden, to mention a few.

The period of analysis ranges between the years 2008 to 2017. However, due to the scarcity of data in some selected cases, this paper may refer to a different timeline to guarantee the efficacy of the research. The literature covering PPP in the healthcare sector is very scarce and of relatively poor quality. This dissertation will sometimes refer to less rigorous studies but will take care to underline their limitations.

LITERATURE REVIEW

Public-Private Partnerships

There is no single, universally acceptable definition of PPP. It seems to depend on the economic systems of countries, and also on the operating field. The World Bank (2015) describes PPP as a long-term agreement involving a private party and a Government unit for providing a community benefit, in which the private party abides substantial risk and management responsibility, and remuneration is linked to performance. However, this definition looks broad and does not fit the purpose of this paper. A definition brought by Reich (2002) describes PPP as an agreement connecting one private for-profit organization

and one public or non-profit organization that has agreed to share a common objective to create social values and to share the effort and benefits. For Kickbusch and Quick, PPP in healthcare means to bring together a number of entities for the common objective of improving healthcare for populations based on mutually agreed responsibilities and values (Kickbusch and Quick, 1998) while maintaining a balance of power between the involved actors in the process (Buse and Walt, 2000).

By combining both previous definitions, PPP shall be understood in this paper as a form of cooperation between the Government and private sector, including Non-Governmental Organizations (NGOs) in which they agree to work together with the purpose of delivering healthcare services.

Why PPP in healthcare systems?

The collective reason for engagement in a PPP is financial (Kosycarz et al., 2019). In the healthcare sector in particular, the motivation for PPP can also be linked to burdens related to an aggregate aging population, chronic diseases, and shortage in curative treatment. The shortage of funds that characterize developing countries has pushed them to incorporate in their health systems both private (profit and not for profit) and public sector for the provision of health infrastructure, goods, and services. By moving in this direction, PPP in SSA's healthcare services has led to meaningful transformations mainly in public health programs, including HIV, reproductive health, and malaria (Forum on Public-Private Partnerships for Global Health and Safety et al., 2016).

The role of PPP in healthcare in SSA is unquestionable because it offers a useful and sustainable drive for the establishment of UHC and a supreme chance for the developing world to do well, while performing well (IFC, 2011). Nevertheless, some scholars are skeptical of the impact of PPP in healthcare sector in developing countries. They consider that only big PPP in healthcare brings development results to this group of countries. The small PPP does not provide the poor with adequate or sufficient and affordable access to facilities (Estache and Philippe, 2012). This paper also examines the reason why some PPP in healthcare is not translating into development particularly in SSA.

Prerequisites for PPP in healthcare systems

The background analyzing environment for PPP is very broad and differs according to the field and location. Casady et al. (2018) understand that in general, PPP requires the backing of regulatory quality, market consistency, socio-political will, strong Governance, and

institutional indicators to attain long-term goals. Some scholars such as Ketl and Teisman go further by emphasizing that PPP in healthcare is not self-administering, but it requires a strong and competent Government to manage as well as restructuration of policy-making processes capable of adjusting into the existing institutional framework (Kettl, 2011; Teisman, 2002).

Depending on approaches and field of study, one can use Good Governance Indicators to analyze the environment for PPP. Other studies have emphasized transparency, accountability, and corruption in the public sector (CPIA) index to examine the environment for PPP. Many tools can be brought into consideration to analyze public-private collaborations. In other words, there is no specific standard framework dedicated to analyze PPP in healthcare. It depends on the field, location, and circumstances.

This paper found the research was done by the Economist Intelligence Unit (EIU) in 2015, regarding the conditions for PPP in SSA to be more complete and adequate to examine PPP in healthcare services in the region. Six variables: regulatory framework, institutional framework, operational maturity, investment climate, financing, and subnational adjustment are considered to examine PPP in SSA (EIU, 2015). While the variables utilized by EIU (2015) largely explain most of our studies, this paper has found that the SSA case has to be analyzed by bringing into consideration other variables that are commonly forgotten or neglected for an effective PPP in healthcare services in the region.

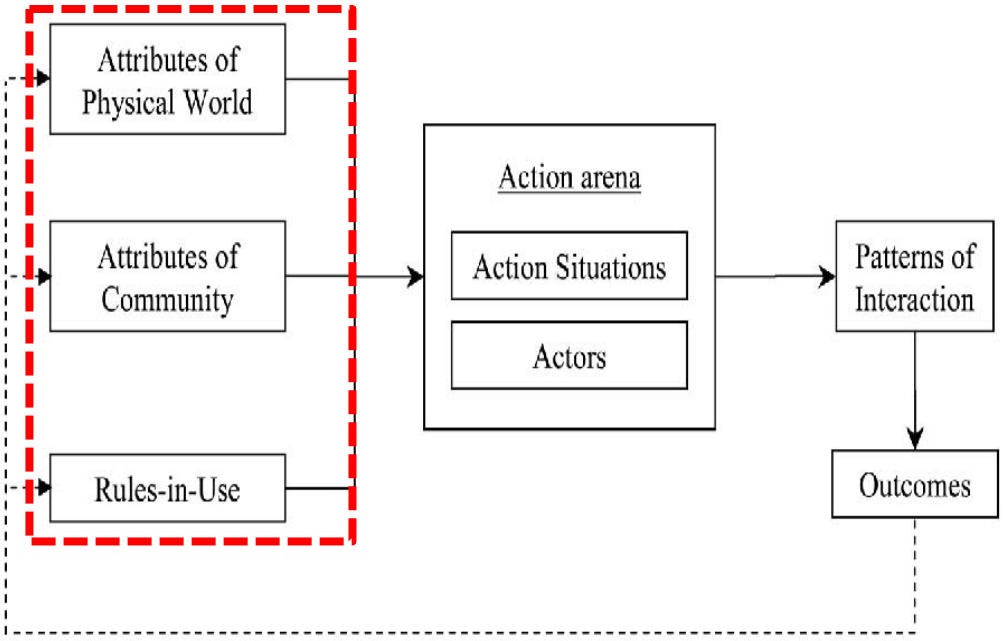
THEORETICAL BACKGROUND

In order to define how PPP in SSA's healthcare systems can be more adequate, effective, and sustainable, this paper relies on an institutional analysis approach also known as the Institutional Analysis and Development (IAD) framework. IAD framework was developed in 2009 by Elinor Ostrom – an American political scientist. Ostrom's thesis, which was awarded the Nobel Prize in the same year, attempts to enlighten and predict the "outcomes of Governance structures", the actors' positions, as well as the role of both formal and informal rules in a social system and the interaction among them.

The framework considers 7 required principles in order to meet policy effectiveness: (1) define the policy analysis objective and the analytic approach, (2) analyze physical and material conditions, (3) analyze community attributes, (4) analyze rules-in-use, (5) integrate the analysis, (6) analyze patterns of interaction and (7) analyze the outcomes (see figure 1).

This research has chosen the IAD framework as edifying theory, because PPP activities fit within the collective action for the delivery of communal facilities, in this case, healthcare services or "the commons". Also, this framework explains how institutional incentives affect social infrastructure in developing countries.

Figure 1: Ostrom's institutional analysis development framework.



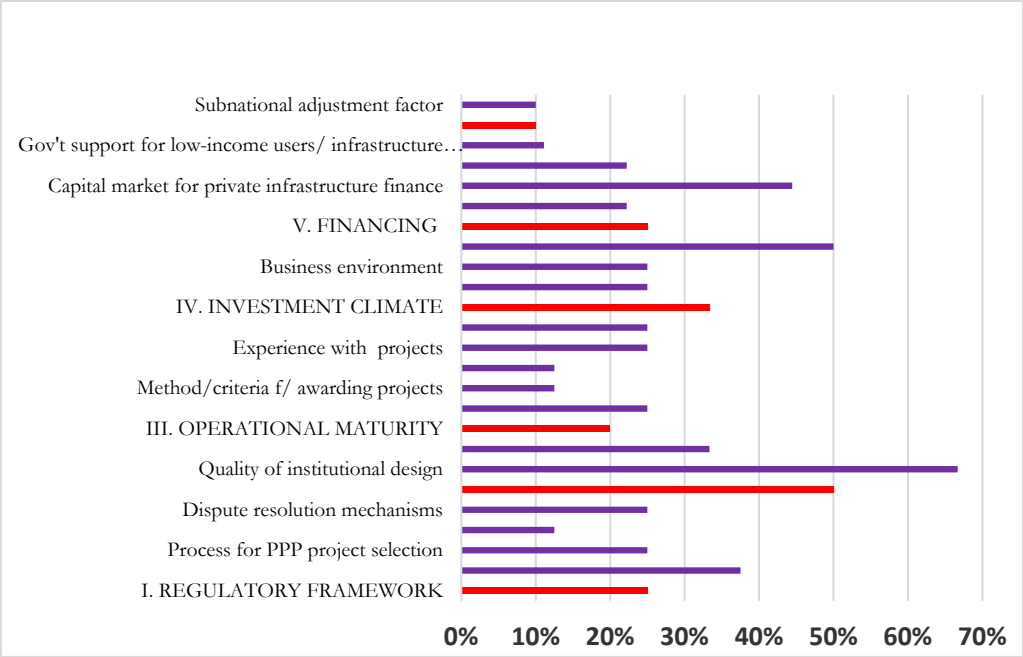
Source: Ostrom (2010)

Deriving from the IAD framework (see figure 1), this paper focuses on 'context and attributes of community which is translated as necessary socio-economic conditions to design and implement the PPP collaboration in healthcare services and the linkage between this and the 'rules-in-use', such as healthcare Governance in SSA. 'Action arena' is implicit to PPP agreements in healthcare systems and the alliance between 'actors' which encompasses public and all non-public stakeholders in healthcare services delivery; different 'action situations' such as specific projects comprising PPP on this social area.

THE ENVIRONMENT FOR PPP IN SUB-SAHARAN AFRICA

Nowadays, the SSA region has been one of the attractions and destinations for foreign investments that even contribute to the growth of the local private sector. In this regard, SSA countries have seen this as the opportunity to integrate the private sector in their socio-economic goals through PPP. According to the EIU (2015), most African Governments are encouraging PPP with specific laws or frameworks. PPP is on the respective national plans of African legislators and various countries have been passing innovative rules, policies, and regulations in order to comfort up its implementation.

Figure 2: Assessment of environment for PPP in SSA.

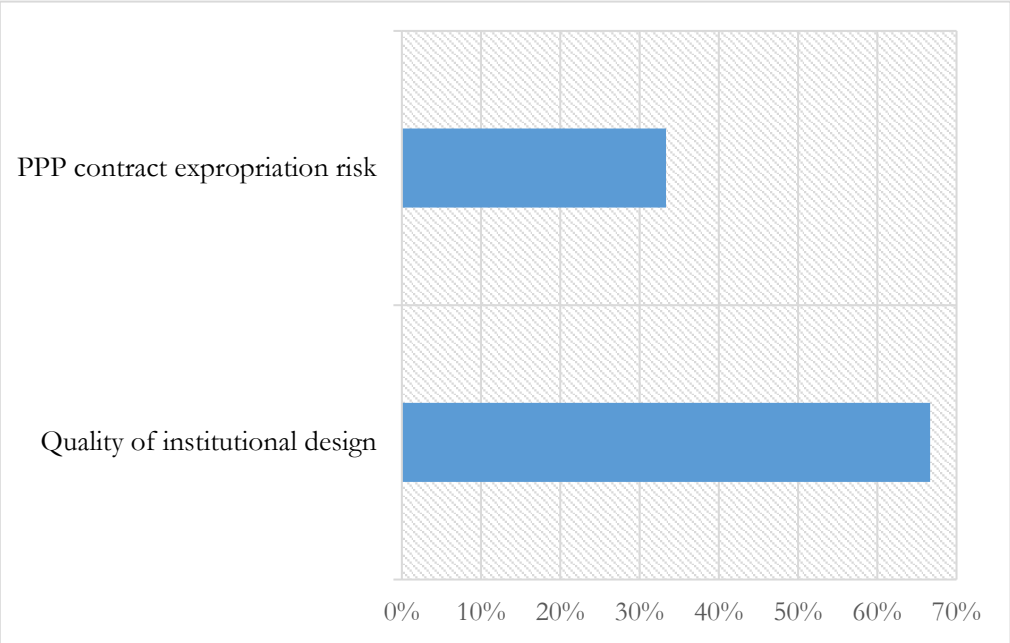


Source: EIU Dataset (2015)

Figure 2 shows the profile of different and necessary variables for a sound environment for PPP in fifteen SSA on six variables: regulatory framework, institutional framework, operational maturity, investment climate, financing, and subnational adjustment. All variables figure out a different degree. The best position belongs to an institutional

framework (50%) in detailed terms (see figure 3). This means the SSA region has, in theory, a reasonable institutional design to attract the private sector for PPP arrangements. However, there are ruptures or variations of PPP laws in different sectors.

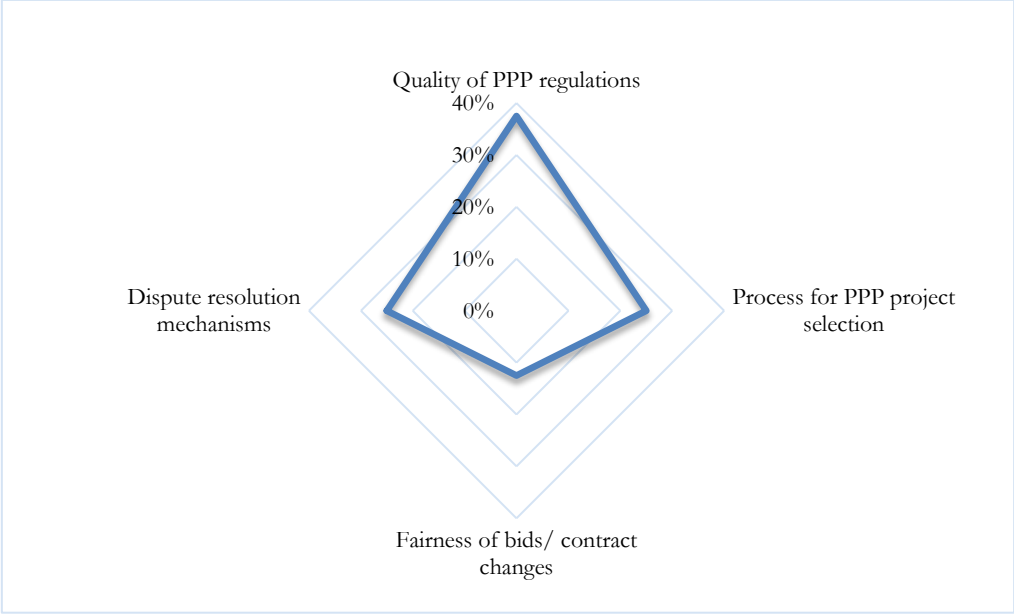
Figure 3: Institutional framework profile in SSA.



Source: EIU Dataset (2015)

The institutional structure is similarly affected by a regulatory quality which ranks on average only 25%, mostly because although the quality of regulations is relatively satisfactory (see figure 4), this component is undermined by poor decision making on projects selection (33%), along with poor dispute resolution mechanisms which rank 25%. Within this variable, the most critical point of PPP arrangements in SSA is associated with the unfairness of bids and contract modifications (13%). This paper attests to justify this performance as a result of the predominance of informal negotiations of PPP agreements which are also linked to poor rule of law, including corruption and vested interests between the policymakers and policy implementation.

Figure 4: Regulatory quality performance in SSA.

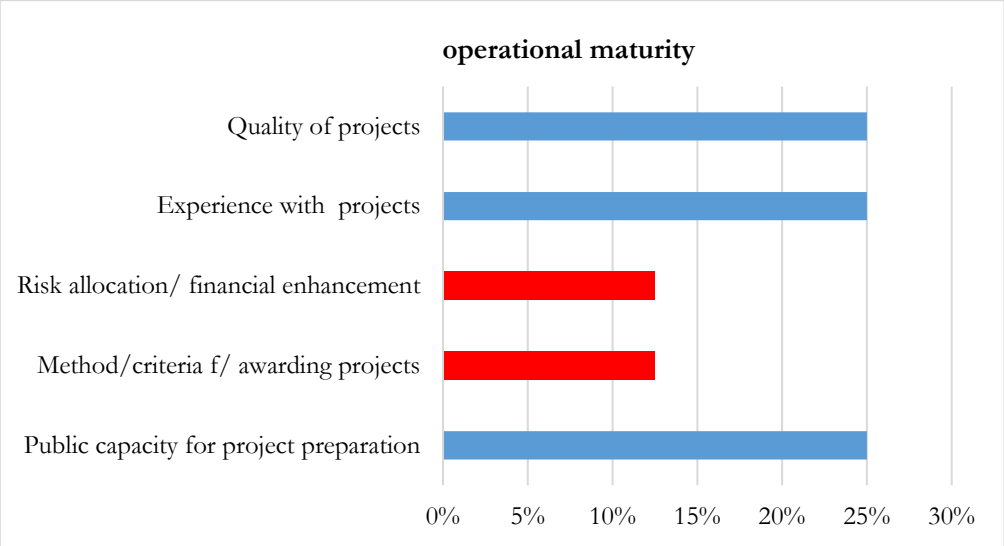


Source: EIU Dataset (2015)

Figure 5 displays another bottleneck affecting PPP formation in SSA. Most countries in the region have no sufficient experience in managing PPP and, if there's any, the disparity across sectors is huge. In other words, the disparity is explained by sectoral experience. For example, some countries have operational maturity in transportation and water supply, but no experience in healthcare or education. As a result, the risk allocation between private and public sectors along with the methods and criteria of awarding projects constitute the most unfortunate part for PPP in the region.

Political distortion also hinders PPP implementation and investment climate. The general business environment reforms made by many SSA countries in the last decade have influenced more investor-friendly laws and frameworks. Regulations and macroeconomic stability through investment incentives and easiness of doing business have boosted space for PPP in the region. Though, political distortion such as corruption, transparency, political instability, violence, and poor Good Governance indicators, in general, remains a challenge. Among the three indicators measured in this category (political will, business environment

Figure 5: SSA experience with PPP projects.



Source: EIU Dataset (2015)

and political distortion) – the first two are positive for most countries. The overall score is, however, brought down by low performance under the political distortion category, which evaluates the level of political influence affecting the private sector (EIU, 2015).

Other relevant components for PPP are financial institutions. With the exception of South Africa, many SSA countries lack financial institutions in quantity and quantity. Even in countries in frank financial growth, the mechanism to access credit are less clear and non-affordable, impeding therefore the access to services offered under PPP.

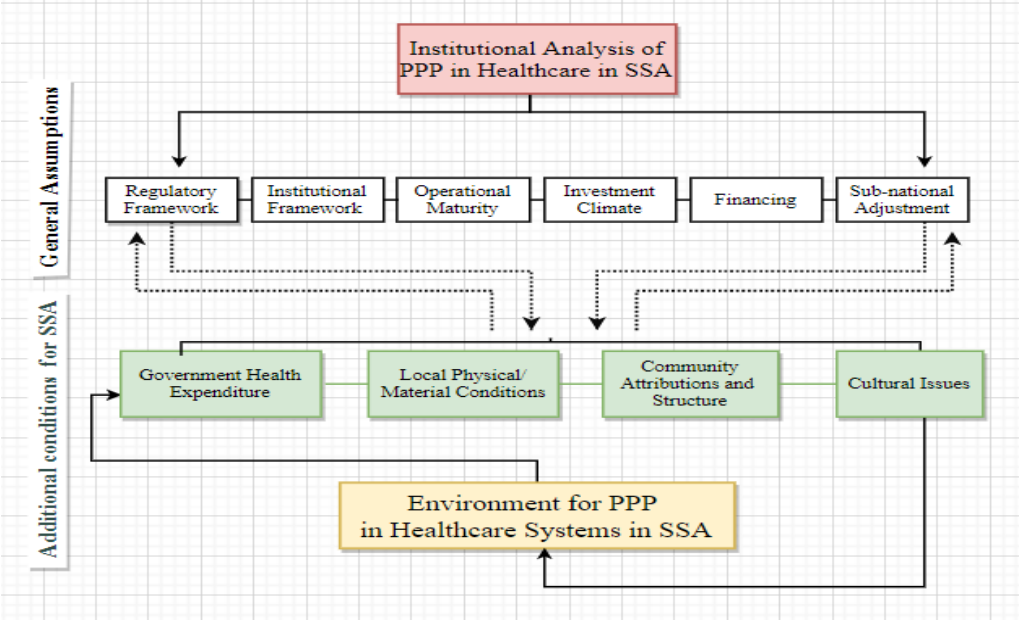
The last component is a subnational adjustment. In many cases PPP arrangements are administratively centralized, consequently, the capacity to manage them at the subnational level is lower. The EIU (2015) states however that in some SSA countries where PPP is centralized, it has helped to improve harmonization and efficiency as well as a strong decision-making process. Nevertheless, the centralized approach showed some risks. It ties PPP to conflict of interest, making some leadership to individually benefit from the partnerships rather than embed them in the Governmental structure.

Additional conditions for PPP in Sub-saharan Africa

Ostrom (1999) stresses out the role of institutions as a key factor for development. Yet, Todaro and Smith (2003) emphasized the role of cooperation between the public and

private sectors within PPP arrangements to boost economic development. The EIU report has emphasized six elements that are important for a sound PPP: regulatory framework, institutional framework, operational maturity, investment climate, financing, and subnational adjustment (EIU, 2015). However, this paper understands these elements are not sufficient or fully adequate to explain the necessary environment for PPP in SSA, particularly in healthcare services. Assuming the importance of the six aforementioned variables, and agreeing with Ostrom's IAD approach, this paper has added four more to analyze the PPP in healthcare services in the SSA context: Government expenditure in healthcare services, local physical and material conditions, community attributions, and cultural issues (see figure 6).

Figure 6: Additional conditions for PPP in SSA.

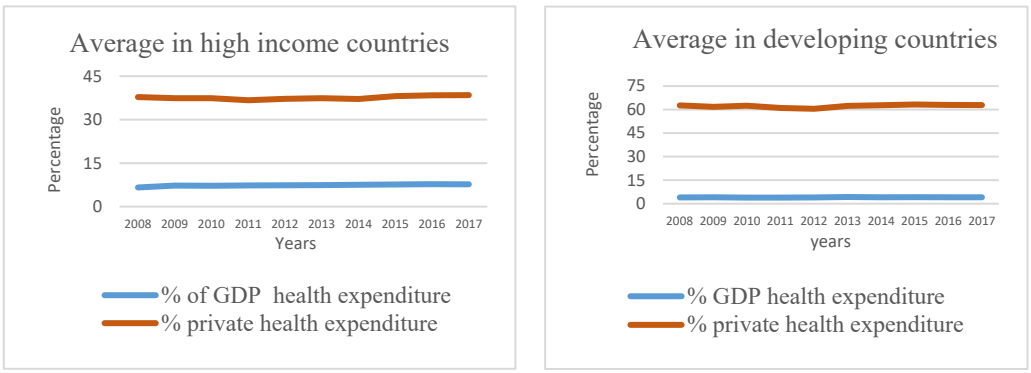


Source: Author

Analyzing Government expenditure in healthcare services is important because there is a relationship between PPP and national health expenditure in SSA. A study conducted by Farag et al. found that for a 1% increase in health Official Development Aid (ODA) Government health expenditure decreased by 0.14% to 0.19% in SSA countries (Farag et al., 2009). On the other hand, the average percentage of Gross Domestic Product

(GDP) participation in healthcare services among developed economies grew between 6.6% in 2008 to 7.6% in 2017, while in developing countries it observed no significant change, ranging between 3.9% in 2008 to 4.04% ten years later. Consequently, a large number of the late group of nations has been relying their health systems on the private sector through PPP arrangements. More than 60% of healthcare services are carried out by NGOs or lucrative private health deliverers, while in developed countries the participation of the private sector is less than 40%.

Figure 7: Comparative health expenditure between developed and developing economies.



Source: World Bank (2020). World Development Indicators, 2008-2017 [Time Series]

The recent rise of PPP in healthcare systems in developing countries has been explicitly moved by two reasons: (1) the need for improvement of healthcare delivery services and (2) the Government's budgetary constraints (Miller J., 2000; Savas, 2000). Health systems in developing countries are generally poor. A recent study conducted by Oleribe et al. (2019) identified insufficient budgetary allocation to health as the major challenge for healthcare services in SSA because as illustrated in figure 7, developing countries contribute statistically less for healthcare compared to the group of advanced economies. Furthermore, the SSA region has unfavorable physical conditions to attract PPP in healthcare or to make it sound. Poor road infrastructure, shortage of electricity and water represent the major challenges. Some studies found that material factors such as income, living conditions, lack of resources and investments impede PPP development especially in SSA region (EIU, 2015; Lynch et al., 2000).

Another variable to consider when addressing healthcare issues in the region is the community's economic, social, and physical environment in which people live (Hillemeier et al. (2003). Assessing community characteristics in SSA is important when analyzing PPP in healthcare because it determines the capacity of the community to afford and utilize services locally provided within a PPP arrangement.

Lastly, culture and traditions are determinants in this discussion. SSA communities have a large reliance on traditional medicine and other beliefs that have an impact on favoring conventional medicine. This fact also directs the impact on the effectiveness of healthcare products delivered within a PPP framework. Kamugumya and Olivier (2016) in their research analyzing PPP programs in Tanzanian districts have found that cultural habits are one of the obstacles hampering the operation of PPP at the subnational level.

Case Studies of PPP on healthcare systems in Sub-saharan Africa

South Africa

With a GDP of more than U$ 349.6 billion as of 2018, South Africa is the second-largest SSA economy only surpassed by Nigeria. The healthcare provision through Governmental schemes is considerably well developed including three components, namely tax-funded public system, social insurance arrangements, and contribution from private health insurance (Wits School of Governance, 2017). However, as it is in almost all SSA countries, the South African Government can only spend less than 5% of GDP in financing healthcare services (which is yet higher than the SSA average). As a result, more than 40% of these services are covered by the private sector and other insurance schemes (World Bank Indicators, 2008-2017; WHO's Global Health Expenditure Database).

The PPP context in South Africa is described within the Public Finance Management Act of 1999, which established a regulatory framework for PPP in the country. Ten years later, this framework came into effect, with the creation of the National Treasury (Republic of South Africa, 1999). Through this Act, South Africa could raise healthcare PPP initiatives in the country and it performs the highest operational maturity among SSA countries, including a high level of technical assistance (Whyle and Olivier, 2016). South Africa is the single country in the region with sufficient financial market depth to fully enable PPP financing. Its banks are well regulated and well-capitalized, there is a large and reliable local market for hedging instruments, and its ability to structure finance is strong (EIU, 2015). These elements have enabled the country to engage in healthcare PPP such as

contracting out healthcare services provision - a contract delegation of the healthcare-related responsibility by the Government to a private entity in exchange for a fee (Mills and Bloomberg, 1998; Lagarde et al., 2009). This agreement is translated into medical services in hospitals, clinics, and through private physicians, but also included medical services contracted out to mining companies and NGOs (Whyle and Olivier, 2016).

Several literatures report the strength of the financial sector in South Africa, enabling the environment for *co-location* healthcare arrangement framework (Hellowell, 2013; Whyle and Olivier, 2016). In South Africa co-location initiatives allow private hospital provision to those who can afford private healthcare services, easing the public burden in Government healthcare units and, consequently alleviating the flooding of patients waiting for primary healthcare. PPP in the local healthcare system include, according to Jokozela (2012):

a. Co-location PPP: Universitas and Pelonomi Hospitals in Free State Province– Government owned hospitals that provide academic services to private academic institutions for research and other purposes; promote retaining of healthcare professionals in the public sector. The private entity pays for the right to use the facilities and services. Also, patients using these hospitals can choose in site either they prefer public or private services;
b. Equity Partnership: State Vaccine Institute: located in Polokwane (Pretoria), this institute dedicated to human vaccine development was initially a public entity, until the local government decided to privatize in order to attract the private sector to meet international vaccine standards and therefore the national goals. Both Government and private party share the business participation assets;
c. Private Financing Initiative (PFI): Albert Luthuli Hospital in KwaZulu-Natal: Public-Private tertiary level hospital. The private party provides equipment, maintenance, management services, and technology. The public party pays for the services provided.

Corporate social responsibility (CSR) is another initiative that delivers an opportunity to strengthen the PPP in healthcare services in the country. The most comprehensive example of CSR in healthcare can be found on mobile monitoring and reporting systems. The mobile network operator, Vodacom, in collaboration with the Government on mobile health (m-health) with other corporations including Cell C and MTN, granted cellphones to the National Department of Health. These companies provide

network connectivity access to a central database with health-related information at no cost (Kula and Fryatt, 2013). The environment for PPP in South Africa is generally good and it has been subsidizing the PPP development in the country (see figure 8).

Figure 8: Score of environment for PPP in South Africa.

Overall score	70.7
Regulatory framework	75.0
Institutional framework	75.0
Operational maturity	75.0
Investment climate	46.4
Financial facilities	91.7
Subnational adjustment	50.0

Source: EIU (2015)

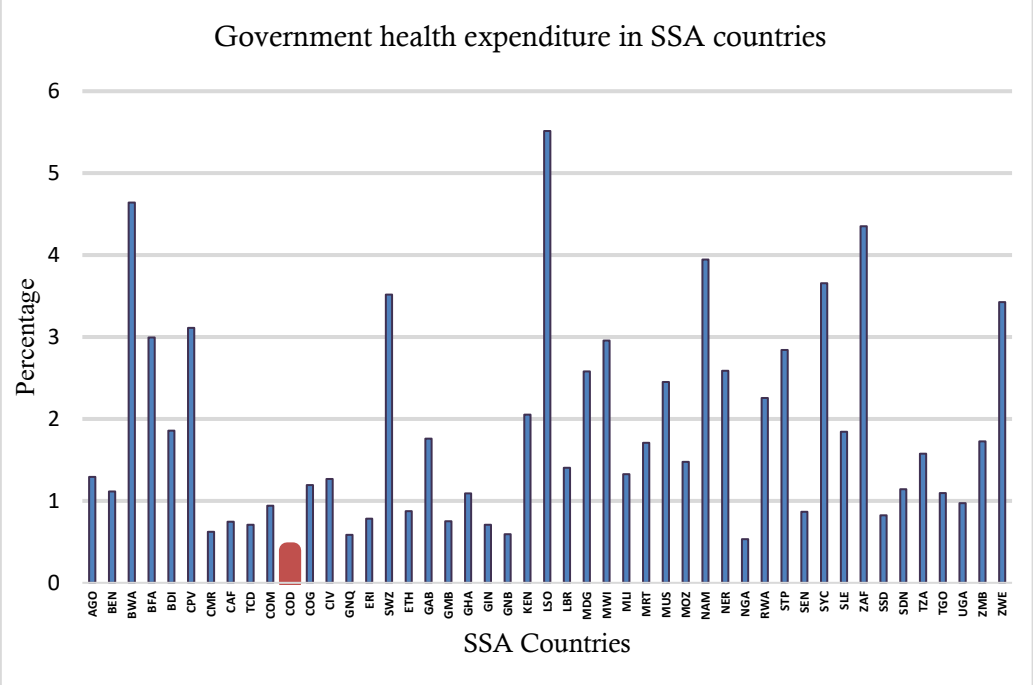
Nevertheless, with the positive explosion of PPP in the South African healthcare system, some challenges such as the emergence of an oligopoly in the healthcare market, expensive services, and decreasing public sector's role have surged (Jokozela, 2012). Another bottleneck for PPP effectiveness is the incorporation of traditional healers in a PPP framework in a country where the dominant healthcare system is based on allopathic medicine also considered as 'complementary' and 'alternative' medicine (Odeyemi and Bradley, 2018). Political stability and the presence of violence and crime as well as high levels of corruption undermine the investment climate and consequently the climate for healthcare PPP in the country.

Democratic Republic of Congo

As in many SSA countries, DRC Government expenditure in healthcare services is not significant. Located in the Central African region, DRC is an Equatorial country prone to infectious diseases such as malaria, HIV, TB, and the burden of maternal and child mortality. Despite this reality, the contribution of the DRC Government on delivery of healthcare services is recorded as the lowest among SSA countries (1.8%), contributing a modest 0.39% of its GDP, as of 2017.

Figure 9 reveals how minor DRC Government investment in healthcare services is. This fact has opened the opportunity to more privatized-prone healthcare services to serve more than 80 million inhabitants.

Figure 9: Government health expenditure in SSA countries (DRC highlighted).



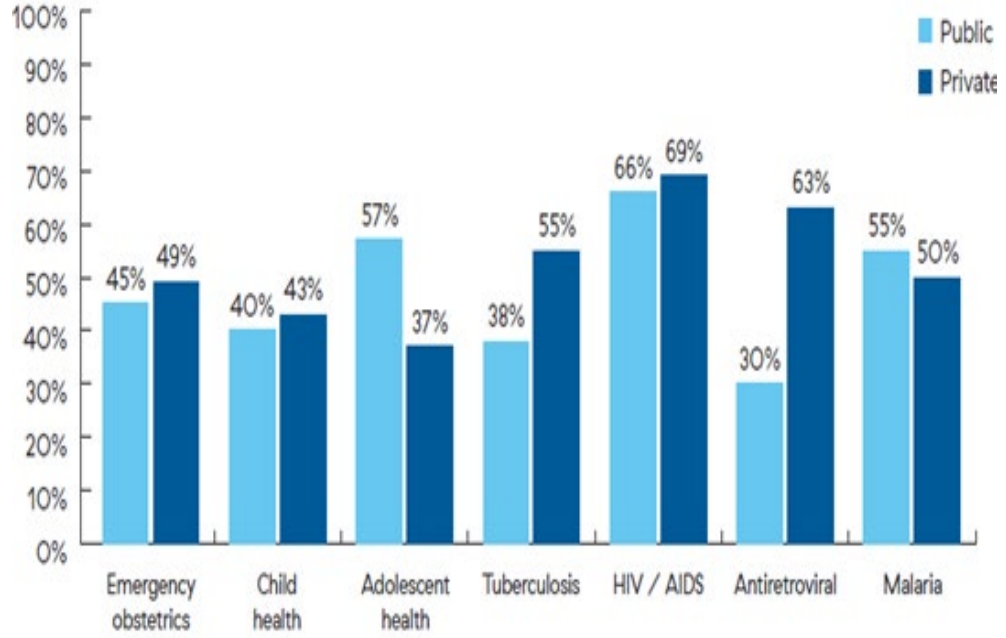
Source: World Bank (2020). World Development Indicators, 2017 [Time Series]

A research conducted by the Sustaining Health Outcomes through the Private Sector Plus (SHOPS), a policy reformulation project designed by local Government and development partners to strengthen healthcare PPP in the country, tracked out that with the exception of malaria treatment, other services are predominantly delivered by private entities that not always are aligned or partnered with the Government or included in a PPP framework (SHOPS, 2019), as evidenced on figure 10.

Amid the Government efforts to strengthen healthcare PPP in terms of institutional and regulatory frameworks, many legislation for the improvement of outcomes of healthcare delivery has been arranged. However, this has been challenging due to the inadequate availability of supervisors, current regionalization process, and opaque regulatory processes, lack of familiarity with Ministry of Health regulations, and

misunderstanding about which directorate or division to consult (SHOPS, 2019). The root of problems is even more profound. SHOPS describes the problem by assessing local political, and socio-economic conditions. Ongoing political instability discourages investment, diverts attention from economic issues and increases the cost of doing business (SHOPS, 2019). In fact, the 2019 Doing Business Report ranks the country the 183rd out

Figure 10: Share of healthcare programs between public and private entities.



Source: Ministry of Public Health (2014)

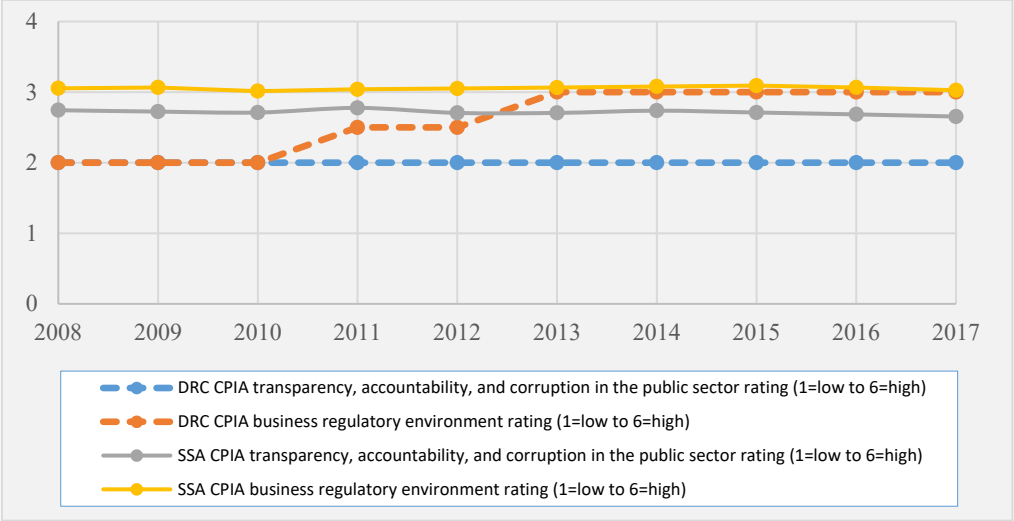
of 190 countries (World Bank, 2019). In other words, DRC has very little experience in managing PPP projects, especially in healthcare service delivery. Project selection and awarding criteria are in many cases unclear or unfair and occur in a very informal way and sometimes with no framework regulating it (EIU, 2015).

Financial institutions' performance in DRC is largely poor and it hinders the healthcare private operators from accessing the capital for investment. As of 2016, the second-largest African country in terms of size had only 19 bank establishments and 120 microfinance organizations and associations. Operational maturity, financial incapacity, political instability in the Eastern part of the country, combined with poor Good

Governance indicators such as a high level of corruption have created space for proliferation of private facilities largely operating independently and often with a shortage of qualified personnel, equipment, supplies, salaries, or incentives to provide quality services (SHOPS, 2019).

Studies have recognized the role of foreign investment in boosting the local private sector, however, the drivers for investments in DRC are very insignificant. Figure 10 displays that DRC's CPIA score is only 2 out of 6 between 2010 and 2017, which is below the regional score. The business regulatory environment is catching up the regional levels (3 out of 6), however other variables such as inexperience in project operations, poor banking network, and additional physical conditions such as availability of electricity, water, and road infrastructure undermine all the efforts for PPP (World Bank, 2017).

Figure 10: Comparative CPIA scores in SSA and DRC.

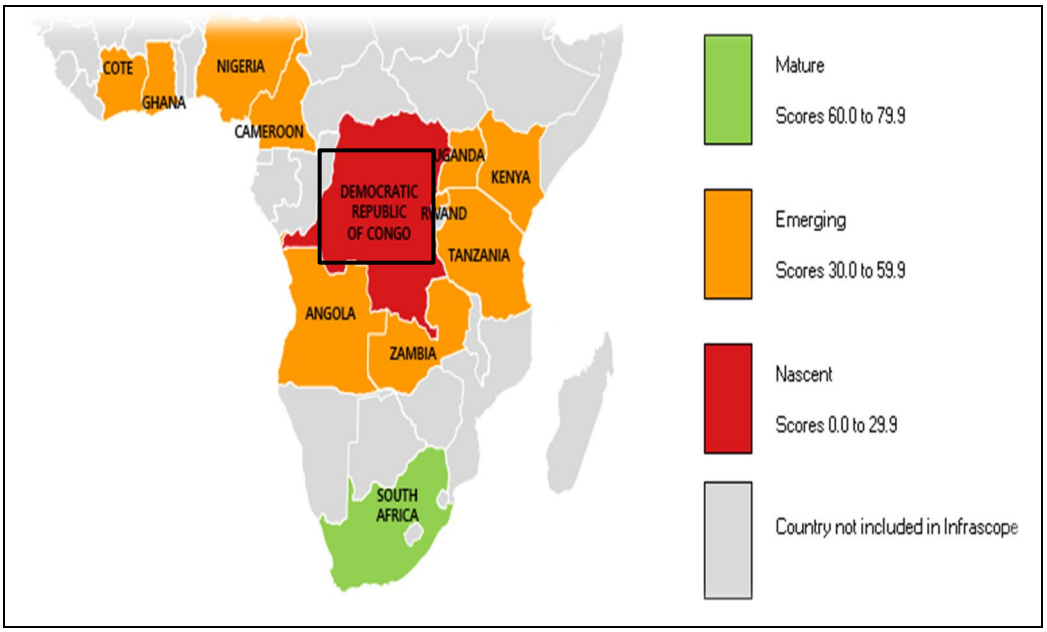


Source: World Bank (2020). World Development Indicators, 2008-2017 [Time Series]

The CPIA profile and other reasons make DRC's capability to design and implement PPP projects to be classified by the EIU 2015 Report (see figure 11) as "nascent" or simply beginner because it displays signs of PPP implementation that are even challenged by overall institutional profile, local material conditions, community attributions which is highly relying on traditional or allopathic medicine as well as the patterns of socio-political and economic interaction.

The literature this paper has reviewed could not find any sound PPP in healthcare services in DRC. Some PPP initiatives such as performance-based financing (PBF) had been introduced in the country from development partners led by the Department for International Development (DFID) endorsed by the Ministry of Health. Nevertheless, a study carried out by Maini et al. (2018) when analyzing the impact of the PBF initiative on the salary of health workers in DRC has concluded that the initiative could not work out because a large part of the public officials do not even have regular salaries.

Figure 11: DRC's Score on environment for PPP in SSA.



Source: EIU (2015)

All this policy gap has pushed Congolese health users to one of the largest household's out-of-pocket payments for healthcare services in SSA, enlarging therefore their exposure from all health risks. The International Monetary Fund (IMF) 2019 Country Report recognized that the regulatory environment in the country has been improving in the last decade, however, there are gaps between regulation and implementation including embedded vested interests among stakeholders.

Tanzania

Three events have influenced the set on of the process for private sector operation in Tanzania: (i) Private Hospitals Regulation Amendment Act of 1991 – dedicated especially to health units regulation for medical treatment and dental care, (ii) the Health Sector Reforms formulated in 1994 and in 1996 which approved and appropriated the health sector reform strategy, and finally (iii) the Local Government Reform Programme of 1998 which formulated the decision making and accountability policy at a local level. These documents made it clear the Government's intention to work closely with the private sector (for profit) and NGO (Itika et al., 2011).

Tanzania is one the fastest-growing SSA economies with nearly 7% annual GDP growth between 2000 to 2017. Private sector engagement is an essential component of this achievement. Thanks to the collaboration with the private sector, Tanzania (along with Benin), shifted in 2019, from lower-income status to low-middle income economy. Private sector participation includes the operation in healthcare delivery services.

Earlier in 2015, the Report of the EIU has described a steady growing environment for PPP in the country, notably on investment climate, institutional framework, institutional quality, and local adjustment (EIU, 2015). However, other components such as operational maturity and financial facilities have remained a challenge. Risk-sharing mechanisms between public and private sectors need to be improved (EIU, 2015). White et al. (2013) stress out that there have been some developments in PPP in the country, however, the Government has not fully engaged the private stakeholders in health policy and planning. Kamugumya and Olivier (2016) went deeper by assessing the collaboration ties between healthcare private providers and public entities at the subnational level. The study found out that in Tanzania, a large number of NGOs, particularly the faith-based organizations and traditional birth attendants have been operating without any type of agreement or if there is any, at least it went through informal means. These informal arrangements include human resources training; resources sharing, participation in planning, basket funding, supply of drugs, and medical consumables mostly to improve the healthcare programs such as family planning, child immunization, HIV/AIDS testing, and counselling (see table 1).

Table 1: Types of existing PPP at district level in Tanzania.

Type of Providers	Type of Contractual Agreement	Type of Collaboration
Faith-Based Provider	None	Provision of RCHS but excludes family planning. Supplies are provided free of charge, and staff are seconded from local government. In return services offered are free of charge.
Faith-Based provider	None	Informal arrangements at village level for staff availability.
Faith-Based provider	None	Informal arrangements between public facilities, and the private provider such as transfer of vaccines from one facility to the other during power blackout.
Private pharmacies and faith-based providers	General Contract	Contractual arrangements between the National Health Insurance Fund (NHIF) and private providers, but restricted to pharmacies and faith-based providers. ADDO and private for profit are not part of providers' network.
Maternity home	None	Various forms of PPP arrangements with the maternity home such as outreach- point for immunization, free of charge supplies for some RCHS including Prevention of Mother to Child Transmission of HIV (PMTCT) however, services are not entirely free, clients have to contribute and the contribution is determined by the provider.
Jointly operated facility, private estate company and government	None	The company provided a building, house for seconded staff, employ some staff, and procure and maintain a stock for its employees, while the government provides, supplies through its Integrated Logistics System for the community, and overall oversight of the facility, and second staff. RCHS are provided as per government guidelines.
Out sourcing	None	In case of out-of-stock at the Medical Store Department. The district procurement officer would purchase a new stock from the appointed contractor, though the contractor tends to change each year.

Modified from source: Kamugumya and Olivier (2016)

Even within this reality, private entities are still the main healthcare providers especially in rural areas of Tanzania. However, due to poor subnational regulation gaps, PPP

collaborations are almost informal, lacking criteria, accountability and consequently making it difficult to measure the impact evaluation.

Why so many informal healthcare PPP arrangements in a country with relatively reasonable Governance indicators? To answer this question, this paper seeks to explore the social interactions and how they shape the development framework:

a) Tanzanian society is largely influenced by *ujamaa* principles which are founded on eradication of racism, restoration of the attitudes of brotherhood, and of sharing and cooperation, and to protect the freedom of independence of Tanzania through self-reliance (Cornelli, 2012); and
b) U*jamaa* values are sometimes related to "laissez-faire" behavior - abstention by the Government from interfering in the market business.

Notwithstanding this apparent disorder mainly at the subnational level, the Tanzanian Government in coordination with development partners, have implemented between 2004 and 2014 the Tanzania National Voucher Scheme (TNVS) – a relevant healthcare PPP agreement financed by the DFID and managed by the Ministry of Health aiming to provide pregnant women and infants with subsidized insecticide-treated nets. TVNS included a discount, the fixed top-up, and the hybrid voucher to vulnerable people, mainly in rural areas. As a direct outcome, it achieved universal coverage and equity and continuous protection of the vulnerable populations (Kramer et al., 2017).

However, Fabre and Straub (2019) in a study analyzing the healthcare PPP on voucher schemes program in Tanzania, have noted the lack of information from users, lack of transparency (dubious or unclear eligibility criteria) and users' financial incapacity have impacted access to those healthcare services. Kramer et al. (2017) add that in remote under-populated areas, retail prices were generally higher due to higher transportation costs that targeted beneficiaries could not afford. The USA President's Malaria Initiative (PMI) Report has described that TNVS project was defunded in 2014 after reports of provider fraud (Tanzania Malaria Impact Evaluation Research Group, 2016).

Rwanda

There is no shortage of literature when it comes to Rwanda's recent development trends. While this paper raises the limited availability of literature regarding PPP in healthcare; this cannot be applied to this small East African country. The reason is because Rwanda has

achieved impressive institutional developments since the 1994 genocide and subsequent civil war, turning the country into an international transformation model.

In 2016, Rwanda's overall rank in economic competitiveness was third-best in the SSA region (IMF, 2017). Unlike the other SSA cases where the gap of Government in financing healthcare services has given space for a strong presence of the private sector in the field, Rwanda's private sector is very small and fragmented even with Government low expenditure in healthcare (Government of Rwanda, 2012). A submission made by Dhillon and Phillips (2015) prefers to attribute the success of Rwanda in healthcare services to an innovative policy and the harmony between Government and development partners within Government-driven priorities. Basically, in a 10 years period (2008-2017), Rwanda did finance no more than 2% of its GDP to healthcare, nevertheless, it is higher compared to the SSA average.

Table 1: Comparative health financing between Rwanda and SSA average.

	Indicator	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
Rwanda	% of GDP Gov't Health Expenditure	1.9	2.0	2.2	2.3	2.2	2.2	2.3	2.2	2.3	2.3
SSA		1.7	1.9	1.9	1.9	1.9	1.8	1.7	1.8	1.8	1.9
Rwanda	% of Private Health Expenditure	26.8	25.0	23.5	22.4	20.1	21.4	18.2	17.0	15.6	15.3
SSA		54.7	53.0	51.6	50.6	50.6	51.6	52.0	52.2	52.9	52.7

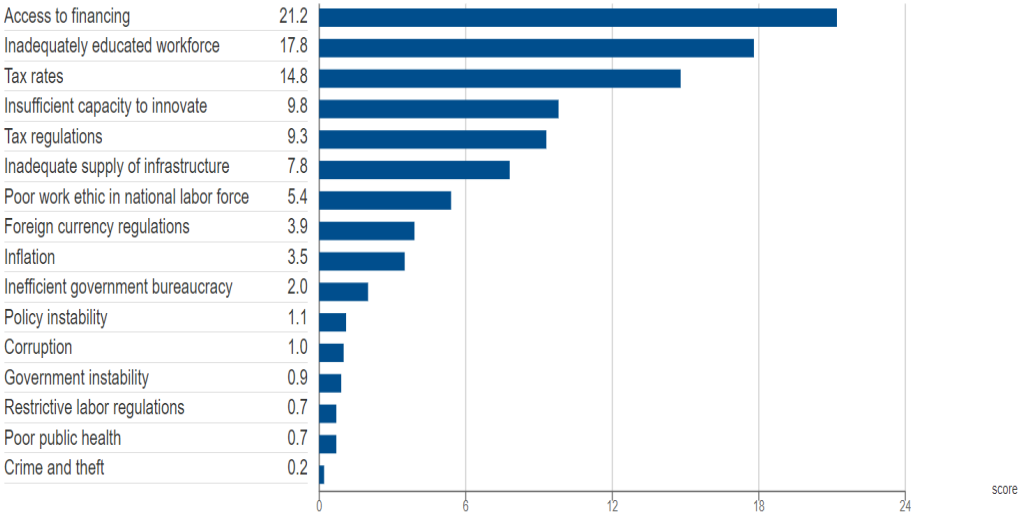
Source: World Bank (2020). World Development Indicators, 2008-2017 [Time Series]

Despite performing relatively good institutions, the Rwandese economic conditions are not considerably attractive for the private sector. A survey was done by the World Economic Forum's Executive Opinion and other done by local Government has

found that economic infrastructure hinder the private sector development: access to financing (the main problem), access to electricity, enforcing contracts, inadequately educated workforce, insufficient capacity to innovate, high tax rates and inadequate infrastructure (World Bank Group, 2017; Government of Rwanda, 2012).

Poor economic infrastructure especially in rural areas has diverted the concentration of healthcare private entities in the capital city, Kigali, where more than 177 for-profit health facilities and 216 pharmacies and wholesalers are located while the rest of the country is underserved by the private sector (USAID, 2015). Nonetheless, Rwanda's Good Governance indicators such as of low levels of corruption, accountability. Government stability has contributed to the introduction of insurance schemes in more than 90% nationwide – the highest coverage in the SSA region. Although largely based in Kigali (see figure 12), the existing PPP in the health industry has promoted the current UHC. Furthermore, in collaboration with the private sector Rwanda introduced and successfully implemented in collaboration with development partners the PBF approach for maternal and child healthcare services.

Figure 12: Most problematic factors for private sector development.



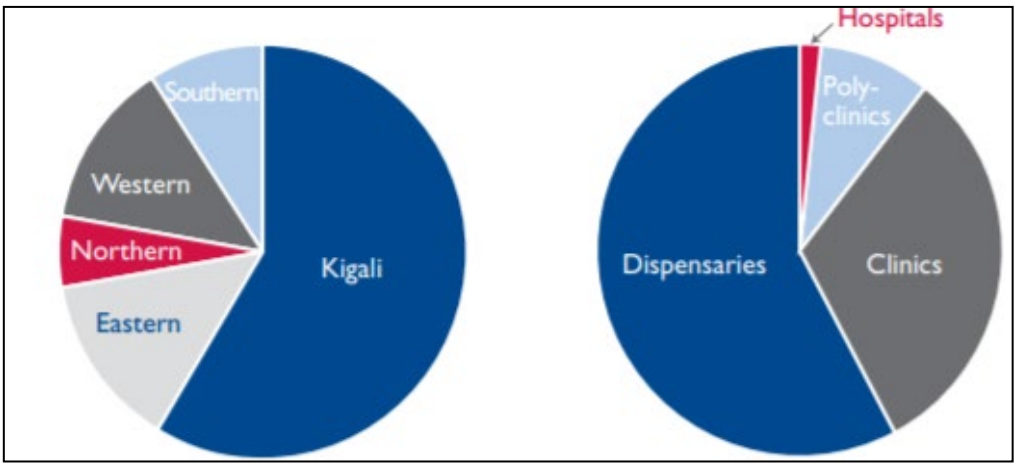
Note: From the list of factors, respondents to the World Economic Forum's Executive Opinion Survey were asked to select the five most problematic factors for doing business in their country and to rank them between 1 (most problematic) and 5. The score corresponds to the responses weighted according to their rankings.

Source: World Bank Group (2017)

By implementing PBF, Rwandese Government and development partners understood that quality of healthcare delivery could be achieved by associating outputs to financial stimuli subjected to explicit norms for quality of care, and strong monitoring and evaluation (Looij, 2009).

With motivated health workers through financial incentives, combined with political will, Rwanda achieved considerable health indicators. Not only political will and financial incentives drove Rwanda health policy to success, but also to more ownership of resources (sustainability), greater performance at the community level, including sending money directly from the Ministry of Health to the health facilities' account in the district and so, local leaders and population could decide on better strategies to maximize the gains.

Figure 13: Geographic distribution of private health sector/private health sector by facility type.



Source: USAID (2015)

The most sound PPP is the One Family Health social franchise model, which has created 92 private health posts in the country, as of 2014. However, due to poor socio-economic conditions, it experienced inconsistent payments and incomplete fulfillment of the terms of PPP in some districts, including operational immaturity and poor capacity for document preparation (USAID, 2015; Byomuhangi, 2019).

CONCLUSION

The PPP performance in the healthcare sector is translated by a symbiotic relationship between institutional setting and accessibility to healthcare services. However, this interdependence is not sufficient to describe the effectiveness of PPP projects in most of SSA's healthcare systems. This paper could verify that PPP in South Africa's healthcare services is solid. The environment for PPP is met in almost all components, with exception of corruption and levels of violence. This background has been allowing the creation of PPP initiatives such as PFI, co-location contracts, CSR and equity partnership. Consequently, all these PPP arrangements have increased and improved the access to healthcare services in the country. However, the integration of all stakeholders within the framework (traditional and conventional), the over privatization, and affordability of those services for the users remains a challenge in the country which is still struggling to achieve UHC.

PPP in DRC has been negatively impacted by a poor institutional performance that undermines the environment for PPP in healthcare. Socio-economic conditions are also inappropriate. In order to attract private operators, the Congolese Government has seen development partners as key stakeholders to support the regulation of private healthcare operators in the country. However, this effort has been confronted with vested interests, since most of the private healthcare entities are owned by public officers.

In Tanzania, PPP in healthcare is largely operated by the non-profit private sector which mostly collaborates within an informal agreement with the public sector, especially at the district level. Tanzania has a relevant PPP regulatory framework. However, in many cases, local Government and users are not informed about this. When informed, they find themselves economically incapable to afford the services provided within a PPP structure.

Despite the non-favorable physical and material environment for PPP, Rwanda has demonstrated that political will is the highest strength available for the implementation of PPP in healthcare. Likewise, the fact the country is a relatively small monoculture with a population that speaks the same language, almost same religion (70% of its population are catholic Christians), and the historical path including the recent memories of genocide may have helped them to embrace a sound healthcare system with more determination.

Looking back to initial propositions, this research has shown the role of institutions as a determinant factor for the effectiveness of PPP in healthcare in SSA, and in fact, it has been increasing the access to healthcare services. However, this affirmation does not fully

answer the requirements for the SSA case. Our final conclusion is that additional elements such as culture, local material conditions, community attributes, and Government expenditure in healthcare services are important for PPP access and effectiveness.

This paper must acknowledge the limitations of the study. In particular, it should be noted that some other factors that may influence the performance of PPP in healthcare may not have been fully controlled for and also considering the limited number of cases this paper has focused on. While this would have been desirable, this research has been constructed to make a prototypical analysis regarding the elements for a sound PPP in healthcare in the SSA region. Therefore, this paper takes caution in inferring adequately final conclusions.

ENDNOTE

This paper is abstracted and improved from the author's master thesis.

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