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Emergent views on public private partnerships in public hospitals in Zimbabwe

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Abstract

This study assesses emergent themes, views on the engagement of public private partnerships (PPPs) in Zimbabwe's public hospitals. Zimbabwe's public healthcare has witnessed a steady decline at the turn of the century. A faltering Zimbabwean economy over the years has left the State unable to fund and sustain public healthcare. In this light, PPPs are seen as a viable route in resuscitating the ailing public healthcare in Zimbabwe. PPPs bring forth some key tenets of *laissez faire*. This at times contradicts with public healthcare traditional practices. Public healthcare remit falls under the ambit of the State. The X-efficiency theory argues that State backed public entities are inherently inefficient. PPPs become necessary to reduce the inefficiencies. Forty three semi structured interviews were conducted with three of the six public hospitals in Zimbabwe. The interviews assessed emergent thematic views from the public hospitals on the engagement public private partnerships. A substantial majority favoured PPPs in resuscitating the ailing public hospitals. Assessing the life-world perspectives is vital if PPPs are to have a successful run in public healthcare system.

Keywords: Public Hospitals; Public Private Partnerships; X-Efficiency; Public Sector; Private Sector

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1. Introduction

1.1. Background of the Study

There are six major public hospitals in Zimbabwe. These are namely Mpilo Central Hospital, United Bulawayo Hospitals, Ingutsheni Central Hospital, Parirenyatwa Central Hospital, Harare Central Hospital and Chitungwiza Central Hospital. The first three are located in Bulawayo, the second largest city in Zimbabwe whereas the last three are located in Harare, the Capital. A brief synopsis of the public health care in Zimbabwe revealed the following: - In the 1980s Zimbabwe had one of the best healthcare facilities in the sub-Sahara region (MoHCC, 2012). However, the 1990s saw a decline in healthcare (MoHCW, 2010). The decline was more pronounced in public healthcare sector than its private counterpart. This decline was largely due to a plethora of factors, such as the drought of 1992, the worst ever seen in Zimbabwe (Marquette, 1997). This had a knock off effects on Zimbabwe whose economy is largely agrarian in nature. Zimbabwe was thrown into the midst of a financial crisis. This left the State incapacitated in meeting its social obligations on funding public health. Inevitably, public health care declined over the years. Exodus of skilled personnel followed. Medicines became scarce in public health. Those who could afford private healthcare went private. Zimbabwe's health system once the epitome of success with many countries crumbled (Johnston, 1999). The years 2008-2009 saw public hospitals more or less closing doors as the lack of supplies took its toll (Sollom, 2009). Furthermore, the budgetary allocation of resources to public hospitals by the State was inadequate (UNDP, 2015). In 2009 the State heralded PPPs as a possible avenue in resuscitating the ailing public hospitals. This led to the State's enactment of regulatory supporting framework. These were namely the Public-Private Partnership Policy (2010), Public-Private Partnership Guidelines (2010), Public Private Partnership: Legislative Review for Zimbabwe (2010) and the Institutional Framework, Public-Private Partnership (2010). These were meant to spearhead the formation of PPPs within the various areas of the ailing economy (MoHCC, 2012). In 2015, The Joint Venture Act (Chapter 22:22) (JVA) was introduced. The JVA was adopted to support the existing PPP framework. In essence, this is the mother Act governing PPPs.

In Zimbabwe the JVA (2015) serves as the main guide for all PPP formations. The Act stipulates that;

> *'…joint venture agreement means an agreement between a contracting authority and a counterparty, approved under this Act, in terms of which the counterparty undertakes to perform a contracting authority's function on behalf of the contracting authority for a specified period; and the counterparty receives a benefit for performing the function by way of compensation from funds appropriated by Parliament; or funds obtained by way of loan by the contracting authority; or user levies; or revenue generated from the project; or any combination of the foregoing and the counterparty is liable for the risks arising from the performance of its function; and public resources may be transferred or made available to the counterparty…'*

The PPP formats provided by the Act are namely Build and Transfer (BT), Build, Lease and Transfer (BLT), Build, Operate and Transfer (BOT), Build, Own and Operate (BOO), Build, Own, Operate and Transfer (BOOT), Build, Transfer and Operate (BTO), Contract, Add and Operate (CAO), Develop, Operate and Transfer (DOT),

Rehabilitate, Operate and Transfer (ROT), Rehabilitate, Own and Operate, Build, Own, Operate and Maintain Contract, Lease Management Contract, Management Contract, Service Contract, Contract of Services, Supply Operate and Transfer.

PPPs were introduced to Zimbabwe in 1994, when the State partnered players in the construction of the Limpopo Toll Bridge under a Build-Operate and Transfer (BOT) arrangement (Chagumira and Dube, 2010).The most noticeable PPP in Zimbabwe of late is the Plumtree-Bulawayo-Mutare Railway rehabilitation project implemented by Group Five of South Africa with funding from Development Bank of South Africa (DBSA) in 2014. On 15 December 2014, one of the six public hospitals in Zimbabwe engaged a laundry firm for the provision of on-site laundry services based on a Build-Lease and Transfer (BLT) arrangement. The terms of engagement cited as follows;

> "*The Lessee shall supply new laundry equipment and linen and refurbish the department and make other changes which will assist in the performance of the agreement…after such refurbishment, upgrading and installation the Lessee shall provide all laundry services required by the Lessor.*"

On the other hand the Lessor was to pay the Lessee for the laundry services for a period of five years after which the Laundry and all the improvements will be handed over to the Lessor (The Central Hospital). The PPP arrangement faltered and the parties seemed to be entangled in an unclear relationship due to the lack of accountability, responsibility and transparency. This deficit left Lessee with an unfettered monopoly over the hospital laundry services. As of consequence the laundry infrastructure and equipment lays in rubbles.

In terms of the PPP arrangement, the public sector in this paper refers to public hospitals and all government institutions. Public healthcare and public hospitals are used interchangeably as they are held as the one and same entity. The word private in PPP models refer to the for-profit private incorporating commercial enterprises of any size (Galea et al., 2014) and the non-profit private denoting to Non-Governmental Organizations (NGOs), philanthropies and other not-for-profits, (Abuzaineh et al., 2018). For purposes of this paper, the word private shall refer to for- profit commercial enterprises. The word partnership in this study refers to long term, task oriented, and formal relationships (Oktavianus et al., 2018). Privatization refers to the transfer of ownership in which the public sector ceases to be a party.

PPPs can play a more paramount role whose impact can be evidenced at times, in the resuscitation and rehabilitation of existing infrastructure in the public institutions than building new ones. This may also encompass building or buying new equipment where the existing is dilapidated (World Bank, 2013). Successful PPPs are branded by thorough planning, good communication, consultation of the public, strong commitment from parties and effective monitoring, regulation and enforcement by the State. The issue of pricing is important as the private partners enter into PPPs to make profits whereas the State's mandate is to offer cost-effective utilitarian service delivery. Through embarking on partnerships, public and private actors often realize benefits such as technology transfer, increased influx of direct foreign investment, shared risk, creation of jobs, facilitation of creative and innovative approaches competition as well as healthcare infrastructure development. Through pulling resources, ideas and expertise together PPPs can realise innovative strategies

to solve difficult problems (Abuzaineh et al., 2018). Other potential advantages for engaging PPPs are enhanced efficiency of already established health infrastructures; health and poverty reduction.

1.2. Statement of the problem

In Zimbabwe, the public health system has been customarily the largest provider of health-care services. Mission hospitals and non-governmental organisations play a complementary role (MoHCW, 2013). The infrastructure in the public health institution used to be kept intact through good management and maintenance. The years of economic malaise (2000-2009) witnessed a sharp reversal of this trend, with the public sector rolling back the services (Chagumira and Dube, 2010).The privately run health institutions more or less managed to absorb the burden tacitly placed upon them by the public sectors' failures, but only for those who could afford their highly priced service charges. The health sector in Zimbabwe has remained under funded with budgetary trends from 2012 to 2016 showing a downward trend of both the allocated and released funds to this sector (ZIMCODD, 2016). This has caused major public health service providers in the country to operate below capacity despite the increasing patient turnover rates.

1.3. Objective of the study

The purpose of the study was to assess emergent thematic views from the public hospitals on the engagement public private partnerships.

2. Literature review

Leibenstein (1966) proffered the X-efficiency hypothesis of PPPs. This hypothesis holds that State backed public entities are inherently inefficient. PPPs are therefore necessary to reduce the inefficiencies. The participation of the private sector enables public entities to respond to market forces more competitively (Huil, 2014). PPPs might help derive value for money if they are established in an environment entrenched in the stakeholder view of practice (Burger and Hawkesworth, 2011). This entails risk sharing and proper delineation of authority, communication and information channels, responsibility and accountability (Bal et al., 2013).

The X-efficiency argues that the States' bureaucratic organisational structures and distortionary interventions can cause inefficiencies in public institutions. PPPs can be a remedial source in rejuvenating public entities (Chagumira and Dube, 2010) to align with the market forces and become more competitive (Abuzaineh et al., 2018). Public-Private-Partnerships usually involve a private actor, providing a bundle of services such as the design and construction of a hospital (ZIMCODD, 2016). The difference of bundling from traditional contracting out of services is that separate contracts are drawn up to provide value-for-money that cannot be realized by contracting out services separately (Estache and Saussier, 2014). The amalgamation of design, operation and maintenance over the life of an asset, within a single-project finance package, enhances performance and reduces whole-of-life costs.

PPPs are often resorted to for their potential in creating a formidable mechanism for the remedy of complex problems through leveraging on the strengths of different partners. PPPs have become a remedy to health care glitches worldwide (Abuzaineh et al., 2018), and of late there has been zeal for using PPPs to mend the delivery of health and welfare services for a wider range of health problems (Espigares, 2009). PPPs merge the strengths of private actors which include innovation, technical knowledge and skills, managerial efficiency and entrepreneurial spirit, and the role of public actors. These include social justice, social responsibilities public accountability and local knowledge in order to foster an enabling environment providing high quality health infrastructure and services (Boyer et al., 2010; Hong et al., 2018).

A typical PPP web includes government departments, technical and financial advisers, funders, investors, and consumers of public assets/services (Noble and Jones, 2006). They should not duplicate or deviate from the national health policies and priorities but rather should be optimally incorporated into the national health framework whilst immune to any conflict of interest

(Raman and Bjorkman, 2009). The potential advantages of engaging PPPs include enhanced efficiency of already established health infrastructures; health and poverty reduction (Sharma and Seth, 2011). They allow the public sector to embark on otherwise unaffordable. PPPs cover the so-called infrastructure gap between what the government can afford *vis a vis* what people need. They work best for medium-sized projects which can be established as stand-alone entities with a low-risk profile (Brinkerhoff and Brinkerhoff, 2011). Development of a PPP should not be viewed as an outcome, but a process and an output. In Africa, the success of PPPs in healthcare is usually dampened by the lack of credible and capable private partners. Operational and process related challenges common in PPPs include the legislative frameworks, polices/operational strategies, participatory approach to decision making, governance structures/power relationships, criteria for selection, sustainability and accountability (Newman, 2004).

Most African countries lack credible and capable private partners for PPP arrangements (World Bank, 2014). If PPPs are to provide an effective remedy to arrest issues of poverty reduction, equity, cost containment and quality improvement a lot of groundwork is needed to establish effective legal and regulatory framework, accountability and transparency and the indispensable mutual trust that is ideal for partnerships to flourish (ibid). As such Governments should seek to simplify regulations and be open dialogue. Dialogue is the key. PPPs operate on the fringes of the public and private sector. Politically, they represent a third way in which government provide certain public services. The private sector through summoning its experience, expertise, technology and innovative ways achieves greater operational efficiency in asset procurement and service delivery. The overall project cost savings can be realised by striving for the lowermost possible total lifecycle costs whilst maximizing profits (Cheung et al., 2005). PPPs usually involve a private actor, providing a bundle of services. Separate contracts are drawn up to provide value-for-money that cannot be realised by contracting out services separately. Grimsey and Lewis (2004) define value for money (VFM) as the fusion of whole lifecycle risks, costs, quality and completion in order to meet public requirements. The determinants of VFM are completion, risk transfer, long term nature of contracts, performance measurement and incentives, performance measurement and the use of an output specification and private party's management skills.

3. Methodology

3.1. Research design

The study utilized a case study research design. A case study is an in-depth exploration, often undertaken over time such as a policy, programme, intervention site, implementation process or participant. PPPs in the healthcare sector are still in their infancy in Zimbabwe (Chagumira and Dube, 2010). The case study research design helps in defining new terms and clarifying existing concepts within this PPP environment. The participants were selected for their or likely involvement with PPPs at these public health care institutions.

3.2. Data gathering instruments

Forty three semi structured interviews were conducted with three of the six public hospitals. These were namely Mpilo Central Hospital, Chitungwiza Central Hospital and Parirenyatwa Central Hospital. The interviewees were drawn from the following personnel namely the Executive Board Members, the management, the Consultant Doctors and General Practitioners and the senior personnel of the following departments; Radiotherapy, Maternity and Pediatric Hospital, Physiotherapy, Operating Theatres, Information Technology, Workshop. In addition two interviewees were from The Ministry of Finance's Joint Ventures Unit. The Joint Ventures Unit main functions include the a) consideration of project proposals submitted, b) make findings/assessment on their affordability/feasibility to the contracting authority and; c) to act as an advisory role to the State.

4. Results

Only one of the six public hospitals has had many years of full- fledged involvement with PPPs. It was noted that a weak regulatory system was seen as one the major constraint facing the success of PPPs in public hospitals. It was submitted that if PPPs were to be adopted, the right to health could be compromised as health services could become expensive. The interviews cited poor governance structures in Zimbabwe which mitigated the success of PPPs in public health institutions. In this respect governance refers to tenets like rule of law, transparency and accountability as espoused by one official from the Joint Venture Unit that,

> *"…good governance moulds an enabling environment for parties to commit to a long-term partnership and inculcates a sense of confidence among the investors".*

The respondents posited that good governance is critical as it fosters a platform for innovation, productivity, trust, accountability, efficiency and predictability of the business environment which encourages Foreign Direct Investment. PPP arrangements can realize value for money. Information gathered from the respondents indicates that, PPPs can also breed inefficiencies due to lack of competition. Through signing the contract document the private partner acquires the sole right to lock out other potential partners to its advantage. Quite a number of respondents noted that there is an inherent culture gap between the public and the private

partners. This can result in a loss of confidence. What motivates the private sector into PPPs is profit making whilst the public sector is lured by social attractiveness. These divergent views can breed mistrust and lack of confidence in both parties/actors. Other challenges mentioned by the respondents were political interference, poor accountability and transparency and lack of commitment. It was also noted that the private sector is sometimes hesitant in taking the risks that accompany a PPP. Taking ownership of risks necessitates accountability and responsibility.

It was noted that the public hospitals do not have either the necessary resources to commit to PPPs nor the necessary dexterity to start-up or manage a PPP arrangement. In addition public health institutions in Zimbabwe were more used to traditional procurement of infrastructure services. It was mentioned that, PPPs ought to be commercially viable to attract private companies. However decisions in public entities are not at all times taken for their commercial viability but for their utilitarian ends. A substantial majority favored the PPP route in resuscitating the ailing public hospitals. However some were of the view that PPPs were not an option at public hospitals as they may result in exorbitant charges which would be uncharacteristic of public institutions.

The enablers for successful PPP arrangements were revealed by the respondents as a good and functional regulatory framework, good governance, closing the culture gap which traditionally does not favour PPPs between the public and private actors. Other enablers include full commitment by both public and private actors, accountability and transparency, improved efficiency and honouring contractual obligations. It was found that the public hospitals were ill-prepared to partake in PPPs due to the lack of capacity to originate and implement PPPs coupled with the general bias towards traditional public procurement.

The JVA was mainly designed to guide big infrastructural projects such as roads and the railways. This Act is another barrier to business especially as the State has far too many interwoven regulations which retards and discourage investments. As echoed by John Robertson (a leading economist in Zimbabwe) that

> '*…it is already different to start and register a company in Zimbabwe now. One has to go through these units and committees if they want a joint venture. We are supposed to be easing doing business and this complicates the doing business environment even more."* (Chagumira and Dube, 2010).

5. Discussion

The State should seek to minimise bureaucracy and provide skills and expertise which are not usually available in the public sector. There is need to strengthen governance systems and institutions. This means greater accountability, transparency and movement towards efficiency and effectiveness in the public service. Public sector management skills should be horned. Public healthcare should be accessible, affordable, reliable and of good quality. PPPs need an enabling economy coupled with the political will. The State should seek to foster a creative and enabling environment for PPPs. PPPs require clarity on policy and framework. Contract

enforcement, the rule of law, protection of property/minority rights, governance structures/bureaucracy, tax systems and economic policies are the vitals to successful PPPs.

6. Conclusion

The paper concludes that PPPs can resuscitate and rehabilitate public hospitals. For PPPs to work the private and the public sector must be willing to uphold the key tenets of good governance such as accountability, transparency, efficiency and effectiveness. Good governance is vital. A mutual understanding should be realised by both parties. The Public healthcare system should let go of some of its behavioral practices such as the bureaucratic traditional procurement of services which favours internal sourcing. Competency is the key. The JVA (2015) is too broad and all encompassing. An all encompassing is Act is arguably ineffective and not fit for purpose. At tailor made Act for PPPs is the ideal. Commitment and mutual trust is a must. The lack of political commitment, institutional decay, the high cost of doing business due to absent expenditure and maintenance on the infrastructure impedes PPPs in Zimbabwe. Statistics reveal that the State spent virtually nothing on infrastructure in 2009, $200 million in 2010, $300 million in 2011, $300 million in 2012, $100 million in 2013, $200 million in 2014, $300 million in 2015, $500 million in 2016 and about $300 million in 2017 despite the huge deficit in infrastructural development and upkeep. The quoted figures are in American Dollars.

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