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Utilizing Public Private Partnerships in Fighting Covid-19: Can the Public Sector Overcome Coronavirus Challenges Alone?

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Abstract
The perennial economic crisis in Zimbabwe has crippled the once superior health delivery system thereby reducing the country's capacity to cope with the global COVID- 19 pandemic. As of 16 August 2020, Zimbabwe recorded 5251 cumulative cases; 3037 active cases, 2092 recoveries and 132 deaths and the figures are growing faster than expected against the background of inadequate PPE for health personnel working at the country's health facilities. This health crisis has overburdened the government's weak systems coupled with lack of serious interest to attract the private healthcare players through PPPs arrangements. The health sector is unacceptably underfunded with a budget allocation of US$7 per capita against the recommended US$34 per capita per annum. Ultimately, these gaps result in loss of life and untold suffering of the poor who are not able to access the services of the private players in the healthcare provision. Included in the Zimbabwe's new constitution (2013) section 76 (1), is the government's responsibility to ensure every citizen and residents have access to basic healthcare provisions. In its response to the COVID-19, it is expected that the Zimbabwe government should observe the set minimum standards. Globally, governments are facing budget constraints to adequately finance healthcare provisions and systems. It is therefore against this background that some countries are embracing Private Public Partnerships as joint efforts to improve healthcare service delivery to save lives. Key enablers for the successful implementation of public private partnerships are: strong political leadership, favourable policy and effective organisational capacity. 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. As such, governance of sustainable PPPs in healthcare financing is an area for further research. 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 for good PPPs governance.

Keywords: Governance, Healthcare, Coronavirus, public -private partnership

Introduction
The perennial economic crisis in Zimbabwe has crippled the once superior health delivery system challenging the country's capacity to cope with the global COVID- 19 pandemic. In the face of this deadly virus, testing has become a challenge signalling the country's inability to effectively address challenges posed by this pandemic. At the onset of the outbreak in the country, the Government had no testing kits and many cases were being turned away at the main isolation facility located at Harare's Wilkins Hospital due to incapacitation. This has resulted in Zimbabwe Association for Doctors for Human Rights (ZADHR) taking the Government to court over its failure to provide frontline doctors with personal protective equipment like face masks, arguing that medics in the country's exposed health sector will perish.

According to MoHCC (2020), as of 16 August 2020, Zimbabwe recorded 5251 cumulative cases; 3037 active cases, 2092 recoveries and 132 deaths and the figures are growing faster than expected against the background of inadequate PPE for health personnel working at the

country's healthcare service providers. This health crisis has challenged the government's weak systems and lack of interest to attract the private healthcare players through PPPs arrangements.

The Zimbabwe National Health Strategy 2016-2020, illustrates that 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, as observed by the World Health Organisation (2020), 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 & 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. 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, and ZIMASSET in 2015-2018 which were meant to improve the serious economic crisis that Zimbabwe was in, the situation in the health delivery system has drastically deteriorated (International Monetary Fund, 2019).The IMF assert that the economic hardships in the country have further aggravated the situation due to budgetary constraints to meet the requirements of the public health institutions coupled with corruption and malpractices that had crippled the public institutions.

A document from the Ministry of Health and Child Care EHealth, (2012-2017) states that 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 (UNDPZ, 2020). The health sector is unacceptably underfunded with a budget allocation of US$7 per capita against the recommended US$34 per capita per annum (WHO, 2019). Ultimately, these gaps result in loss of life and untold suffering of the poor who are not able to access the services of the private healthcare providers.

This paper reviews the global trends in embracing PPPs in healthcare and strategies other nations are employing to strengthen stakeholder relationships for sustainable healthcare delivery to save lives. The paper will argue that PPPs are a factor to consider due to their financial muscle, flexible policies and agility. The paper will also argue that life is a human rights issue and the government must not claim monopoly over healthcare delivery but should involve eligible private health players with capacity to partner it in order to meet the goals of SDG 3 that expresses the need for health for all by 2030.

Constitutional Health Delivery Obligations

Included in the Zimbabwe's new constitution (2013) section 76 (1), is the government's responsibility to provide access to basic healthcare services to all citizens and residents. Section 76 (3) compels government to ensure that no person is denied emergency medical treatment in any healthcare facility. Instructively, section 51 of the constitution compels the government to protect human dignity.

Apart from constitutional provisions, Zimbabwe is an affiliate to the International Convent on Economic, Social and Cultural Rights (ICESCR) which imposes a duty to protect the right of everyone to enjoyment of the highest attainable standard of physical and mental health. Zimbabwe is also party to the International Covenant on Civil and Political Rights and the African Charter on Human and Peoples Rights, both of which guarantee the right to life.

Set Health Standards

As a measure to ensure acceptable healthcare governance as outlined by OECD (2012) recommendation for public governance of PPPs, the Committee on Economic, Social and Cultural Rights set minimum standards which must be fulfilled at all times for member states. These standards focus on quality, availability, accessibility and acceptability of healthcare services. It spells out that; healthcare facilities should be equipped with clean, safe and adequate water supply, sanitation, equipment and medicine including skilled medical professionals. Healthcare facilities should have adequately trained and fairly-paid medical personnel, essential medicines should be made available to all, and should be accessible to all without discriminating. Accessibility here, entails physical accessibility, economic accessibility and access to information. The standards also outlines that healthcare services should be provided in a manner that complies with medical ethics.

Accordingly, measures that are undertaken by the Zimbabwe government in fighting COVID-19 pandemic should comply with these minimum standards. Reports availed by ICJ (2020) alleged that; there was gross under-testing of people despite showing most of the COVID-19 symptoms. The report highlighted that government was establishing fully equipped COVID-19 healthcare facilities but exclusively for the political elites and their associates. It further revealed that, there was no running water at designated COVID-19 care and isolation centres, insufficient staffing, lack of training of healthcare workers on proper handling of COVID-19 related patients, absence of equipment such as ventilators and, mishandling or ill treatment of patients at COVID-19 centres. These challenges may not be peculiar to Zimbabwe but a global challenge.

Global Healthcare Challenges

Abuzaineh, Brashers, Foong, Feachem, and Da Rita (2018) assert that 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. They argue that owing to these challenges healthcare systems are increasingly strained and are struggling to expand access and deliver high-quality healthcare services in line with 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 (2006) and Casady (2020) 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, USAID (2006) and International Journal of Health Policy and Management (2017) submits 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 and 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. Baxter and Casady (2020) argued 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, Hodge, Graeme and Greve (2010) 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. Casady (2020) emphasising the need for proactive and strategic healthcare PPPs noted that 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, according to Baxter and Casady (2017), 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 Hanlon, Hellowell, Eldridge and Clarke (2020), the key question of universal health coverage is an ethical one since it is a human right. They point 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. It is therefore against this background that some countries are embracing PPPs as joint efforts to improve healthcare service delivery to save lives.

PPPs- Definitions

The OECD (2012) observed that there is a variation of PPPs definition including accounting frameworks between countries giving examples of Korea, United Kingdom and South Africa. Korea defines a PPP project as a project to build and operate infrastructure such as roads, schools, ports, railway-lines, and environmental facilities which were predominantly constructed and run by government funding, with private capital, thus tapping the creativity, innovation and efficiency of private players.

South Africa defines PPPs as a commercial transaction based arrangement, between a government institution and a private partner with clearly specified roles and responsibilities of each party to the partnership in terms of control and use of state property by a private player. The United Kingdom defines PPPs as an arrangement characterised by the public sector working jointly or in –collaboration with private sector. In this broader sense, according to OECD (2010), they can cover all types of collaboration across public –private sector interface involving collaborative working together and risk sharing to deliver policies, services and infrastructure. 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. Kosycarz, Nowakowska and Mikołajczyk (2018) argue that 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.

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 (Burger, Philippe and Hawkerworth, 2011). 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, 2019; 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 & Mikołajczyk, 2018). In direct contrast to privatization, the public accountability is maintained with PPPs.

The Advent 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. Kett and Donald (2011) point out that the trajectory of PPPs is found in the New Public Governance (NPG) 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 & Chigumira, 2010).

Common PPPs Models

There are several of models which can be adopted, according to OECD (2012), depending on the requirements of the Healthcare system. The OECD outlines these joint partnerships to 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) (Languille 2017 and Medhekar 2014).

According to Dube and Chigumira (2010) under the Buildand-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.

For Abuzaineh et al., (2018), in health care there are three basic PPPs models, namely, the infrastructure-based model; for building 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.

Global Trends in Healthcare Services under Covid-19

The World Health Organisation (2020) reported that some countries have already capacitated the private sector to reinforce their COVID-19 responses. According to WHO (2020) England, France, Germany, the Lombardy region in Italy and South Africa, have engaged private sector to increase testing capacity and add extra hospital beds, ventilators and health workers to their response capacity. It is reported that countries such as Australia and Spain have applied a different approach, granting authorities' power to request resources from the private sector such as healthcare

service facilities, equipment and staff as and when they are needed. For avoidance of profiteering, WHO (2020) observed that those who are in partnership with the private sector have been granted a tariff for this additional capacity as a measure to discourage the private players from making huge profits for providing these essential services, facilities and, equipment.

In England, according to WHO (2020) the National Health Service took over governance of all healthcare facilities that treat COVID-19 patients and other urgent operations and treatments. Additional governance issues and partnerships agreements cover WHO, (2020); inpatient respiratory care to COVID-19 patients, urgent elective care services during the surge, diagnostic capacity to maintain urgent priority elective and cancer pathways, inpatient non-elective care to help free up bed capacity, and making staff available for redeployment in other settings. According to WHO (2020), payments for service rendered are structured and made by the central government directly, based on actual costs per patient subject to independent review by auditors. As a result, (WHO,2020), an additional 8000 hospital beds, 1200 more ventilators, 10000 nurses, 700 doctors and over 8,000 other clinical staff have been included in the response effort.

In Italy, in general, and Lombardy in particular, private sector healthcare providers have been contracted from onset in response to the COVID-19 pandemic. Dialogue among key stakeholder was opened for the provision of a cafeteria of specified healthcare services. In an effort to create space for the COVID -19 patients any arrangement with the private sector was made in order to reduce the number of admissions in non-urgent and outpatient care WHO,2020). Due to increasing demand for more space to cater for emergencies the arrangement for non-urgent and outpatient was suspended altogether.

This was achieved through having contracts between regional authorities and accredited private hospitals, on a retrospective per case basis and payment would be set to provide no above-cost remuneration (Montgu & Chakraborty, 2020). WHO (2020) reported that in France several inter-sectoral collaboration emerged that included the private hospitals agreeing to cancel all non-urgent activities to free up beds including 100000 interventions per week, redeployment of beds to tackle COVID-19 demand, seamless transfer of patients between public and private sector facilities, and the provision of lists of private sector employees that are to be made available for deployment by the public sector as part of the response.

In order to speed up the purchase of COVID-19 and other treatments by the private sector, the public sector relaxed the existing strategic purchasing arrangements. Effectively, some 800 for profit health facilities, and 704 non-profit health facilities were engaged in the COVID-19 response accommodating the private sector in the response resulting in prominent private hospitals like Ramsay Sante treating 10% of COVID-19 intensive care unit patients in Paris (WHO, 2020).

WHO (2020) observed that private sector diagnostic capacity was substantial in Germany with the ability to analyse 58,000 tests per day, which capacity was dedicated for COVID-19 response. According to WHO, there were 54 laboratories offering SARS-CoV-2 PCR tests, of which 22 were private. Mindful of the objectives of private laboratories to make money, testing for SARS-CoV-2 PCR tests was free at the point of use under all insurance schemes that included statutory and private health insurance. Like Italy, existing reimbursement systems for diagnostic services in Germany were deployed to speed-up purchasing of additional tests. As reported by Association of Accredited Laboratories (ALM) (2020) privately owned laboratories and policlinics analysed over 260000 SARS-CoV-2 PCR samples in just one week in March, 2020.

In South Africa, WHO (2020) observed that the public sector was negotiating per case tariff with the private sector for the uninsured COVID-19 cases and receive reimbursement. The arrangements included private sector hospitals accessing purchasing of COVID-19 and other urgent treatments. Privately insured patients were receiving care and non–insured patients were able to access free privately delivered care subject to the ongoing public/private-negotiations.

Casaby (2020) argued that while these countries took different approaches to private sector involvement in their response, they have one common thing, to save life. It is argued that they have long practised PSE as a matter of routine management of their health systems leading to the understanding of the private health sectors' capabilities, how to engage them and what governance instruments are required and strong direct and indirect financing modalities.

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, according to Elston,Cartwright, Ndumbi and Wright (2017), 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 (United Nations General Assembly,2012). 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 in a lower risk-adjusted cost to the state, that is, better value for money. Sarmah (2019) 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 is one of the guiding tenets of UHC and SDG 3.

Casady, Eriksson, Levitt and Scot (2018) are of the view 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. They however, point out that PPPs have potential risks such as loss of control by government, increased costs, political risks, unreliable services, in ability to benefits 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. Baxter (2017) 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. Taylor, Nalamada and Perez (2017) argued 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.

Conditions for the Successful Implementation of PPPs

Key enablers for the successful implementation of public private partnerships, according to the World Bank (2018); Casady and Baxter (2020) are: strong political leadership, favourable policy and effective organisational capacity.

A. Strong Political Leadership support

International Finance Corporation (IFC) (2011) believe that the political leadership should establish a clear, predictable institutional frame work supported by competent and well-resourced authorities. It should ensure public awareness of the relative costs, benefits and risks of PPPs and conventional procurement. In-depth understanding of PPPs requires active consultation and engagement with stakeholders as well as involving users in defining the project and subsequently in monitoring service quality. OECD (2012) asserts that, only if the political level is aware of and accepts the costs and benefits of using PPPs can the issues around PPPs be tackled and balanced appropriately with stability and predictability.

With the changing approaches to management of organisations, large and small, public or private, the political leadership must apply strategic planning and management approaches in order to effectively satisfy the public interest.

According to Pearce and Robinson (2011), the concept of strategic management builds on the definition of strategic planning, recognising that although planning is the prelude of strategic management, it is insufficient if not followed by the development and implementation of the plan and the evaluation of the plan in action.

Therefore, in the public sector, leaders must become strategic thinkers in leading organisation and its culture and changing it when necessary. Bryson (2010) echoed that strategic thinking and strategic leadership are increasingly important to the continued viability and effectiveness of governments, public agencies and non-profit organisations of all sorts. He emphasised that without strategic planning it is unlikely that these organisations will be able to successfully meet the numerous challenges that face them.

Here, strategic leadership is demonstrated by individuals in all areas of the organisational environment who possess skills and qualities to create and communicate vision and effect change through interactive leadership (Mitchel, 2017)

B. Favourable Policy Environment

The government should adopt a series of measures to boost growth including stimulating consumption, further opening up foreign investment, supporting private enterprises and encouraging technological innovation. The policy environment should not be static, but constantly changing in response to changes in the political and economic arenas, to changes in availability and cost of healthcare technologies and the emerging public health issues. Having supportive pro-health policies is integral to the existence of successful health systems and strong PPPs programmes. According to USAID (2017) a supportive or enabling policy environment is defined as one of which:

- Laws and executive orders mandate provision of products and services without imposing undue restrictions on providers or eligibility requirements on clients;
- Government and civil society leaders openly speak in favour of healthcare services and healthy practices;
- Public and private resources are adequate to ensure full population coverage;
- The policy formulation process is characterised by good planning principles and broad participation.

Therefore, in Africa for the political leader to improve efficiency and effectiveness, World Bank (2015) argued that we require:

- ✓ *Updating the legislative framework.* In most countries, legislation governing the civil service dates back several decades. Such legislation in most cases does not provide the civil service with the authority or flexibility to share information or engage with business and the non-profit sector for the co-production of public goods (World Bank 2011).
- ✓ *Reforming organizational structures and processes.* Civil servants operate in very pyramidal public organizations and their work is organized in compartmentalized silos. Procedures and practices are cumbersome and inefficient and do not provide scope for initiative and innovation. Structures and procedures need to be simplified and streamlined to provide civil servants with the ability to network among themselves and with others and to innovate. The main challenge in this respect is striking a balance between offering flexibility and guaranteeing accountability and integrity, particularly in the areas of financial management and procurement.
- ✓ *Promoting the sharing of information.* "Open government" initiatives should be introduced to promote the sharing of information and increase transparency. The sharing of information and knowledge facilitates the involvement of other actors in the delivery of services and also enables civil servants to take advantage of information resources through cloud computing. The creation of common

data platforms to be shared among various agencies would facilitate information exchange and sharing among civil servants.

- ✓ *Modernizing public administration education and training.* Public administration schools and institutes offer a strong curriculum in traditional disciplines, such as political science, economics and social sciences, but are extremely behind in developing newly required competencies and behaviours. Their curricula should also focus on building competencies in collaboration, networking, public-private partnerships and citizen engagement. Competencies in using social networks and current information infrastructure should be embedded in core curricula. The same can be said for pre-service or in-service training programmes offered by civil service schools or training departments.

C. Effective Organisational Capacity

As argued by Grepin (2016) the complexity of public private partnerships require a number of capacities in government both in terms of skills, institutional structures and legal framework. There should be a robust system of assessing value for money using a prudent public sector comparator, transparent and constant guidelines regarding non-quantifiable elements in the value for money judgements. It also involves being able to classify, measure and contractually allocate risk to the party best able to manage it and the ability to monitor the public private partnerships contract through its life.

Capacity is a set of attributes that help or enable an organisation to fulfil its missions (RAND SAATCH Institute, 2018). Capacity is understood differently across sectors and organisations, as different sectors are driven by differing sets of incentives, while the private sector companies typically aim to generate and increase profit, public sector organisations tend to prioritise public service delivery and efficiency. Centre for Diseases Control (2017) listed five major components of capacity: resources, organisational factors such as effective leadership, external helping networks, specialised skills to undertake development projects and political resources.

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.

Conclusion

Healthcare scholars like Hanlon and Hellowell (2020) believe that drawing on private sector resources and capacity is critical because in almost all countries, and especially in low- and middle- income countries (LMICs), the private health sector provides a significant proportion of essential health services and products to the population. Research by Glassman, Chalkidou and Sullivan (2020) shows that the private sector is the dominant source of treatment for children with fever or cough in a sample of 70 LMICs. New research commissioned by WHO in 2019 showed that the private sector provides nearly 40 per cent of health care across the majority of WHO regions and provides 62 per cent of health care in the EMRO region.

In the current global context, as observed by Clarke and Hellowell (2020) the pandemic is simply overwhelming public health systems, and turning to the private sector for additional capacity has become an important part of the campaign to save lives. Owing to increasingly shrinking fiscal space most countries are turning to PPPs in various sectors as well as the health care sector (Asogwa & Odozibodo, 2016). 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 Mutopo, 2017). 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 which Sajani and Aktaruzzaman (2014) described as a 'black box". There is need for further research on what governance model of PPPs is conducive for a sustainable healthcare financing in Zimbabwe. As such, this is an area which needs to be critically considered before large scale PPPs can be ventured into.

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