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ABSTRACT

Many people in developing countries are exposed at a greater risk to access essential healthcare services. According to the World Health Organization (WHO) and the World Bank, 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 partnerships (PPP) approach to achieve Universal Healthcare Coverage (UHC) and therefore ensuring healthy lives and promoting well-being for all at all ages. A number of publications have raised the importance of institutions for effectiveness of PPP. Very few have raised influential requirements to examine the effectiveness of PPP considering to SSA's socio-economic specific context.

The objective of this paper is to examine the applicable environment for PPP in healthcare systems in SSA and policy implication for Mozambique.

Methodologically, five SSA countries: Cameroon, Democratic Republic of Congo (DRC), Tanzania, South Africa, Rwanda were selected as case studies. By applying both descriptive and data analysis, this paper has observed: (1) a general decrease of resources allocated by respective developing countries in SSA Governments for healthcare services; (2) increasing participation of private sector in healthcare delivery; and (3) the outcomes resulting from the participation of private sector through PPP has been determined by the quality of institutions; however, additional variables such as cultural characteristics, community attributes and physical or material conditions are required in SSA context.

Key-words: *public-private partnerships; private sector, institutions, healthcare services.*

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List of Acronyms and Abbreviations

AAA	Accra Agenda for Action
AAAA	Addis Ababa Action Agenda
CPIA	Country Policy and Institutional Assessment
CSR	Corporate Social Responsibility
DFID	Department for International Development
DP	Development Partners
DRC	Democratic Republic of Congo
EIU	The Economic Intelligence Unit
FDI	Foreign Direct Investment
GDP	Gross Domestic Product
HIV	Human Immunodeficiency Virus
IAD	Institutional Analysis and Development
IMF	International Monetary Fund
MoH	Ministry of Health
NGO	Non-Governmental Organizations
ODA	Official Development Aid
PBF	Performance Based Financing
PFI	Private Financing Initiative
PPP	Public-Private Partnerships
SGD	Sustainable Development Goals
SHOPS	Sustaining Health Outcomes through the Private Sector Plus
SSA	Sub-Saharan Africa
TNVS	Tanzania National Voucher Scheme
UHC	Universal Healthcare Coverage
UNECE	United Nations Economic Commission for Europe
USAID	United States Agency for International Development
WHO	World Health Organization

CHAPTER I – INTRODUCTION

Patterns of delivering goods and services have been changing as result of increasing private sector development and Government failure to provide some services. Amid this reality, the current trend has been to integrate the private sector to support Government's gap. This collaboration is broadly known as Public-Private Partnerships (PPP), in which both parties share responsibilities and principles.

Michael Todaro and Stephen Smith in the book 'Economic Development' raise two questions: (1) "what are the sources of economic development and long-term growth?"; (2) "why are the less developed countries poor, and what can they do about it?" Todaro and Smith (2003). To answer the first question, the scholars suggest the reorganization and reorientation of economic by engaging private sector into PPP framework. Likewise, responding to second question, the scholars recommend enhancement of institutional quality as requirement to boost the private sector comparative advantage: program flexibility, delivery of technical capacity, efficacy and efficiency, and risk sharing (Todaro and Smith, 2003, 61-64).

The 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 indorses the need to put into place the empowering institutions, procedures and processes surrounding PPP in order to achieve its comparative advantages. The spurs for choosing PPP have been mentioned by many scholars and in many international events. The Third International Conference on Financing for Development or the so called "*AAAA*" (The Addis Ababa Action Agenda)

held in 2015, pointed out that "both public and private investment have key roles to play in infrastructure financing, including through public private partnerships" (United Nations, 2015, para. 48).

Various theories on PPP advise for harmonization between economic reasonableness, regulation how can public sector intervene in this framework. However, harmonization implies a set of conditions, including regulatory framework, institutional framework, operational maturity, and investment climate, financing and subnational adjustment (EIU, 2015).

Global support for PPP in infrastructure including in healthcare services seems stronger than ever before and has been transformational (Leigland, 2018). Many developing countries have been choosing PPP as solution for their health systems. 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 in developing countries households do not have sufficient income to pay for healthcare services and Governments are challenging to achieve UHC goals (Sachs, 2012).

In 2015, the United Nations under Sustainable Development Goals (SDG) has identified UHC as the main vehicle for ensuring healthy lives and promoting healthcare services since it is a better framework to guarantee financial protection of health users from hardship including possible impoverishment due to out-of-pocket payments (World Health Organization and World Bank, 2017). However, the achievement of UHC goals, require economic and socio-economic and institutional conditions. The "Africa's Pulse" an annual

report of the World Bank Group examining different socio-economic aspects in Africa, makes it clear that there are causal relationship between levels of Governance in order to achieve PPP effectiveness in SSA (World Bank Group, 2017).

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. This document stresses out the importance of cooperation between private and public sectors to meet the health-related indicators, as mechanism to target the UHC (UN General Assembly, 2015, p. 16)[1]

Nevertheless, this research has noted the outcome resulting from the participation of private sector in improvement in each country is determined not only to biophysical and material conditions, but also by the quality of institutions.

The final goal of this research is to make a contribution of developing countries institutions in managing PPP in healthcare, and further examining of lessons and implications for Mozambique.

1. Research Question

Notwithstanding the aforementioned rationality behind PPP in general and in particular in health sector, this research 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 private sector for a betterment of respective healthcare systems, the effectiveness vary from country to country.

[1] Ibid.

First, this paper observed that most of literature emphasizes the role of institutions for the competitiveness of PPP. However, most of those researches on institution effectiveness have been done in developed world where possibly economic conditions are more relevant than institutions. Secondly, a number of literature addressing healthcare issues in SSA examines the impact of private sector in improving the healthcare Governance; not the opposite. Based on aforementioned indications, this paper attempts to look for answers to the following question:

To what extent institutions are relevant for the effectiveness of PPP in healthcare in SSA countries? Are institutions the most important requisite for effectiveness? Is there an universal model?

2. Objective of Research

The main aim of this paper is to make a critical study of relevant PPP in healthcare industry in SSA countries and assess the conditions of its effectiveness, and policy implications for Mozambique.

3. Hypothesis

H_0 (causal hypothesis): Institutions and Good Governance are key determinants for effectiveness of PPP in healthcare in SSA; and

H_1 (relational hypothesis): PPP in healthcare improves the accessibility for healthcare delivery health-related indicators in SSA.

4. Research Methodology

4-1. Descriptive analysis

This research is founded in healthcare PPP literature by focusing selected cases in SSA: Cameroon, Democratic Republic of Congo (DRC), Tanzania, South Africa, Rwanda, and Mozambique (policy-targeted country). The criteria of case studies selection were as follows: (1) current trend suggests that most of PPP projects have been implemented in developing countries with the focus on two regions namely SSA and South Asia; (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 scarcity of data in some selected cases, this paper may refer different timeline to guarantee the efficacy of the research.

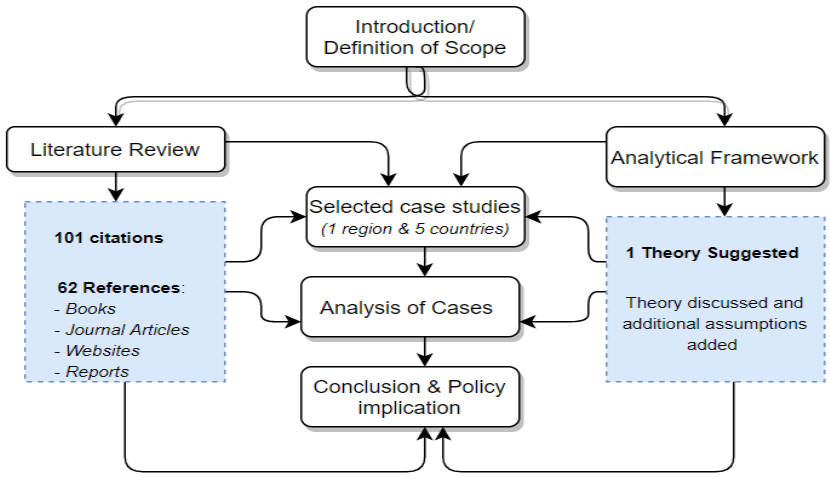
4-2. Numerical Analysis

Data to illustrate the SSA countries and selected countries' expenditure in healthcare system was tracked from WHO's Global Health Expenditure Database and Word Bank Development Indicators. Data regarding the environment for PPP in SSA was tracked from the Economic Intelligence Unit (EIU) and the World Bank Database. World Governance Indicators were used to measure the profile of institutions. Some other data illustrations was brought from the literature this paper has reviewed.

4-4. Systematic Analytical Process

This research is guided by following systematic analytical process (see figure 2).

Figure 1: Systematic Analytical Process.



Source: Author

5. Problems and Limitations

Fabre and Straub in their publication "The Economic Impact of Public Private Partnerships (PPPs) in Infrastructure, Health and Education" have stated that "the literature covering PPP in the healthcare sector is very scarce and of relatively poor quality" (Fabre and Straub, 2019, p. 49). This dissertation will sometimes refer to less rigorous studies but will take care to underline their limitations.

CHAPTER II: LITERATURE REVIEW

1. Definition of Concepts

1-1. Public-Private Partnerships

There is no single, universally categorical definition of PPP. It seems to be depending on economic systems of countries, and also on 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 to the purpose of this research. The definition brought by Reich (2002) from Harvard University, in his article 'Public-Private Partnerships for Public Health' describes PPP as an agreement connecting one private for-profit organization and one public or non-profit organization that have 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 common objective of improving healthcare for populations based on mutually agreed responsibilities and values (Kickbusch and Quick, 1998) while maintaining balance of power between the involved actors in the process (Buse and Walt, 2000).

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

1-1-1. Why PPP in Healthcare Systems?

The collective reason for engagement in a PPP is financial (Kosycarz et al., 2019). Also, many healthcare systems have been facing burdens related to an aggregate aging population, chronic diseases and shortage in curative treatment (Irina et al., 2006).

The shortage of funds that characterize developing countries have pushed them to incorporate in their health systems both private (profit and not-profit) and public sector for provision of health goods and services. A Report of World Bank points out however, that in developing countries, including in SSA, PPP has been playing a relatively small role in infrastructure (including in healthcare infrastructure), ranging only between 15% to 20% (Independent Evaluation Group, 2014). PPP in developing world, especially in SSA PPP in healthcare services have 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).

Nonetheless, the role of PPP in healthcare in SSA is unquestionable. It has been playing a useful and sustainable role for establishment of UHC in many countries. PPP in healthcare in this group of countries offer a supreme chance to do well, while performance good (International Finance Corporation, 2011). Nevertheless, some scholars are skeptical on the impact of relatively small predominant PPP in developing countries. They consider that only big PPP in healthcare bring development results to the developing countries. The small PPP do not provide the poor with adequate or sufficient and affordable access to

facilities (Estache and Philippe, 2012). This paper examines the reason why some PPP in healthcare are not translating into development in developing countries particularly in SSA.

1-1-2. Prerequisites for PPP in Healthcare Systems

The background to analyzing environment for PPP are very broad and differ according to the field and location. Casady et al. (2018) understands that in general, PPP in require the backing of regulatory quality, market consistency, socio-political will and 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 are not self-administering, but they require a strong and competent government to manage it and restructure policy-making processes capable to adjust into the existing institutional framework (Kettl, 2011; Teisman, 2002). Casedy et al (2018) when examining the PPP effectiveness in England stressed that an effective PPP has to meet five variables of governance arrangements, namely: institutional cooperation, long-term infrastructure contracts, public policy networks, urban and downtown economic development, and civil society/community development.

Depending on approaches and field of study, one can use Good Governance Indicators the World Bank Group to analyze the environment. Other studies have emphasized the transparency, accountability, and corruption in the public sector (CPIA) index to study 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 filed, location and circumstances.

This paper found the research 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 SSA. Six variables: regulatory framework, institutional framework, operational maturity, and 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 cases, this paper has found that 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.

1-2. Theoretical Background

1-3. Institutional Analysis Approach

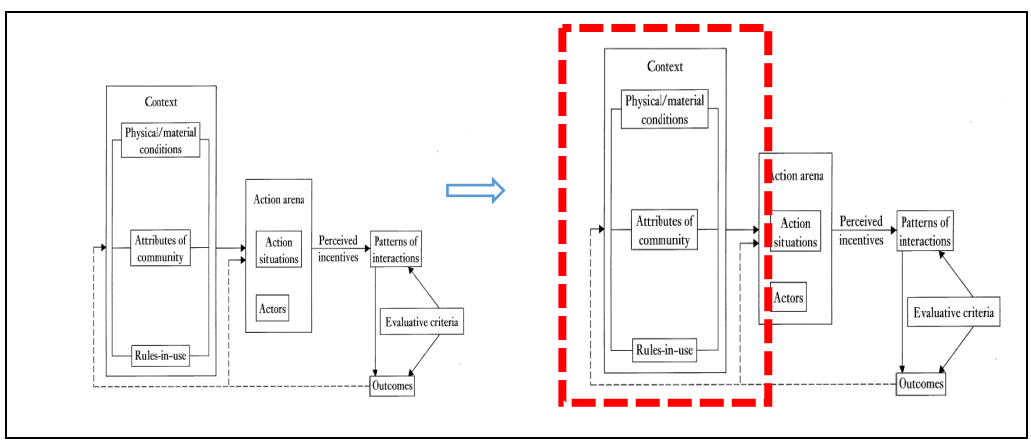
In order to define how the PPP in SSA's healthcare systems can be made more adequate, effective and sustainable, this research relies on institutional analysis approach also known as Institutional Analysis and Development (IAD) framework.

IAD framework was developed in 2009 by Elinor Ostrom – an American political scientist. Ostrom's thesis which was awarded 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.

IAD framework consider 7 principles 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 the theory, because PPP activities fit within the collective action for the delivery of communal facilities, in this case healthcare services or "the commons". Also, the IAD framework explains how institutional incentives affect social infrastructure in developing countries.

Figure 2: Ostrom's Institutional Analysis Development Framework.



Source: Ostrom (2010)

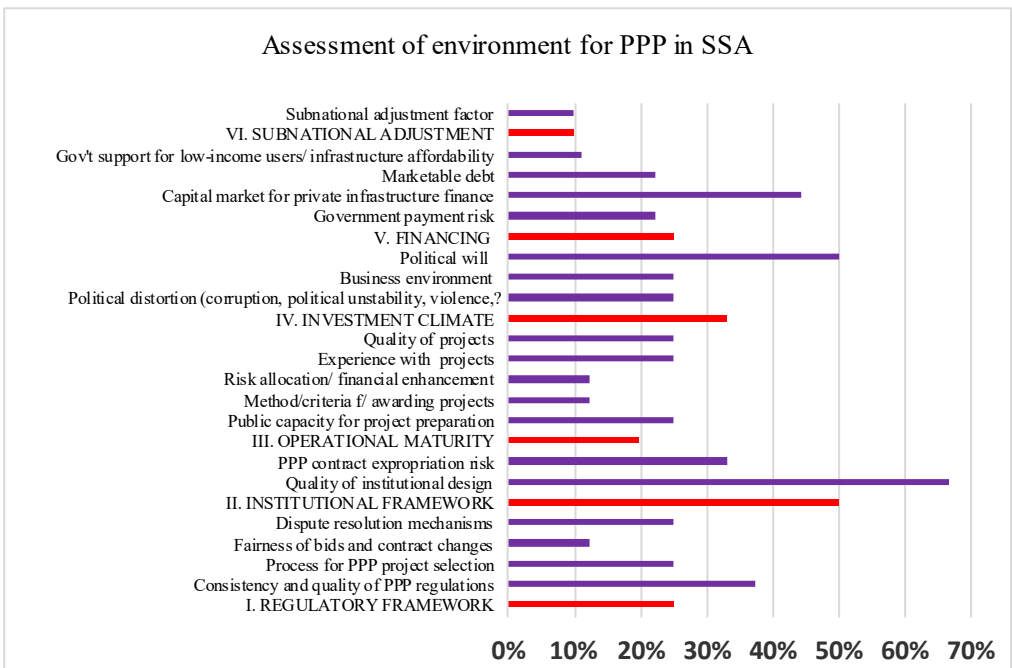
Deriving from the IAD framework, this paper focus on 'context and attributes of community' which is translated as necessary socio-economic conditions to design and implement the PPP collaboration in healthcare services and the linkage between this and the 'rules-in-use', such as healthcare Governance 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; and different ‘action situations’ such as specific projects comprising PPP in healthcare.

CHAPTER III: THE ENVIRONMENT FOR PUBLIC-PRIVATE PARTNERSHIPS IN SUB-SAHARAN AFRICA

Nowadays, SSA region has been one of the attraction and destination for foreign investments that even contribute for the growth of local private sector. In this regard, SSA countries have seen this as 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 PPP specific laws or frameworks. PPP are on the national plans of African legislators, and various countries have been passing innovative rules, policies and regulations in order to comfort up its implementation.

Figure 3: Assessment of Environment for PPP in SSA.

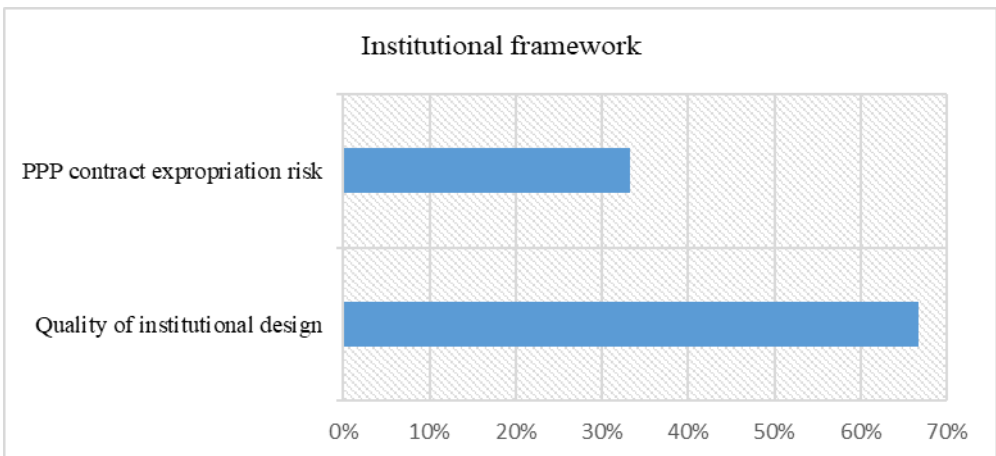


Source: EIU Dataset (2015)

The figure 3 shows the profile of different necessary variables necessary for a sound environment for PPP in SSA in six components: regulatory framework, institutional framework, operational maturity, and investment climate, financing and subnational adjustment. These components represent the average of fifteen countries in SSA, almost a half. All variables figure out a different degree.

The best position belongs to institutional framework (50%) in detailed terms. This means that generally, SSA region has, in theory, reasonable institutional design to attract the private sector for PPP arrangements. But the report of the EIU (2015) found out that there are ruptures or variations of PPP laws in different sectors.

Figure 4: Institutional Framework Profile in SSA.

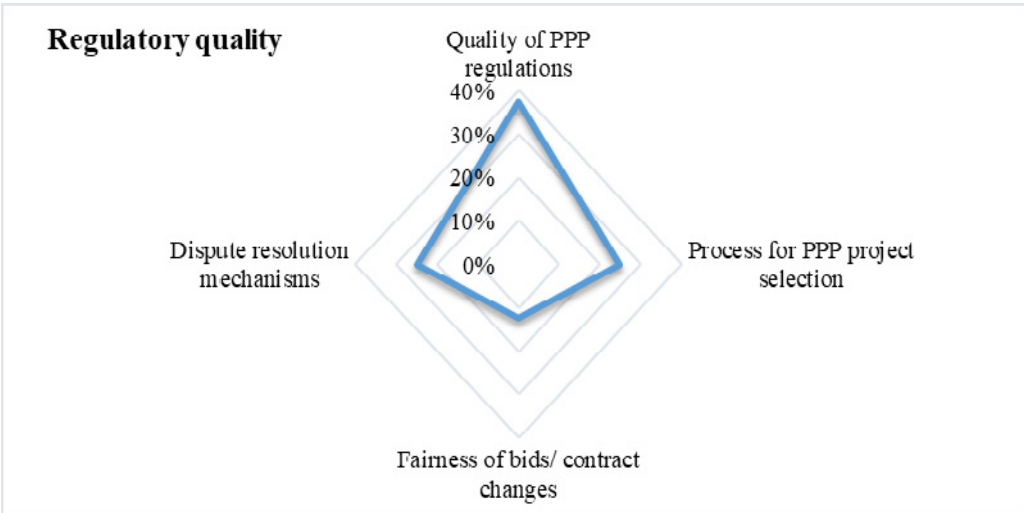


Source: EIU Dataset (2015)

Institutional structure is similarly affected by regulatory quality which ranks in average only 25%, mostly because although the quality of regulations is relatively satisfactory, this component is undermined by poor decision making on projects selection,

unfairness of bids and contract modifications - the most critical point of PPP arrangements in SSA, along with poor dispute resolution mechanisms.

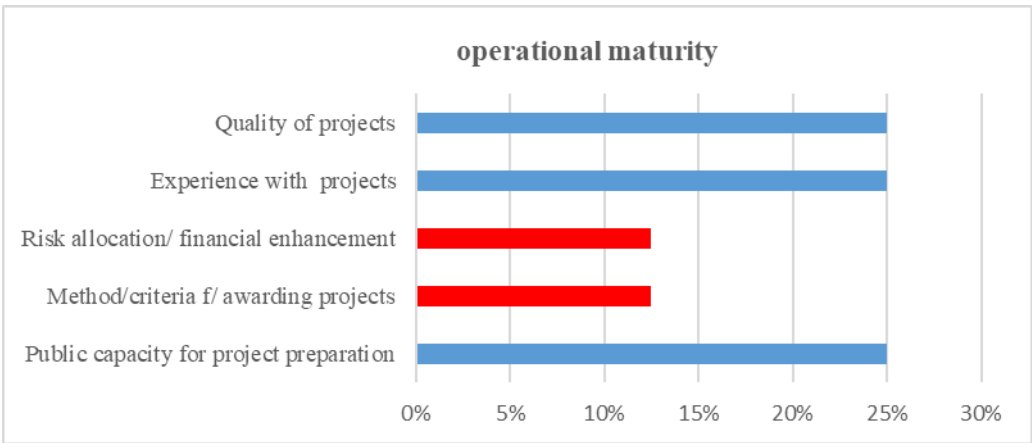
Figure 5: Regulatory Quality Performance in SSA.



Source: EIU Dataset (2015)

Another bottleneck affecting PPP formation in SSA is operational maturity. 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 disparities is explained by sectoral experience. For example, some countries have PPP experience in transportation and water supply, but no experience in healthcare or electricity. As 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.

Figure 6: SSA Experience with PPP Projects.



Source: EIU Dataset (2015)

Political distortion also impedes PPP implementation and investment climate. The general business environment reforms made by many SSA countries in the last decade have influenced a 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 remain a challenge. Among the three indicators measured in this category (political will, business environment 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, p. 18).

Other relevant component for PPP are financial institutions. With exception of South Africa, many SSA countries perform very low quality of financial institutions, since "local markets for private infrastructure finance are slowly developing in the remaining countries, but hedging instruments are less robust, and there is a heavy reliance on external funding" (EIU 2015, p. 20). As result, one of the challenges is that the disbursement factor has been influencing the concerns of PPP environment due to the poor ability of potential consumers to afford the services offered under PPP.

The last component is subnational adjustment. Although PPP is generally administratively centralized, almost all SSA countries have sub-systems of PPP at province, district and municipality levels. Nevertheless, the capacity to manage PPP at subnational levels is lower compared to national level. The levels of difference between locally implemented PPP and national one is determined by political system and its administrative division. The EIU (2015) stats however that in some countries where PPP is a centralized, it has helped to improve harmonization and efficiency as well as a strong decision-making process. Nevertheless, centralized approach had 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.

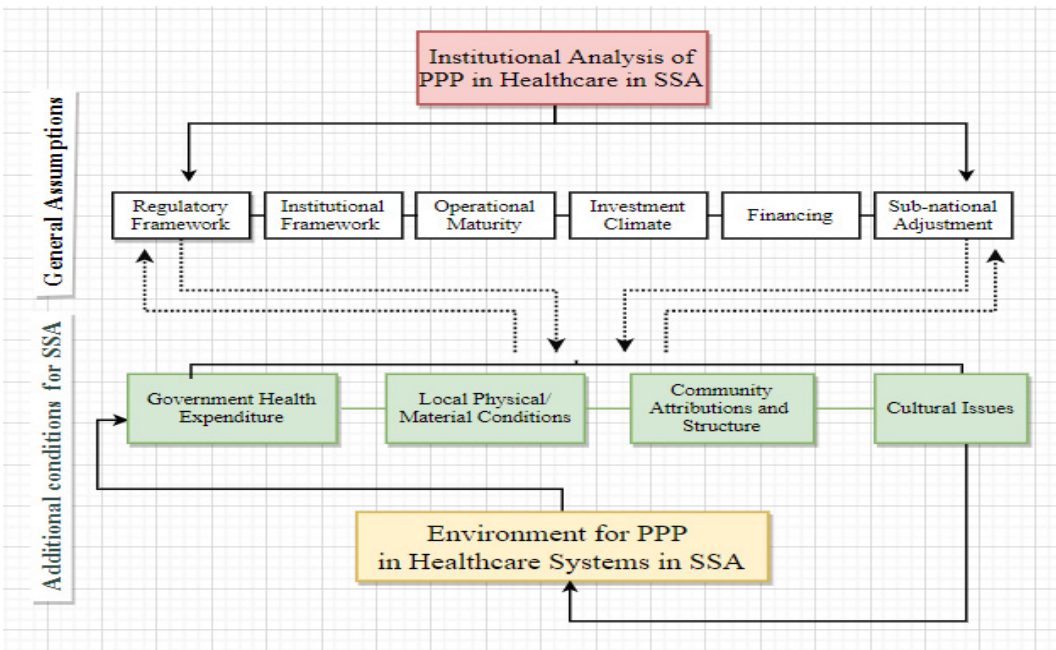
1. Additional Conditions for PPP in SSA

Ostrom (1999) stress out the role of institutions as key factor for development. Todaro and Smith (2003) emphasized the role of cooperation between public and private sector (PPP arrangements) to boost economic development. The EIU Report

has emphasized six elements which are important for a sound PPP: regulatory framework, institutional framework, operational maturity, investment climate, financing and subnational adjustment (EIU, 2015). Nevertheless, this research 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 SSA context: Government expenditure in healthcare services, local physical and material conditions, community attributions and cultural issues (see figure 7).

Figure 7: Additional Conditions for PPP in SSA.



Source: Author

Analyzing Government expenditure in healthcare services is important because there is a relationship between external funds 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 low income countries (Farag et al., 2009). Well, most of private sector in SSA result from ODA (which in many cases is channeled through NGO operating in health sector).

Furthermore, SSA region has unfavorable physical conditions to attract PPP in healthcare or make it effective. 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 (EIU, 2015; Lynch et al., 2000).

Another component to consider when addressing healthcare issues in SSA are 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 those it determines the capacity of community to afford and utilize services locally provided within a PPP arrangement.

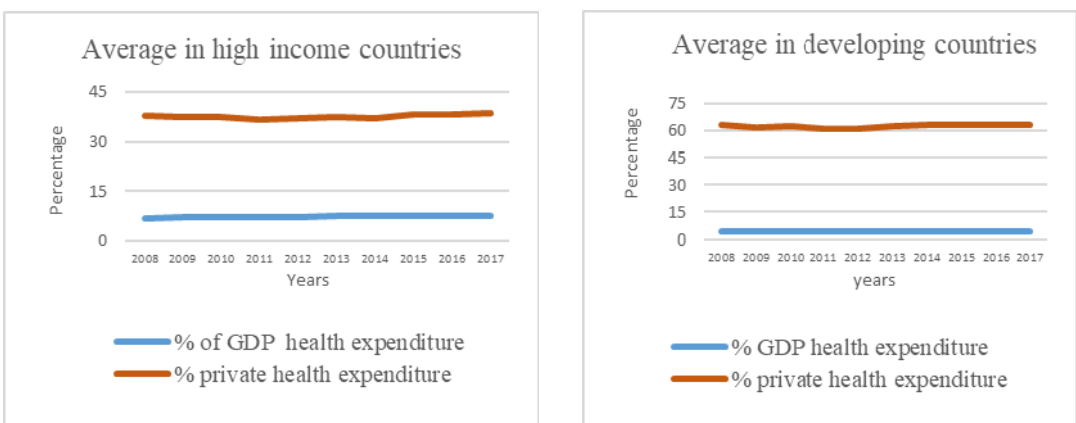
Lastly, culture and culture are determinants in this discussion. SSA communities has large reliance on traditional medicine and other beliefs that have impact on favoring conventional medicine. This fact also directs the impact for effectiveness of healthcare products delivered within a PPP framework.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

In conclusion, while examining selected cases, this research integrates the general assumptions and additional conditions for PPP in healthcare in SSA.

2. Case Studies of PPP on Healthcare Systems in SSA

The recent rise of PPP in healthcare systems in developing countries has been moved explicitly by two reasons: (1) need for improvement of healthcare delivery services and (2) reduction of Government 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 challenges for healthcare services in SSA. In developing countries the contribution of respective Governments for healthcare is very low compared to the group of advanced economies (see figure 8).

Figure 8: Comparative Health Expenditure between Developed and Developing Economies.



Source: World Bank Development Indicators

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 developing countries have relied their health systems to private sector through PPP arrangements. More than 60% of healthcare services are carry out by NGO or lucrative private health deliverers, while in developed countries the participation of private sector is less than 40%.

The private sector operation, including the non-profit entities has eased the healthcare services in the region, with the emphasis on access to the primary healthcare services. Conversely, the general environment for PPP and additional specific factors for SSA have been shaping the quality of PPP in local healthcare systems and its outcomes, as we try to demonstrate by following case studies.

2-1. South Africa

With the GDP of more than U$ 349.6 billion as of 2018, South Africa is the second largest African 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 SSA countries, South African Government can only spend less than 5% of GDP in financing healthcare services, which still higher for SSA average. As result more 40% of these services are covered by 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 creation of 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 African countries, including high level of technical assistance (Whyle and Olivier, 2016). South Africa is the single country in SSA 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, p. 10).

These elements has enabled the country to engage 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 in "medical services in hospitals, clinics and through private physicians, but also included medical services contracted out to mining companies and NGO" (Whyle and Olivier, 2016, p. 1520).

Several literature reports the strength of financial sector in South Africa, enabling environment for *co-location*[2] 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 a primary healthcare. PPP in 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 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 public entity, until Government decided to privatize in order to attract 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,

[2] Co-location is a long term partnership through which a portion of a Government health facility is granted for use by a private entity, in profit for payment and specified benefits to the public party.

maintenance, management services, and technology. The public party pays for the services provided.

Corporate social responsibility (CSR) is another initiative that delivers opportunity to strengthen the PPP in healthcare services in South Africa. The most comprehensive example of CSR in healthcare can be found on mobile monitoring and reporting system. The mobile network operator, Vodacom, in collaboration with 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 a central database with health-related information at no cost (Kula and Fryatt, 2013).

The environment for PPP in South Africa is overall good and it has been contributing for PPP development (see figure 9).

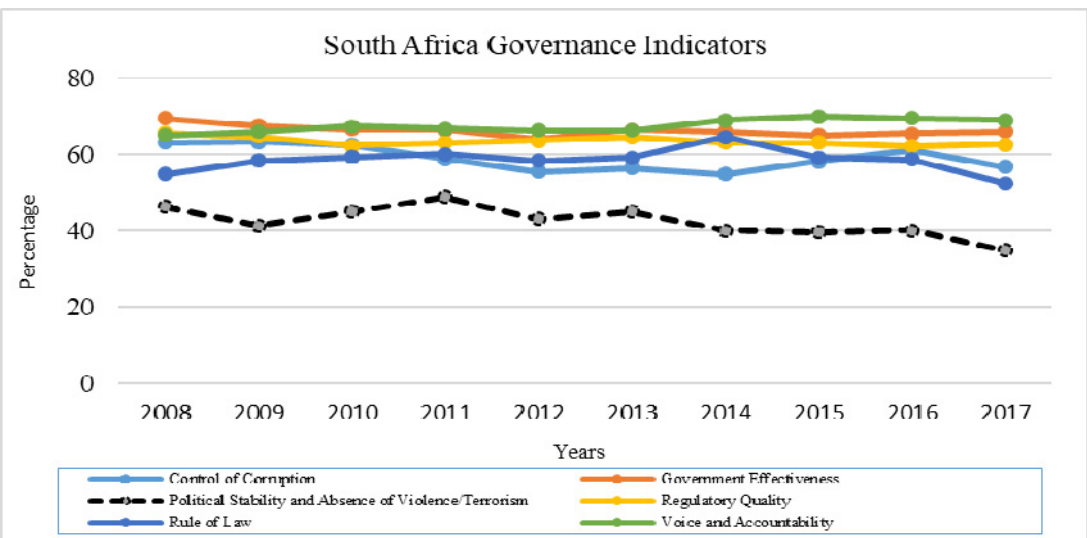
Figure 9: Score of Environment for PPP in South Africa.

	Score
OVERALL SCORE	70.7
1) REGULATORY FRAMEWORK	75.0
2) INSTITUTIONAL FRAMEWORK	75.0
3) OPERATIONAL MATURITY	75.0
4) INVESTMENT CLIMATE	46.4
5) FINANCIAL FACILITIES	91.7
6) SUBNATIONAL ADJUSTMENT	50.0

Source: EIU (2015)

However, the positive explosion of PPP in South African healthcare system has brought some challenges: surge of oligopoly in healthcare market, expensive services and decreasing therefore the public sector's role (Jokozela, 2012). Another challenge for PPP effectiveness is to incorporate the traditional healers in a PPP framework in a country where dominant healthcare system is based on allopathic medicine also considered as 'complementary', 'alternative' or 'non-conventional' medicine (Odeyemi and Bradley, 2018). Political stability and 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 (see figure 10).

Figure 10: South Africa Good Governance Indicators.



Source: Worldwide Governance Indicators

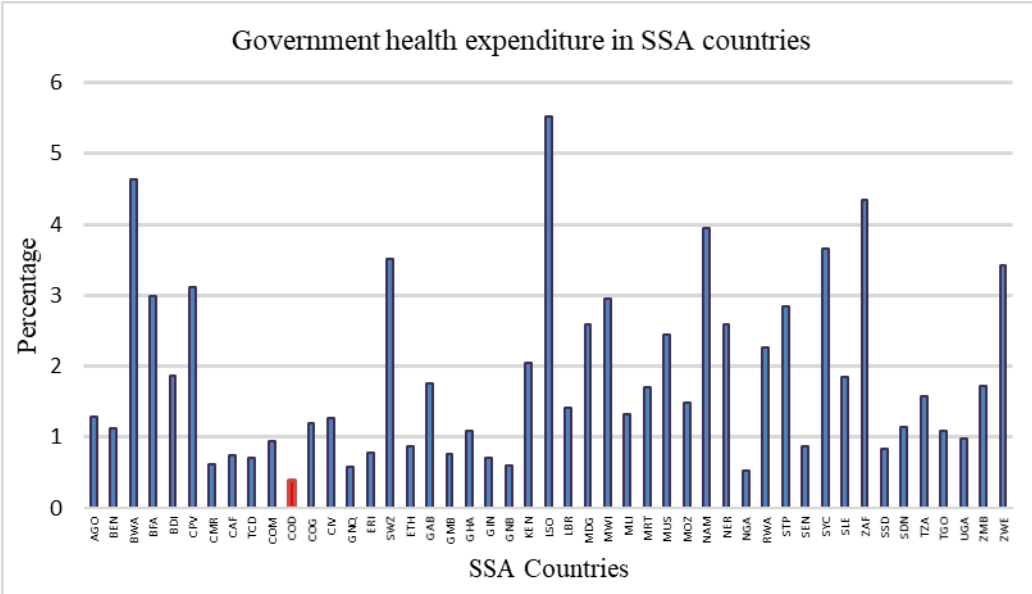
Conclusion

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. As result, all these PPP arrangements have increased and improved the access to healthcare services in the country. However, the integration of all stakeholders in the framework (traditional and conventional), the over privatization and affordability of those services for the users remain a challenge in the country which still struggling to achieve UHC.

2-2. Democratic Republic of Congo

As many SSA countries, DRC Government expenditure in healthcare services is not significant. Located in Central African region, DRC is 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 DRC Government on delivery of healthcare services is recorded as the lowest among SSA countries (1.8%), contributing modestly 0.39% of its GDP in healthcare, as of 2017.

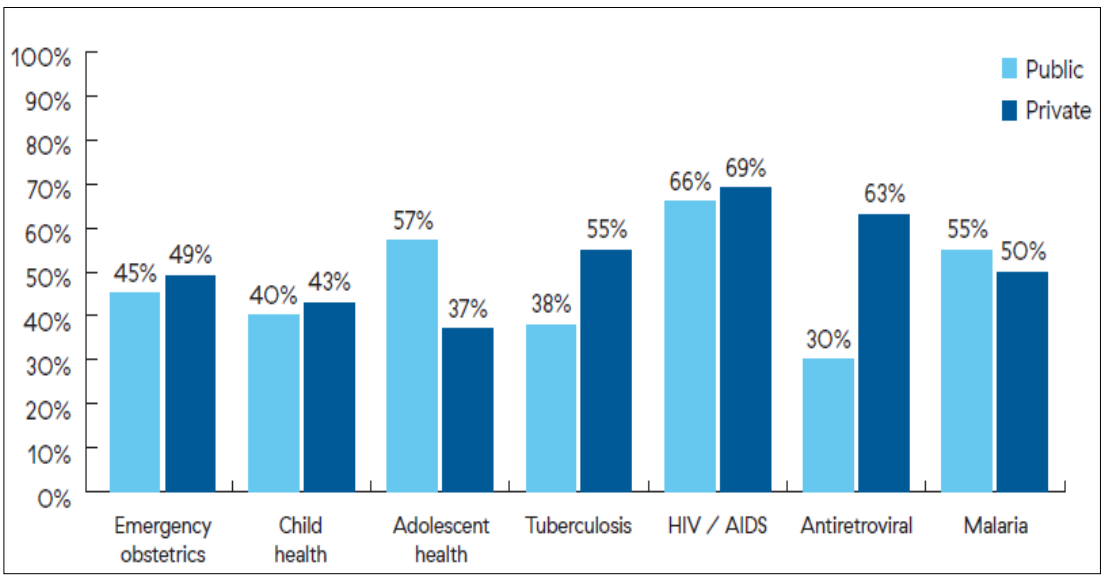
Figure 11: Government Health Expenditure in SSA Countries.



Source: World Development Indicators.

This figure 12 reveals how minor is DRC Government investment in healthcare services. This fact has open the opportunity to a more privatized-prone healthcare services to serve the more than 80 million inhabitants. A research done by the Sustaining Health Outcomes through the Private Sector Plus (SHOPS) - a project designed by local Government and development partners (DP) to strengthen the 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 Government (SHOPS, 2019).

Figure 12: Share of Healthcare Programs between Public and Private Entities.



Source: Ministère de la Santé Publique (2014)

Amid the Government efforts to strengthen healthcare PPP in terms of institutional and regulatory frameworks, many legislation for improvement of outcomes of healthcare delivery have 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 (MoH) regulations and misunderstanding about which directorate or division to consult (SHOPS, 2019).

Nevertheless, the root of DRC 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, p.1). In fact, the 2019 Doing Business Report

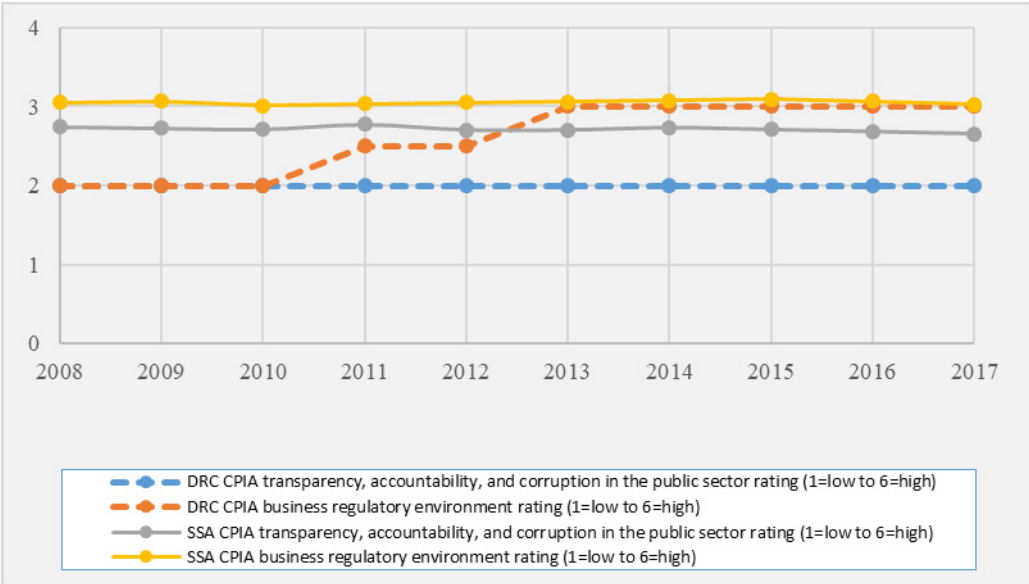
ranks the country the 183th out of 190 countries (World Bank, 2019)[3]. In other words, DRC has very little experience in managing PPP projects, especially in healthcare services delivery. Project selection and awarding criteria is in many cases unclear or unfair and occur in a very informal way and sometimes with no framework regulating it (EIU, 2015).

Financial institutions performance in DRC is largely poor and it hinders the healthcare private operators to access 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 (export.gov, 2017)[4].

Finally, the general weakness of operational maturity, financial incapacity, political instability in Eastern provinces of the country, combined with poor Good Governance indicators such as high level of corruption have generated many "private facilities largely operating independently and often lack training, qualified personnel, equipment, supplies, salaries, or incentives to provide quality services" (SHOPS, 2019, p. 7).

[3] https://www.doingbusiness.org/content/dam/doingBusiness/media/Profiles/Regional/DB2020/SSA.pdf, [accessed on August 25, 2020].
[4] Export.gov. (2017). Congo (DR) - Executive summary. Retrieved from: https://www.export.gov/article?id=Congo-Democratic-Republic-Executive-Summary, [accessed on August 22, 2020].

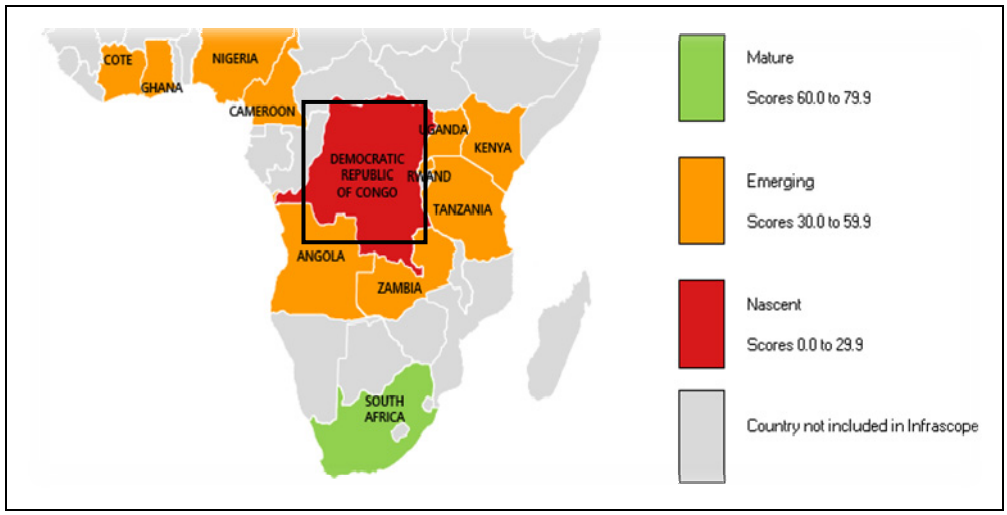
Figure 13: Comparative CPIA Scores in SSA and DRC.



Source: World Bank Development Indicators

Many studies have recognized the role of foreign direct investment (FDI) in boosting the private sector, especially in SSA. However, the drivers for FDI in DRC are very insignificant. The figure 13 displays DRC's transparency, accountability, and corruption in the public sector (CPIA) score has been constant (2 out of 6) between 2010 and 2017, which is below the regional score. 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, road infrastructure and so on, undermine all the efforts for PPP. These and other reasons make DRC capability to design and implement PPP projects to be classified by the EIU 2015 Report as "nascent" (see figure 14).

Figure 14: DRC's Score on Environment for PPP in SSA.



Source: EIU (2015)

The literature this paper has reviewed could not find any sound PPP in healthcare services in DRC. Some initiatives such as results based financing or simply performance based financing (PBF)[5] had been introduced from various different DP led by Department for International Development (DFID) endorsed by the MoH. Nevertheless, a study carried out by Maini et al. (2018) when analyzing the impact of PBF initiative on salary of health workers in DRC has concluded that the initiative could not work because large part of the public officials do not even have salary.

Shockingly, the WHO's Global Expenditure Database[6] – a framework data tool regarding country reforms to make progress towards UHC has reported "no existence" of insurance schemes, such as compulsory medical saving account, compulsory private

[5] The PBF is a healthcare result-based financial incentive and performance rewards that is intended to contribute to improvement of public or private health provider in order to deliver an improved operational quality of healthcare services.
[6] WHO's Global Expenditure Database: https://apps.who.int/nha/database/Select/Indicators/en, [accessed on August 20, 2020].

insurance schemes, social health insurance schemes, compulsory contributory health insurance schemes. Social insurance contributions and social insurance contributions from employers exist since 2011 but it has been difficult to get the detailed information.

All this policy gap has pushed Congolese health users to the one of largest household's out-of-pocket payments for healthcare services enlarging therefore their exposure from all health risks. The International Monetary Fund (IMF) 2019 Country Report[7] recognize that the regulatory environment has been improving in the last decade, however there are gaps between regulation and implementation including embedded vested interests among stakeholders.

Conclusion

Poor institutional performance has impacted negatively the efforts to establish a collaboration between public and private sector. Not only institutional quality undermine the environment for PPP in healthcare. Socio-economic conditions are also inappropriate. In order to attract the private operators, Congolese Government has seen DP as key stakeholders to support the regulation of private healthcare operators in the country. However, this effort has been confronted with conflict of interest, since most of the private healthcare entities are owned by public officers.

From the time when DRC is incapable to push the private sector in line with national healthcare goals, it is even more difficult is to address UHC in terms of insurance

[7] International Monetary Fund (2019). *Democratic Republic of the Congo; Staff-Monitored Program and Request for Disbursement Under the Rapid Credit Facility; Press Release; Staff Report; and Statement by the Executive Director for the Dem,* IMF Staff Country Reports 19/388, International Monetary Fund.

schemes. Although health insurance schemes are documented in national strategic plans, none insurance scheme has been translated to practice. As a result, the health users, particularly those who face financial hardship have to battle to get a single primary health treatment.

2-3. Tanzania

Three events have influenced the set on process to the private sector operation in Tanzania, namely the (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 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, p. 9).

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 the economic development of the country. Thanks to this fact, Tanzania (along with Benin), shifted in 2019, from lower-income status to low-middle income economy.[8] 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

[8] https://blogs.worldbank.org/opendata/new-world-bank-country-classifications-income-level-2020-2021, [accessed on September 7, 2020].

quality and local adjustment (EIU, 2015). However, other components such as operational maturity and financial facilities have remained a challenge, as stated on the report. “Key challenges to be overcome include lack of capacity and experience in Government. In addition, risk-sharing mechanisms between public and private sectors need to be improved…” (EIU, 2015, p. 39). White et al. (2013) in their publication “the role health sector assessment: strengthening health outcomes through the private sector project”, stress out that there have been some developments in PPP in Tanzania, however 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 subnational level. The study found out that large number of NGO, 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 RCH S 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.
PFP and PNFP providers	None	Informal arrangements for assistance when a public facility runs out-of-stock such as for syringes, gloves, etc. Such assistance is usually free of charge but at times a replacement has to be sent at a later stage. Some private providers receive reagents for Voluntary Counselling and Testing (VCT) services.
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 RCH S 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. RCH S are provided as per government guidelines.
Traditional Birth Attendant (TBAs)	None	There are some of facilities that have introduced incentives for TBAs who facilitate referrals of pregnant mothers for facility delivery.
NGOs/ Private company	MoU	Partnership with NGOs (at local or national levels) in construction of staff houses, renovation of facilities, sexual and reproductive health initiatives, and HIV/AIDS prevention care and treatment initiatives.
Parastatal-based facilities	None	Parastatal-based facilities now operating like public facilities. Initially they had their own arrangements managed through their respective Ministerial headquarters.
Research Institute	MoU	Research project-oriented collaborations. The partnership is initiated at a time when the project is commissioned, and ends at the end of the project. It may involve construction and renovation of buildings, operating, and then transfer.
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.

Source: Kamugumya and Olivier (2016).

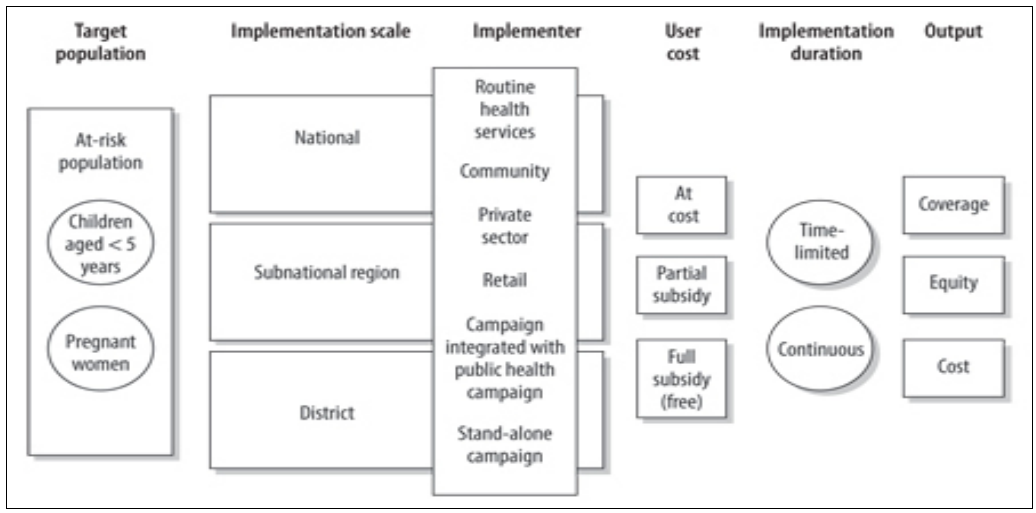
Even within this reality, private entities are still the main healthcare providers especially in rural areas of Tanzania. However, due to poor subnational regulation gaps, the operation of these PPP collaboration is almost informal, lacking of criteria, accountability and consequently making it difficult 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.

Tanzanian society is largely influenced by *ujamaa* principles which are founded on "eradication of racism, restore the attitudes of brotherhood, and of sharing and cooperation, and to protect the freedom of independence of Tanzania through self-reliance" (Cornelli, 2012, p. 78). This paper adds tolerance spirit as one of *ujamaa* principles. These values are sometimes related to "laissez-faire" behavior - abstention by Government from interfering in market business. This might be the reason why many of private healthcare deliverers found in the system a fertile environment to operate out of Government regulation.

Notwithstanding this apparent disorder mainly at subnational level, 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 DFID managed by the local MoH with the objective 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 direct outcome it "achieved universal coverage and equity and continuous protection of the vulnerable populations" (Kramer et al., 2017, p.1).

Figure 15: Characteristic Flux of Voucher Scheme Program Involving PPP in Tanzania[9].



Source: Willey et al. (2012)

However, Fabre and Straub (2019) in a study analyzing the healthcare PPP in developing countries, including 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 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 achieved its goal of distributing two million nets in 2013, but was defunded in 2014 after reports of provider fraud" (PMI, 2017, p. 44).

[9] The figure was extracted in a study conducted with 12 African countries, including Tanzania where voucher schemes under DFID funds for fighting malaria programs were introduced.

Conclusion

Healthcare PPP in Tanzania is largely operated by non-profit private sector which mostly collaborates in an informal consensus with public sector, especially at 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.

2-4. Cameroon

Cameroon has an estimated population of 24.5 million as of 2017. With GDP per capita of around 1.5 thousand dollars as of 2018. Cameroon's Human Development Index scores have worsened in the past two decades, including the performance in healthcare indicators giving space for a surge private healthcare operators, especially in urban areas (Taptue et al., 2015). As trial to implement the UHC policy in the country, Cameroonian Government in coordination with the DP implemented, between the years 2004 to 2015 the PBF strategy in health sector. However, this project has faced some challenges linked to general institutional setting.

Bertelsmann Stiftung (2020) highlights three variables to examine the current socio-economic status: economic transformation, Governance index; and political transformation. Among the three, the component regarding political transformation (particularly the rule of law and stability of democratic institutions) has the lowest scores. Political transformation index undermine the environment for development of PPP in Cameroonian healthcare system. Das et al. (2008) have well stated that in politically

unstable countries, the quality of healthcare offered to poor patients is very often seriously deficient.

A publication of WHO and Government of Cameroon (2017) has raised the political instability, terrorist attacks by Boko Haram in Far North, a secessionist insurgency in the Anglophone, and deadly epidemics as the bottlenecks and operational challenges for effective implementation of specific health interventions.

The economic performance of Cameroon is generally reasonable. However, Government spend less than 1% of its GDP in healthcare services. This situation pathed a way for private health sector to occupy up to 80% of coverage.

Cameroon has also face challenges regarding health policy decentralization and subnational adjustment. A research prepared by Mba and Ongolo-Zogo points out a "fragmented framework in order to establish standard operating procedures for the management of district resources, the enforcement and measurement of accountability of NGO, civil society organizations" (Mba and Ongolo-Zogo, 2012, p. 7). Gaps derived from regulatory framework and subnational adjustment give space to corruption in many cases resulting from the fragmented norms between national and district levels.

Amid all these challenges and similarly to DRC case, Cameroon encountered a way to UHC by adopting a healthcare PPP based on PBF in three regions, namely East, Littoral, South West and North West. An Agency was designated to design, monitor and evaluate the performance contract.

Despite the Cameroonian Government effort to improve the healthcare services delivery by PPP based BPF, most of private healthcare deliverers did not join the initiative.

Taptue et al. (2015) found out that many of them did not meet criteria of eligibility to join the BPF initiative because lacked an authorization from Government, as fewer than 30% of the private healthcare providers were licensed. However, the project could allow a relative increase of the number of health unities both public and private facilities going for the initiative. The project subscribers have contributed for increase on institutional delivery and maternal and reproductive health services. Different literature point out that have improved many health issues, such as:

- PBF improved the quality of data for monitoring and evaluation;
- PBF improved contracting and regulation of the private sector;
- Improved the quality of healthcare services: technical quality of health cares improved significantly in the three regions; and
- Improved the referral services through monitoring and evaluation meeting with all stakeholders (De Allegri et al., 2018; Taptue et al., 2015).

Conclusion

Cameroon example teaches us that even within institutional challenges something can be done. The PBF healthcare PPP pilot project implemented in three regions is an illustrative example. Nevertheless, the country effort to strengthen the healthcare delivery through PPP initiatives is shaped by government policy, governance, capacities of the stakeholders, socio-economic and political interactions.

2-5. Rwanda

There is no shortage of literature when it comes to Rwanda recent development trends. While at beginning of this research we have emphasized 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 SSA region (IMF, 2017)[10]. One year later, the country was amongst the economies with the major developments in business regulations (World Bank Group, 2017)[11], while at same time show progress on life expectancy at birth from 29 in the genocide year to 68 in 2018. The maternal mortality ratio has fallen from 1,270 per 100,000 live births in the same period (Word Development Indicators).

Unlike the other SSA cases which the gap of Government in financing healthcare services has given space for strong presence of 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) prefer to attribute the success of Rwanda in healthcare services to an innovative policy and the harmony between Government and DP within Government-driven priorities.

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[10] International Monetary Fund (2017). *Rwanda; Staff Report for the 2017 Article IV Consultation, Seventh Review Under the Policy Support Instrument, and Second Review Under the Standby Credit Facility- Press Release; Staff Report; and Sta*, IMF Staff Country Reports 17/217, International Monetary Fund.

[11] World Bank Group (2017). *Doing Business Economy Profile 2017,* World Bank Other Operational Studies 25607, The World Bank.

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 SSA average.

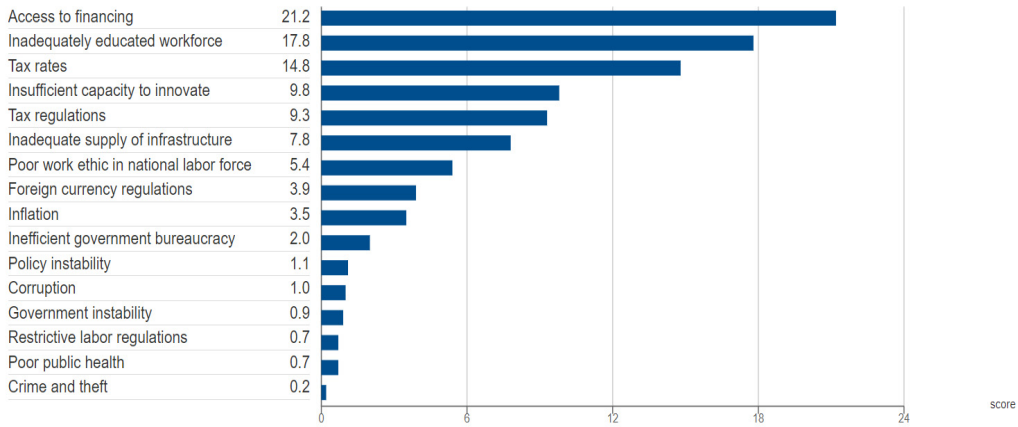
Table 2: Comparative Health Financing Between Rwanda and SSA Average.

	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	% of GDP, Gov't health expenditure	1.7	1.9	1.9	1.9	1.9	1.8	1.7	1.8	1.8	1.9
Rwanda	% private health expenditure	26.8	25.0	23.5	22.4	20.1	21.4	18.2	17.0	15.6	15.3
SSA	% private health expenditure	54.7	53.0	51.6	50.6	50.6	51.6	52.0	52.2	52.9	52.7

Source: World Development Indicators

Despite performing relatively good institutions, the Rwandese economic conditions are not considerably attractive for the private sector. A survey 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, inadequate educated workforce, insufficient capacity to innovate, high tax rates and inadequate infrastructure (World Bank Group, 2017; Government of Rwanda, 2012).

Figure 16: 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)

Poor economic infrastructure especially in rural areas has contributed to concentrate most of healthcare private entities in 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, and the five private insurers cover about 10% of the population" (USAID, 2015, p. 2).

Nonetheless, Rwanda's Good Governance indicators such as of low levels of corruption, accountability Government stability have contributed to achievement of UHC through insurance schemes in more than 90% nationwide – the highest coverage in SSA region. Although largely based in Kigali, the existing PPP in health industry has promoted the current UHC.

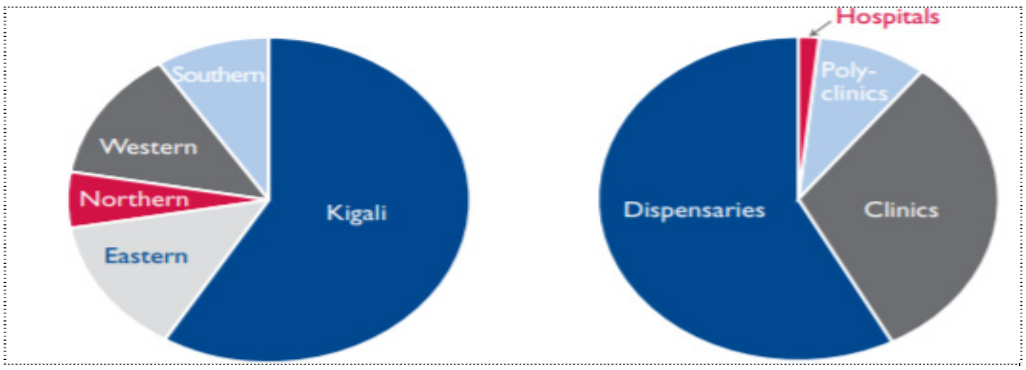
Rwanda introduced and implement successfully the PBF approach for maternal and child health care services is largely conducted by foreign aid, with strong collaboration of DP. By implementing PBF, Rwandese Government and their DP understood that quality of healthcare delivery could be achieved by associating outputs to financial stimuluses. In this regard, "the MoH by introducing PBF had provided clear and explicit norms for quality of care, inspected these and set consequences for compliance (or not) to these norms" (Looij, p. 21), with a strong monitoring and evaluation.

With highly motivated health workers through financial incentives, combined with political will, Rwanda achieved considerable health indicators and almost all health insurance schemes: voluntary health insurance, social health insurances, Government subsidies and so on. Not only political will and financial incentives drove Rwanda health policy to success, but also to more ownership of resources (sustainability), greater performance at community level, including sending money directly from MoH to the health facilities' account in the district and so, local leaders and population could decide on better strategies to maximize the gains.[12]

Although in small scale, most of healthcare PPP are located in capital city because of poor socio-economic conditions at the district level. Similarly, most of the healthcare private operators serve as dispensaries (where patients get medicines and drugs) and clinics, but even those services are largely located in Kigali.

[12] National diffusion of a policy: the experience of Rwanda with exploiting, extending, and sustaining Performance-Based Financing for better health out-comes (2005–2015). Research report, Rwanda. The University of Rwanda, College of Medicine and Health Sciences, School of Public Health, November 2015.

Figure 17: Geographic Distribution of Private Health Sector/ Private Health Sector by Facility Type.



Source: USAID (2015)

The most sound PPP is One Family Health social franchise model[13], which has created 92 private health posts in the country, as of 2014. However and again, the socio-economic conditions, it experienced inconsistent payments and incomplete fulfillment of the terms of the PPP in some districts, operational immaturity, including poor capacity for document preparation (USAID, 2015; Byomuhangi, 2019).

Conclusion

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 in Rwanda. Likewise, the fact the country is a relatively small monoculture with a population that speaks the same language, almost same religion (70%

[13] Social franchise model is an authorization granted by a government to a private entity enabling them to carry out specified commercial activities, in this case, healthcare services.

of its population are catholic Christians), and the recent memories of genocide may have helped them to embrace a healthy healthcare system with more determination.

3. Comparative Table of Case Studies

The table below shows that South Africa offers better environment for PPP, which is higher than the SSA's average, followed by Rwanda. Tanzania shows a steady growing environment, while Cameroon case is hindered by investment climate. DRC performs the weakest case in all studied components (see table 3).

Table 3: Comparative table of studied cases

	Regulatory framework	Institutional framework	Operational maturity	Investment climate	Financing	Subnational adjustment
SSA Average	●	●	◐	◐	◐	☽
South Africa	●	●	●	◐	●	◐
DRC	☽	☽	○	◐	☽	○
Tanzania	◐	◐	◐	◐	◐	☽
Cameroon	●	●	○	○	◐	◐
Rwanda	●	●	◐	◐	☽	●

Notes: ○ = No data or very weakly mentioned; ☽ = very weakly mentioned; ◐ = partially mentioned; ● = mostly mentioned.

CHAPTER IV: CONCLUSION AND POLICY IMPLICATION FOR MOZAMBIQUE

1. Conclusion

The PPP performance in healthcare reveals a symbiotic relationship between institutional settings to attract private health operators. However, this interdependence is not sufficient to describe the effectiveness of PPP projects in SSA healthcare systems.

South African case has demonstrated a significant impact of its physical and material conditions and community attributes to achieve a relatively effective PPP in healthcare mostly dominated by for-profit entities. However this paper raise awareness concerning the growing opportunity for oligopolies; while incorporation of traditional healers in the country healthcare PPP framework is recommended.

DRC case revealed two aspects: (1) how poor Governance can hinder policy implementation; (2) DP and local private healthcare operators cannot improve the system if there is no political will. Government should be game changer; not the private sector. Embedded vested interests hinder the print of documented policies into implementation.

Tanzania case has revealed that its community social interaction derived from *ujamaa* principles may impede the alignment of private sector at the district level. Local physical and material capabilities are not suitable for a sound PPP in healthcare. Most of health users are confronted with problems of transportation to access existing PPP healthcare services in a country where the reliance on allopathic medicine is dominant.

Cameroon case taught us that something can be done even within a weak political environment. The strategy to achieve UHC can start as pilot project within a certain region of the country; while political will is a driver for success of Rwandese healthcare system – a country with little favorable physical material conditions. It seems that historical path and cultural homogeneity are playing an important role in this achievement.

Looking back to initial hypothesis of this paper, this research has shown the role of institutions as determinant for effectiveness of PPP in healthcare in SSA, and in fact, it increases the access for healthcare services. However, this affirmation does not fully answer the requirements for SSA case. Additional elements such as culture, material conditions, community attributes, and Government expenditure in healthcare services are important for both effectiveness and access.

This research must acknowledge the limitations of 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. While this would have been desirable, this research has been constructed to make prototypical analysis regarding the elements for a sound PPP in healthcare in SSA region. Therefore, this paper takes caution in inferring adequately final conclusions.

2. Policy Implication for Mozambique

There are a number of policy suggestions that arise from our findings. First, despite being largely dominated by private sector, Mozambique has a mingling of public and private operators and a significant and the role of DP. The private healthcare providers are basically NGO, lucrative private sector, informal providers such and traditional healers.

Secondly, MoH has not yet defined its strategy to engage with the private sector. A new framework to engage the private sector is currently being discussed with DP.

Based on cases this research has studied, it is an opportunity to consider the following findings: (1) the local adjustment issues in the context of decentralization scenario – postulate the role of the provinces and districts in the framework; (2) incorporation of allopathic medicine practitioners (traditional healers) in the framework; (3) necessity to observe local physical and material conditions both to guarantee the healthcare PPP attractiveness and effectiveness; (4) a harmonization of regulatory framework with the cultural habits to make sure that there will not be a shock between health services providers and users, and also to guarantee that healthcare PPP services are affordable for patients; (5) PPP initiatives are known and assumed by local users and finally to guarantee that different stakeholders are involved in consultation process, including the establishment of strong monitoring process.

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사하라 사막 이남 아프리카 의료 시스템의 민관 파트너십에 대한 기관 분석 : 모잠비크에 대한 정책 시사점

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요약

개발 도상국의 많은 사람들이 필수 의료 서비스에 접근하기 위해 더 큰 위험에 노출되어 있습니다. 세계 보건기구 (WHO)와 세계 은행에 따르면 세계 73 억 인구 중 절반 이상이 필수 의료 서비스를 모두받지 못하고 있습니다. 이러한 부담을 최소화하기 위해 사하라 사막 이남 아프리카 (SSA) 국가는 공공-민간 파트너십 (PPP) 접근 방식을 통해 민간 부문을 수용하여 UHC (Universal Healthcare Coverage)를 달성하여 모든 연령대의 건강한 삶을 보장하고 웰빙을 증진했습니다. . 많은 간행물이 PPP 의 효율성을위한 기관의 중요성을 제기했습니다. SSA 의 사회 경제적

맥락을 고려하여 PPP 의 효과를 조사하기위한 영향력있는 요구 사항을 제기 한 사람은 거의 없습니다.

이 백서의 목적은 SSA 의 의료 시스템에서 PPP 에 적용 가능한 환경과 모잠비크에 대한 정책 시사점을 조사하는 것입니다.

방법 론적으로 5 개의 SSA 국가 : 카메룬, 콩고 민주 공화국 (DRC), 탄자니아, 남아프리카 공화국, 르완다가 사례 연구로 선택되었습니다. 설명 및 데이터 분석을 모두 적용함으로써이 백서는 다음을 관찰했습니다. (1) 의료 서비스를 위해 SSA 정부에서 각 개발 도상국이 할당 한 자원의 일반적인 감소; (2) 의료 서비스 제공에 대한 민간 부문의 참여 증가; 그리고 (3) PPP 를 통한 민간 부문의 참여로 인한 결과는 기관의 질에 의해 결정되었습니다. 그러나 문화적 특성, 커뮤니티 속성 및 물리적 또는 물질적 조건과 같은 추가 변수가 SSA 컨텍스트에서 필요합니다.

키워드 : 공공-민간 파트너십; 민간 부문, 기관, 의료 서비스.

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