



A rural health clinic in Masianokeng, outside the capital Maseru, 2014. It takes more than three hours to travel to the nearest health facility for 25 per cent of people in Lesotho's rural areas. Photo: Sophie Freeman/Oxfam

A DANGEROUS DIVERSION

Will the IFC's flagship health PPP bankrupt Lesotho's Ministry of Health?

The Queen 'Mamohato Memorial Hospital was built to replace Lesotho's old main public hospital under a public-private partnership (PPP) – the first of its kind in a low-income country. The PPP signed in 2009 was described as opening a new era for private sector involvement in healthcare in Africa, and was seen as the International Finance Corporation (IFC)'s flagship model to be replicated across the continent. Instead, the Ministry of Health in one of the poorest and most unequal countries in the world is locked into an 18-year contract that is already using more than half of its health budget (51 per cent), while providing high returns (25 per cent) to the private partner. This is a dangerous diversion of scarce public funds from primary healthcare services in rural areas, where three-quarters of the population live. Lesotho's experience supports international evidence that health PPPs of this kind are high risk and costly, and fail to advance the goal of universal and equitable health coverage. The IFC should be held to account for the poor quality of its advice to the Government of Lesotho and for marketing this health PPP as a success internationally, despite its unsustainable costs.



1 INTRODUCTION

The Queen 'Mamohato Memorial Hospital, which opened in October 2011, was built to replace Lesotho's old main public hospital, the Queen Elizabeth II (QE II) Hospital, in the capital, Maseru. It is the first of its kind in Africa – and in any low-income country – because all the facilities were designed, built, financed, and operated under a public–private partnership (PPP) that includes delivery of all clinical services. The PPP was developed under the advice of the International Finance Corporation (IFC), the private sector investment arm of the World Bank Group. The promise was that the PPP would provide vastly improved, high-quality healthcare services for the same annual cost as the old public hospital.

Today, the PPP hospital and its three filter clinics:

- cost \$67m per year – at least three times what the old public hospital would have cost today – and consume more than half (51 per cent) of the total government health budget;
- have necessitated a projected 64 per cent increase in government health spending over the next three years, 83 per cent of which can be accounted for by the budget line that covers the PPP;
- are diverting urgently needed resources from primary and secondary healthcare in rural areas where mortality rates are rising and where three-quarters of the population live. Despite the severe shortage of qualified health workers, the human resources budget will see a real-terms cut over the next three years, rising by an average of just 4.7 per cent per year (significantly lower than inflation);
- are expecting to generate a 25 per cent rate of return on equity for the PPP shareholders and a total projected cash income 7.6 times higher than their original investment;
- are costing the government so much that it believes it will be more cost effective to build a brand new district hospital in the capital to cater for excess patients rather than pay the private partner to treat them – a plan that was announced in the budget speech in February 2014.

Lesotho, a small, mountainous land-locked country surrounded by South Africa, faces enormous development challenges. One of the most unequal countries in the world, the Gini coefficient is 0.53¹ and the richest 10 per cent of households account for more than half of total consumption.² More than 57 per cent of its population (the Basotho) live below the poverty line.³ Poverty is 50 per cent higher in rural areas than in urban areas.⁴

Lesotho has the world's third highest burden of HIV and AIDS, with prevalence 26 per cent for women and 19 per cent for men.⁵ Life expectancy has fallen from 60 years in 1990 to just 50 years in 2011,⁶ and infant and maternal mortality rates are rising.⁷ Under-five mortality is 40 per cent higher for the poorest quintile than for the richest, and the variations in mortality rates between those living in the capital region and

those in rural areas are as wide.⁸ Poor households are less likely to seek healthcare, citing cost and distance as the major barriers; 25 per cent of the poorest quintile and 25 per cent of people who live in rural areas have more than three hours to travel to their nearest health facility.⁹

The need to address poverty and extreme income and health inequality in Lesotho could not be more urgent. Oxfam's recent research has highlighted the powerful role that free, universal and equitable public health services can play in reducing inequality in rich and poor countries alike.¹¹ The International Monetary Fund (IMF) agrees that spending on health and education is critical to achieving economic growth and tackling inequality.¹² The World Bank Group itself is guided by two clear goals – to end extreme poverty and promote shared prosperity – and its President, Jim Yong Kim, has repeatedly emphasised the central role played by universal health coverage (UHC) and equity in health in achieving these goals.¹³

To advance UHC and redress health inequity, the World Bank has recommended that Lesotho prioritise health and nutrition in the heavily under-resourced rural areas.¹⁴ The government's ten year health sector reform plan in 2000 – partly funded by the World Bank's International Development Association (IDA) – emphasised the need to improve essential health interventions in under-served areas.¹⁵ While few questioned the need to radically refurbish or replace the capital's dilapidated public hospital, a World Bank document did raise questions about the cost effectiveness and equity of the proposal, citing evidence that it is generally the wealthier in society, and men rather than women, who make heaviest use of expensive hospital services.¹⁶

Given this context, and the fact that it appears that alternative public financing options were available and should have been further explored with the Government of Lesotho, it is very worrying that the IFC was able to pursue such a costly and risky strategy for replacing the old national hospital.

'People here really need us, but in some cases it is heartbreaking when we refer them to the hospital in town and they tell us they are unable to go because they cannot afford the transport fare. I always ask myself: am I serving the people who motivated me to work here or am I here to just helplessly watch them suffer and die?'

Nursing Assistant, Ha-Mokoto Clinic, 50km from Thaba-Tseka town¹⁰

2 THE LESOTHO HEALTH PPP

Health sector public–private partnerships (PPPs) come in a variety of forms, from the outsourcing of specific support services such as catering, to more complex arrangements that include financing, building, designing and facilities management of hospitals. The Lesotho health PPP, described by one expert as the most ambitious PPP undertaken internationally,¹⁷ is one of only a handful of similar projects worldwide.¹⁸ The private sector partner was to not only partly finance, design, build, maintain and operate the new 425-bed hospital (35 beds to be run separately as a private patient unit) and its three filter clinics, but also to employ all its own health workers and provide all clinical services on behalf of the government for the 18-year contract period. On contract completion, the hospital and clinic would pass into government ownership.

‘The PPP hospital in Lesotho is one of the most innovative health projects and activities we see on the continent. It is just exciting to see how, without really adding to public expenditure, you are able to deliver so much more value for money for the Basotho, for the people, for those patients who need hospital care.’

Ritva Reinikka, Director of Human Development, World Bank Africa Region¹⁹

Box 1: Healthcare public–private partnerships

Some form of PPP exists in almost every national health system. The most common example is the sourcing of medical products from the private sector. This paper examines a particular type of health PPP – the construction of a health facility and ongoing provision of services by a for-profit private partner within a public system of provision. PPPs of this kind can take a variety of different forms.²⁰

- **Franchising:** Public authority contracts a private company to manage an existing hospital
- **DBFO (Design, Build, Finance and Operate):** Private consortium designs facilities based on a public authority’s specified requirements, builds the facility, finances the capital cost and operates the facility
- **BOO (Build, Own, Operate) or BOOT (Build, Own, Operate, Transfer):** Public authority purchases services for a fixed period (say 30 years), after which ownership remains with private provider, or in the case of BOOT, reverts to public authority
- **BOLB (Buy, Own, Lease back):** Private contractor builds the hospital; the facility is leased back and managed by the public authority
- **PPIP (Public Private Integrated Partnership) or Alzira Model:** Private contractor builds and operates the hospital, with a contract to provide clinical care for a defined population

Australia has the most diverse range and mix of these models, while the UK’s hospital building programme has been dominated by the Private Finance Initiative (PFI), a DBFO model. Lesotho’s is among only a handful of hospital PPPs worldwide that incorporates the delivery of clinical services – sometimes referred to as a PPIP.

In 2009, the PPP contract was awarded to Tsepong Ltd, a consortium led by Netcare – a private South African hospital operator and a major multinational company – and a group of local economic empowerment shareholders.²¹

Under the PPP, Netcare is contracted to treat all patients presenting at the Queen ‘Mamohato Memorial Hospital, up to a maximum of 20,000 inpatients and 310,000 outpatients annually. Patients pay the same user fees as they would in any public facility. Certain services such as transplants, elective

cardiac and vascular surgery, chemotherapy, and radiotherapy are excluded from the contract for reasons of affordability.²² Like the old QE II Hospital, under the PPP the new hospital was contracted to function as the country's clinical teaching facility for health professionals.²³

In return, the government pays an annual unitary fee that covers capital repayment and service delivery costs. The fee should be adjusted only for inflation or if additional services beyond those in the contract are agreed and incorporated. If Netcare fails to uphold agreed performance standards, the government can make penalty deductions from this fee. Any patients served in excess of the maximum number covered by the contract are charged to the government at a rate of \$4.72 per outpatient and \$786 per inpatient (at 2007 prices and excluding VAT and annual inflation).²⁴

The World Bank provided a grant of \$6.25m via the Global Partnership on Output-Based Aid during the initial stages of the project, to help cover the costs of the filter clinics before the main hospital had opened.²⁵

The theory and rationale behind the Lesotho health PPP was that the private sector operator would produce better results for exactly the same annual cost to government as the old public hospital.

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Ritva Reinikka, Director of Human Development, World Bank Africa Region.²⁶

Well before the PPP contract was signed, the IFC, as transaction advisor to the Government of Lesotho, said it was a major success, proposing it as a model for other countries to replicate. In 2007, Bernard Sheahan, the IFC's Director of Advisory Services, said:

*'This project provides a new model for governments and the private sector in providing health services for sub-Saharan Africa and other regions. The PPP structure enables the government to offer high-quality services more efficiently and within budget, while the private sector is presented with a new and robust market opportunity in health services.'*²⁷

'This project provides a new model for governments and the private sector in providing health services for sub-Saharan Africa and other regions.'

Bernard Sheahan, IFC Director of Advisory services

Despite a significant body of evidence highlighting the high risks and costs associated with health PPPs in rich and poor countries alike (see Section 5), similar IFC-supported health PPPs are now well advanced in Nigeria, and in the pipeline in Benin.²⁸ The UK's Department for International Development (DFID) has provided \$5m in funding to the IFC to further expand its health PPP advisory work.²⁹ Financial support for the IFC advisory facility on health PPPs is also being provided by the governments of the Netherlands, South Africa and Japan.³⁰

The IFC has consistently highlighted its own role as transaction advisor to the Government of Lesotho for the health PPP, for which it earned a 'success' fee of approximately \$720,000 when the contract between the government and Tsepong was signed.³¹ The central role of the IFC – which included acting on behalf of the government in the planning, tendering and contract negotiation and agreement – was confirmed by all of the Lesotho health PPP stakeholders interviewed for this report.

3 HOW THE PROJECT HAS FAILED TO BE COST NEUTRAL

Far from being cost neutral (the main selling point of the PPP), soon after the new hospital opened in 2011, one health PPP academic and journalist, John Lister, used the limited data that were available to suggest that costs for the new privately run hospital were already double that of the old public hospital.³² Lister also identified several unfavourable terms in the PPP contract that left the government exposed to escalating costs in the future.³³

Calculations commissioned and published by the IFC confirmed that in 2012/13, the annual cost of the new hospital was between two and three times the costs of the old hospital.³⁴ In its most expensive year before closure, in 2006/7, the old hospital cost 28 per cent of Lesotho's total health budget.³⁵ In 2012/13, the new private hospital cost \$45m – more than 41 per cent of the total health budget.³⁶ According to the project's baseline study, anything over 40 per cent of budget consumption should be considered as risking adequate financing being available for district health services.³⁷

Figures made available by the Lesotho Ministry of Health suggest that in 2013/14 the cost of the new private hospital has escalated further to between 3 and 4.6 times what the old public hospital would have cost today.³⁸ The figures suggest that the PPP now consumes as much as 51 per cent of the total health budget, or \$67m per year.³⁹ The real cost of the new privately run hospital is already nearly two and a half times the amount that was agreed as affordable between the Government of Lesotho and the IFC before the contract was awarded.⁴⁰

It should be noted that claims made by the World Bank or others that cost escalation can be largely attributed to the higher than expected number of patients using the hospital can be countered by the fact that even if these excess costs were excluded, the total cost of the PPP in 2013/14 would still amount to 44 per cent of the total health budget.⁴¹

One government minister Oxfam spoke to confirmed that the PPP is *'eating more than half of the health budget'* and is *'hitting the government hard'*. Netcare's Operations Director took the view that the new hospital had had minimal financial impact to date, but that *'unfortunately it will come through this financial year and it will have an impact which I think was unexpected'*.

Costs are predicted to spiral further. For 2014/15, the government allocation for the PPP had already been exceeded by costs submitted by Tsepong before the new financial year started.⁴² This included an unexpected \$6.6m request by Netcare for the government to top up the salaries of workers in the privately run hospital. A welcome recent increase in salaries for government-employed health workers has produced a pay gap between the public and privately run facilities,

The PPP is 'eating more than half of the health budget. It is hitting the government hard'.

Minister, Government of Lesotho

leading to staff retention problems at the new hospital. While there may be strong grounds to demand Netcare internalises these costs, the company argues that they should be compensated for by the government.⁴³ If the government accedes to this request, this is likely to become an ongoing additional cost, and if it doesn't, the hospital will not have sufficient capacity to meet demand.

A representative of one of the smaller shareholders in the Tsepong consortium expressed concern about the financial viability of the PPP for the government: *'Tsepong continues asking for more money, more money, more money. For me, it is a serious concern that the hospital should be run affordably. It is so expensive. I think it is going to exhaust the budget of the Ministry of Health.'*

This concern was echoed by a senior official within the Ministry of Health: *'We don't think we will be able to sustain these payments. We don't think we will be able to bear that weight.'*

While costs of the PPP escalate for the Government of Lesotho and Basotho taxpayers, the financial model for the Lesotho PPP confirms that the IFC helped to structure a contract projected to generate a 25 per cent rate of return on equity for Netcare and the broader Tsepong shareholders.⁴⁴ This compares with a norm of between 13 per cent and 18 per cent equity return on similar hospital Private Finance Initiative projects in the UK – a rate already considered to be highly profitable.⁴⁵ At the close of the Lesotho health PPP contract in 2026, it is projected that Tsepong shareholders will have generated a total cash income 7.6 times higher than their original investment.⁴⁶

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Tsepong shareholder

Factors contributing to rising costs

There are multiple and wide-ranging reasons for the high and escalating cost of the PPP. Referring to the international evidence available (see Section 5), many of these reasons seem inherent to health PPPs and raise serious questions about why the model was even proposed in a low-income, low-capacity context. Other cost increases appear to be a result of bad advice given by the IFC in its role as transaction advisor to the Government of Lesotho.

The following provides an incomplete but concerning analysis of the contributing factors at play. A comprehensive analysis is impeded by the lack of transparency associated with PPPs, and because information that is arguably in the public interest to disclose is hidden by commercial confidentiality.

- **Cost escalation during the final stages of contract negotiation.** It is very common in health PPPs for the contractor to increase its costs once it has entered the *preferred bidder* stage. At this point, the public sector is in a weaker negotiating position and the private sector can 'hold-up' the public sector, pushing up prices and reducing the extent of risk transfer to themselves.⁴⁷ The Government of Lesotho was especially vulnerable in these negotiations due to the significant lack of competition in the bidding process – there were only two bidders. It

is clear that Tsepong succeeded in increasing the baseline annual unitary fee to \$24m (excluding VAT) – 42 per cent above the value originally agreed as ‘affordable’ by the Government of Lesotho and the IFC.⁴⁸ Other changes must also have taken place to explain the faster than expected fee escalation. As transaction advisor, at that point, the IFC should have recognised and acted on the future serious financial risks of the PPP for the government.

- **Flawed indexation of the unitary fee.** In any PPP, private providers incur fixed costs such as debt repayments, and inflation-sensitive operational costs. To reflect this, only a portion of the annual unitary fee paid by government to the private provider should be adjusted according to inflation. The financial model for the Lesotho PPP suggests that at least 30 per cent of Tsepong’s costs are fixed in the form of debt repayments.⁴⁹ In practice however, the entire unitary fee charged to the government is subject to annual increases in inflation.⁵⁰ Furthermore, the increase is calculated using a complex composite inflation index heavily influenced by the rate of medical inflation (the combined cost of medical products and services) in South Africa, rather than Lesotho.⁵¹ Not only does this mean that the Government of Lesotho is already paying a significantly higher than justified unitary fee to Tsepong, but it has also been exposed to potentially significant future cost escalation associated with South Africa’s normally high medical inflation rates.⁵² The failure of the IFC to correct this flawed and unfair model suggests it has failed to act in the best and long-term interests of the Government of Lesotho.
- **Costs incurred for extra patients.** Accurate patient demand projections are crucial for cost certainty, and some in the Ministry of Health believe that IFC-commissioned estimates based on the old public hospital were too low and made insufficient allowances for the poor standard of record-keeping.⁵³ There may also have been an incentive for those promoting the PPP to underestimate demand if this reduced the initial unitary fee.⁵⁴ Official figures show a hospitalisation rate of 3.2 per cent of the population each year, equivalent to 64,000 inpatients.⁵⁵ The PPP caters for less than a third of this figure in what is the country’s main tertiary facility. In its first full year of operation (2012), the number of inpatients and outpatients exceeded the PPP maximum limit by 17 per cent and 21 per cent respectively, resulting in an additional cost to government of \$4.3m.⁵⁶ In 2013, the cost for excess patients charged to the government more than doubled to \$9.4m.⁵⁷
- **Increase in referrals to South Africa.** Part of the rationale for the health PPP was to reduce the need for costly patient referrals to South Africa for specialist services unavailable in Lesotho. Instead, referrals increased by 61 per cent between 2007 and 2012.⁵⁸ Accurate up-to-date figures were difficult to obtain, but Netcare claim that referral numbers are now stabilising and have reduced by 12 per cent in the last year.⁵⁹ Key informants confirmed that the government is struggling to meet the charges to Netcare for referral costs and is behind on its payments. The lack of transparent and accurate information on referral numbers or practices is problematic and should be fully investigated.

- **Extra services.** The flexibility required to respond to unpredictable future health service and system needs is at odds with a contractual approach that locks in responsibilities for the public and private partners. Any unforeseen variation on the contract requires renegotiation, including on price. This has already occurred several times in the short life of the Lesotho health PPP and has added to its cost. Key Ministry of Health officials interviewed for this report felt that the balance of power during contract negotiations was clearly in Netcare's favour due to their pre-existing experience. One government minister also said that there were many loopholes in the contract that left the government exposed to future rising costs.
- **Poor management and oversight of the PPP.** Robust and well-resourced management and oversight by the public sector is crucial in any PPP to ensure that the private partner upholds its responsibilities and performance standards, and is financially penalised if it fails to do so. One of the IFC's baseline studies for the PPP in 2009 found that *'at present, sufficient expertise in hospital operations, financial oversight and analysis and systems analysis to manage the PPP contract in the interests of the Government and people of Lesotho does not exist...'*⁶⁰ All the public and private stakeholders of Lesotho's health PPP that Oxfam spoke to for this report said that the Government of Lesotho still lacked the capacity and experience to manage the PPP effectively. This suggests that not only was the government ill-advised to push forward with the PPP, but that the IFC's dedicated support to the government on PPP capacity-building throughout the lifetime of the project has failed to produce tangible results. One senior Ministry of Health official said there was no supervision of Netcare's performance, and financial penalties were not being applied when standards fell. A key informant from Tsepong said, *'the Ministry of Health is not managing the contract at all and Netcare could be doing anything and they would not know'*. Many stakeholders were also concerned that the PPP went ahead despite the absence of a national PPP policy or framework.
- **Late payment and loan default interest charges.** Due to rapidly escalating costs, the Ministry of Health is struggling to pay the monthly fees to Tsepong. For every late payment, penalty charges are incurred, amounting to an estimated \$755,000 to date.⁶¹ Late payments have also resulted in Tsepong defaulting on its own loan to the Development Bank of Southern Africa on a number of occasions.⁶² Not only does this threaten the continuing viability of the PPP, but it could negatively impact on the Government of Lesotho's international credit rating and ability to raise affordable capital in the future.^{63,64}

The high cost of private financing

An IFC-commissioned study in 2013 suggests that it is appropriate to discount the capital repayment costs charged to the Lesotho government in comparing the price between the old and new hospitals. This is because the government would have had to pay these capital costs anyway to build a new hospital.⁶⁵

This seems to be a case of moving the goal posts – the rationale for the PPP was that the total cost of the new hospital would be the same as the old. The argument also neglects two key facts. First, that the Government of Lesotho paid a significant 34 per cent (US\$38m) of the upfront capital costs for the hospital in order to reduce the future unitary fee to be paid to Tsepong.⁶⁶ An investment of this scale (plus an additional US\$8m for infrastructure improvements to service the hospital site) carries significant opportunity costs for the government⁶⁷ that have not been factored in to IFC commissioned cost comparisons to date. Secondly, borrowing capital via the private sector will always be more expensive than governments borrowing on their own account. As savings on clinical services have not been delivered by the Lesotho PPP, it is even more important to consider the higher cost of private capital finance. The overall weighted average cost of capital for Lesotho's health PPP (interest payments on debt plus equity returns) is very high, at 13.6 per cent.⁶⁸ In light of this high cost, it is critical to question whether cheaper alternatives to financing the build of the new hospital were comprehensively pursued. The World Bank have said that an IDA concessional loan (normally provided with a service charge of only 0.75 per cent with 10 years' grace and 40 years' maturity) for the full amount was not possible due to insufficient space in the country's lending window.⁶⁹ Key informants told us that an offer of match funding the government contribution was made by Irish Aid, in partnership with other donors. This option would have left a financing gap of only \$34m for the build of the hospital.⁷⁰ Arguably, this would have made concessional multilateral or bilateral lending more viable. A further alternative might have been for the government to borrow on its own account. The government has been issuing Treasury Bonds with 10 year maturity at a 10 per cent interest rate.⁷¹

4 WIDER IMPACTS OF THE HEALTH PPP

Performance of the new PPP hospital

Improving the overall quality and impact of hospital care is clearly an important outcome measure of the health PPP. According to an IFC-commissioned study, the new hospital has reported a 41 per cent overall reduction in the hospital death rate, a 65 per cent reduction in deaths from paediatric pneumonia, and a 22 per cent decline in the rate of stillbirths compared with the old public hospital.⁷²

Areas for concern reported in the same study however, include a 40 per cent increase in the death rate for patients on medical wards and a 27 per cent rise in the death rate among female patients on surgical wards.⁷³ There are also ongoing complaints about waiting times⁷⁴ and claims of reduced accessibility for lower-income patients due to the additional transport costs to reach the new hospital – though these equity concerns have unfortunately never been reviewed.⁷⁵

With at least three times the level of expenditure on the PPP hospital in comparison with the old hospital, one would expect significant improvements in clinical performance. However, it is not possible to take the reported clinical indicators at face value for a number of reasons. First, trends in hospital mortality rates are notoriously difficult to standardise and compare, including possible changes in patient demographics and case mix over time.⁷⁶ Second, hospital mortality rates provide no indication of overall population-based mortality rates. For example, any change in hospital services or patient case mix might have an impact on mortality rates outside of the hospital. For these reasons, and because the IFC and Netcare are under tremendous pressure to demonstrate improved performance, the Government of Lesotho and/or the World Bank Group should commission an independent, rigorous and system-wide evaluation of clinical performance and impact.

The World Bank has made claims that the new hospital is more cost-efficient than the old with a 22 per cent lower per patient cost.⁷⁷ The figures used are misleading. The IFC-commissioned endline study is clear that it did not have sufficient data to compare costs accurately between the old and the new hospital or to separate costs between outpatients and inpatients.⁷⁸ Even so, based on the cost charged to the government by Tsepong, the figures show per patient costs are 23 per cent higher in the new hospital. When taxes are excluded this reduces to a 6 per cent higher cost. It is only when capital costs are also deducted that the cost reduces to 22 per cent less per patient than the old hospital.⁷⁹ As mentioned, it is unclear how the World Bank justifies the discounting of capital costs – these costs are inherently higher in PPPs and should therefore be factored into any fair cost comparison between public and private sector options for hospital procurement and services.

Performance improvements of any kind are welcome, but the rationale for the Lesotho health PPP was to bring improved results for the same level of public expenditure. It is therefore reasonable for the Government of Lesotho and Basotho taxpayers to have expected even greater improvements and broader-based impact relative to cost, even in the first two years of operation. It is also reasonable to question whether the same results could have been achieved via a less expensive route, leaving more resources to provide other health services to address rural–urban and other health disparities. These questions about direct and opportunity costs and cost-effectiveness remain unanswered by the IFC and the World Bank in their reviews of the health PPP.

The new hospital is also not operating as a full teaching hospital as intended; to date, no medical students have been trained. Previous World Bank analysis identified the old QE II Hospital as the *'locus of professional education and specialist training in the country'*.⁸⁰ Key informants told us that critical training functions of the old hospital have been lost under the PPP, including extensive inductions for newly arrived doctors from different countries and outreach training by senior clinicians at district hospitals.

'The main reason the [health] budget is increasing is because of Tsepong.'

Senior official in the Lesotho Ministry of Health

Implications for the rest of the health system

There is no doubt that costs for the Lesotho health PPP are rising at an unsustainable rate. In an effort to fulfil its legal obligation to meet these costs, the Government of Lesotho has proposed an extraordinary 64 per cent increase in the total health budget over the next three years.⁸¹ Such commitment to increased health spending would normally be celebrated. However, in this case, at least 83 per cent of the proposed increase can be accounted for by the budget line that covers the health PPP.⁸² And as a senior Ministry of Health official confirmed: *'The main reason the budget is increasing is because of Tsepong.'*

'Not enough money goes into primary health care and the biggest budget has always gone to QE II. It is worse with the new hospital, which takes even more. If primary health is meant to be the cornerstone of our health system, you think this should take priority rather than it being the other way around.'

Dr Ntšekhe, Manager of Senkatana Clinic

With such severe skewing of the budget, detrimental impacts on other national health and development priorities are unavoidable. While the total health budget is set to increase by 64 per cent by 2016/17, agriculture and education will experience a cut in real terms, with below inflation rises of just 14 per cent and 7 per cent respectively over the same period. The ramifications of this are likely to be significant; as the Minister of Development Planning said: *'Health is increasing but this will be at the expense of something else. We may be able to treat people if they get ill but we will not be able to ensure they have enough to eat.'*

The resource squeeze for rural health care

Lesotho is off track to meet its health-related Millennium Development Goals (MDGs), and there is agreement that while more spending is important, reversing the country's poor progress in health and advancing equitable universal health coverage requires prioritising investment in primary and secondary health services in rural areas, where more than three-quarters of the population live.⁸³

For example, the maternal mortality rate in the capital Maseru is four times lower than the national average.⁸⁴ So while it is encouraging that the new PPP hospital is reporting a 10 per cent reduction in maternal mortality, there is an urgent need for more resources to address the significantly higher numbers of pregnant women who die in poor rural areas for want of access to antenatal care, skilled delivery attendance, and emergency obstetric care.⁸⁵

The Lesotho government is making welcome endeavours to get back on track to achieve the health MDGs, including an MDG Accelerated Framework in 2011, joint investment with the Millennium Challenge Corporation to upgrade primary healthcare centres,⁸⁶ a 2009 National Reproductive Health Policy, and a renewed Primary Health Care Strategy. However, progress on implementation is slow, and rural areas experience persistent challenges, including insufficient skilled personnel, poor staff retention, stock-outs of medical supplies, inaccessible and inadequate infrastructure, and poor transport.⁸⁷

Government health expenditure was already skewed towards tertiary, urban-based care.⁸⁹ The health PPP has dramatically exacerbated this inequitable trend by absorbing over half of the Ministry of Health's budget in 2013/14, up from 28 per cent for the old public hospital in 2006/7. The Christian Health Association of Lesotho (CHAL) runs approximately 40 per cent of the country's health facilities, predominantly in rural areas.⁹⁰ Yet in 2013/14, the government allocation to CHAL was equivalent to just over a quarter of that spent on the health PPP.⁹¹

Despite the severe shortage of qualified health workers in rural areas, the government is planning a real-terms cut in the health personnel budget, with just an average annual 4.7 per cent rise over the next three years.⁹² Moreover, the vaccine budget is set to fall by a total of 1.2 per cent.⁹³ Yet, over the same period, the budget line that covers the health PPP will increase by 116 per cent.⁹⁴ A senior Ministry of Health official described how *'the PPP hospital has had a bad impact on how we've allocated resources over the last two years. There are less and less resources for primary health care and district services.'*

Even the Operations Director of the PPP hospital has acknowledged this important problem, saying: *'I don't think it is currently a financial problem but it has the potential to create a big gap in terms of health care funding for the rest of the country.'*

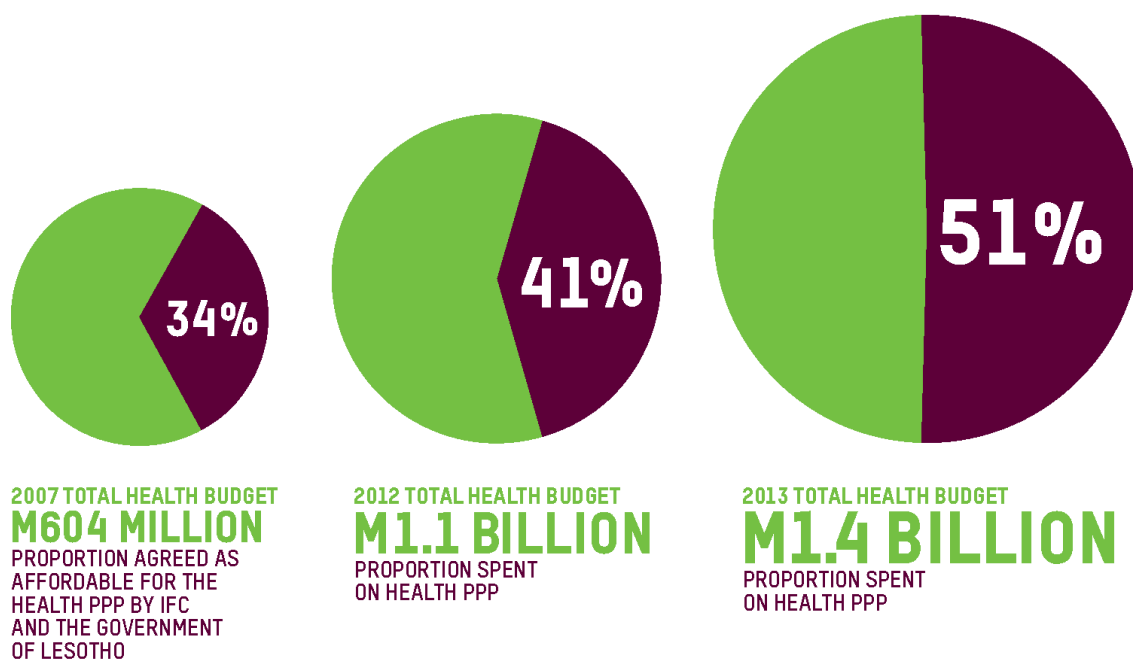
'Many mothers here only manage one or two clinic visits. Expecting them to all make it into town when in labour, and in many cases at night, is insensitive and unrealistic. It's not safe to have a heavily pregnant woman walk or ride on a horseback that far on such a poor road.'

Chief, Butha Butha District⁸⁸

'We are not happy here because the working conditions are just terrible. We are not getting the incentives we were promised....Apart from the trauma associated with helplessly watching communities struggle to access our services, we are also struggling to survive.'

Nurse-midwife, Ha-Makoto Clinic, 50km from Thaba-Tseka town⁹⁵

Figure 1: Lesotho's health budget and the costs of the PPP, 2007–2013



Note: The US\$ equivalent amounts for the health budget total are 2007: \$57m; 2012: \$108m; 2013: \$133m

Supporters and critics of the health PPP interviewed for this report agreed that the poor state of the rest of the health system and lack of investment in primary healthcare is encouraging those sick patients who can afford to travel to the capital to seek care at the new hospital. This problem is only set to get worse, as the PPP consumes ever-increasing amounts of the national health budget. The Minister of Planning and Development has said that in hindsight, *‘the new hospital should have been part of a broader package of investment to upgrade the entire health system’*.

The proposed ‘cost neutral’ health PPP is now costing the government so much that it believes it will be more cost effective to build a brand new district hospital in the capital to cater for excess patients, rather than pay Netcare to treat them – a plan that was announced in the budget speech in February 2014.⁹⁶

The biggest losers of the health PPP in Lesotho are the majority of Basotho people who live below the poverty line in poor rural areas, who have little or no access to decent healthcare. As the country’s health financing crisis escalates, the option of reintroducing and increasing user fees at primary and secondary level facilities has already been tabled for debate.⁹⁷ Such a devastating and retrograde move in Lesotho would further exacerbate inequality and increase rather than reduce access to healthcare for the majority of the population. World Bank President, Jim Yong Kim, recently stated that user fees for healthcare are both ‘unjust and unnecessary’.⁹⁸

‘The PPP hospital has had a bad impact on how we’ve allocated resources over the last two years. There are less and less resources for primary health care and district services.’

Senior official from the Lesotho Ministry of Health

Local economic empowerment

One important objective of the health PPP from a government perspective was to promote local economic development. The PPP agreement stipulated that rising levels of capital expenditure should be directed to local enterprises during the lifetime of the partnership.⁹⁹

However, this issue has become an area of significant contention among Tsepong shareholders, and some key informants considered this a threat to the future viability of the PPP. There have been accusations made by some of the shareholders that Netcare has failed to uphold the contractual agreement to sub-contract pre-specified business operations to smaller shareholders in the Tsepong consortium, and is instead channelling contracts almost exclusively through South African firms without board approval.¹⁰⁰ Netcare claims that actual expenditure does not support these allegations.¹⁰¹

Excessive foreign involvement and weak local participation in the health PPP was identified as a risk by the World Bank, reflecting previous privatisation efforts in Lesotho. It recommended that the World Bank and IFC provide strong technical assistance to help overcome this problem.¹⁰² From the perspective of local shareholders, however, it seems that such support has been lacking. Local economic empowerment should be a crucial outcome of any investment by an international financial institution in any developing country. The PPP's performance against this objective should be fully assessed.

5 A MODEL TO COPY?

The Lesotho health PPP is ambitious and complex, and the first model of its kind to be tried in a low-income country. The theoretical cost saving and value for money potential of PPP financing and delivery lies in effective risk transfer to the private sector and, in turn, the effective management of that risk by the private sector in the form of improved performance and greater cost efficiency in its operations. In the case of Lesotho, this potential benefit has not been realised, and the costs are already escalating to unsustainable levels.

The IFC has acted irresponsibly, both in terms of its role as a transaction advisor to the Government of Lesotho and in its marketing of the Lesotho health PPP as a successful model for other low-income countries to replicate. As one senior Ministry of Health official said: *'The IFC were transaction advisors. We're in this because of them. They should have done better and they must help us to get out of this mess.'* The performance of the IFC's flagship model does not bode well for others attempting to replicate it, but do health PPPs of this kind still hold the potential to deliver value for money and cost effectiveness in other low-income countries?

Perspectives from Lesotho

Many of the key stakeholders Oxfam spoke to in Lesotho said they would advise other low-income countries not to copy the country's health PPP model. One of the minor shareholders of Tsepong, said: *'The IFC has flaunted this model all over the world and Netcare sings its praises. But they are deceiving the world. Those who are influential should be stopped before they cause more damage to other countries, especially poor countries.'*

Chefa Lehlohonolo, Director of the Consumer Protection Association (Lesotho), said: *'Unfortunately the World Bank is promoting these kinds of PPPs as a one size fits all model, thinking it will solve all the health problems in developing countries.'*

Even the government officials interviewed who expressed support for PPPs in principle advised extreme caution about proceeding with such models in the health sector, especially in low-income countries with limited experience and capacity to negotiate PPP contracts. All stakeholders we spoke to recommended a much higher level of transparency and accountability than was evident in the Lesotho health PPP process, to reinforce public scrutiny and understanding. Many called for a forensic audit of the PPP to reveal agreements and activities to date, and to better understand what went wrong and how problems might be mitigated – something that would be extremely valuable for other countries considering similar ventures.

'The IFC were transaction advisors. We're in this because of them. They should have done better and they must help us to get out of this mess.'

Senior official in the Ministry of Health

'Unfortunately the World Bank is promoting these kinds of PPPs as a one size fits all model, thinking it will solve all the health problems in developing countries.'

Chefa Lehlohonolo, Director of Consumer Protection Association (Lesotho)

The international evidence

Experience from other countries suggests that the problems Lesotho has experienced with its health PPP cannot simply be attributed to its low-income, low-capacity status or the poor quality advice of the IFC.

England is the longest-running and largest testing ground for health PPPs in the form of private finance initiatives (PFI) – a more limited model than Lesotho's in that it excludes delivery of clinical services. By 2012, hospitals worth a total of £11bn had been built or were under construction under PFI agreements.¹⁰³ The lifetime costs of these hospitals will amount to nearly six times this value, at £64bn by 2039.¹⁰⁴

However, no valid evidence has been provided to support the theory that PFI provides cost efficiency or value for money in the UK.^{106,107} To the contrary, a House of Commons Treasury Committee report on PFIs recently concluded that:

- the cost of capital for PFI projects is double that for direct government borrowing;
- there is no clear evidence of savings and benefits in other areas of PFI to offset the significantly higher cost of private finance;
- PFIs perform more poorly in some areas than traditionally procured projects, including in design innovation and building quality;
- PFIs are inherently inflexible, largely due to their financing structure and costly and complex procurement procedures.

In its recommendations to the UK government, the Committee said PFIs should be used as sparingly as possible.¹⁰⁸

Just as in Lesotho, large inflexible payments for PFI projects have put pressure on the UK's National Health Service (NHS) to cut jobs, working conditions and salaries.¹⁰⁹ Increasing patient throughput and reducing beds and staff to address the PFI 'affordability gap' have raised concerns about capacity and patient care.¹¹⁰

Again, just as in Lesotho, the early days of PFI in the English NHS saw significant health budget increases to cushion affordability pressures.¹¹¹ Despite this, by 2012 more than 30 NHS trusts faced the prospect of radical restructuring and cuts in order to service unsustainable PFI debts.¹¹² In the same year, 22 hospital trusts reported that PFI bills were endangering their clinical and financial future.¹¹³ The government was forced to provide £1.5bn in emergency funding.¹¹⁴ One trust has since been put into administration as a direct result of PFI debts, and others have announced the closure of accident and emergency (A&E) and maternity services.¹¹⁵

Health PPPs are being replicated internationally with similar outcomes, challenging the underlying theory that the private sector is intrinsically more efficient and responsive than the public sector.¹¹⁶ Cross-country evidence on health PPPs points to trends of increased costs compared with traditional procurement routes, compromises on quality, difficulties in future-proofing facilities, and, in many cases, prohibitive complexity.¹¹⁷

'The high costs of PFI debt charges means that the NHS can only operate anything from a third to half as many services and staff as it would have done had the scheme been funded through conventional procurement.'

Allyson Pollock, Professor of Public Health research and policy at Queen Mary, University of London, UK¹⁰⁵

'When the calculations go wrong, they can go very wrong indeed; and even some of the relatively low-cost, first-wave PFI schemes are now facing big problems.'

Dr John Lister, Senior Lecturer in Health Journalism at Coventry University, UK

In Australia, the failure rate for health PPPs is estimated to be in excess of 50 per cent, with numerous hospitals having returned to government ownership.¹¹⁸ Research has also shown that, after adjusting for case mix, public hospitals in Australia are more efficient than those that are privately operated.¹¹⁹ A systematic review identified 149 comparisons of for-profit and not-for-profit health facilities (of various types) undertaken over the past two decades in the USA. Of these studies, 88 concluded that non-profit facilities performed better with respect to cost, outcomes of care, access and social mission, 43 studies found no difference, and 18 reported for-profit facilities to be better.¹²⁰ A PricewaterhouseCoopers report on Japan concluded that inflexibility in PPP contracts was a serious problem; as a result, service provision was becoming so expensive that in several cases the government could not continue to make the payments.¹²¹

A growing number of PPIPs (partnerships like Lesotho's that include clinical service delivery) in Spain, Portugal, and indeed, the PPP in Lesotho, are said to be based on the so-called success model of Alzira Hospital in Valencia, Spain.¹²² The Alzira PPIP hospital contract operates at below Spanish benchmark costs. Claims of success overlook the fact that cost savings have largely been achieved through: staffing levels 25 per cent below equivalent public sector hospitals; reduced salaries and longer working hours; and restrictions on the range of services offered, leaving patients who need more expensive sophisticated treatment to use public hospitals instead.¹²³ The Alzira Hospital generates a profit of only 1.6 per cent.¹²⁴ This raises doubts that the model would be affordable if run on a truly commercial basis.¹²⁵

International commentators and experts on health PPPs highlight the lack of accountability and transparency that seem to characterise these projects, and the risks they pose to democracy.¹²⁶ As was the case in Lesotho, it is the norm for most of the detailed negotiations and calculations to *'take place in secret and remain shrouded in commercial confidentiality. This can mean that there is little if any objective scrutiny, with all the information in the hands of people with a vested interest and predisposition to press ahead with the contract.'*¹²⁷ This is especially concerning for the growing number of health PPPs now being proposed in many middle-income and some low-income countries, including Turkey, Malaysia, Brazil, Mexico, South Africa, Chile and Peru. Impact data on these PPPs appears unavailable to date.¹²⁸ Finding any information at all in the public domain on the IFC-supported health PPPs in Benin and Nigeria has been particularly challenging.

6 CONCLUSIONS AND RECOMMENDATIONS

The Lesotho health PPP has been described as opening a new era for private sector involvement in health care in Africa. Instead, the Ministry of Health in one of the world's poorest and most unequal countries is locked into an 18 year contract which already consumes 51 per cent of its budget. Far from being cost neutral, government spending on the IFC's flagship health PPP is spiralling; drawing resources away from other urgent healthcare needs and exacerbating health inequalities across the country.

Lesotho's experience supports the international evidence that health PPPs can be extremely high risk and costly, and strongly suggests that they should be avoided, especially in low-income, low-capacity contexts where they constitute a threat to the entire health system. Instead, lessons should be learnt from successful countries making most significant progress towards universal health coverage, all of which rely heavily on public financing and delivery of healthcare.^{129 130} As such, explicit preference should be given for financing health infrastructure and services via lower-cost publicly channeled financing. This could include concessional and non-concessional multilateral and bilateral funding.

IFC should be held to account for the poor quality of its advice to the Government of Lesotho and for marketing this health PPP as a success internationally, despite its unsustainable cost.

Oxfam and the Lesotho Consumer Protection Association make the following recommendations.

In Lesotho

The World Bank Group should:

- finance and publish a fully independent and transparent expert financial audit and broader review of the Lesotho health PPP in partnership with the Government of Lesotho, including a presentation of the full range of options available to remedy the negative impact of the partnership. The review should cover, but not be limited to options for contract renegotiation, termination and mitigation in order to reduce costs to the government. The World Bank Group should finance independent, not IFC provided, advice and support to the Government of Lesotho in this process if requested;
- scale up funding to support the Lesotho Ministry of Health to uphold and fully implement its commitment to revitalise primary healthcare and especially to rapidly increase the number of nurses, doctors and other health workers.

The Government of Lesotho should:

- fully implement its commitment to revitalise primary healthcare, prioritising investment in rural areas where more than three-quarters of the population live;
- build and strengthen the capacity of the Ministry of Health and Ministry of Finance to manage the PPP contract and reduce cost escalation as effectively as possible. This should include supervision of Tsepong's performance and ensure that financial penalties are applied when standards fall. Tsepong should be held to account for its obligation to operate the PPP hospital as a fully functioning teaching hospital;
- create a platform to actively engage civil society in monitoring and evaluating service delivery at the PPP hospital and across the health sector more generally;
- publish a full financial statement and explanation of costs of the PPP to date, to support public scrutiny and understanding;
- avoid further health PPPs unless and until the Tsepong PPP has been fully reviewed, audited and the findings published; and it can be proven, using national and international evidence, that health PPPs constitute a more appropriate, cost-effective, and equitable approach to healthcare financing and delivery than publicly financed options in Lesotho.

Tsepong Ltd should publish a full financial statement and explanation of costs to date invoiced to the Government of Lesotho. This should include a full explanation for services that are not yet provided that are included in the original PPP contract and any additional services agreed with government and invoiced for since that time. Tsepong Ltd should also provide evidence to demonstrate how it is upholding its contractual obligation to local economic empowerment.

Internationally

The World Bank Group should cease all IFC advisory work in support of pipeline health PPPs until and unless:

- the IFC's role in the Lesotho health PPP has been fully and transparently audited and reviewed and explanations have been published as to why the high-risk and unaffordable contract was pursued;
- the competency and appropriateness of the IFC as a transaction advisor on health PPPs on behalf of low- and middle-income country governments has been fully and independently investigated, with results published and reviewed by the World Bank Group Board;
- a full independent review has been undertaken and peer-reviewed evidence provided to support the appropriateness, cost-effectiveness, clinical and equity impact of health PPPs in low-income, low government capacity contexts;
- commitments can be made in the case of any future proposed health PPP supported by the World Bank Group to: conduct and publish a comprehensive value for money and equity impact assessment, demonstrating that potential benefits from PPP financing and service

delivery outweigh extra costs and risks, especially for the rest of the health system; maximize transparency and accountability by ensuring full stakeholder participation, including national parliaments and citizens, at all stages of PPP development; ensure that projected revenue expenditure on PPPs is made explicit in national debt strategies and country sustainability analysis.

The World Bank should implement its commitment to universal health coverage and equity in health by prioritising investment in free universal public services with an emphasis on primary and secondary healthcare in low- and middle-income countries

- The governments of the UK, the Netherlands, Japan and South Africa should urge the World Bank Group to implement the above recommendations and they should review their financial support to the IFC for this high-risk, high-cost model of health financing and delivery.
- Low- and middle-income country governments should avoid replicating the Lesotho health PPP model and avoid seeking advice from the IFC on health PPPs until and unless the IFC's competency has been fully investigated and confirmed. Instead give preference to public financing options for health infrastructure and services as a proven way to accelerate progress towards universal and equitable healthcare for all.

NOTES

Nineteen interviews were conducted in Lesotho for this report in February 2014 with representatives from the Government of Lesotho, Netcare, Tsepong Ltd, health worker associations, civil society organisations, the Christian Health Association of Lesotho, as well as district level and other health practitioners. A focus group was conducted with several Tspong Shareholders. Due to the sensitivity of the Lesotho health PPP most of the individual interviewees preferred to remain anonymous.

- 1 World Bank (2010), 'Lesotho. Sharing Growth by Reducing Inequality and Vulnerability: Choices for Change. A Poverty, Gender, and Social Assessment', Report No.: 46297-LS, Washington DC: The World Bank, http://www-wds.worldbank.org/external/default/WDSContentServer/WDSP/IB/2010/08/05/000333038_20100805000656/Rendered/PDF/462970ESW0P1011Official0Use0Only191.pdf
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- 4 World Bank (2010) op.cit.
- 5 Ibid.
- 6 World Health Organization, (2013) 'World Health Statistics 2013'. Available from http://www.who.int/gho/publications/world_health_statistics/2013/en/, last accessed 28th March 2014.
- 7 World Bank (2010) op. cit.
- 8 Ibid.
- 9 Ibid.
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- 12 IMF (2014), 'Sound policy design: the efficient way to cut inequality', IMF Survey magazine: Policy, www.imf.org/external/pubs/ft/survey/so/2014/POL031314A.htm
- 13 For example, Speech by World Bank Group President Jim Yong Kim on Universal Health Coverage in Emerging Economies, Center for Strategic and International Studies Conference on Universal Health Coverage in Emerging Economies, Washington DC, 14 January 2014, www.worldbank.org/en/news/speech/2014/01/14/speech-world-bank-group-president-jim-yong-kim-health-emerging-economies; Speech by World Bank Group President Jim Yong Kim at the Government of Japan-World Bank Conference on Universal Health Coverage, Tokyo, 6 December 2013, www.worldbank.org/en/news/speech/2013/12/06/speech-world-bank-group-president-jim-yong-kim-government-japan-conference-universal-health-coverage
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- 16 Ibid. http://www-wds.worldbank.org/external/default/WDSContentServer/WDSP/IB/2005/09/29/000090341_20050929090746/Rendered/PDF/32003.pdf
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 - 21 One important objective of the health PPP from a government perspective was to promote local economic development via the involvement of small and medium local businesses.
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 - 24 The payment for excess patients in local currency is M50 for inpatient and M8,326 for outpatients and is set at the base date of the contract – April 2007. It is escalated each year according to a complex inflation index heavily influenced by South Africa's medical inflation rate. It should be noted that in the Payment Schedule for the Tsepong PPP, the prices appear the wrong way round – i.e. M50 for inpatient and M8,325 for outpatients. It has been assumed this is an error, but it is one that should be double checked by the Government of Lesotho.
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 - 29 'Pilot Health PPP Advisory Facility', HANSHEP website (Harnessing non-state actors for better health for the poor), www.hanshep.org/our-programmes/pilot-health-ppp-advisory-facility
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 - 31 Information seen by Oxfam
 - 32 Lister's early analysis of the Lesotho health PPP was partly financed by Oxfam GB and his work published on the Oxfam hosted site www.globalhealthcheck.org. He has since published updated analysis in his own publication Lister, J. (2013) Health Policy Reform: Global Health versus Private Profit, UK, Libri Publishing
 - 33 J. Lister (2011) 'Lesotho hospital public private partnership: new model or false start?' <http://www.globalhealthcheck.org/?p=481>.
 - 34 The cost of the new privately run hospital is calculated at between 123% and 226% more than the old Queen Elizabeth II Hospital (QE II). Vian, T. et al op. cit. pp. 21
 - 35 The IFC-commissioned Endline study seems almost purposively misleading on this point. The study claims that in the baseline year of 2006/7, the old QEII hospital cost 38.5% of the total budget. But the figure used unfairly includes not only the old QE II Hospital but also referrals, Maseru District health centres and filter clinics, QE II's allotment for Laboratory and Research, Pharmaceutical Services, and Blood Transfusion. The fairer comparator expenditure figure from the baseline study (also used in the Endline study to calculate the cost of the QE II in today's figures) is M98,061,948 in 2006/7. As a proportion of the total health budget of M344,333,030 in 2006/7, expenditure on the QE II therefore consumed 28%.
 - 36 T. Vian et al op. cit.
 - 37 Ibid. pp. 22
 - 38 Our estimated total cost of the health PPP for 2013/14 is M714 million (see following endnote). Using the same baseline figures and methodology used by the authors of the IFC commissioned endline study for the PPP, this cost amounts to between 197% and 364% higher than the QEII hospital would have cost in 2013/14, or between 3 and 4.6 times more. It should be noted that a small proportion of cost increases may be accounted for by additional services not in the original contract but now provided by Tsepong such as transport and a blood bank.

- 39 The estimated total cost of the PPP in 2013/14 is M714 million or \$67m (average 2013 exchange rate to US\$ at 10.59750 www.xe.com). The total health budget for 2013/14 was M1.4 billion and the estimated projected outturn or total health expenditure in February 2014 was M1.6 billion. The estimated total cost is based primarily on information provided by a senior official within the Ministry of Health. The figure was broken down into the estimated total unitary fee, referrals, interest fees and penalties for late payments, transport, and shortfalls in payments carried over from 2012/13. Some carry over costs from the previous year are included in the estimated figure for 2013/14 and therefore may not be a true reflection of future annual costs. However, the senior official from the Ministry of Health said that under-payment is likely to be a recurring issue from year to year due to affordability problems so these costs need to be accounted for. The total figure provided by the Ministry of Health also included M46 million for excess patients from the previous two years. Although this is due for payment in 2013/14 and will therefore come out of the same financial year budget we are aware this figure was included in the IFC commissioned endline study figures for the cost of the PPP in 2012/13. We therefore decided to exclude this figure from the estimated total cost for 2013/14. Also added to the total cost estimate was an invoice for M100 million for excess patients for 2013 that was yet to be processed by the MoH (but was confirmed to us by a key informant from Tsepong).
- 40 The original cost to the government that was agreed as 'affordable' between the World Bank and the Government of Lesotho was M180,4 million per annum excluding VAT, stated in 2007 terms and indexed to CPI. (Cited in 'The Kingdom of Lesotho: New Referral Hospital Public Private Partnerships – Request for Best and Final Offers', 30 October 2008, Netcare Consortium and IFC). In 2013/14 this would amount to M298.8 million per annum when adjusted for inflation and including VAT. The real cost of the PPP in 2013/14 is 2.4 times this value at an estimated M714 million.
- 41 The cost to government of excess patients in 2013 was M100 million, confirmed by a key informant from Tsepong.
- 42 Information provided by senior official in the Ministry of Health
- 43 Ibid.
- 44 According to the Kingdom of Lesotho New Referral Hospital Financial Model by Tsepong (PTY) Ltd, 20 March 2009 the projected nominal Post Finance Internal Rate of Return is 25.2%
- 45 V. Vecchi, M. Hellowell and S. Gatti (2013) 'Does the private sector receive an excessive return from investments in health care infrastructure projects? Evidence from the UK'. Health Policy 110(2–3):243–270
- 46 All figures taken and calculated from the financial model for the Tsepong PPP
- 47 M. Hellowell and A. Pollock (2009) 'The private financing of NHS hospitals: politics, policy and practice', Economic Affairs 29(1): 13–19.
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- 49 All figures taken and calculated from the Financial Model for the Tsepong PPP
- 50 As outlined in the Tsepong PPP Payment Schedule
- 51 Ibid.
- 52 South Africa's normally high rate of medical inflation is widely regarded as being driven by price escalation of private medical services in the country rather than the cost of medicines which are more heavily controlled by the government. While it might be prudent to factor in the cost of South African medical products in the composite inflation index used by the Lesotho PPP, due to significant dependence on important goods from South Africa, the price of medical services in South Africa is less likely to have a significant impact on Tsepong's running costs. As such it is inappropriate that South African medical inflation has such a strong (57% weighting within the composite inflation index) influence on the fee paid by the Government of Lesotho to Tsepong. It is of note that medical inflation in South Africa has been unusually low in the past few years and so will not have had a significant bearing to date on the cost of the unitary fee. The Government of Lesotho remains at high risk however, that South African medical inflation rates will return to their high norm in the near future.
- 53 The Endline study also noted significant discrepancies in estimates of patient numbers at QEII reporting that one nurse manager at QEII suggested that the registers could have missed between 10 and 20% of patients. T. Vian et al op. cit.pp 31
- 54 M. Hellowell op. cit.
- 55 J. Lister (2013) Health Policy Reform: Global Health versus Private Profit, UK, Libri Publishing, pp 109
- 56 M46 million as calculated in T. Vian. et al op. cit and using 2013 average exchange rate to US\$ at 10.59750 www.xe.com
- 57 M100 million confirmed by Tsepong key informant and using 2013 average exchange rate to US\$ at 10.59750 www.xe.com

- 58 From 1,353 in 2007 to 2,173 in 2012. T. Vian et al op. cit.
- 59 Communication from Netcare, 28 March 2014
- 60 Lesotho–Boston Health Alliance 2009: 72 cited in Lister (2013) op. cit.
- 61 The estimated cost of interest charges passed to government given by a Tsepong key informant was M8 million and using 2013 average exchange rate to US\$ at 10.59750 www.xe.com
- 62 Information given by Tsepong key informant.
- 63 M. Hellowell op. cit.
- 64 To secure financing for the project the Government offered certain loan assurances to the DBSA through a Direct Lenders Agreement. S. Downs, D. Montagu, P. da Rita, E. Brashers and R. Feachem (2013). 'Health systems innovation in Lesotho: Design and early operations of the Maseru Public-Private Integrated Partnership', Healthcare Public-Private Series , No. 1. San Francisco: The Global Health Group, Global Health Sciences, University of California, San Francisco and PwC. Produced in the USA. First Edition, March 2013
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- 65 T. Vian et al op. cit.
- 66 Figures taken from the Tsepong PPP Financial Model and converted to US\$ using 2013 average exchange rate to US\$ at 10.59750 www.xe.com
- 67 M. Hellowell op. cit. (2013)
- 68 According to the Tsepong PPP Financial Model the overall return to equity = 25.19% (accounting for 15% of total). The return on the DBSA loan = 11.61% (accounting for 85% of total). So the overall blended interest rate, in effect Tsepong's Weighted Average Cost of Capital = 13.647%.
- 69 Communication with World Bank on 28 March 2014
- 70 The Tsepong PPP Financial Model confirms the total funding required to build the hospital was M1,164,541,000. With a government contribution of M400 million matched by donors this would leave a financing gap of M365 million. Using 2013 average exchange rate to US\$ at 10.59750 www.xe.com
- 71 Prospectus for Lesotho Government Treasury Bonds, [http://www.africanbondmarkets.org/fileadmin/Countries/Lesotho/Central_Bank_of_Lesotho/Lesotho_10_Yr_Bond_Prospectus.2011.Jun.1%20\(1\).pdf](http://www.africanbondmarkets.org/fileadmin/Countries/Lesotho/Central_Bank_of_Lesotho/Lesotho_10_Yr_Bond_Prospectus.2011.Jun.1%20(1).pdf)
- 72 All clinical outcomes reported are from T. Vian op. cit.
- 73 Male and female medical ward patients had higher mortality rates at QMMH (33% and 30%, respectively) compared to QE II (26% and 19%, respectively). Mortality rates in female surgical patients increased (from 6% to 7.6%) at QMMH compared to QE II, T. Vian op. cit.
- 74 Reported in T. Vian. op. cit. and confirmed by every stakeholder of the PPP we interviewed.
- 75 The old public hospital was situated in the centre of the capital Maseru while the QMMH is in a Greenfield site on the outskirts of the city. A number of stakeholders of the health PPP said the increased transport costs for poor patients were a matter of concern and the IFC-commissioned Endline study recommended that access and equity should be evaluated.
- 76 Other reasons could include changes in the way patients and conditions are classified; and changes in hospital discharge criteria.
- 77 World Bank communication to Oxfam 28 March 2014, and World Bank (2013) op. cit. pp14
- 78 The lack of data led the authors of the endline study to assume an average ratio of 3 outpatients to 1 inpatient to estimate a per patient unit cost. The charges made by Tsepong to the government for excess patients outpatients and inpatients (M50 and M8.326 respectively at 2007 prices) alone suggest this ratio is far from accurate.
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- 81 Government of Lesotho 'Estimates of the Kingdom of Lesotho for the financial year 2014/15.' Made available by the Ministry of Health and the Lesotho Public Accounts Committee
- 82 The budget line referred to is 'Purchase of health services' and refers to expenditure by government on third party or non-government health care providers. The budget for purchase of health services will increase from M651m in 2013/14 to M1.4 billion in 2016/17. While the total health budget increases from M1.4 billion in 2013/14 to M2.3 billion by 2016/17. Government of Lesotho (2014) op.cit.
- 83 E.g. World Bank (2005) op. cit
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- 91 In 2013/14, the Christian Health Association of Lesotho (CHAL) received M190million from the Government of Lesotho. 80% of CHAL's costs are paid for by government. Figures confirmed by CHAL's Executive Secretary and the Ministry of Health.
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- 93 The vaccine budget was M20m in 2013/14 falling to M19.8m in 2016/17. Government of Lesotho, 2014 op.cit
- 94 The budget line 'Purchase of Health Services' includes the PPP and other government expenditure on third party providers, primarily NGOs. The budget line is projected to rise from a budget of M651million in 2013/14 to M1.4 billion by 2016/17. Government of Lesotho 2014 op. cit.
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For further information on the issues raised in this paper please e-mail advocacy@oxfaminternational.org

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