Health System Innovation in Lesotho
Design and early operations of the Maseru public-private integrated partnership

Healthcare public-private partnerships series, No. 1
Executive Summary
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Ordering information
This publication is available for electronic download from the Global Health Group’s and PwC’s websites.

Recommended citation

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Images
Cover photo provided courtesy of Richard Feachem.
Acknowledgements

We are grateful for the expertise and experience so generously shared during the development of this report. While the report was prepared by the UCSF® Global Health Group and PwC, information and insights contained in the report were provided by the following organizations:

- Apparel Lesotho Alliance to Fight AIDS (ALAfA)
- Clinton Health Access Initiative (CHAI)
- Ditau Health Solutions
- The Healthcare Redesign Group
- Lesotho Boston Health Alliance (LeBoHA)
- Lesotho Ministry of Health and Social Welfare
- Lesotho Ministry of Finance and Development Planning
- Millennium Challenge Corporation
- Netcare Limited
- Partners in Health
- Tsepong (Pty) Ltd
- The World Bank Group
Health System Innovation in Lesotho

UCSF®/PwC report series on public-private partnerships

About the report series
This report on the Queen 'Mamohato Memorial Hospital and the public-private integrated partnership (PPIP) formed for the design, construction and operation of the hospital (including the provision of clinical services) is the first in a series of publications on public-private partnerships (PPPs) to be jointly authored by the UCSF® Global Health Group and PwC. This series aims to highlight innovative PPP models globally and to disseminate lessons learned and leading practices for the benefit of current and future projects around the world.

About the Global Health Group
The Global Health Group at the University of California, San Francisco (UCSF®), Global Health Sciences is an “action tank” dedicated to translating major new paradigms and approaches into large-scale action to positively impact the lives of millions of people. Led by Sir Richard Feachem, formerly the founding Executive Director of the Global Fund to Fight AIDS, Tuberculosis and Malaria, the Global Health Group works across a spectrum, from research and analysis, through policy formulation and consensus building, to catalyzing large-scale implementation of programs in collaborating low- and middle-income countries.

One of the Global Health Group’s programmatic focus areas is the role of the private sector in health systems strengthening. The Global Health Group studies a variety of innovative delivery platforms that leverage the strengths of the private sector to achieve public health goals. The Global Health Group has identified public-private partnerships in general, and public-private integrated partnerships in particular, as a promising model to improve health systems globally, including in developing countries.

For more information about the Global Health Group, visit: globalhealthsciences.ucsf.edu/global-health-group.

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PwC is one of the largest healthcare professional services firms, advising governments and private enterprises on every aspect of business performance, including: management consulting, business assurance, tax, finance, advisory services, human resources solutions, and business process outsourcing services.

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About public-private partnerships
The past three decades have witnessed a growing tendency by governments of countries at all income levels to seek out long-term partnerships with the private sector in domains such as transport, infrastructure and energy. While starting considerably later and much more cautiously, a parallel trend has emerged in the health sector. In the past ten years, there has been a rapid expansion and acceleration of interest in public-private partnership (PPP) models for health, across many continents and income levels.

PPPs are a form of long-term contract between a government and a private entity through which the government and private party jointly invest in the provision of public services. Through this arrangement, the private sector takes on significant financial, technical and operational risks and is held accountable to defined outcomes. PPPs can be applied across many sectors and typically seek to capture private sector capital or expertise to improve provision of a public service.

PPPs are characterized by the long-term nature of the contract (typically 20+ years), the shared nature of the investment or asset contribution and the transfer of some risk from the public to the private sector. These features distinguish a PPP from other contracts existing between governments and the private sector, which might not be considered PPPs.

PPPs provide governments with alternative methods of financing, infrastructure development and/or service delivery. Ideally, PPPs also give private parties the opportunity to “do well while doing good.” Ref 9 PPPs can make private capital investment more attractive to the private sector, reduce the risk profile for private investment in new markets or otherwise ease barriers to entry in new markets, all in service of defined public policy goals.
In healthcare, the public-private partnership approach can be applied to a wide range of healthcare system needs: construction of facilities, provision of medical equipment or supplies or delivery of healthcare services across the spectrum of care. While relatively simple “design, build, finance and maintain” models, like the British hospitals built under private finance initiatives (PFIs), remain the most commonplace, an increasing number of governments are experimenting with or considering more ambitious models, including public-private integrated partnerships (PPIPs), which include the provision of clinical services within the private sector scope of the PPP. Ref 23

**About public-private integrated partnerships**

This case study focuses on the Queen ‘Mamohato Memorial Hospital, a PPIP in the Kingdom of Lesotho.

PPIPs are a special form of PPP, designed to achieve significant and sustainable improvements to health systems at national or sub-national levels through both capital investment and service delivery. Ref 23

PPIPs position a private entity, or consortium of private partners, in a long-term relationship with a government to co-finance, design, build and operate public healthcare facilities and to deliver both clinical and non-clinical services at those facilities for a long-term period. PPIPs enable governments to prudently leverage private sector expertise and investment to serve public policy goals, specifically the goal of providing high-quality and affordable preventive and curative care to all citizens. PPIPs aim to be “cost neutral” to patients, who incur the same out-of-pocket payments, usually zero or minimal, as they did in the previous, often dilapidated and perhaps poorly run public facilities. These facilities revert to government ownership at the end of the contract term, ultimately guaranteeing government ownership of the facilities. Ref 7,23

PPIPs are characterized by the following four key attributes:

- **A design, build, operate and deliver (DBOD) model:** The private partner or consortium designs, co-finances, builds, operates and delivers clinical care in one or more health facilities, often including a tertiary hospital and surrounding primary and secondary facilities. This model is commonly called a “DBOD”. Unlike other PPPs, PPIPs go beyond private investment in buildings and maintenance, as the private partners are also responsible for delivering all clinical services at the facilities, from surgery to immunization to ambulance services.

- **Government ownership of assets:** The healthcare facilities are ultimately owned by the government upon termination of the PPIP contract.

- **Long-term, shared investment:** A PPIP comprises a long-term commitment by both the government and the private partners to provide health services for a defined population. Both partners invest significant resources into the project, supporting long-term dedication and a common interest in successful outcomes.

A successful PPIP must exist for a decade or more to give both public and private partners sufficient time to develop sustainable systems, processes and overall operations based on informed strategic planning and improvement through feedback loops.

- **Risk transfer:** Under the DBOD model, the private partners, not the government, are responsible for meeting defined service quality benchmarks. In this way, the private partners assume risk for delays and cost overruns in the construction phase as well as ongoing operational risk including human resource issues and failure to achieve efficiency in service delivery. Governments remain involved in ensuring service quality through regulation, contract management and/or monitoring activities. Ref 7,23

PPIPs are further characterized by their motivating policy goals:

- **Quality of care:** Improved quality of care for all at the PPIP facility and possibly across the health system;

- **Equity of access:** Unrestricted access to PPIP facilities by all, regardless of income level or social status;

- **Cost neutrality:** No change in out-of-pocket costs for patients utilizing a PPIP healthcare facility and, in some cases, cost neutrality for the government’s annual expenditure for the PPIP facilities and services relative to conventionally built and operated facilities. Where both measures of cost neutrality are achieved, the PPIP has achieved “cost neutrality squared,” or “(cost neutrality)²”;

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• Predictable government health expenditures: Fixed payments to support predictability in healthcare budgeting and stability of national health expenditures; and

• System-wide efficiency gains: High and transparent standards for service delivery and outcomes with the potential for raising performance expectations and accountability for the entire national healthcare system. Ref 7,23

Finally, effective management of inherently complex PPIPs necessitates careful monitoring being carried out independently when necessary. In an ideal model, a jointly appointed independent monitor routinely assesses project performance against metrics and outcomes mutually developed by both the public and private partners. Appropriate penalties and/or rewards are clearly tied to assessed performance. Ref 7,23

In previous publications, the Global Health Group has noted that data collection around PPIPs is challenging. Ref 7 In general, while showing a positive trend, the available academic literature is lacking analyses of—and even summary information on—PPIPs. Often there are commercial sensitivities and legalities that inhibit both public and private actors from revealing financial data, health outcomes and other project details. In high-income countries, political and regulatory factors (including national audit and budgeting departments) can ensure that upon completion, cost-efficiency and other data from the project are made available to the public. In developing countries, project data have not been made publicly available, but greater transparency should be an important goal for future projects.

We hope that this report and associated publications, including future reports in this series, will enhance the literature and evidence base for PPIPs (and other innovative PPP models) and contribute to a growing understanding of this important alternative for improving healthcare infrastructure and clinical delivery around the world. Some have argued that PPIP solutions are not scalable or generally applicable, especially in very low-income settings. While low income settings will require careful specification of required services versus nonessential services and careful consideration of the long-term affordability of contract design, the example presented here clearly demonstrates that a PPIP solution is possible even in a resource poor environment. Still, each PPIP must be tailor-made for its unique purpose and circumstances. There are common lessons and themes, but there are also myriad details which are site- and context-specific. These details matter and getting them right is, and will continue to be, at the heart of success. Ref 7,23

Methodology

Between January and October 2012, study researchers conducted qualitative interviews in Lesotho, South Africa, and the United States. Participants included employees of Tsepong (Pty) Ltd, Netcare Limited, the Lesotho Ministry of Health and Social Welfare, the Lesotho Ministry of Finance and Development Planning, the World Bank Group and multiple non-governmental organizations (NGOs) with operations in Lesotho.

The authors of this publication also conducted grey and peer-reviewed literature reviews on PPPs, PPIPs and the Lesotho PPIP specifically to inform the development of this case study. Print and web references are listed at the back of this report, and citations throughout the document refer to sources by the numbers established in this list of references.

Audience

The primary audience for this report is the governments of low and middle-income countries (LMICs), including policymakers in ministries of health and ministries of finance. This report may also be helpful to others studying how best to leverage the private sector to strengthen health systems, including donor agencies, non-governmental organizations, academic institutions and private health entities.
Executive summary

After a decade-long planning effort, Queen ‘Mamohato Memorial Hospital (QMMH) opened to serve the people of Lesotho on October 1, 2011. The project represented the first time a Public Private Integrated Partnership (PPIP) was established in sub-Saharan Africa and, moreover, in a lower income country anywhere in the world. The project was also the largest government procurement of health services in Lesotho history.

Lesotho is a small, mountainous nation of 11,720 square miles (30,335 sq km) entirely surrounded by the Republic of South Africa, with a population of around 2 million people. Lesotho’s greatest healthcare challenge is the HIV/AIDS pandemic: 23% prevalence in the adult population. The Lesotho healthcare system is predominantly publicly funded (61% of total health expenditure, 57% public hospitals), and healthcare spending represents 11.1% of GDP.

In 2000, it became apparent that the national referral hospital and district hospital for Maseru (Lesotho’s capital), Queen Elizabeth II (QEII) required replacement. After conducting a feasibility study and evaluating multiple alternatives, the Government elected to proceed with a PPP solution for hospital replacement. After engaging transaction advisors, the Government issued a tender for a PPIP project, posing the question to the private sector: for the same level of expenditure at QEII, how much more can the private sector provide in quality, breadth and volume of healthcare services?

Following a competitive tender process, Tsepong (Pty) Ltd, a consortium comprised of the private South African hospital operator Netcare and various local partners, was selected as the preferred bidder and ultimately contracted with the Government to design, build and construct a 425-bed (390 public beds, 35 private beds) hospital and attached gateway clinic, refurbish and re-equip three urban filter clinics and then provide all clinical and non-clinical services for the duration of the 18-year contract. Taken together, the hospital and filter clinics formed a health district that supported application of integrated care to improve efficiency and expand access to services for Maseru and the Kingdom of Lesotho. This ambitious project placed particular emphasis on health system strengthening and local economic development and, if successful, could provide a template for similar projects across the African continent.

The Government made significant up-front payments for hospital construction and construction site preparation (approximately US $58 million) so as to reduce the risk profile of the project and reduce downstream annual unitary payments. Approximately $95 million in financing was arranged through the Development Bank of Southern Africa (DBSA) and the Tsepong consortium contributed approximately $500,000 in equity toward capital expenditures. Annual unitary payments of approximately $30 million, which reimburse Tsepong’s capital and operating expenses, were not scheduled to begin until hospital construction was complete, so a $6.25 million grant from the World Bank’s Global Partnership for Output-Based Aid (GBOPA) was arranged as part of the PPIP contract.

With the contract, the Government greatly expanded the scope, quality, and volume of services available through the new national referral hospital with an approximate 7.5% increase in annual operating cost as compared to QEII. User fees at QMMH were equal to fees at other public hospitals, so patients paid no more for significantly improved care at QMMH, which is accessible by referral only.

Independent monitors were appointed to evaluate the quality of both construction and operations phases, and formal structures were established in the PPIP contract for joint oversight by Tsepong and the Government.
While the hospital had only been open for one year at the time of our data collection visit, numerous lessons can still be learned through the Lesotho experience. Notable challenges to date include:

- Significant, immediate demand for healthcare services at the newly opened filter clinics and hospital that has greatly exceeded contract targets in the first year of operations;
- Payment delays (both the GBOPA grant and periodic unitary payments from the Government);
- Significant cultural change for nurses, physicians, and staff working at QMMH;
- Negative media reaction during the project’s first months;
- Challenges for physician recruitment due to comparatively low salaries; and
- Delays in establishing PPP units in the Government and strengthening the Government’s contract management capabilities.

Despite these challenges, both public and private parties reported significant early achievements, including improved clinical outcomes for patients and an improved work environment for employees. Operations at QMMH have been transformed through application of strong management systems and leadership, installation of new equipment and current information technology. Early achievements include:

- Opening of the first Intensive Care Unit and Neonatal Intensive Care Unit in Lesotho;
- Reported improvement in maternal and infant mortality, post-surgical mortality, and clinical management of HIV/AIDS and related diseases;
• Establishment of guidelines and incentives that have translated into improved staff performance;
• Investment in significant training programs to enhance the skills of QMMH employees and strengthen the broader Lesotho healthcare system;
• Immediate reduction in costs associated with drug purchasing and the treatment abroad program; and
• Formation of a strong partnership between public and private parties.

Despite the early stage of the project, the Lesotho experience already holds many lessons for others considering similar PPIP or PPP initiatives, including the need to:
• Customize the PPP solution to local healthcare needs, as established in comprehensive baseline or feasibility studies;
• Access broad, appropriate expertise, including local knowledge;
• Assign strong project leadership and develop a pipeline of next generation of public and private leaders early on;
• Develop extensive plans and training programs early in the project effort; and
• Build government capacity for contract management from the outset of the project.

Overall, the case study of QMMH demonstrates the ability of a lower income country to engage the private sector in new ways and, in a relatively short period of time, transform the quality of care being provided to its population. Future success will depend on the project’s ability to weather changes in public and private leadership and manage significant demand for healthcare services to avoid allowing QMMH to become “an island of excellence” within a struggling health system. Future evaluation and greater availability and transparency of project data will be essential to establish the impact and success or failure of the project.

Figure 2: PPIP timeline

Hospital replacement need identified

2000 2001 2002 2003 2004 2005 2006 2007 2008 2009 2010 2011 2026

October 2002: Hospital replacement need identified

October 2003: Completion of initial feasibility study to evaluate options for replacing QEII

November 2007: Project tender documents issued

October 2008: Contract execution/ commercial close, subject to financing clause

March 2009: Financing clause signed/financial close. Construction begins

October 2010: QMMH and Gateway Clinic open for business under Tsepong management

March 2011: Refurbished urban filter clinics open for business under Tsepong management

October 2011: QMMH and Gateway Clinic open for business under Tsepong management

December 2026: Completion of 18-year contract
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