Our post “Ailing public hospitals in PNG: a radical remedy from Africa?” on the Devpolicy Blog last year summarized available information of a public private integrated partnership (PPIP) in Lesotho as a possible model to consider in the reconstruction and operation of dilapidated hospitals in PNG. We posed the question: “If PNG wishes to reconstruct its major hospitals and improve the quality of their services, is the Lesotho PPIP model an option to be considered?”

Since then, two reports have become available on the Lesotho PPIP. These are the 133 page final report of the Endline study for Queen Mamohato Hospital Public Private Partnership (PPP) conducted by the Centre for Global Health and Development at Boston University, published on 20 September, 2013; and an Oxfam Briefing Note of 7 April, 2014, entitled, A dangerous diversion: will the IFC’s flagship health PPP bankrupt Lesotho’s Ministry of Health? Both make interesting reading and highlight lessons from the Lesotho model, identifying ways in which the model could be improved and what further evaluation is needed. Beyond that, the reports are quite divergent in their purpose and conclusions.

The Boston University report was commissioned by the IFC and conducted by the Lesotho Boston Health Alliance (LeBoHA). LeBoHA researchers collected detailed baseline and endline indicators on the situation at Queen Mamohato Hospital (QEII) and the filter clinics, including indicators of access to services, utilization, clinical quality of care, referrals, patient satisfaction, staffing and health outcomes. The data show substantial improvements in clinical quality, access and patient satisfaction compared to baseline. The report rejects criticisms including that “quality of care, patient experience, and outcomes ... are not much different
from baseline and yet the GoL is paying a great deal more”.

The report acknowledges that the PPIP hospital costs more than the old QEII for a variety of reasons, including the addition of new services (such as a 10 bed intensive care unit and an eight bed neonatal intensive care unit, along with additional labor rooms, operating theatres, and accident and emergency), as well as significant increases in volume. The former QEII expenditures were calculated as 38.5% of the Ministry of Health (MOH) budget at baseline. The report estimates that at the originally contracted service level, which was 25% more for hospital services and 87% more for outpatient visits, the PPP hospital would have consumed 37.2% of the MOH budget. But improved access has made the utilization levels much higher than anticipated and, when this excess volume is considered, the costs of the PPIP have risen to 41.2% of the MOH budget.

The report recommends the need for improved monitoring and oversight of the partnership, a process for reviewing Independent Monitor reports to assure accuracy of data and the need to examine the full cost of services more closely.

In contrast, the Oxfam report comes out strongly on the attack against the Lesotho PPIP, the IFC, World Bank, Netcare (the hospital operator) and private sector solutions in general. It is highly critical of the quality of the advice given to Lesotho in the lead up to the PPIP decision, and the quality of support provided subsequently. It incorrectly states that the replacement of the referral hospital was not part of a broader health sector investment plan. It also raises the need for resources for primary and secondary care in rural areas, which were part of the original health sector plan, but were unfortunately never implemented.

While the Oxfam report recognizes that services have improved under the PPIP, it calls for another independent, system-wide evaluation of clinical performance and impact. It also claims that the new hospital cost at least three times what the old public hospital would have cost today, at more than half (51%) of the total government health budget, significantly higher than the LeBoHA and MOH
Some of the Oxfam criticisms of the project include:

- Unfavourable terms in the PPIP contract and inflexibility have left the government exposed to escalating costs in the future.
- There is a lack of transparency associated with the contract terms because of commercial confidentiality.
- Referrals to South Africa have increased, despite the rationale for the health PPIP being to reduce the need for these referrals.
- There has been poor management and oversight of the PPIP by the Government of Lesotho, and insufficient IFC support to the government on PPIP capacity-building of the project.
- Rapidly escalating costs have meant that the MOH is struggling to pay the monthly fees and penalty charges are being incurred for every late payment.

Both Lesotho’s MOH and Netcare have disputed the Oxfam report in the media. MOH operations adviser for health planning and statistics, Majoel Makhake, has defended the project as a good one and the health outcomes as very impressive. She has countered that Oxfam did not undertake a lot of research to come to the conclusions they made. She stated that the percentage of the health budget going to the PPIP was closer to 30%. In the same press report, Netcare CEO Richard Friedland disputed Oxfam’s claim that Netcare would get a 25% return on its investment as “grossly inaccurate”.

There is not a great deal that the reports agree upon. They were written for different purposes with different methodologies. They do agree that the PPIP hospital has delivered far better services than its dilapidated predecessor, but that financial sustainability is a key challenge that needs to be addressed.

Tertiary hospitals are part of every country’s health care system. They are complex, expensive and difficult to manage and maintain the quality of. One of the
most important lessons to be learned from the Lesotho and other PPIP projects is that enhanced access to high quality health services will lead to an increased use of these services by the people. Making choices to balance the iron triangle of cost, quality and access are issues that governments at all income levels must confront.

Beyond that, the recent reports certainly show that there are further lessons to be learned and questions that remain to be answered from the Lesotho experience, which we will continue to follow with interest.

Neelam Sekhri Feachem is the CEO of The Healthcare Redesign Group Inc. Jane Thomason is the CEO of Abt JTA.

Disclosure

About the author/s

Neelam Sekhri Feachem
Neelam Sekhri Feachem is the CEO of The Healthcare Redesign Group Inc.

Jane Thomason
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Lesotho hospital
PPIP under fire
By Neelam Sekhri Feachem and Jane Thomason
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The Prime Minister of PNG publicly decries the state of PNG hospitals, and regularly approaches his near neighbor Australia for help to improve them. The poor state of PNG hospitals is a consequence of a long slow deterioration of infrastructure, and weakening governance and management. Initially hospitals were made delegated functions when decentralization was first implemented, and were then re-centralized, followed by a well-intentioned, but insufficiently thought through move to place them under independent Boards reporting directly to the Health Minister. Port Moresby General Hospital, the leading tertiary referral hospital in PNG, arguably is not of a standard that the government, the medical and nursing fraternity nor the general public find acceptable. The highly motivated Board have recently appointed an expatriate hospital manager to try and turn the trajectory for the hospital. Will this be enough? Or is more radical surgery worth considering? Let us at least pose the question, so that it can be debated publicly. Can PNG do what Lesotho did to turn its tertiary referral hospital around – radically, decisively and very much for the better?

What did Lesotho do?

Lesotho, a small mountain kingdom, surrounded by the Republic of South Africa was confronted with decaying and low quality publicly run hospitals. The flagship hospital of the health system was the Queen Elizabeth II (QEII), the country’s 100-year-old only national referral hospital, located in the capital Maseru. A legacy of British Colonial rule, QEII was crumbling, consuming increasing amounts of the government budget, and delivering poor and deteriorating services.

Rather than repeat the failed investments of the past, the Minister of Finance,
Tim Thahane, decided to experiment with a radical new idea. What would happen, he asked, if we offered the private sector the same amount of money we spend today on this run down public hospital? What could they offer us? Could we get better quality and better services for the people of Lesotho, at the same price?

The answer has been a resounding yes.

**Enter the Public Private Integrated Partnership**

A Public Private Integrated Partnership (PPIP) is an innovative PPP in which the government enters into a long-term contract with a private operator to build, design, operate and deliver a full range of clinical services to a population. This model harnesses private capital and management expertise, while retaining public ownership and oversight of health services. Experience in other countries, particularly in Valencia, Spain, has shown that the model can have a significant impact on the quality and efficiency of health care. [1]

But can this work in a low-income country? Lesotho’s example is instructive.

Given that it had to make a major infrastructure investment on QEII, the PPIP solution met all of the government’s key policy goals by:

- Making capital expenditures affordable in the near term
- Providing Government budget stability through defined and predictable health expenditures
- Transferring risk to the private sector for construction delays or cost overruns for a large and complex building project
- Transferring significant operational risk for the delivery of complex health care services, while capturing the efficiencies of private sector management
- Providing an economic engine for growth for locally owned businesses.

Working with the International Finance Corporation (IFC) as transaction advisors,
the government issued an open international tender which posed a challenge to all bidders: for the same level of expenditure as QEII, how much more could the private sector deliver in quality, breadth, and volume of health care services?

After a formal and transparent bid process, the Tsepong Consortium was awarded an 18-year contract to build a 425-bed hospital linked to three primary clinics, offer a full range of secondary and tertiary care (some of which had previously been referred to South Africa); integrate hospital services with primary care for Maseru; and make a major commitment to enhancing the limited human resources capacities of the country. As in all PPIPs, the government retains ownership of the assets, and the facilities must provide services to the population originally served by the public facilities, at no additional cost to patients.

Tsepong is jointly owned by Lesotho doctors, who also provide specialist services to the hospital; doctors and specialists from South Africa, a local firm for Basotho women, members of the local chamber of commerce, and Netcare Limited, a South African hospital management firm, and a South African private health care provider.

The new arrangement represents a major shift in role for the Ministry of Health from a provider to a purchaser of care, with responsibility for improving value for money and quality of services provided to the people of Lesotho. To assist the Ministry of Health in this unfamiliar role, an Independent Monitor has been appointed to measure compliance with the detailed performance indicators specified in the contract and to assess associated penalties for not achieving performance levels. Indicators cover a full range of clinical service quality, equipment, drug supply management, information technology, and staff certification and training. For example, 85% of patients with a provisional diagnosis of myocardial infarction must receive aspirin within 30 minutes of evaluation; and the fully automated medical record system must be up and operational at least 99% of the time. In addition, after an initial stand-up period, the hospital is required to obtain accreditation by the Council for Health Service
Accreditation of South Africa.

And what about the money?

The PPIP structure provides for co-financing of capital expenditures for construction, refurbishment and equipping the hospital and associated clinics; and also provides for an ongoing payment from the government to the Consortium for service delivery at the facilities. Both repayments are contained in a single unitary payment. This payment did not begin until after the hospital was opened and started seeing patients. This was 3 years after the contract was signed. All upfront expenses were covered by the Consortium.

Under the contract Tsepong provides almost 30% more hospital admissions and 87% more outpatient visits for an estimated 7% increase in operating costs over Queen II. If service volumes exceed contracted amounts, additional fees are paid to Tsepong, but the government must approve these increases. Under this payment structure, the government is basically contracting for a fixed volume of patients (inpatients and outpatients). This volume based payment structure, has not been without its problems, and the cost of the additional public activity has been a source of some tension between the government and the operator.

This is not the only payment structure option for a PPIP and it is worth looking at how other countries have dealt with payment structures differently. In the Turks and Caicos for example, the operator is paid on a capitation basis, similar to the Alzira model in Spain. This model has some advantages as it incorporates a broader healthcare picture which includes primary care, rather than the traditional “let’s build a big Hospital” approach.

The way it is now

The clinics and hospital were completed on time and on schedule. After one year of operation in the new Queen Mamohato Memorial Hospital, maternal mortality has decreased by 50% despite treating much more complex cases. Overall patient...
mortality decreased from 12% to 7% and there has been a large increase in patient satisfaction. A range of clinical capabilities have been established for the first time in Lesotho, such as neonatal intensive care, thus saving lives and reducing expensive referrals to South Africa. A fully electronic medical record and reporting system has been implemented to allow detailed performance monitoring on a large set of quality and service indicators.

A key objective of the government was to increase human resources capacity in the country. There has been extensive training of physicians and nurses. Previous shortages of doctors and nurses have been addressed through international recruitment and the return of Basotho professionals to the country.

The tangible increase in quality, service and facilities has come at a price. In the first year, the hospital surpassed its negotiated volumes. The PPIP represents an island of excellence in a sea of mediocrity. In the longer run, the strengthening of other parts of the health system (including district hospitals and outlying health facilities) remains a priority, so that patients will not need to travel to the capital to get quality care. But, given the previous state of affairs, this is a good problem to have.

**Lessons for Papua New Guinea**

This approach could be an option worth considering in PNG. However, it represents a significant change in mindset for PNG and the generally accepted view of how the health system operates. PNG has a tradition and comfort level with government-owned and operated hospitals. To follow Lesotho would mean that the government would need to make a paradigm shift from “provider” to “steward” of the health system. This would require both new skills, and a new way of understanding the government role in ensuring health services are provided – but not necessarily providing them.

We expect that such a transition from a publicly owned and run hospital to a PPIP such as in Lesotho would be challenging. Doubtless, opposition politicians will
accuse the government of privatizing the health care system, even though all facilities remain in public ownership. Most likely, trade unions would object. Initially, doctors with entrenched interests in the old ways may resist the change. But experience suggests that they quickly become converts once they experience the greatly improved working conditions and clinical opportunities.

These problems can be overcome but they require strong and bold political and technical leadership.

The fundamental driver of change is an unequivocal recognition that the current system is broken and that further investment will not fix it. Something new is needed. Public hospitals in Papua New Guinea are an extreme example of the inability of the post-independence period to maintain the standards that should be enjoyed by the population. Despite the best efforts of many and funding from government and donors alike, hospitals continue to under perform. If you keep doing as you have always done, you will get what you have always had... a new solution is needed.

The experience of Lesotho needs at least to be on the table and in the public debate. We believe that it is possible to change the discourse on hospitals in PNG – but is there the political will and courage to accept the radical surgery to do so?

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