Towards Explaining the Cause of PPP as a Dangerous Diversion of Meager Resources in Lesotho

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Abstract: **The article examines the greatly marketed Public-Private Partnerships (PPPs) as a means towards realizing solutions on the protracted health challenges in the Kingdom of Lesotho. It is premised on the idea that while there may be differing views on the appropriateness and inappropriateness of the PPPs in Lesotho, what remains an issue of concern is the decision to invest in an arrangement that the country has little or no experience in, especially on the health sector. To further explain this particular problem, the paper employs three theoretical approaches to analyze Lesotho's decision to invest in the PPP. This article is motivated by the question, what led to the Lesotho PPP in the form of Queen 'Mamohato Memorial Hospital being considered a dangerous diversion of the Ministry of Health meagre resources? As a point of departure, the conceptualization of PPP is explored. The article will proceed to provide a background on the PPP in Lesotho, theoretical approaches as well as touching on the literature and general implications of the model in Lesotho.**

Keywords: **Public-Private Partnership, Infrastructure, Health**

I. INTRODUCTION

The Public-Private Partnerships (PPPs) are increasingly being promoted as a solution to the shortfall in financing needed to achieve the Sustainable Development Goals (SDGs). From economic infrastructure, such as railways, roads, airports and ports, to key services such as health, education, water and electricity, the much touted model of PPP is being employed to deliver such infrastructural developments in various countries in both the global north and south (Gondard, 25 September 2018). However, this model has not come without serious negative financial implications for countries, and in Kingdom of Lesotho's health sector and the country at large.

It is important to note this early that the ability to secure private investment and or new sources to finance the infrastructure through the Special Purpose Vehicle (SPV) (a subsidiary created by a parent company to isolate financial risk) is one motivation for the Lesotho government to have taken the PPP among many other motivations. By implication, the use of SPV also means that PPP in Lesotho was financed off-balance sheet. But the problem is not so much about the manner in which the project was financed, but the actual decision of investing in the PPP, arguably as shall be demonstrated, without a clear forecasting and understanding of the model in its totality. I note and acknowledge that various problem diagnosis may be adopted by different scholars towards explanations of the Lesotho problem with the PPP in the health sector.

In light of the focus of this paper, it proposes that the problems of PPP in Lesotho can best be understood through the theoretical lenses of Asymmetric Information, Agency theory and Incomplete Contracts respectively as they both build on one another. The essay also acknowledges that while there is a problem of management of infrastructure due to lack of expertise in this area in the Lesotho government, the cause of the current financial burden can be traced to the initial decision to invest in the PPP in Lesotho. As a point of departure, the conceptualization of PPP and its background in Lesotho is explored.

Conceptualizing Public Private Partnerships

Public Private Partnerships (hereafter PPP) definition is not so much nebulous as though it may variously, in terms of the wording be explained, but the general idea in terms of what it is, seems to be in concert.Yescombe (2007) defines PPP as a long term contracting mechanism between the public sector (maybe national, state, provincial, or local level) and private (non-state) in order to provide public services, which are and or were traditionally the domain of the public sector to provide. The World Bank also posit that PPPs can be understood to mean long-term contracts between a private party and a government agency, for providing a public asset or service, in which the private party bears significant risk and management responsibility (World Bank, 2016). Put simply, both definitions signal an important aspect of an agreement, which is a partnership that the two parties enter into for the purpose of the provision of an asset or a service.

According to Sulser (2018), PPP is a long-term contract between a private party and government entity, for providing a public asset or service, in which the private party bears substantial risk and management responsibillity, and renumeration linked to perfomance. All the above definitions are in concert in terms of the nature of parties that constitute PPP. Striking in similarity also, is the defintion provided by the World Bank and that of Sulser, where they emphasize the risk bearing is by the private sector. While such is true even in the case of Lesotho, the burden of risk seems to have also been placed, peradventure in as far as PPPs are concerned, arguably on the side of the government, such that the PPP threatens the Ministry of Health budget, as will be explored.

The aforementioned definitions suffice to be adopted by the paper due to the extent of their similarity. Furthermore, while PPP in the Health Sector in Lesotho is a new phenomenon, and arguably in Africa, the PPP has variously been marketed in the past. According to Osborne (2000), 1990s saw the establishment of the PPPs as a key tool of public policy across the world. The touted PPPs according to Osborne were not only seen as cost-efficient and effective mechanism for the implementation of public policy across a range of policy agendas but they have also been articulated as bringing significant benefits in their own right, some of which are stated below. In concert with Osborne, in as far as the advertising of PPP is concerned, Richard (2008), also provides that, it is in the 1990s, that government sectors were keen to seize opportunities for the private sector to participate in supporting the development of related infrastructure and public services within the PPPs framework. The PPP covers a wide area of infrastructural activities such as construction and the maintenance of government infrastructure assets, as well as management of assets like schools and hospitals.

Despite associated drawbacks that accompany the establishment and or investment in this new public management approach, some of which will be dealt with later, PPPs present some notable opportunities to achieve a number of public policy outcomes, which include but not limited to; the chance to reform the local public services, making them more accessible to the local community and more responsive to their needs; as well as the opportunity to develop cost-efficient ways of providing local services to meet the social needs which are able to utilize resources from both the public and private spheres (Osborne, 2000).

Meanwhile, a further understanding of the PPPs is through various models in which such a partnership between the private and the public sector may be realised. As indicated below, these various models may simply be referred to as types of PPPs. A number of scholars, including Mckee, Edwards and Atun (2006), have presented different models/types of PPPs as recapitulated below;

MODEL	DISCRIPTION
Franchising	Public authority contracts a private company to manage existing hospital
DBFO (Design, Build, Finance, Operate)	Private Consortium designs facilities based on public authority's specified requirements, builds the facility, finances the capital cost and operates their facilities.
BOO (Build, Own, Operate)	Public Authority Purchases Services for a fixed period, say 20 or 30 years, after which ownership remains with private provider
BOOT (Build, Own, Operate, Transfer)	Public Authority purchases services for a fixed period after which ownership reverts to public authority
BOLB (Buy, Own, lease back)	Private Contractor lease hospital; facility is leased back and managed by public authority.
Alzira model	Private Contractor builds and operates hospital with contract to provide care for a defined population.

Source: Mckee, Edwards, & Atun (2006)

Background of Public-Private Partnership in Health Sector in Lesotho

It is now a common knowledge that the government of the Kingdom of Lesotho had contemplated on options for a new national hospital to replace the old Queen Elizabeth II (QEII) hospital. In 2000, it became ostensible that the national referral hospital and Maseru district hospital QEII required replacement. The facility was plagued by dilapidated infrastructure, poor management systems and human resource shortages, all of which were contributing to a significant decline in service quality. Spending was inefficient and escalating at a fast pace: the operating budget for QEII had grown by 50% between 1995 and 2000, during the same period that service volumes and quality were declining (Downs, Montagu, da Rita, Brashers, & Feachem, 2013, p. 16).

A litany of challenges had also bedeviled the Ministry of Health. These challenges included among others, rigid public service rules that undermined an effective responsive operation that might have better evolved to meet new healthcare challenges and correct operational inefficiencies, a highly centralized organizational structure that concentrated decision-making power in only a few individuals, a slow and burdensome personnel disciplinary process, a slow accounts payable process that often led to significant delays in vendor payment and a weak data collection and reporting process to support planning and operations. Furthermore, many services were unavailable through the Lesotho public health system and required referral for treatment in South African facilities at premium prices. In 2001 this treatment abroad program cost the Government M10 million ($1.2 million)*(at the time of the writing of their report)* and periodic price increases at contracted Bloemfontein facilities indicated this program would fast become unsustainable (Downs, Montagu, da Rita, Brashers, & Feachem, 2013, p. 16).

As a response to these challenges, the country's health sector reform program was launched and government explored options that will speak to the pressing need of improved health servicesfor the same level of expenditure at QEII. Due to the capital constraints of the Ministry of Health at the time, four (4) options for hospital replacement were considered as clearly indicated by(Matthew, 2010);

- Finance the full capital sum from the Government domestic budget with the Government overseeing the construction phase and subsequently managing clinical and non-clinical services in the new facility;
- Borrow from the World Bank or other third party who might lend money on concessional terms with the Government overseeing construction and subsequently managing clinical and non-clinical services in the new facility;
- Construct the new hospital building under a PPP arrangement similar to the Ministry of Health headquarters project with the Government managing

clinical and non-clinical services following construction;

- Tender for a single operator to design, build, partially finance and operate the hospital, including full provision of clinical and nonclinical services and employment of all personnel.

The eventual decision was an investment in the PPP (last option above), a move which was considered bold given the government's limited experience in managing PPPs, the lack of a legal framework for PPPs, and the complexity of the project under consideration(Downs, Montagu, da Rita, Brashers, & Feachem, 2013). The investment in this area was also a result of government having reached out to the World Bank in 2006 to assist on how the private sector could help develop critical public health facilities that would more effectively function to provide efficient, higher quality care and services. It is in the same year that the International Finance Corporation (hereafter IFC) was mandated to be the transection advisor, assisting the government in structuring PPP that included constructing a new 425-bed national referral hospital and gateway clinic, and refurbishing and re-equipping three primary care clinics (World Bank, 2016).

The Queen 'Mamohato Memorial Hospital in Lesotho was built under PPP to replace the old main public hospital and became the first of its kind in a low-income country. This arrangement that entered into force in 2009 was labelled as opening a new era for private sector involvement in healthcare in Africa, and was seen as the IFC's flagship model to be replicated across the continent (Oxfam & Lesotho Consumer Rights Protection, 7 April 2014). But according to the Oxfam report, 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 signalled a dangerous diversion of scarce public funds from primary healthcare services in rural areas.

Recently, Lesotho government and its partner in the PPP arrangement find themselves at lock heads over some issues including contractual responsibilities as will be discussed later. The PPP also face various challenges such as managing high demand for health services which is a result of inadequate primary health care facilities. It also faces the challenge of inadequate referral system which all these challenges briefly mentioned find their way into the government coffers. Meanwhile, the Oxfam report declaratively state that 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. It proposes that the IFC should be held accountable for the poor quality of its advice to Lesotho government and for marketing this health PPP as a success internationally, despite its unsustainable costs. But how the government of Lesotho ended up investing in this initiative is what the essay now turns to and invokes three theoretical frameworks to explain these problems.

II. THEORETICAL FRAMEWORK(s)

The government of Lesotho's decision to invest in the PPP is first of all understood through the lenses of Asymmetric Information, a theory first introduced in George A. Akerlof's 1970 paper The Market for "Lemons". Akerlof (1970) speaks to the issue of quality uncertainty and the market mechanism, in which he develops asymmetric information with the example case of automobile market. His basic argument is that in many markets the buyer uses some market statistic to measure the value of a class of goods. Thus, he provides that the buyer sees the average of the whole market while the seller has more intimate knowledge of a specific item.

This theory thus shares light on the state of the Lesotho government on this particular arrangement of PPP. According to account of interviews in Oxfam & Lesotho Consumer Rights Report (2014:16), government officials of Lesotho expressed support for PPPs in principle but advised extreme caution about proceeding with such a model in the health sector, especially in low-income countries with limited experience and capacity to negotiate PPP contracts. This theory acknowledges and highlights the importance of information in financial transactions, thus giving some level of assurance that had the buyer, in this case Lesotho, had sufficient information about the product (PPP), the net result would have been either stopping the agreement or renegotiating the terms of the agreement.

But the Asymmetric Information can only help us understand in so far as the information is concerned. If anything, it rests on the assumption that information is key and fails to account for other intervening factors such as political ambitions and self-interests of the individuals within the government of Lesotho as the principal and the World Bank's International Finance Corporation (IFC) as the agent. This behaviour is further explained by Agency theory. According to Jensen (2000), an agency relationship can be defined as a contract under which one or more persons (the principal(s)) engage another person (the agent) to perform some service on their behalf which involves delegating some decision making authority to the agent.

As is the case, the government of Lesotho engaged the services of IFC as its agent to coordinate and ensure the contract signing of the PPP. Among other things IFC played a very important role of advising. However, it is very important to note that for the government to be able to sign a contract with a private party called Netcare, a South African based company, IFC gets a reward in the form of a fee. This fee of USD723, 000.00 (about M12,000,000.00 in Lesotho currency) (Boloetse, 2018) is what can best be described and or argued as having invoked an opportunistic behaviour in the agent, as well as to see through the establishment of the much touted PPP. This ambition in the form of opportunistic behaviour may have clouded the judgement of the agent in terms of

realizing the context within which the PPP was to operate in Lesotho.

The Oxfam report, which has extensively carried a research in this area, reported that the agent has acted irresponsibly, both in terms of its role as a transaction advisor to the Lesotho government and in its marketing of the Lesotho health PPP as a successful model for other low-income countries to replicate. It quotes one interviewee, a senior Ministry of Health official having 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.'

But one would think that now that the PPP is becoming a pain to the Lesotho government and the general public, the government would be able to renegotiate the terms of the agreement, more so as the concerns have since been registered shortly after the hospital in question operated. However, it appears that it is not really that easy and would even cost the government more to persuade the private partner to come to the negotiation table. This has largely been attributed to the nature of the of the PPP contract which privilege the partner more than the government. This scenario can be understood from the perspective of Incomplete Contracts.

The theory of Incomplete Contracts builds on the foundation of the agency theory and the asymmetric information theory. It explains why it may be beneficial to leave contracts "incomplete", that is to not consider some rights explicitly, for example (Grossman & Hart, 1986). The effect is caused by the asymmetry of benefit caused by giving all rights to the other party who then does not have an incentive to work for the benefit of those rights. As is the case, this theory builds on the foundations of the two theories discussed prior and explains why today, the government of Lesotho has found it difficult to renegotiate the terms of contract. The contract failed to take into account the changing environment, thus failing to leave room for some amendments at any time necessary in the provisions in line with the changing environment. The fact that the government of Lesotho seems not to be able to terminate the contract that has become a burden to the Ministry of Health in terms of finances, signal that the contract it entered into is not incomplete.

Literature on PPPs and General Implications in Lesotho

It has been demonstrated earlier that the main motivation for the government to consider PPP model is the ability to bring in new sources to finance public infrastructures and services, and the manner in which the PPP was marketed. Weber and Alfen (2010) define project financing (a method employed by the government of Lesotho on Queen Mamohato Memorial Hospital) to mean the financing of a particular, clearly definable economic unit (project) in which mainly depends on the project cash flow. The key characteristics in financing a PPP project includes project company (SPV); cash flow-based lending; risk sharing structure; limitation of liability; and off-balance sheet finance. This is the finance aspect of the PPP in question in Lesotho.

The PPP in Lesotho was developed under the advice of IFC, the private sector investment arm of the World Bank Group and it is the first of its kind in Africa because all the facilities were designed, built, financed, and operated under a public–private partnership (PPP) that includes delivery of all clinical services.The promise was that the PPP would provide vastly improved, high-quality healthcare services.

The public hospital in question was built at a cost of at least US$100 million (about M1, 700, 000, 000.00 in Lesotho currency) and is being operated under an 18-year contract between the Ministry of Health in Lesotho and a consortium assembled by Netcare, one of the large operators of private hospitals in South Africa and the United Kingdom. It is the 425-bed facility is an outpost of stylish architectural functionalism in threadbare in the country. Like Netcare's hospitals in South Africa, the Queen Mamohato, which opened in 2011, is a spacious clinical oasis furnished with technologically-advanced care units and patient-friendly lounges and wards (Webster, 2015).

But today this infrastructure development threatens to bankrupt the tiny Kingdom of Lesotho's Ministry of Health. According to (Kabi, 2020), the government in 2018/19 financial year spent 699 million Maloti of the 2, 5 billion Maloti health budget on this PPP. It is the challenges that Lesotho and other countries face which have led to the raising of concerns and expression of caution over this much marketed model (PPP). This brings in the issue of risk sharing and risk management in as far as the PPPs are concerned. Risk sharing and risk management is one of the most important aspects of the PPPs, which the private sector or partner and the public sector should take into account ahead of an agreement, as from the public administration idea, risk distribution is a significant objective of PPPs(Teisman & Klijn, 2002).

According to Albertus (2019), PPPs are planned to guarantee that risk is apportioned for both the private and public sector to guarantee decrease in cost overruns and value-positive consequences for the people but that experiential research reveals that this has not continually been attained. It is further indicated by Pollock, Price and Player (2007), that a UK study, which revised UK Treasury, forms, shows evidence of enormous cost overruns, deferrals, and terminations of PPP projects, which were ultimately remunerated by the citizens. The private sector frequently have higher procedural knowledge of risk features and are capable to bargain as well as impact the design of PPP contracts to decrease their own risks, at the expense of the people and or public entity(Loosemore & Cheung, 2015).

The aforementioned has further led to this article exploration of more literature on this model implication. Clive, Hodges, and Schur (2003) provide that the PPP arrangement for ICT services, for example, has globally made headlines as a result of termination and renegotiation of such agreements for ICT service providers. They provide that for numerous intentions,

the renegotiation of contracts has not been an uncommon incidence. But renegotiation as demonstrated through the theory of incomplete contract, is not that easy in the case of Lesotho.

Further concern on the PPPs have been delivered by Johnston and Gudergan (2007), as well as Vining and Boardman (2008) who criticised them as a neoliberal approach to privilege private enterprises with no thought for citizens and society. Another damning verdict that cements Johnston and Gudergan stance on the PPPs has been that delivered by(Estache & Serebrisky, 2004), who have pointed that even international groups such as International Monetary Fund and the World Bank repeatedly push this prototype on governments in unindustrialized and emerging countries. From this, there is a sense of the extent to which PPPs are inappropriate to the least developed countries, although this is a narrow way of lookig at it, in light of the fact that even some developed nations have experienced struggles with PPPs.

But perhaps a more relevant concern to our context has been that advanced by Bosely (2014), who stated that, the use of the PPP to build hospitals have a poor track record even in the developed wealthy west. Public Finance Initiatives have proved a heavy financial burden on the NHS in England, where 22 hospital trusts in 2012 said repayments were endangering their clinical and financial future. This is especially worrying in the case of Lesotho as, worse, the country did not have any experience on this particular arrangement, and thus even the monitoring of the project will be very difficult.

Lack of understanding and disregard for concerns is the basis upon which the paper built its argument as earlier indicated. Logic dictates (ceteris paribus), that had the government of Lesotho done proper forecasting which would help it plan well, the current threat of financial burden would have been minimised. As is the claim of asymmetric information, it is empirically clear that people possess different information. The information they possess affects their behaviour in many situations. In the market where one ponders to buy goods, the seller adjusts the price of an item based on his or her knowledge of the prices of similar items on the market and the condition of the item among other factors. The buyer similarly can have information about the prices of similar items in the market. But what the buyer probably does not have is the same depth of information about the quality of the item as its seller. There is clearly an information asymmetry between the two parties at issue (Auronen, 2003).

A report authored by Cecilia Gondard empowered by Eurodad gave an in-depth, evidence-based analysis of the impact of 10 PPP projects that have taken place across four continents, in both developed and developing countries. These case studies built on research conducted by civil society experts in recent years and have been written by the people who often work with and around the communities affected by these projects. The countries included are: Colombia, France, India, Indonesia, Lesotho, Liberia, Peru, Spain and Sweden. The sectors they cover are: education, energy, healthcare, transport, and water and sanitation.

Their research revealed that all 10 projects came with a high cost for the public purse, an excessive level of risk for the public sector and, therefore, a heavy burden for citizens. It picks in the case of Lesotho that Queen Mamohato Memorial Hospital has had significant adverse and unpredictable financial consequences on public funds. It reveals that "latest figures suggest that in 2016 the private partner Tšepong 'invoiced' fees amount to two times the affordability threshold set by the Government and the WB at the outset of the PPP. Contributing factors to cost escalation include flawed indexation of the annual fee paid by the government to Tšepong (unitary fee) and *poor forecasting*(emphasis added)," Gondard (25 September 2018).

On the other hand, the Oxfam report which specifically investigated Lesotho's PPP revealed its financial implications that, the hospitals in question together with 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 (Oxfam & Lesotho Consumer Rights Protection 7 April 2014).

III. CONCLUSION

The state of the PPP in Lesotho is indeed worrying. While the infrastructural development in question is credited for improved quality services in comparison with the old hospital, the financial burden that is a product of, arguably lack of information and or personal ambitions, poor forecasting and

planning have ushered in a bad reputation for this infrastructure in the health sector of developing countries. According to Marriott(2018, p. 22),Lesotho has some of the world's highest recorded disease burdens, as well as high maternal and infant mortality rates, and serious inequity remains in the distribution and reach of services across the country. Spending per capita in the capital city Maseru is double the amount of the second place district. Whilst the PPP cannot be blamed for some of the long-term structural constraints to progress, including poor management and budgeting, and the unequal distribution of human resources, the cost and the inflexibility of the hospital PPP significantly curtails the ability of the government to invest where need is greatest.

Indeed the declarative statement by the Oxfam report that what we are witnessing in Lesotho is a dangerous diversion of resources is true. Going further, the need for proper consultations, weighing of advice on the development of appropriate infrastructure has never proven very important as is today.This view can further be cemented by the lessoned learned in the case of the current PPP under discussion, as concluded by Marriott(2018, p. 22) that, there are multiple and wide-ranging reasons for the high and escalating cost of the Lesotho PPP hospital. Marriott continues that many reasons seem inherent to health PPPs and raise serious questions about why the model was proposed in the context of Lesotho. Other cost increases appear to be the result of poor quality advice and ill-informed or irresponsible decision making about the contract and its financial model.

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