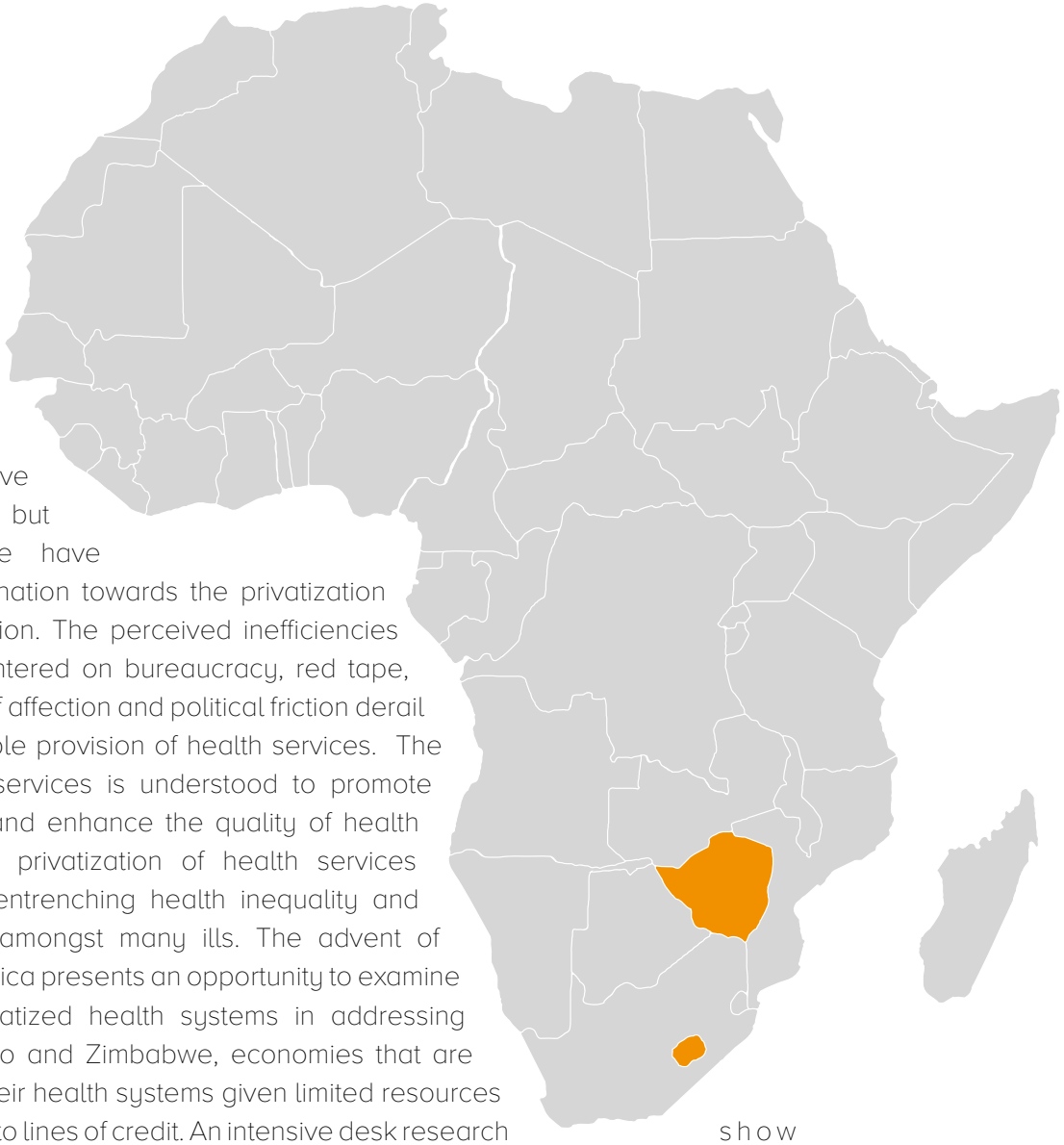
POLICY BRIEF

THE IMPACTS OF THE PRIVATIZATION OF HEALTH IN THE COVID-19 RESPONSES OF LESOTHO AND ZIMBABWE

EXECUTIVE SUMMARY



The provision of health services was predominantly a preserve of the government, but the winds of change have brought a growing inclination towards the privatization of health service provision. The perceived inefficiencies of the public sector centered on bureaucracy, red tape, corruption, economies of affection and political friction derail the efficient and equitable provision of health services. The privatization of health services is understood to promote efficiency, robustness, and enhance the quality of health systems. However, the privatization of health services has been blamed for entrenching health inequality and exclusion of the poor amongst many ills. The advent of COVID-19 in Southern Africa presents an opportunity to examine the contribution of privatized health systems in addressing the pandemic in Lesotho and Zimbabwe, economies that are struggling to upgrade their health systems given limited resources and constrained access to lines of credit. An intensive desk research show that the health systems of Lesotho and Zimbabwe are privatized though at varied degrees. Lesotho has a Faith-Based Organization serving a significant proportion of the population and a giant public-private partnership deal meant to be the epitome of health service provision. Zimbabwe has innumerable profit-oriented private players that also dominate numerous specialist medical fields. Notably, the increase in health fiscal support during the COVID-19 era is meant to fight the pandemic but the impact remains subdued. The corporate sector, international donors, and international development partners played a pivotal role in fighting COVID-19 in the two countries as the usual private health service providers faced limited expertise and bed capacity to contain the pandemic. The corporate sector has taken a lead in gathering resources to acquire 1.1 million COVID-19 vaccines in Lesotho whilst Zimbabwe has received significant donations of various vaccines supplemented by vaccine purchases by government, albeit the inadequacy of the same. Whereas the privatization of health services is met with a number of policy challenges, it is imperative for governments to dedicate more resources to the health sector and meet international benchmarks such the Abuja Declaration. Also, the structuring of PPP must be backed by a well-thought financing strategy to inculcate sustainability into the future. The private sector also must invest in diversifying their market and serve the remote areas and complement government's disease prevention motive and equity in health access. The liberalization of the health sector must be associated with rigorous compliance monitoring to nip malpractices.

LIST OF ACRONYMS

AU	African Union
CHAL	Christian Health Association of Lesotho
CSOs	Civil Society Organizations
CSOs	Civil Society Organizations
EPRL	Emergency Preparedness and Response Loan
FBO	Faith Based Organization
ICU	Intensive Care Unit
LPPA	Lesotho Planned Parenthood Association
MDGs	Millennium Development Goals
NCDs	Non-Communicable Diseases
NHSP	National Health Strategic Plan
PPIPs	Public Private Integrative Partnerships
PPP	Public Private Partnerships
PSI	Population Services International
QMMH	Queen Mamohato Memorial Hospital
SACU	Southern African Customs Union
SADC	Southern Africa Development Community
UNICEF	United Nations Children's Fund formally United Nations International Children's Emergency Fund
WHO	World Health Organization

TABLE OF CONTENTS

LIST OF FIGURES

LIST OF TABLES

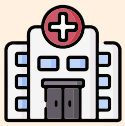
INTRODUCTION

Health – a second-generation fundamental basic human right must be equitably accessed and protected from any form of manipulation or abuse. Accordingly, governments in Southern Africa and the greater of the African continent strive to invest in the best health facilities that are designed to serve every citizen equitably. However, recent developments in policy discourse indicates that leading policy scholars support the privatization of health services as a way of promoting efficiency, robustness, and quality of health systems. Truthfully, Africa has encountered various complex and complementing challenges which impede effective service delivery across the public sector. On account of poor governance, inefficiency, corruption, nepotism, economies of affection and ineffectiveness; the bureaucracy, red tape, and political friction in the public sector is thought to threaten the provision of health service. Therefore, private players – some driven by market, profit, and peculiar interests – are well positioned to provide health services at the requisite quality and impartially. Privatization has assumed varied formations, all directed towards advancement of economic and service delivery.

Nevertheless, the privatization of health services has been blamed for entrenching health inequality (as the poor might not afford privatized health services), incompetent regulatory capacity of the government, loss of expert health personnel to the private sector and escalated malfeasance of public health institutions amongst many ills. The advent of COVID-19 in Southern Africa presents an opportunity to examine the contribution of the private sector in addressing health and humanitarian crisis in embattled countries (Lesotho and Zimbabwe), whose struggle has been to upgrade their health systems and resources. All the same, private healthcare actors have multiplied (in their different forms and nature) in these countries. Accordingly, this policy brief seeks to develop an evidence base aimed at influencing policy and practice reforms from the implications of privatization in promoting equity in access to quality health services in Lesotho and Zimbabwe.

The objectives of the policy brief are annexed hereunder:

To document the status, extent, and forms of privatisation in Lesotho and Zimbabwe,



To critically assess the impact (negative and positive) of privatisation on health rights in the two countries,

To analyse and identify gaps in regulatory and policy instruments governing privatisation, in the focus countries pre-and during COVID-19 with a specific focus on challenges, successes and best practice in the roll out of the respective country COVID-response plans,

To analyse the role of CSOs and development partners in the area of privatisation in the countries, and

To develop clear recommendations for Government's and CSO's work on pushing against privatisation of health services.

THE NATURE OF HEALTH SECTOR IN LESOTHO AND ZIMBABWE

2.1 Lesotho

Lesotho has a total of 286 health facilities, 265 of these being primary health care centers, 20 district general hospitals serving as secondary health facilities, whilst Queen Mamohato Memorial Hospital (QMMH) is a tertiary referral hospital situated in the capital, Maseru. The government in Lesotho operates 55% of the hospitals and 40% of the primary health centers. According to UNICEF (2016), the health workforce is unbalanced as the ratio of nurses and doctors to the population are below the World Health Organisation (WHO) and African Union (AU) average. This has led to the inequitable and unbalanced distribution of health workers among various health facilities across the country. To this end, there is need to guarantee fair, equal, and efficient health services accessible to all by making sure that the ratio of doctors and nurses is reconfigured to 2.6 doctors and 12.0 for approximately 1000 population (UNICEF 2016). There is also need for a judicious administration in distributing health staff among various health facilities across the country to ensure administrative efficacy of public health.

The National Development Plan and National Health Strategic Plan (NHSP) 2017-2027 guides the health sector. According to the NHSP 2017–2027 the National Vision of Lesotho is to ensure the availability of universal health coverage. The core of the aforementioned blueprints is skewed towards:

- improving the coverage of health facilities,
- improving planning, health information and the public financial management system,
- improving quality and coverage of health prevention,
- improving systems for pharmaceuticals,
- improving the health laboratory system,
- establishing institutions for development of high-end skills, and
- strengthening public-private partnership.

The legislature guiding the Lesotho health sector is cordially calibrated to promote Public Private Partnership (PPP) with the aim to enhance the quality of citizen's healthcare (Vian et al. 2013). In 2006, in a bid to maximize limited healthcare resources and guarantee long-term improvement in healthcare services and facilities, the government effected a landmark and milestone PPP to build a state of the art, 425-bed National Referral Hospital – the Queen Mamohato Memorial Hospital (QMMH) to replace its ageing predecessor, Queen Elizabeth II hospital1. Apart from the hospital, the PPP project also sort to refurbish three strategic filter clinics, delivery of all service material for 18 years, adjacent gateway clinic, private management of facilities as well as training of health care professionals. Lesotho`s PPP serves as a prototype/model to increase private sector participation and intervention in Sub-Saharan Africa`s overburdened health system. It is worth noting that, the Lesotho PPP is the first of its kind in the African health system.

2.1 Zimbabwe

Mutizwa (2020) citing Zimbabwe Service Availability and Readiness Assessment Report (ZSARA) (2015) noted that, there are 1, 634 primary health facilities and 214 hospitals in Zimbabwe. The government owns 120 hospitals, 66 hospitals are owned by missions and 32 hospitals are privately owned. Over the years, Zimbabwe has acknowledged the essential and indispensable value of health, which is engraved in the Zimbabwean Constitution, Section 76 as a fundamental human right. The provision of health services in Zimbabwe is currently implemented in line with the National Development Strategy (NDS) 1 and the National Health Strategy (NHS) (2021-2025). In Zimbabwe, the NHS provides strategic direction for the provision of health services. The NHS is in alignment with Sustainable Development Goals (SDGs), goal 3 to be specific which advocates for equitable quality health services (UNICEF 2020). The need to reduce mortality and morbidity rate is at the core of NHS.

The Zimbabwean Health Sector (ZHS) is afflicted with challenges such as weak learning institutions and facilities, poor management and operational capacity, limited-service capacity which culminates into infrastructural gaps. Mutizwa (2020) notes that, weak political will, corruption[2], nepotism and economies of affection have affected quality and equitable health services. The politically connected and elite prefer foreign health facilities instead of developing and rejuvenating local hospitals. This is substantiated by the fact that Parirenyatwa Group of Hospitals which is supposed to be the nerve-center of Health Care in Zimbabwe is now in a dilapidated state and some patients are being referred to Mission Hospitals (Karanda) in Mount Darwin (Mutizwa 2020).

It is worth noting that, the government acknowledges that the health sector is underfunded for reasons beyond and at times circumstances under its control (UNDP 2015). In a bid to overcome funding challenges and guarantee organizational capacity the government in 2009 heralded PPPs as a "possible avenue in resuscitating the ailing public hospitals" (Dube and Kunaka 2019). This culminated in the enactment of supporting regulatory frameworks such as: Public-Private Partnership (2010), Public-Private Partnership Guidelines (2010), Public-Private Partnership Policy (2010) as well as the Public Private Partnership: Legislative Review for Zimbabwe (2010) and the Institutional Framework (Chagumira and Dube 2010). According to the Ministry of Health and Child Care (2012) the aforementioned supporting regulatory frameworks were meant to spearhead the formation of PPPs within the various areas of the ailing health sector. PPPs in Zimbabwean public health are different from those in Lesotho. In Zimbabwe, they usually refer to corporation between a private entity and the government in

1 In January 2007, the Government of Lesotho initiated the tender to replace the ageing Queen Elizabeth II hospital. On 27 October 2008, it signed a contract with Tšepong, a consortium led by Netcare, a company based in South Africa, to design, build, part-finance and operate a 425-bed tertiary hospital (the Queen 'Mamohato Memorial Hospital) in the capital city, Maseru, and a gateway clinic adjacent to the hospital. The project also refurbished and re-equipped three 'filter' clinics, also located in the capital at Qoaling, Mabote and Likotsi, that would manage patient referrals to the hospital

2 Obadiah Moyo, former Health Minister was charged with criminal abuse of office over the alleged awarding of a $60 million contract for COVID-19 to Drax International LLC. This was in direct violation of Public Procurement and Disposal of Public Assets Act (Chapter 22:23) as Drax's ability to deliver was not assessed and the tender bidding process was not followed.

the supply of ambulances, medication, laundry stuff or even outsourcing of expertise. This policy brief explores hybrid PPP in a later section in the context of Lesotho.

The characterization of the health systems in Lesotho and Zimbabwe requires further introspection into the budgetary support of the same by the governments.

2.1 Lesotho and Zimbabwe health budgetary allocations pre and during COVID-19 era

The public health sectors of Lesotho and Zimbabwe are experiencing a myriad of multifaceted challenges. These challenges are political, regulatory, and structural although they all have the same ramification on the quality and accessibility of health. Underfunding has also been a great threat to affordable, efficient, and effective public health. Even so, Lesotho and Zimbabwe are taking positive strides in funding their health systems as projected by their budgetary allocations from 2017-2021. Nonetheless, it is critical to note that, the duo`s health budgets are still below the Abuja Declaration which notes that 15% of the National Budget should be dedicated towards the health sector. Tables 1 and 2 substantiate the above assertion.

Table 1: Lesotho budget allocation for health (2017-2021)

YEAR	AMOUNT ALLOCATED	% OF THE TOTAL BUDGET
2017	M1,962.4 million	12%
2018	M2,480 million	12.7%
2019	M2,433 million	12.3%
2020	M2,494 million	12.8%
2021	M3,00 million	13%

Source: AFRODAD Compilation of Lesotho Health Budget Allocation from 2017-2021

Table 2: Zimbabwe budget allocation for health (2017-2021)

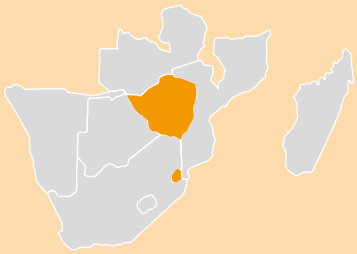
YEAR	AMOUNT ALLOCATED	% OF THE TOTAL BUDGET
2017	US$281.98 million	6.9%
2018	US$473.9 million	8.3%
2019	US$694.47 million	8.9%
2020	US$300.0 million	10%
2021	US$659 million	13%

Source: AFRODAD Compilation of Zimbabwe Health Budget Allocation from 2017-2021

Tables 1 and 2 concur on the positive trajectory of public health budgetary support by the governments of Lesotho and Zimbabwe post COVID-19. Seemingly, the increase in the budgetary support since the advent of COVID-19 in Lesotho and Zimbabwe reflects extra government responsibility in fighting COVID-19. This policy brief further examines the drivers and impact of these health budgetary allocations.

`2.1.1 Drivers of health budgetary allocations

The drivers of health budgetary allocations for Lesotho and Zimbabwe are largely structural, political, and weak institutional reforms leading to poor revenue collection and leakages. The drivers of health budgetary support are not limited to the following:

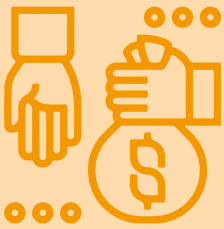


Domestic resource mobilization challenges

The economies of Lesotho and Zimbabwe are undiversified and commodity-based hence their failure to expand the tax base resulting in dwindling tax revenue. Zimbabwe missed its revenue targets since 2018, and tax revenue as a percentage of GDP continues to decline progressively (Zimbabwe Labour and Economic Development Research Institute 2020). The World Bank statistics show a declining trend of tax revenue to GDP for Lesotho given the decline in SACU revenue, although Lesotho's revenue/GDP ratio remain higher than that for Zimbabwe (World Bank 2018). The limited resources thereof constrict public investment in health.

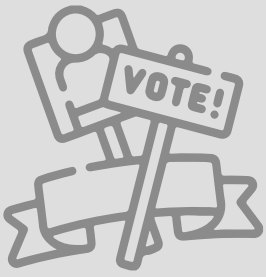
Dry credit lines

Zimbabwe's foreign debt legacy challenges explain the dried credit lines. This explains why the World Bank Group failed to avail financial packages for Zimbabwe's fight against COVID-19. Although Lesotho accessed RCF and RFI packages, further assumption of debt might trigger unsustainability as the national debt stood at 47.17% in 2020. This limits the quantum of resources available to support the health sectors of the two countries.



Illicit financial flows and corruption

Weak institutions cultivate resource leakages through illicit financial flows and corruption especially in Zimbabwe where the state lost US$15 billion diamond revenue. Lesotho also featured in the UNCTAD 2020 report on illicit financial flows in Africa as a victim of trade-related illicit financial flows through under invoicing and positive trade gaps of high value minerals. These practises significantly reduce resources that could make significant impact in health service provision.



Unstable political environments

The governments of Lesotho and Zimbabwean separately face unstable political environment and the need to consolidate power by the governing regime. To this end, less attention is given to the health care system and health allocations are below international benchmarks (Coelho and O'Farrell 2009). The Abuja Declaration which stipulates that 15% of African states' budgets should be directed towards health[3] has been missed by the Lesotho and Zimbabwean governments.

3 The Abuja Declarations and Frameworks for Action on Roll Back Malaria was a pledge made in 2001 by members of the African Union during a conference in Abuja, Nigeria. In it, the member nations pledged to increase their health budget to at least 15% of the state's annual budget.

2.1.2 Impact of budgetary health allocations

Because of misplaced interests, the health sectors are consistently funded by donors while governments prioritize their security sectors. As noted by Chilunjika and Mutizwa (2019), African governments tend to invest in sectors that guarantee them political expedience. The impact of insufficient health fiscal support is that they make it impossible for the two nations to operate their health care systems effectively and efficiently. The health systems of Lesotho and Zimbabwe exclude the poor and vulnerable societies as public health care is in dilapidating state. HIV/AIDS has remained a threat to both countries and Lesotho ranks third globally with respect to HIV prevalence at 23%. Whereas Zimbabwe's HIV prevalence is slowing, it has remained high as resources to fight the disease are progressively waning. Inadequate health funding has suppressed innumerable health indicators (infant mortality rate, maternal mortality, stunted growth, TB prevalence etc) in Lesotho and Zimbabwe.

The advent of COVID-19 exposed how weak the health systems are as they could not guarantee the availability of ventilators to patients even at a ratio of 1:300. The frontline workers for some time went on strike in both nations expressing their concern over unavailability of Personal Protective Equipment (PPE) – provisions that must be considered basic and vital in the fight against the COVID-19 pandemic. Health personnel in both countries also protested poor emoluments thereby interrupting health service provision. The poor salaries and risky working environment have seen both countries losing experts to the diaspora. The budgetary allocations in the two nations from 2017 to 2021 have entrenched social and economic injustices by continuing to systematically marginalize vulnerable communities as the public health centres are under equipped. The resources invested in the health sectors are not linked to health impact implying slack management and possible misappropriation of resources. Attempts to adopt PPP aggravates the situation as it has made health services unaffordable to the general masses thereby violating their second-generation rights (World Bank 2018).[4]

Amidst the poor impact of public health care services, private actors in health services provision have proliferated in both countries. An account of the concept of privatization as applied in the health sector, the size and role of privatized health facilities are detailed hereunder.

4 The Second-generation rights, Also called or called" economic, social and cultural rights", are those rights belonging to the list of human rights That had a formal appearance in governments and in society after the First World War. Second generation rights refer to the rights of all subjects to have a good life in economic, educational and work. The right to free primary and secondary education, and access to public health.

PRIVATIZATION OF HEALTH SERVICES

The concept of privatization has varied meanings though it is widely used to denote the deliberate adoption of government functions by the private sector.[5] Privatization thus defines the changing private sector responsibility in the provision of public goods such as health through a matrix of structures not limited to contracting out[6] and load shedding.[7] The privatization of health services thus encompasses the provision of health services by privately owned entities inclined on profit maximization or privately owned non-profit organizations and households (Mugwagwa et al. 2017). This policy brief construes privatization of health services to formal for-profit corporations (private curative services and private health insurance), not for profit/faith-based institutions (FBOs) and hybrid structures such as Public Private Integrative Partnerships (PPIPs) and support from development partners and NGOs. Privatization of health services thus is taken to imply the "financing and provision of health services outside the direct control of the government" (Foster 2012: 5).

3.1 The share and role of private players in health sector

This policy brief explores the share (structure), role, and impact of private health service provision in Lesotho and Zimbabwe. Empirics show that the private sector improves access and equity to health services, as well as efficient provision of health services. Also, the private sector brings in more resources thereby bridging the funding gap in the health services sector. This allows government to channel resources to more deserving societies. Therefore, the intervention of the private sector in the health services delivery is additive to better distribution of the same in the society (Mugwagwa et al. 2017).

However, the private sector is criticized for overpricing its services compared to government institutions thereby serving the 'haves' and excluding the poor. The private sector is therefore incriminated for constricting affordability, access,

5 The responsibility on privatized functions might remain with the public sector.

6 Responsibility remains with the government for tasks done by the private sector.

7 The private sector takes full responsibility of tasks and the performance of the same.

and equality. The critiques of the private sector are oblivious of the segmentation of the health market based on ability to pay for the services. The analysis also lacks introspection into the institutional set up, the business models, capitalization and the interlace between the private and public sector in the delivery of health services (the personnel in the private sector is trained by the public sector). Therefore, the relationship between the private sector and the public sector with respect to health service provision is more of the degree of complementarity, competition, substitution and or crowding out (Jansen & van der Made 1990).

3.1.1 Lesotho

Lesotho's health sector comprises of the public sector financed by the government and the private sector funded by development partners, donors, and the private operators. The footage of the private sector in marked by the operations of individual specialists, non-governmental organizations (NGOs) and FBOs such as the Christian Health Association of Lesotho (CHAL). Other players are privately owned medical society companies and private hospitals. Ramashamole and Tsamae (2015) notes that the imprint of private health players is limited when compared to the need for health services across the country. For instance, the Lesotho Planned Parenthood Association (LPPA) has nine clinics in urban areas only. The same applies to the four hospitals owned and run by the Red Cross Society and five Population Services International (PSI) testing and counseling centers across the whole country.

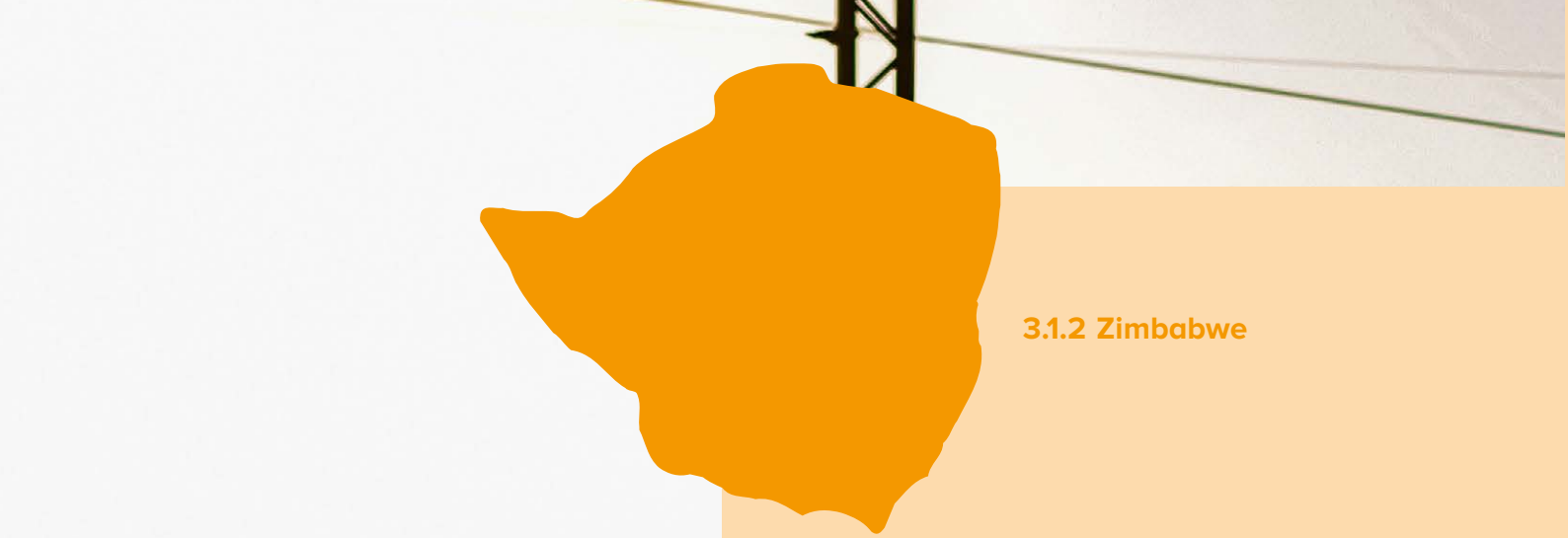
The government sealed a Public Private Partnership (PPP) in 2006 with CHAL obligating CHAL to service at least 30% of the population through its network of hospitals and primary health facilities constituting 20% of the total primary health care centers and 40% of hospitals in Lesotho (World Bank 2018).[8] Effectively, CHAL hospitals are publicly funded but privately owned and managed. The government also entered a Public Private Integrated Partnership (PPIP) with International Finance Corporation (IFC) and Tsepong (a South Africa consortium owned by Netcare) to develop Lesotho's only premium health center – QMMH. The PPIP, the largest of its nature in Sub-Saharan Africa developed a 425-bed memorial hospital in the capital launched on the 1st of October 2011. This privately managed investment has well-trained health personnel meant to reduce maternal and HIV mortality.[9]

8 The contribution of the non-profit players to the national health services sector increased between 2013 and 2018 from 38% to 40%.

9 Lesotho has third highest HIV prevalence ratio globally.

The QMMH launched the first ever Intensive Care Unit (ICU) and Neonatal ICU Care Unit in Lesotho. A positive impact in maternal and infant mortality, post-surgical mortality and the management of HIV/AIDS and associated diseases has since been realized. The launch of the QMMH has intensified investment in training of specialists as the Lesotho health system lacked a sufficient complement of specialist health personnel (doctors, pharmacists, radiographers, physiotherapists, and dentists on the endless list). Other achievements of the PPIP include a reduction of pediatric pneumonia death by 65%, a decline of 50% in still births, a decline of 17% in hospital deaths and a10% fall in maternal death. Also, operational efficiency improved under private management of QMMH as drug acquisition costs declined (Oxfam 2014; World Bank 2018).

However, viability challenges of the PPIP threatens its continuity as the government of Lesotho has failed to pay Tsepong's PPIP fees since 2013/14 as PPPs of such nature are costly to finance. The QMMH remains "an island of excellence against a dilapidated health system" (Oxfam 2014: 4) thus more must be done to upgrade the whole health system. Despite the huge public investment in QMMH, other health indicators are still poor (infant mortality rate stood at 59/1000 whilst maternal mortality was at 1020/100000 and HIV prevalence of 23%). The PPP with CHAL has increased CHAL hospitals' bed occupancy rates given the widely held perception that private CHAL hospitals are better managed and provide better service compared to publicly run hospitals (PwC 2013; World Bank 2018).



3.1.2 Zimbabwe

Zimbabwe increasingly recorded a tally of non-state actors in the provision of health care services such as international donors, foreign and domestic corporates, CSOs, and other hybrid actors. The intensification of the trend is a function of hamstrung public investment in health given the deterioration of the once-vibrant economy – crippling the health sector (weakening the capacity of clinics, hospitals, and health service infrastructure in the country). The supply of drugs has been stifled whilst recurring health workers' unrest coupled with the freeze on health personnel recruitment[10] worsened the performance of the impaired sector. The falling health indicators explain Zimbabwe's failure to meet health related MDGs given the surge in Non-Communicable Diseases (NCDs), a slow decline in HIV and TB morbidity, irreparable medical infrastructure and en-masse brain drain (Mugwagwa et al. 2017). Accordingly, the National Health Strategy 2009-2013 (extended to 2016 and 2020) recognized the essence of a multi-stakeholder11 approach in the financing and provision of health services. Foster (2012) notes that 6.7% of health centers are owned by owned by FBOs and they all receive government funding as they operate in rural areas, hence promote access to health. This mimics Lesotho's PPP with CHAL.

An account of the growth of the private sector in the Zimbabwean health sector is detailed in Fact Box 1. A factual presentation of the scope and structure of the private sector players in the health sector

10 Medical staff vacancy was 70% in some health facilities
11 Private sector, local authorities, communities, FBOs and funding partners.

is marred by data deficiency. Nevertheless, by 2009, capital investment in the health sector was skewed in favor of the private sector. A glimpse of the same is presented hereunder (Munyuki and Jasi 2009):

- Government owned 2% of all dental services,
- Private sector owned 90% of all medical laboratories,
- Physiotherapy was exclusively owned by the private sector,
- Retail pharmaceutical entities were privately owned,
- There were over 700 private consulting facilities in the country,
- Private sector operated the bulk of the radiography services,
- Speech and occupational therapy sectors were dominated by the private players.[12]

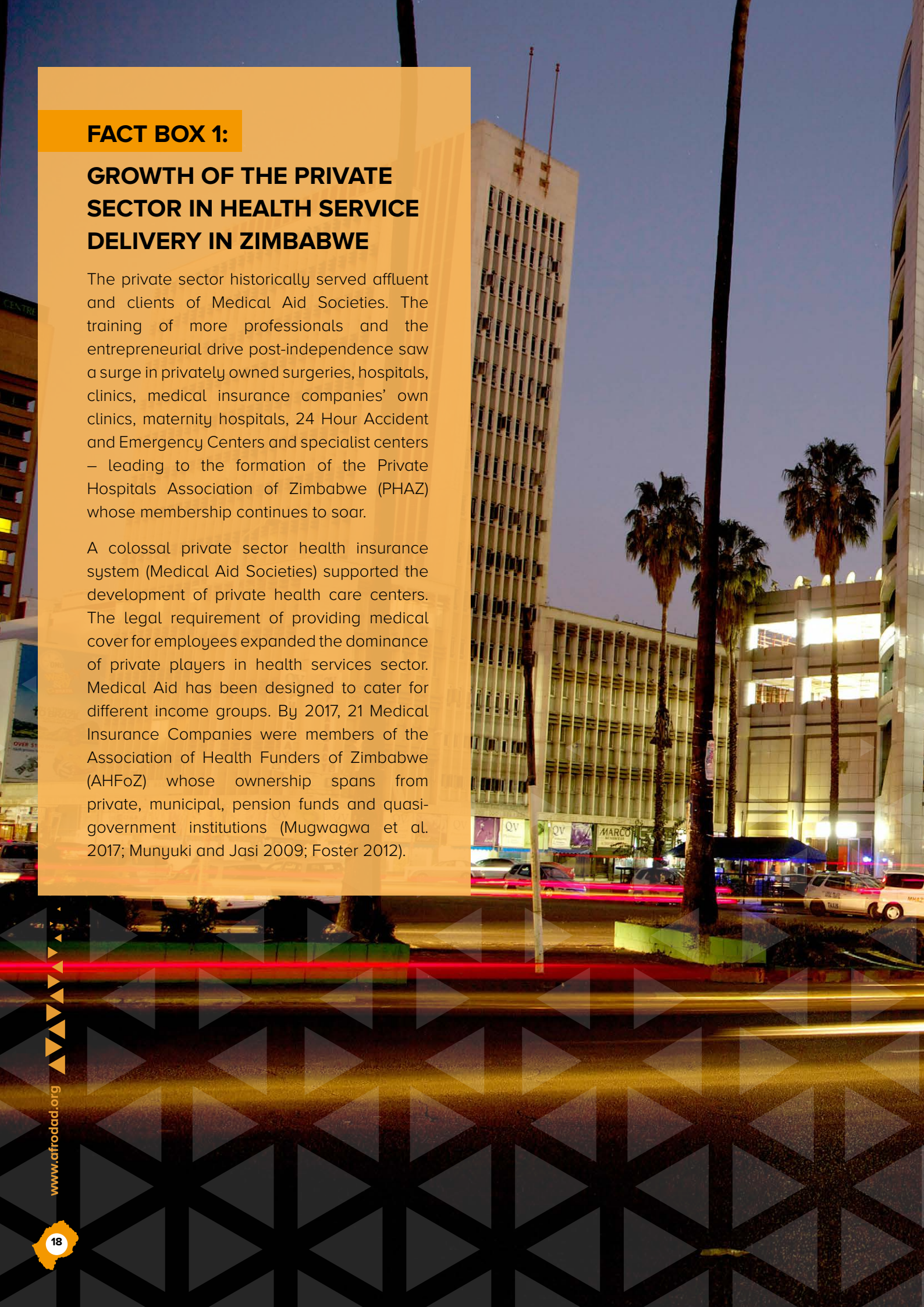
Whereas the private sector is visible in the provision of health services in Zimbabwe, the overall impact is affected by gaps that still exist. As much as the gaps show health access exclusion, the same gaps present an opportunity for the expansion of private sector participation in health service provision or presents a room for further government intervention. Figure 1 presents the role, impact, and gaps of the private sector in the provision of health services in Zimbabwe. The facets in which the private sector intervenes in the provision of health care are service delivery, health workforce, information, medical products (vaccines and technology), financing and governance as shown in Figure 1.

Figure 1: Private sector involvement in Zimbabwe's health sector (2013-2015)

Health system building block	Stakeholders and their interventions	Impact	Existing gaps
Service delivery	Individuals and consortia setting up private hospitals, private clinics and private wards in public hospitals	Improved service provision in most urban and provincial hospitals.	Populations in rural and farming communities still underserved
Health workforce	Medical school bursaries by some mobile phone companies and health insurers and health staff retention allowances by bilateral and multilateral donors	Stabilisation of staff numbers, morale and skills levels in some health facilities	Staff retention mainly in urban facilities. There is also unequal burden sharing between health facilities in that government trains and loses staff to private health sub-sector. Underfunded MOHCW unable to absorb all trained nurses. Emigration of junior doctors due to poor emoluments
Information	Support from mobile phone companies for health information systems, solar energy and internet connectivity at rural hospitals across the country	Up to 80% of rural hospitals and clinics able to provide and access information instantly	Some rural and farming communities still lack infrastructure for internet and would benefit from resuscitation of abandoned technologies such as radio communication systems
Medical products, vaccines and technologies	Support by multilateral donors for decentralisation of screening and treatment services for NCDs	Specialist NCD centres mainly in major cities Harare and Bulawayo.	Disconnect between diagnosis and treatment e.g. chemotherapy still centralised and costly
Financing	Public and private medical insurance schemes to cover user fees	Country has 33 medical insurance providers, with diverse and innovative packages that include individual and family packages, which allow access to different categories of health facilities	Only 10% of the Zimbabwe's 13million population has medical aid cover; the urban and rural poor cannot access specialist health care unless they can pay for it out-of-pocket
Leadership/Governance	Multilateral donor, civil society and corporate sector support of the review of the Public Health Act	Public Health Act 15:09 now in place, emphasising need for broad-based stakeholder awareness and collaboration	Awareness-raising efforts on Act and other strategies are under-resourced, not widely spread and ad hoc, hence many social and institutional actors remain unaware of their role in implementation

Source: Mugwagwa et al. (2017)

12 Appendix 1 shows a historical account of the ownership distribution of health facilities between the public and private sector.



FACT BOX 1:

GROWTH OF THE PRIVATE SECTOR IN HEALTH SERVICE DELIVERY IN ZIMBABWE

The private sector historically served affluent and clients of Medical Aid Societies. The training of more professionals and the entrepreneurial drive post-independence saw a surge in privately owned surgeries, hospitals, clinics, medical insurance companies' own clinics, maternity hospitals, 24 Hour Accident and Emergency Centers and specialist centers – leading to the formation of the Private Hospitals Association of Zimbabwe (PHAZ) whose membership continues to soar.

A colossal private sector health insurance system (Medical Aid Societies) supported the development of private health care centers. The legal requirement of providing medical cover for employees expanded the dominance of private players in health services sector. Medical Aid has been designed to cater for different income groups. By 2017, 21 Medical Insurance Companies were members of the Association of Health Funders of Zimbabwe (AHFoZ) whose ownership spans from private, municipal, pension funds and quasi-government institutions (Mugwagwa et al. 2017; Munyuki and Jasi 2009; Foster 2012).


KWAME NKRUMAH

THE IMPACT OF PRIVATE HEALTH SERVICES DURING THE COVID ERA (2020–2021)

This section tracks the impact of private health services during the COVID-19 period of 2020-2021 in Lesotho and Zimbabwe with the intuition of appraising the efficacy of the same in abating the pandemic given the gaps and inefficiencies of public health system.

4.1 Lesotho

The private sector has not played a significant role in fighting COVID-19 in Lesotho as the bulk of the investment is government funded. Medical Aid only covers COVID-19 testing at the doctor's request (if one shows COVID-19 symptoms), otherwise out of pocket cost for testing COVID-19 is exorbitant and out of reach for many. Private health facilities (inclusive of CHAL and QMMH) also refer COVID-19 positive patients to government facilities for either quarantining or treatment as they have limited bed capacity. The corporate sector (Matekane Group of Companies, Econet Lesotho and the Global Fund) intervened by availing resources to capacitate the public health system in fighting COVID-19. These players provided sanitizers, face masks and surgical gloves, PCR machines, and acquisition of ICU beds. These supplies were directed to the Lesotho Correctional Services, Lesotho Mounted Police, Lesotho Defense Forces, and the public hospitals. The private sector has also established the Sesiu, a Private Sector Fund for COVID-19 Vaccine Procurement and 11 corporates have contributed M25 Million as of March 24, 2021 – a gesture that is expected supplement government resources in acquiring COVID-19 inoculants (Ngatane 2021).13 The government also received donations of anti-COVID-19 medical supplies from the First Lady of China as well as COVID-19 rapid test kits from the Jack Ma Foundation (The Global Fund 2020; Government of Lesotho 2020).

Lesotho's strategy of fighting COVID-19 was heavily outsourced as it relied more on international development partners' packages such as the World Bank's Emergency Preparedness and Response Loan (EPRL) and the IMF's Emergency

13 The Sesiu solidarity fund raised enough resources to procure 1.1million Sputnik V vaccine although government is reportedly delaying the process of acquiring the vaccine as the Ministry of Health is still to avail an authorization letter.

Support (Rapid Credit Facility and the Rapid Financing Instrument) designed to capacitate preparedness and response to Covid-19. The Lesotho government received US$ 7.5 million from the World Bank under the COVID-19 Emergence Preparedness Response Project, US$11.66 million under the RFI and US$32.6 million RCF as COVID-19 Relief packages. These interventions portray the incapacitation of the local private sector to finance the fight against COVID-19 hence the intervention of international development partners.

Jhpiego, an international non-profit health organization linked with the John Hopkins University and funded by the U.S. Agency for International Development (USAID) pursued the Reaching Impact, Saturation, and Epidemic Control (RISE)14 Project in Lesotho to address the COVID-19 scourge. Under the RISEP Project, Jhpiego established COVID-19 treatment centers and scaled-up the management of basic respiratory care at 20 hospitals in Lesotho. Jhpiego also ran a context-specific risk communication project meant to conscientize the front-line workers (Jhpiego 2021). The African Development Bank (AfDB) availed resources to Lesotho for strengthening the capacity to manage COVID-19 response strategies as well as upgrade surveillance and publicization of COVID-19 to the populace (SADC 2020).

Overall, the effort of the government, supported by international development institutions and the local corporate sector invested more in the fight as private health service providers took a miniature stance in addressing the pandemic.

4.2 Zimbabwe

The corporate sector, NGOs, foundations and FBOs contributed immensely in the funding health services through the government during the corona period in Zimbabwe as presented hereunder.

- The availing of packages for nurses and doctors A private mobile operator availed a package to supplement the salaries of the front-line workers (nurses and doctors). The health sector was facing a crippling industrial action because of poor salaries thus the package restored normalcy in the provision of health services during the pandemic (The Herald 7 April 2020).
- Information dissemination Private players across the divide invested in spreading the COVID-19 awareness through varied platforms. Mobile service providers were the most active before a court ruling stopped the distribution of COVID-19 updates to mobile phone users. The partnership between the private sector (Promobile and Ecobank) and an NGO (GOAL) reached 2.3 million Zimbabweans between April and July 2020 through mobile advertising units deployed in rural areas. Several organizations such UNICEF, the Zimbabwe Idai Recovery Project (ZIRP), the Irish Aid and USAID were actively involved in promoting information dissemination (Reliefweb 2020).
- Financing the testing of COVID-19 The government enacted legal provisions allowing employers in the essential services sector to test their employees as well as observing WHO guidelines in their operations. This move facilitated the isolation of positive cases thereby lessening the spread of the disease (KPMG 2020). Private hospitals owned by medical societies are also active in testing COVID-19 and issue internationally recognized certificates for travellers. The Jack Ma donation capacitated the testing of COVID-19 trough the donation of laboratory diagnostic test kits, medical masks, and face shields.

14 RISE is a USAID project funded by the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) running for 5 years and is designed to control epidemics through localized partnerships that proffer sustainable and resilient health systems.

- Funding the acquisition of PPEs and ventilators The private sector has participated in capacitating the health sector to fight COVID-19 by contributing not only financial resources to acquire PPEs but also the provision of the PPEs to the government. The private sector, churches and foreign owned corporates provided medical masks, medical protective suits, infrared electronic thermometers, medical isolated eye patches, pairs of sterile latex surgical gloves, surgical shoe covers and computers. Procurement of COVID-19 vaccine. The government launched the National Vaccine Procurement Fund where organizations, individuals and development partners can donate towards vaccine procurement. The government also okayed the procurement of the vaccine by corporates for their employees through the same fund (Ministry of Health and Child Care 2021).
- Preparing hospitals for COVID-19response A case in point is the refurbishment of St. Anne's Hospital by the owners of St. Anne's Hospital, the Catholic Church, and the Solidarity Trust Zimbabwe. Other facilities such as Ekusileni Hospital, Thorngroove Hospital and Mater Dei Hospital were earmarked for capacitation by the Citizens Initiative (China Daily, 20 April 2020).

The private sector however faced limitations with regards to their intervention in fighting COVID-19.

- Limited hospital beds The private sector has shown limited capacity to provide beds for hospitalized COVID-19 patients thus patients had to make do with poor government health facilities that required major facelift against a constricted budget.
- The private Medical Aid Societies did not cover the new scourge and patients had to pay for COVID-19 treatment through out of pocket means. This also pertained to the testing of COVID-19 as medical cover could not be used to pay for such costs.
- The private health institutions same as the public sector lacked expertise and experience in treating COVID-19 cases and required schooling in the shortest time possible to quell the threat of the spreading scourge. Just like the public sector, the private sector lost health personnel to COVID-19.
- The services provided by private health operators are mainly in urban areas thus underrepresentation affected the supposed impact in remote areas such mines, farms and rural areas.

PRIVATE SECTOR PARTICIPATION IN HEALTH SERVICE DELIVERY: POLICY CHALLENGES

The lesions from the experiences of Lesotho and Zimbabwe with respect to the participation of the private sector in the provision of health services laid bare the policy challenges linked to the efficacy of the private sector in health service provision. The policy challenges are presented hereunder.

5.1 Challenges of standardization and compliance monitoring

The evidence from Lesotho and Zimbabwe shows that there is no single large private sector player well-resourced to squarely fit the gaps of health service provision thus multiple players respond to health services gaps at variant times and points in the health system, and in select geographical areas thereby making standardization of operation untenable. In the case of Zimbabwe, the government lacks enough resources and personnel to oversee the level of compliance of the innumerable profit-oriented health service entrepreneurs. Accordingly, the private might flout health provisions deliberately to profit from such motives.

5.2 Complementary/collaborative challenges

Private sector health services providers are on record of failing to complement government effort in providing health services and pursue own entrepreneurial goals whilst capitalizing on either government's legal or fiscal support for their operations. For instance, the Zimbabwean government allowed the private sector to make use of public health facilities to bed their patients in return for specialist services from the private health operators. However, private sector specialists are reluctant to honour their side of the arrangement thereby depriving patients of specialist services. In the case of Lesotho, the government is reportedly stalling the acquisition of 1.1 million Sputnik V COVID-19 vaccine by the Sesiu (Private Sector Fund for COVID-19 Vaccine Procurement). The variant motives for investing in health by public and private entities are not easy to reconcile.

5.3 Curative vs preventive

The private sector pursues curative health services and participate less in preventive health services, a move that derails government's disease prevention motive.

5.4 Entrenchment of health inequality

This policy brief notes that the rural populace in Lesotho same as farming and mining communities in Zimbabwe are excluded from health services given distance to the nearest health centre and the associated cost thereof. The private sector continues to be of service to urbanites thereby leaving the rural areas under-served. This phenomenon is rampant in Lesotho and Zimbabwe.

5.5 Irreconcilable friction between motive and impact

Most private sector health services actors are either commercially oriented or philanthropic thereby dictating the mode of delivery and ultimately the impact. Effectively, it has not been easy to match motive and impact for the various players and policy lacks clarity on the same.

5.6 Deal brokering challenges

The sustainability and continuity of the Lesotho PPIP deal is threatened by the failure of the government to pay PPIP fees to Tsepong as from 2013/2014. QMMH has been gobbling more resources from the fiscus to finance its operations and the related PPIP costs. PwC notes that the type of the PPP is expensive to Lesotho' economy. The Government lacked deal brokering expertise to negotiate better terms. Intervention must balance impact and the financing side.

POLICY AND REGULATORY MEASURES FOR SUSTAINABLE FINANCING OF HEALTH IN SOUTHERN AFRICA

The participation of the private sector in the health sector presents opportunities and vulnerabilities that ought to be addressed by apt policies and regulatory measures. The merged partnership in the provision of health services is critical given the dwindling resource base for health delivery posed by economic contraction, political and social challenges. Accordingly, recommendations are designed to address multiple private players and government.

6.1 Recommendations to development partners

The interventions designed for low-income countries must be properly modelled to accommodate their precarious fiscal positions to ascertain the sustainability of the same. The sustainability challenges facing QMMH could have been avoided at formative stage if the financing structure of the PPIP was affordable.

6.2 Recommendations to the private sector

The private sector must explore inclusive health financing alternatives and exploit virgin markets outside urban areas.

Consider diversifying into preventive health services and complement government effort in preventing diseases.

6.3 Recommendations to the executive/government

The governments of Lesotho and Zimbabwe must fulfill the Abuja Declaration obligation by giving 15% of their budget to the health sector.

While PPP offer the government a chance to provide quality health care, the government should cushion health services to enable the most vulnerable and marginalized communities to have access to the service.

Governments must perfect DRM and realize more resource to invest in equitable health.

Government must invest in monitoring the operations of private health services providers to ascertain compliance.

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Appendix 1: Ownership distribution of health facilities between public and private sector (2006)

Type of Institution	Total	Total owned by government	Total owned by private operators
Dental surgeries	129	3	126
Medical laboratories	114	9	105
Speech & occupational therapy	12	1	11
Physiotherapy	80	1	79
Nursing homes and clinics	33	0	33
Consulting rooms[1]	769	N/A	769
Nurses' consulting rooms	101	N/A	101
Maternity homes/polyclinics	16	0	16
Mission clinics	30	N/A	30
Special clinics	42	0	42
Pharmacies[2]	184	0	184
Hospitals	195	102	93
Municipal clinics	101	101	N/A
Government rural clinics	266	266	N/A
Industrial clinics	139	0	139
Estate clinics	10	1	9
Psychological service	64	0	64
Operating theatres	5	N/A	5
Dietetics	6	0	6
Natural therapy	10	0	10
Emergency services	24	N/A	24
Radiology	41	N/A	41
Optical services	69	N/A	69
Rural district council clinics	217	217	N/A

Source: Munyuki and Jasi (2009)

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