



CASE STUDY

Financing a New Referral Hospital Lesotho

Preface

This case study was developed for use in the CABRI Dialogue on Ensuring Value for Money in Infrastructure Projects. It was undertaken as a five day study.

The aim of the case studies developed for the seminar is not to present a research report of the projects as they are in 2009, but rather to highlight challenges that affected decisions in the areas of appraisal, financing, implementation and monitoring over the life of the projects and to provide a platform for debate, to be enriched by representatives of the case study countries at the seminar.

In the case of the Lesotho case study participants take on the role of officials in the Ministry of Finance who have to advise Cabinet on what route to follow to finance the new hospital. This will take participants back to a decision point already faced by the Government of Lesotho. The case study therefore provides a “What happened in reality” section.

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Abbreviations

DBSA	Development Bank of Southern Africa
FM	Facilities Management
GDP	Gross Domestic Product
GoL	Government of Lesotho
GPOBA	Global Partnership on Output-Based Aid (World Bank)
IFC	International Finance Corporation
M	Maloti (local currency)
MoFDP	Ministry of Finance and Development Planning
MoHSW	Ministry of Health and Social Welfare
NRH	National Referral Hospital
PPP	Public-Private Partnership
PPIP	Public-Private Investment Partnership
QE II	Queen Elizabeth II Hospital
WHO	World Health Organization
WB	World Bank

Financing the new Lesotho Referral Hospital

By Matthew Smith¹

1. Introduction

1.1 The Kingdom of Lesotho needs to build a new referral hospital to replace the aging Queen Elizabeth II hospital in Maseru. The capital cost of the new hospital will be M1.2 bn.

1.2 In this case study, you will be assuming the role of the Minister of Finance of the Government of Lesotho. You have had international exposure to PPP projects through your attendance at conferences and discussion with other Ministers of Finance, particularly from South Africa and OECD countries, where PPP's are widely used. It is December 2006² and already you have played a strong role in implementing the PPP project for the Ministry of Health, which resulted in the building of a high quality new Headquarters. Your decision now concerns the difficult issue of how to finance a new hospital. You are all too aware of the current hospital's deficiencies, and cannot even remember the opening of the hospital way back in 1957. A feasibility study conducted four years ago in 2002 has reinforced the urgent need for a new facility, and a Cabinet meeting is approaching where you have to give your view on how to finance the new hospital. You know that the approximate capital cost of the hospital will be M1.2bn (approximately US\$120m in 2006). There is no possibility of lowering this amount and building a smaller hospital, since it simply won't be adequate for the increasing needs and expectations of the people of Lesotho. So you have four main choices:

- Finance the hospital from the domestic capital budget.
- Borrow from a third party (perhaps the World Bank) and ask the Ministry of Health to oversee the construction and future running of the hospital.
- Obtain finance from a third party (perhaps a private sector operator similar to the company who built the Ministry of Health HQ) who will be contracted to build the hospital and then hand over to the Ministry of Health to run it.
- Make a bold move and obtain a first for the region and put out to international tender a long term contract to build, equip and operate the new hospital.

¹ The author would like to express thanks to the following individuals who have provided information for this case study: Mrs Carla Faustino, IFC, Johannesburg (by telephone), Mrs Khosi Letsie, Budget Coordinator, MoFDP, Mrs M. Makhakhe, Director, Health Planning & Statistics, MoHSW, Mrs Mathuntsane Mohapi (Zondy), PPP Coordinator, MoHSW, Mr Zenzo Ndabula, Project Manager, Netcare Ltd, Mr J. T. Nteso – Director, Public Debt Management Division, MoFDP, Mr Griffiths Thakhisi, Budget Officer, MoFDP

² It is assumed for the purposes of this introduction that the decision on how to finance the new hospital had to be taken in December 2006 at a forthcoming cabinet meeting.

2. The case study

2.1 The existing Queen Elizabeth II Hospital is over 50 years old and in a poor state of repair. A generally accepted view is that the infrastructure could not economically be remediated³ and that the current inefficient spending on QE II was unsustainable.⁴ In addition, it was felt that Government management systems lacked the flexibility to deal with the complexity of running the hospital, and there were frequent staff shortages and problems with equipment.⁵

2.2 An initial feasibility study was made in 2002. Later, four financing options were considered, amongst others, and they are in more detail as follows:

Option 1

2.3 The first option is to finance the capital sum from the domestic budget. You are aware that the 2006/07 Ministry of Health capital budget is only M80m (6% of the Government's total capital spend) and that this obviously falls a long way short of the M1,200m required. However, the MTEF overall capital spending projection which will hopefully become the draft 2008/09 budget figure is indicating a rise from M1,252m to M1,924m, which is good news.

Option 2

2.4 The second option for discussion is to borrow from a third party such as the World Bank who could perhaps lend money on concessional terms and the government, perhaps Ministry of Works, would then oversee the building of the hospital. You sense however a slight reluctance to do this given the WB's preferred approach of finding a PPP solution. You are also slightly hesitant about previous time overruns of the other government capital projects you have observed.

Option 3

2.5 You have had a good experience of using a PPP scheme to contract the building of the new MoHSW headquarters, which although expensive, really led to the development of a world-class premises from which the MoHSW can operate much more effectively than in their previous building.

Option 4

2.6 The final option is to tender for one Operator to design, build, partially finance, equip, and operate the hospital, including the full provision of clinical services. And personnel will be employees of the Operator rather than Government, which would lessen pressure on central payroll costs.

2.7 You have had consultations internally within government and externally with the World Bank, who have recommended that you hire the IFC as lead adviser, and have drawn up a list of advantages about this fourth approach:

- you are intrinsically in favour of a complete solution – an operator who would also manage clinical services as well as infrastructural and non-clinical services;

³ See for example Baseline Study, 12 March 2009, p73

⁴ 'Lesotho Referral Hospital PPP', Principal Secretary presentation, Ministry of Health and Social Welfare to SADIC countries Ministries of Health representatives, April 2009

⁵ Baseline Study, 12 March 2009, p73 reports that "It is our impression that there has been no meaningful or major change in the quality and quantity of services delivered at QE 2 over 1990 to 2007 time period".

- private sector efficiencies could be obtained so as to maximise the quality and quantity of healthcare services given limited resources;
- the MoHSW and the employees working at the hospital could learn from international best-practice about hospital operation and management;
- you've had bad experience in the past of capital projects experiencing time and cost overruns and you could improve the prospect of on-time and on-budget delivery by transferring the risk of late delivery and cost overruns to the Operator;
- by inserting targets for local ownership and over using local firms and staff, you could provide an important boost to the local economy.

2.8 Against these advantages, you are aware of two main disadvantages in Option 4. The first is that both your own Ministry and the Ministry of Health, may have insufficient institutional experience to deal with such a complex PPP contract.

2.9 The only real previous experience which government has had in the past with PPPs was limited to the Ministry of Health, whose headquarters as explained above was paid for under a PPP project. You are aware of a consultancy report, which you only skim-read, but from which you recall that "at present, sufficient expertise in hospital operations, financial oversight and analysis, and systems analysis to manage the PPP contract in the interests of the Government and people of Lesotho does not exist."⁶

2.10 The second disadvantage is the great potential cost of the project using this particular approach. As with most PPPs, the annual Unitary Payment to the operator (which is necessarily a combination of capital repayment, operating cost and profit) will be managed solely as recurrent expenditure, but it would become a legally binding agreement, and it must therefore be affordable.

2.11 You have obtained a copy of a draft consultancy report⁷ which argues that the new hospital cannot be adequately operated for less than 30% of the MoHSW recurrent budget (for the current year 06/07 the QEII hospital budget is M123.5m out of a total revised 06/07 MoHSW budget of M344m), and that as 40% is approached, there will be an increasing adverse and severe impact on district health services. So the report urges the setting of an upper limit (40% or less) of the Ministry of Health recurrent budget to be devoted to the new hospital.

2.12 In terms of the domestic capital injection required you know that the capital cost of the hospital is M1,200m and that whichever of the 4 options is chosen, you likely cannot afford to finance more than one third of this from solely government sources. In addition, you anticipate another amount for clearing a road to the site and providing electricity to it. So after consultation you decide to allocate M175m for the 07/08 NRH capital budget.

2.13 Given that M400m is the maximum which can be financed domestically, then the external funding requirement will be c. M800m. The hospital will take 2.5 years to build and you have been advised by the WB that unless you make a contract for at least 18 years (ie

⁶ Queen Elizabeth II and the New PPP Hospital: Baseline Study, Vol 1, Draft Final Report, 12 March 2009, Lesotho-Boston Health Alliance on behalf of Boston University, p72. Please note therefore this quotation was actually taken from the Baseline Study published in March 2009, but it was probably even more applicable in 2007. It should be noted that since March 2009, the MoHSW have taken further steps in building technical capacity building in this area and are implementing a contract management system to assist in implementing the PPP.

⁷ This was actually taken from the Baseline Study, March 2009, p78, but this conclusion was based on historical data and probably also valid in December 2006.

2.5 building and 15.5 years operating), you will not attract a sufficient calibre of international bidders.

2.14 It is your intention that the Government's recurrent payment for hospital operation and health services delivery would be 'fixed at an amount equal to the current operating costs of the same facilities'. But you are wondering, if the level of medical provision is higher, whether it is reasonable to have a higher cost than previously under the existing hospital? For example, currently the existing hospital sees around 15,000 in-patients a year⁸ and in the plans for the new hospital this will rise to 20,000. And currently the existing hospital sees around 250,000 outpatients per year and this will you think rise to 310,000⁹. So even if the operating costs overall are slightly higher, then it may well be that per patient, the operating cost is lower.

2.15 After all, lower per patient operating costs would be possible by instigation of management improvements, which is one of the expectations of private sector intervention, and you have read that as a result efficiencies can often be increased by 15-20%.¹⁰

2.16 You are also aware that there will likely be other costs outside the Unitary Payment, since not all treatments will be available by the new hospital – it will just be too expensive. For example, CT scans and acute renal dialysis may be included in the Unitary Payment, but chemotherapy, radiotherapy, organ transplants, colonoscopy and chronic renal dialysis may be excluded. Also, it may be that the hospital sees more than the maximum number of patients paid for under the contract, and so these must be paid for at additional cost – similar to the current referral system where patients are treated in nearby Bloemfontein hospital across the boarder in South Africa.

2.17 Controlling the PPP costs borne by the government outside of the unitary payment will be a major challenge. Above inflation cost increases are not uncommon. For example for OECD countries, medical care expenditures are growing as a percentage of GDP. In fact spending on healthcare has grown by 2% in excess of GDP across all OECD countries for almost 50 years.¹¹ And in Lesotho, you are very aware that actual costs per bed have risen from 49 Maloti/day in 1989/90 to 425 Maloti/day in 2006/07, an average annual increase of 12%. This is higher than the annual inflation during the period of 10.6%.¹²

3. What Happened in Reality

⁸ QE II and the New PPP Hospital, Initial Performance and Impact Indicators, Draft Report II, January 2008 (wrongly dated January 2007), p5

⁹ From the patient's perspective, there will be no change in costs. Patient care in Lesotho has historically been over 95% subsidised by Government. The patient pays a small fee for treatment – for example M 10 (US\$ 1) for outpatient visits and M 20 (US\$ 2) for inpatients with additional cots for surgery. These costs will be kept at the same level as at the date of contract signature, and all costs are simply passed through the hospital back to the MoHSW. The Operator does not keep the patient revenue.

¹⁰ See Baseline Study, p82

¹¹ McKinsey Quarterly, 'Healthcare costs: a market-based view', September 2008

¹² Inflation figures are from 90/91 and 06/07

In October 2008, the contract was signed for a new 425 bed¹³ hospital in Lesotho's capital city Maseru, which will serve as the country's principal national referral hospital and will also become the district and regional hospital for the city's 200,000 inhabitants. It will serve as the nation's major clinical teaching facility for health professionals. In addition, a Gateway Clinic will be constructed which will serve as a primary care centre, and also as part of the project, three semi-urban Filter Clinics will be refurbished. The hospital will be built, part-financed and operated by a private sector consortium and after 18 years the hospital will return to government operation.

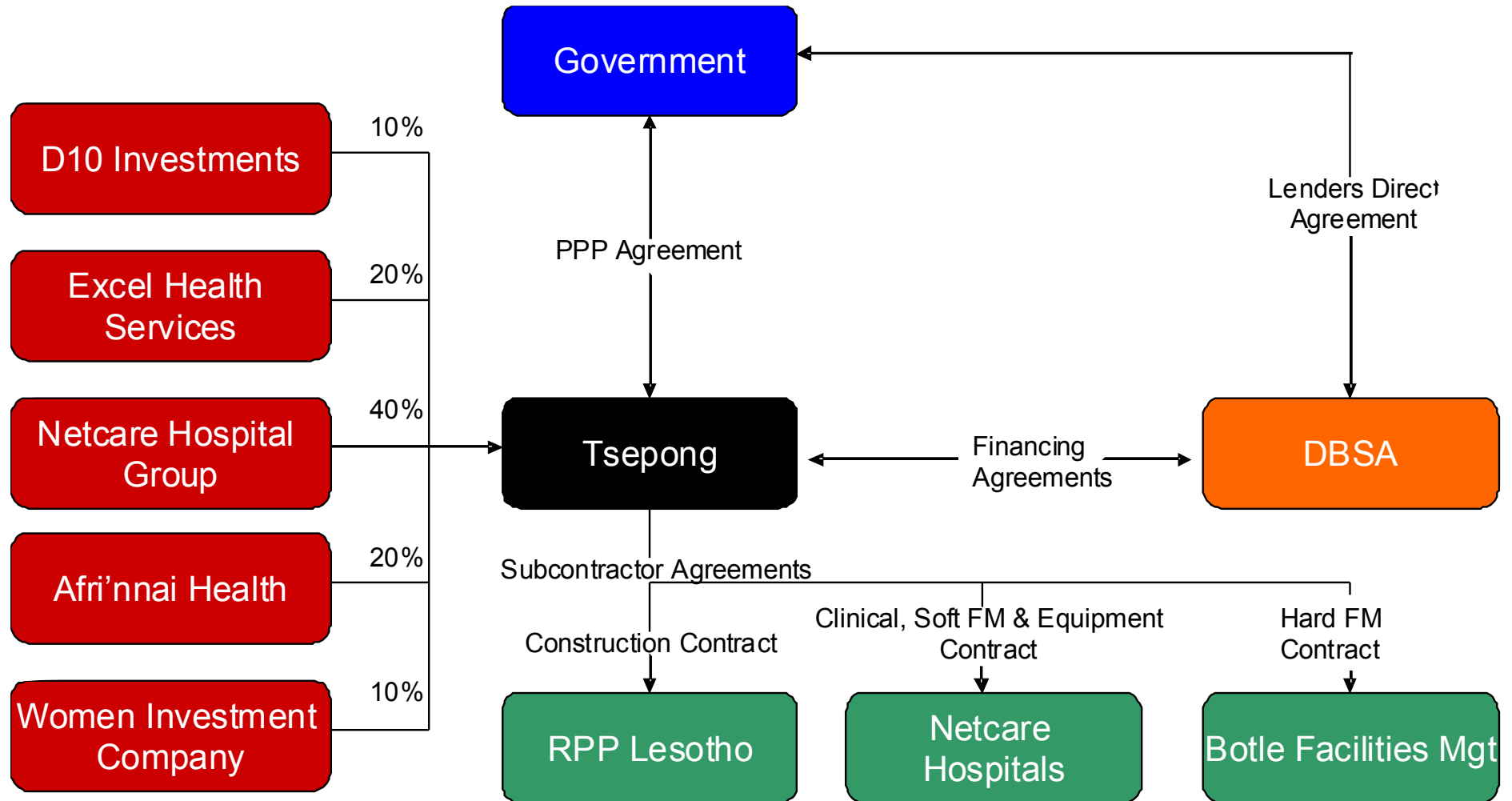
Two bids were received before the October 2007 deadline, and the preferred bidder was announced in December 2007 as a private-sector consortium called Tsepong (Pty) Ltd (hereafter referred to as the Operator). This was a Special Purpose Vehicle (SPV) formed for this specific project and therefore free from any previous debts or contingent liabilities which could otherwise impact its future sustainability. The Operator constituted the following entities:

- Netcare Limited (40%) – a large South African healthcare company with operations in the South Africa and parent of General Healthcare Group, the largest provider of UK private hospitals
- Excel Health (20%) – an investment company for doctors and medical specialists from Lesotho – they will be jointly responsible for supplying the hospital with specialist doctors
- Afri'nnai (20%) – an investment company for doctors and medical specialists from South Africa – they will be jointly responsible for supplying the hospital with specialist doctors
- Women Investment Company (10%) – an investment company for Basotho women – they will be responsible for sub-contracting local security, gardening, linen and laundry.
- D10 Investments (10%) – the investment division of the local Chambers of Commerce – they will be responsible for sub-contracting office facilities, vehicles and food for the hospital.
- It is noted that there is involvement of local and regional stakeholders, with investors, medical staff and service providers. The structure of the PPP¹⁴ is as follows¹⁵:

¹³ 390 public beds and 35 private beds.

¹⁴ The PPP is also referred to as PPIP.

¹⁵ Taken from 'Enhancing Health Systems through Public-Private Investment Partnerships: Lessons Learned from Lesotho', Conference Summary Report, April 2009, p14 and showed the consortium structure as at that date.



The lead financier is the Development Bank of South Africa (DBSA), who will finance 85% of the Consortium funding requirement through debt. The remaining 15% will be financed through equity. For the locally owned consortium members, much of the equity investment is made possible by shareholder loans from DBSA and Netcare Ltd. The equity share from Lesotho based consortium members will progressively increase from 40% to 45% in year 8 and 55% in year 13, through purchase of Netcare Ltd shares.

The World Bank, under the GPOBA initiative, is also supporting the project with an output based US\$6m grant direct to the Operator which will be used to finance the filter clinics in advance of the hospital opening and the first Unity Payment being made.

Timeline

2002 – First feasibility study produced

June 2007 - RFP Produced

October 2007 - Tender deadline

December 2007 - preferred bidder was announced (subject to contract)

October 2008 – main contract was signed (subject to financing clause)

March 2009 - financing clause signed

March 2009 - building work commenced

March 2010 - first filter clinics will open

September 2011 - main hospital will open

March 2026 – 18 year contract will complete

Capital Budget

The capital budget for the MoHSW for 2009/10 is M407m¹⁶, which is around 12% of the total government capital budget. This is around a third of the size of the required capital investment for the NRH, whose capital budget is M1.2bn (US\$ 160m)¹⁷.

National Referral Hospital (NRH) Capital Expenditure (Budget and Actual) for Domestic and Foreign Grants & Loans							
(in Maloti)							
y/e March	NRH Original Capital Budget	NRH Revised Capital Budget	NRH Capital Actual	MoHSW Capital Budget	GoL Total Capital Budget	NRH Revised Budget/MoHSW Budget	MoHSW Capital Budget / GoL Budget
'07	0	0	0	79,776,000	1,252,133,007	0.0%	6.4%
'08	175,000,000	100,000	53,000	307,988,000	1,924,200,000	0.0%	16.0%
'09	90,000,000	5,000,000	85,985,117	242,400,000	2,157,129,000	2.1%	11.2%
'10	200,000,000	400,000,000	n/a	407,000,000	3,450,350,000	98.3%	11.8%
National Referral Hospital approved budget for 2009/10 was M 200m, but this is being revised to M 400m in line with Contract							
Source: GoL Ministry of Finance: Budget Estimates, Budget Department, AGD Department							

M200m was originally approved in the capital budget for 2009/10 but the government is committed under the PPP contract to M400m in 2009/10 and so a re-allocation of

¹⁶ MoHSW's capital budget for 2009/10 is M 407m (of which 57% is domestically funded). This is the fourth largest of the 19 Ministries capital budgets. The M 407m is based on the NRH Original capital budget of M 200,000.

¹⁷ The Maloti is pegged 1:1 to the South African Rand and the current exchange rate at 6th November 2009 is US\$1 = M 7.55

expenditure is currently taking place to enable this obligation to be met.¹⁸ The remaining M800m (67%) capital share will be privately financed by the Development Bank of Southern Africa and the Operator.

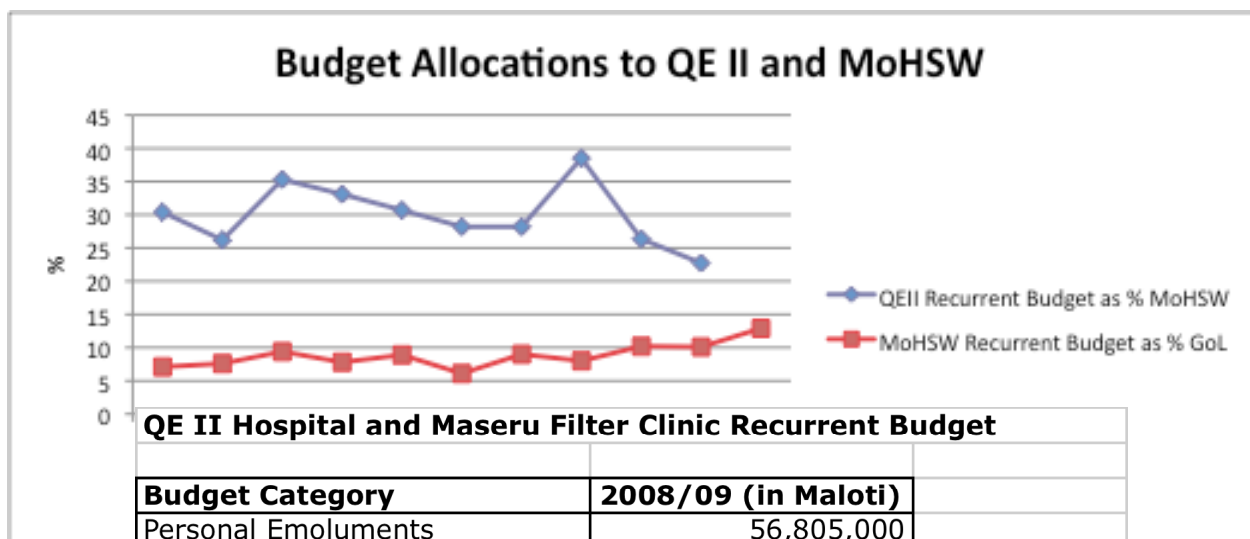
Looking at actual capital expenditure, following contract signature in October 2008, actual expenditure was committed of M86m, which is for capital works ('bulk services') surrounding the site facility such as access roads, electricity, sewerage, telecommunications, and is not counted as part of the M 1.2bn. It could therefore be argued that Government's up front capital contribution is M486m.

It should be noted that it was agreed as part of the Contract that any cost overruns for the capital spend are paid for by the Operator.

Recurrent Budget

As can be seen from the graph below, historically the MoHSW has been allocated between 6% and 10% of the total GoL recurrent budget – with a recent rising trend and in 2009/10 this has risen to a record high of 12.9%, representing M846m out of the total M6,930m recurrent expenditure budget.

Within the MoHSW budget, the QE II has taken between ¼ and 1/3 of the resources, with a high of nearly 40% in 2006/07 and a low of 23% in 2008/09.¹⁹



Budget Category	2008/09 (in Maloti)
Personal Emoluments	56,805,000
Travel and Transport	2,903,000
Power	446,600
Communications	627,000
Other Office Overheads	5,000,000
Printing	60,000
Stationery	398,000
Maintenance of Public Assets	3,500,000
Upkeep of Insitutions	8,500,000
Running Costs	4,000,000
Purchase of Materials	5,000,000
Minor Works	1,500,000
Drugs	24,000,000
Dressings	10,000,000
Office/Non-office equipment	3,560,000
Grants and Subscriptions	60,000
Referrals	28,200,000
Sub-total	158,579,000
Maseru Filter Clinics	3,239,790
Total	161,818,790

Source:

A break is shown

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The Unitary Payment was set at M255.6m per annum, and will be paid quarterly in arrears from the time of hospital completion. It is fixed for the contract term, except for an annual inflation adjustment from the financing clause signature date onwards. Given that the contract between the Operator and Government is confidential, only the overall amount of the payment as required for MTEF budgeting purposes was available, but not any breakdown of this sum into operating costs, debt interest, capital repayment, and Operator profit. But below we make some assumptions to arrive at a possible estimate for operating costs.

As explained above, the Operator is expected to raise c. M800m of the M 1,200m capital budget. The financing clause was signed in March 2009, and the hospital is due to be complete 2.5 years later in September 2011 with the contract concluding 15.5 years later in March 2027. Assuming a 5% cost of capital, the annual interest cost for the first 2.5 years is M100m. The capital repayment amount and annual interest cost using a reducing balance basis is M74.3m per annum over the final 15.5 years of the contract. Assuming that the initial two year interest cost is spread equally over the remaining contract life of 15.5 years, then the total debt repayment and servicing cost will be M80.8m.²¹ If this is the case, then the operating cost plus Operator profit will be M174.8m, and assuming an Operator profit of say 10% of operating cost, then the true operating cost could be around M157m. It must be emphasised that this is only a possible estimate of the true operating cost²² – the real cost is confidential. It is reported by MoHSW²³ that there is a cap on the consortium's profit, but

²¹ At a 10% cost of capital, the equivalent amount will be M 114.6m.

²² Note that no account is taken of the time value of money in these calculations since the Unitary Payment is protected against inflation. Also, it assumes that any Operator financing profit is built into the Cost of Capital. Loan calculation performed by: <http://www.bankrate.com/calculators/mortgages/loan-calculator.aspx> and monthly amounts were simply multiplied to calculate yearly amount.

again it was not possible to obtain any explanation of what the level of this was or how it was determined.

Additional Factors

There are three additional factors which are important parts of the Case Study – local economic empowerment, monitoring of projects and lessons learned from the MoHSW's perspective.

Local Economic Empowerment: In the RFP the government requested bidders to conform to minimum requirements for promotion of Local Economic Empowerment for Lesotho citizens, and the agreed targets with the operator are as follows:

Local Equity: The current level of local equity in the operator is initially 40%, but this will progressively increase to 45% in year 8 and 55% in year 13.

Local Management and Staff Development: In addition, the following targets are set for the ratios of local management and staff:

Local Management Control:

- Year 2: 50% local staff
- Year 5: 80% local staff

Local Women Management Control:

- Year 2: 25% of management
- Year 5: 40% of management

Local Staff employment:

- All years: 80% of all staff employed will be local staff

Skills Development: a minimum of 1% of payroll costs per year will be spent on training and skills development.

Local Subcontracting

It was agreed that capital expenditure to local enterprises would constitute 30% of all capital expenditure. For operating expenditure to local enterprises, the following targets were set:

- Year 1-5: 50% of all operating expenditure
- Year 6-10: 70% of all operating expenditure
- Year 11-18: 100% of all operating expenditure

Community Development

The operator will:

- Cover the annual study and accommodation costs of a medical student
- Fund the treatment of patients with congenital heart disease and cleft lip and palate defects to an agreed value each year

²³ 'Public-Private Investment Partnerships', SADIC Countries Ministries of Health conference summary, prepared by MoHSW, April 2009, p10

- Provide ophthalmology services to the community as part of its 'Sight for you' programme
- Set up at own cost, maintain and operate in coordination with Government a Women and Rape Crisis Management centre at the hospital

Monitoring

In terms of the financing arrangements, the consortium will be paid by the government over the contract duration for services provided at the contracted level of performance, and this performance will be managed independently. The facilities will also have to maintain continued accreditation over the contract term.

For the capital works, an independent certifier was appointed jointly by the Government and the Operator who will examine the site on a regular basis during the construction phase and will provide a certification at the end to ensure that the construction and equipment comply with the required standards.

For the operation of the hospital, an independent monitor has been appointed by the government to perform oversight of service quality and who will administer any financial penalties resulting from deficiencies. Supplementary accreditation reviews will be performed by the Council for Health Service Accreditation of Southern Africa and loss of accreditation could serve as a basis for contract termination.

Lessons Learned so far

The following lessons learned have been identified by the MoHSW²⁴:

- It is essential to clearly define the roles of Government and the Transaction Advisors from project inception to facilitate information flow and decision making.
- Composition of Transaction Advisors and Government teams should have all the necessary technical expertise.
- Feasibility studies and baseline reviews should be as informative as possible to assist in making realistic project and sector assumptions.
- Difficult decisions have to be made especially in service provision.
- Extensive consultations and active participation of all stakeholders should be done from the inception stage to ensure incorporation of contributions from all concerned.
- PPP project will allow the Government to cover other priorities.
- MoHSW and MoFDP teams were involved in bid evaluation and were also intensively involved in negotiations. This has resulted in a wide institutional knowledge of the project across both Ministries.
- Contract management is the core to project success. Capacity of Contract Management should therefore be in place as early as possible because when this takes off, the Transaction Advisors may no longer be available for ongoing support.
- PPP regulations framework is essential, however, it is possible to fit the projects within existing regulations like it has been the case with this one.

²⁴ 'Lesotho Referral Hospital PPP', Principal Secretary presentation, Ministry of Health and Social Welfare to SADIC countries Ministries of Health representatives, April 2009

- The PPP process so far, but systems are yet to be tested that have been put in place to ensure the success of the project.



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