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Breaking New Ground: Lesotho Hospital Public-Private Partnership—A Model for Integrated Health Services Delivery

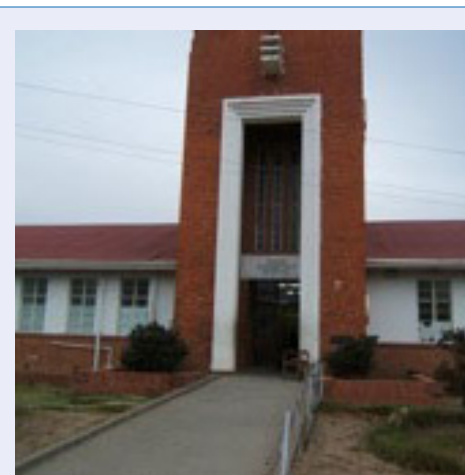
For many years, Lesotho has urgently needed to replace its main public hospital, Queen Elizabeth II. In 2006, to maximize the use of limited resources and ensure long-term improvement in facilities and services, the government adopted the public-private partnership (PPP) approach for a new hospital. IFC's Infrastructure Advisory Services Department advised the government in structuring a PPP for the design and construction of a new 425-bed hospital and adjacent gateway clinic, the renovation of three strategic filter clinics, and the management of facilities, equipment, and delivery of all clinical care services for 18 years. The project has a capital value of over \$100 million, and the private operator—the Tsepong consortium headed by Netcare, a leading South African health care provider—has significant local ownership: 40 percent of shares held by Lesotho-owned businesses, increasing to 55 percent during the project term. This SmartLesson describes this pioneering PPP project, and shares some lessons we've learned from it.

What Makes This Project Different

PPPs in the health sector typically range from simple outsourcing of support services (such as catering or laundry) to the more complex design, build, and facilities management of hospitals. To our knowledge, the Lesotho PPP structure is a first for Africa—and one of only a handful of similar projects worldwide. In addition to the design, build, and full operation of the hospital and associated health care facilities, the Tsepong consortium will deliver all clinical services, with the objective of providing vastly improved, high-quality health care services at an affordable cost. Here are some key differences from other hospital PPPs:

1. Complete Health Care Services Delivery

Tsepong is responsible for delivery of all clinical services, including recruitment of doctors,



The 100-year-old Queen Elizabeth II Hospital, an aging facility functioning at a minimal level, will be replaced by a new facility.

nurses, and other health professionals, and provision of all medical equipment and all pharmaceuticals necessary for clinical services delivery. In addition to the new facility, which will operate as the national referral hospital as well as the district hospital for the greater Maseru area, Tsepong will be responsible for the refurbishment, re-equipping, and operation of three primary health care clinics at Qoaling, Mabote, and Likotsi in the greater Maseru area, allowing it to 1) manage a mini-health care network, and 2) filter and treat less severe cases at the clinic level, freeing up as much hospital capacity as possible.

2. Service Payment

The private operator delivers budget certainty as well as patient-centered care, assuming full patient risk from project inception and agreeing to treat all patients who present at the hospital and filter clinics, regardless of the type of condition, up to a maximum of 20,000 inpatients and 310,000 outpatients per annum—with very few clinical exceptions. The government provides Tsepong an annual fixed service payment for delivery of all services,

escalated only by inflation annually. We know of only one similar full PPP project in a developing country, and that private operator opted for a direct-cost-plus-margin payment basis for the first few years (until patient profiles and disease patterns could be studied) before committing to a fixed cost for clinical care.

3. Performance Monitoring

The Lesotho PPP agreement includes typical performance monitoring—such as payment and penalty mechanisms related to facilities management, equipment, and other nonclinical service outcomes, as well as independent certification of delivery of facilities and equipment. But it also requires additional monitoring:

- *The Lesotho agreement includes a detailed list of both clinical and facilities performance indicators that the private operator must meet in order to receive full payment from the government. Failure to meet a performance indicator will result in a severe penalty deduction (a percentage of the total service payment). The relative importance of clinical versus facilities performance indicators is reflected in the percentages deducted. For example, failure to comply with the infection-control measures (clinical indicator) draws a 1.00 percent penalty; whereas failure to comply with linen and laundry service standards (facilities indicator) brings only a 0.25 percent penalty. A ratchet mechanism for repeated service failure for the same problem increases the penalty deduction for each repeated failure, and service failure that is not remedied can result in termination of the agreement.*
- *The Lesotho project has an independent monitor—a unique role specifically created for this project and jointly appointed by the government and the private operator—to perform a quarterly audit of the private operator's performance against the contractual performance indicators (clinical and nonclinical) and, where performance has not been achieved, determine the penalty deduction that applies. The independent*

monitor is a consortium of companies with specialized experience in PPPs, clinical services, hospital operation and management, medical and nonmedical equipment, information management and technology, and soft and hard facilities management.

- *The private operator is required to obtain and maintain accreditation from the Council for Health Services Accreditation of Southern Africa, and failure to do so can result in termination of the agreement.*
- *The project provides for a Joint Services Committee, established by the government and the private operator, to review performance and discuss and develop mechanisms, procedures, or protocols to improve the services at the hospital and filter clinics. Given the long-term nature of the project, this committee provides a mechanism for altering the hospital's services, by agreement, to address new disease patterns, new technologies, or new national priorities, thereby ensuring that the project remains relevant for the country.*

Lessons Learned

1) The baseline study is important throughout the project.

During project preparation, IFC realized that the expectations of the government and general public were high: a new facility with better equipment and vastly improved services. However, there were many questions as to whether the country (and the average patient) could afford new facilities and better public care. What services would be offered? Could service delivery by a private operator be affordable?

To answer these questions, IFC produced a detailed baseline study of health care costs and services at the existing Queen Elizabeth II hospital and the related filter clinics. The baseline significantly shaped the project design, helped set the performance indicators in the PPP agreement, and improved the government's understanding of what was currently being delivered and what improvements the PPP could bring. The performance indicators are also aligned with the Millennium Development Goals (MDGs) for Lesotho. The baseline study will also be useful for IFC's own monitoring and evaluation work on the project going forward.

2) Evaluation of bids serves to enhance outcomes and affordability.

The challenge was to come up with a bid evaluation structure to accommodate three competing objectives: 1) to procure as many services for as many people at the hospital and filter clinics as possible; 2) to improve the quality of services; and 3) to do so within the government's affordability limit. The best structure we could devise to balance these objectives involved dividing the technical evaluation into three areas:



An architect's drawing of the design for the new hospital.
(Photo courtesy of Netcare)

- **Service Coverage:** Bidders were required to confirm which services they could feasibly provide within the service payment, taking into consideration patient volumes. Services listed by the government in the bidding documents included “mandatory” and “optional.” For example, orthopedic surgery (general and trauma) was a minimum requirement, but bidders who also offered hip-joint replacements within the service payment received additional points. Similarly, diagnostic imaging (radiology, digital X-ray, CT, mammography) was a minimum requirement, but bidders who offered magnetic resonance imaging (MRI) services received additional points. The winning bidder agreed to provide all mandatory services, plus 95 percent of all additional optional services within the service payment.
- **Patient Volumes:** The government stipulated services to a minimum of 16,500 inpatients and 258,000 outpatients at the hospital and filter clinics. Bidders had to commit to a maximum number of inpatients and outpatient visits, and the bidder offering the highest number of patients received maximum points. The winning bidder committed to delivery of services to 20,000 inpatients and 310,000 outpatients per annum.
- **Service Delivery Plan:** Bidders were evaluated on their approach to quality, effectiveness, and efficiency of the services to be provided; compliance with service standards; and how realistic their plans were. This element was evaluated by a multidisciplinary team from the Ministries of Health and Social Welfare and Finance and Development Planning, and IFC.

The technical and financial offers were submitted separately, with the financial offers opened only after the technical evaluation was completed.

3) Defining clinical services is necessary, even if it has to be a highly consultative process.

The service-coverage list developed for the bidding documents was a key element of the bid evaluation, but the definition of that list was a highly consultative process, including Ministry of Health staff, clinicians at the Queen Elizabeth II hospital, private practitioners in Lesotho, and IFC’s technical experts. These discussions were complicated by the inevitable need to balance affordability and expansion of services currently not provided in Lesotho. The parties eventually reached agreement on the minimum types of services believed to be deliverable within the affordability limit by any private operator.

To progress smoothly, such a highly visible, important national project had to be seen as having the support of all key stakeholders. Wide support would not have been there without the consultative process. A key to getting agreement was finding a balance between services perceived to be essential versus services that would be good to have but not essential—plus a constant reference to affordability. A bidding structure that allowed bidders to include optional extras was also helpful in reaching agreement.

4) Integrated service delivery is essential at every level.

Since the private operator is responsible for complete health care service delivery at the hospital and filter clinics, it was important to ensure that it could actually deliver all services—pharmaceuticals, for example. The current national referral hospital is a significant client of the National Drug Supply Organisation (NDSO), the central pharmaceutical and medical-supplies procurement entity for the government. On the one hand, if the private operator were no longer required to use NDSO as a pharmaceuticals supplier, NDSO would lose significant bargaining leverage for the country. On the other hand, if the government forced the private operator to use NDSO, and if NDSO failed to deliver the right drugs on time, the private operator could claim cause for failure to treat a patient. Solution: The private operator entered into a service-level agreement with NDSO, as well as a capacity-building initiative that will enhance NDSO supply and logistics capability, thereby ensuring better service delivery not only to the PPP but also to the broader public health system.

5) Value for money is about more than just project cost and risk transfer.

PPPs generally focus on the concept of value for money, which typically assesses the affordability and risk transfer of a project. By this standard, the Lesotho project is affordable for the government. On an operational cost comparison, the government will not pay much more for the PPP than it currently spends on the Queen Elizabeth II, yet it will receive vastly improved facilities, medical services, and patient care. From a patient perspective, services at the new hospital and filter clinics are affordable and will cost the same as at any other public health facility in Lesotho. The project has also ensured maximum risk transfer to the private operator, protecting the government from most of the financial, operational, and legal risks inherent in a project of this nature.



A benefit of the new facility is the attraction and retention of qualified health professionals.

Other significant value-added elements include:

- **Development of Human Resources:** *Lesotho, like many other developing countries, struggles to attract and retain professional health staff. In this project, the private operator is responsible for recruitment of all staff at the new hospital and filter clinics, and has greater freedom to pay staff salaries that reflect the scarcity of their skills, without being constrained by government salary policies. This project also allows the private operator to create a platform for doctors to serve both the private and public sectors in a controlled manner. The project will also create a working environment that encourages high-quality, patient-centered treatment with the use of modern equipment and greatly improved facilities—one of the key factors in retaining health sector staff.*

- **Training:** *The new referral hospital will be the country's main teaching hospital for physicians undergoing postgraduate training, medical students, nurses and other health professionals, and staff from other public health facilities. These students will have access to equipment and facilities not previously available in Lesotho. This training component is also expected to assist in retaining qualified health sector staff.*

- **Referrals:** *The government currently refers most complicated cases outside the country, since the current facilities at Queen Elizabeth II cannot accommodate them. The new hospital will address many of these cases.*

Human resource (HR) and training costs are built into the financial model, and the private operator commits to spending the amounts allocated to HR and training annually—making these elements part of the overall cost of the project.

Conclusion

The PPP agreement for this project was signed by the government and the private operator on October 27, 2008. Financial close occurred on March 20, 2009, and construction began on March 23, 2009. The filter clinics are expected to be operational at the end of 2009, and the new hospital in July 2011.

The Lesotho Hospital PPP has demonstrated that it is possible in a low-income country to embark on a very ambitious project that is affordable for the country and patients, is attractive to top-quality private investors, expands services to more people, and has the potential to deliver high-quality health services

that address MDGs and the critical shortage of health professionals—key constraints for many developing countries.

Although the project is still in its early stages and the expectation of success is high, there will certainly be challenges and obstacles for the private operator and the government to overcome. A key risk is the high probability that the hospital will reach maximum capacity very early in the project term, requiring the government to rapidly improve the service offering at other hospitals to relieve the pressure on the national referral hospital. Another risk is whether the private operator will be successful in attracting and retaining the numbers of doctors and nurses necessary to ensure effective service delivery. The key factor for the success of this project is the commitment and support of the government demonstrated throughout the project process, from procurement, during negotiations, and to financial close. Government firmly believes this project will deliver meaningful results for the country.



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