
Case Number 1999.0

Lesotho Hospital and Filter Clinics: A Public-Private Partnership

Introduction

Timothy Thahane, Lesotho's Minister of Finance and Development Planning, understood that by championing a public-private partnership to improve his country's health program, he was embarking on a risky course. However, he also knew that without private sector involvement, health services would continue to deteriorate. Lesotho had one of the highest rates of HIV/AIDS in the world. The statistics for tuberculosis were not much better. Patients seeking care of the Queen Elizabeth Hospital found the physical plant in poor shape, services unavailable and basic sanitation standards ignored. As the hospital budget increased, its services continued to decline. As one observer pointed out, the hospital was becoming a disease vector.

Thahane had served as Deputy Governor of the South African Reserve Bank and had spent eleven years at the World Bank.¹ While serving in these capacities, he had become acquainted with the use of the Public-Private Partnership (PPP) model to improve the quality of public services. When he returned to Lesotho and became its Finance Minister, he argued that the construction of a new police station in Maseru, the nation's capital, would be an ideal PPP. However, the Ministry of Public Works disagreed. They saw this idea as a challenge to the agency's traditional role as the designer, constructor, and operator of government buildings. Thahane was unable to overcome this opposition, but when discussions began about constructing a new building for the Ministry of Health, he again argued in favor of involving the private sector. This time he enlisted the Health Minister, Dr. M. Motloheloa Phooko, to help him sell the idea. Together they successfully overcame opposition from the supporters of the old public procurement model, and the new Health Ministry building became Lesotho's first PPP.

Lesotho's health network consisted of loosely connected district hospitals and clinics. At the apex of this system was the national referral hospital —the Queen Elizabeth II Hospital in downtown Maseru, the nation's capital. Since the early 1990s, state health officials had argued that the Queen Elizabeth II Hospital should be replaced. A 2002 report, authored by a consortium of Boston University's (BU) School of Public Health and a group of doctors and senior officials from Lesotho, reinforced this view.² Further, there was a growing awareness that even if the government could afford to build a new hospital, this project alone would not improve the quality of

¹ Author interview with Timothy Thahane, March 13 and 14, 2012.

² Economic Study of Referral Health Services in Lesotho: The Future of Queen Elizabeth II Hospital: Volume I. Bicknell, William, et al. Boston University School of Public Health, Center for International Health, June 14, 2002.

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health care, since it would be providing the same poor services, but in a new building. In other words, Lesotho needed a comprehensive solution that not only included a new referral hospital, but also a network of filter clinics and district hospitals, better doctors and nurses, and an overall health delivery system that met the nation's changing health needs.

Thahane and the Health Minister Phooko felt that private sector involvement would be critical to realizing this goal. But there were few precedents in Africa of having the private sector involved in both the construction and operation of a new public hospital and the provision of clinical services. Further, to design a PPP for a new hospital, the government would need much better information to establish performance standards required to measure whether the private party was providing quality care. To fill this gap, they reached out to the World Bank's International Finance Corporation (IFC), which had fledgling experience in using the PPP model in the health sector. To help them, the IFC asked the BU team that authored the 2002 study to work as technical consultants on the hospital PPP and to conduct a series of baseline studies which would inform both the design of the PPP and overhaul of the country's health system.

To pursue this project, Lesotho had to address several questions: Would the private sector be willing to take on the inherent risk of providing clinical services in an African country? How much more would it cost to run a brand new hospital complex, including three new filter clinics, and could Lesotho afford these additional costs? Performance standards and measures were essential to ensuring that private parties provided the desired level of services. But given that medical technologies and priorities were continually changing, how could these milestones be defined realistically, while remaining sufficiently demanding? How should the private sector's performance be monitored? Finally, if Lesotho established a high quality referral hospital and several state of the art filter clinics in its capital city, Maseru, would people from throughout the region travel to the hospital, bypassing the other 180 clinics and hospitals scattered throughout the country? In this scenario, demand could skyrocket beyond the new hospital's capacity and the Health Ministry's budget to cope with it.

Lesotho

The Kingdom of Lesotho is a constitutional monarchy of 2 million people with a land area about equal to that of Belgium. It is surrounded by the Republic of South Africa and is the only independent nation in the world whose entire territory lies 1000 meters above sea level. Its main economic activities are the sale of water to South Africa, agriculture, mining, and garment manufacturing.

"Lesotho" means the "land of the Basotho people" and originally encompassed the Orange Free State before the Boers conquered a portion of the region in the 1858 war, leaving the country with the less fertile mountainous areas. Soon thereafter Lesotho became a British protectorate and part of the Commonwealth. It was finally granted self-government in 1960. The next thirty years was a period characterized by political instability and frequent changes in government —often as a result of military intervention. Today, it has a parliamentary government with a Prime Minister and a cabinet. The King, Letsie III, occupies an important, but largely ceremonial role.

The country has an annual per-capita income of USD 570, which is higher than that of some African countries, but almost 60% of the population lives below the national poverty line. Its unemployment rate is officially in the vicinity of 25%, but many believe it to be much higher, since its major industry, textiles, has been in decline over the past decade.³

The Queen Elizabeth II Hospital

Every morning at 6 a.m., hundreds of citizens lined up to get medical attention, knowing that the Queen Elizabeth II Hospital allocated medical care on a first-come first-served basis. People arriving late feared that they may not be seen and the fundamentals of care were not being met for a majority of severely ill patients. Many of the buildings dated back over 50 years with the oldest over 100. Morale among doctors and nurses was poor due to the physical conditions and sporadic pay, and the system for processing patients, ordering drugs, and keeping records was extremely inefficient. The annual operating cost of the hospital had increased from approximately 80 million maloti in 2004 to 185 million maloti in 2009, yet services continued to deteriorate.⁴

The Early Stages

By 2002, there was growing consensus that a new referral hospital was needed and that it should be accompanied by several improved filter clinics that would screen patients prior to referring them to the hospital. There was also increasing recognition that private sector involvement would be critical, but no guarantee that a major private company would be willing to take the financial risks of providing *both* the construction responsibility and clinical health services for what was basically a public hospital.

To help design the PPP, Minister Thahane asked the IFC to serve as the project advisor. This request was fortuitously timed, since IFC officials under the leadership of Catherine O' Farrell and Carla Faustino had been looking for countries in Africa that might be interested in using the PPP model in the health care sector. Hence, when the request from Minister Thahane arrived, the IFC jumped at the opportunity.⁵

The Center for International Health at Boston University, officials from the Lesotho Ministry of Health, and the team from IFC had completed preliminary baseline studies prior to the IFC's arrival. These studies were designed to ascertain the condition of the existing health system, and derive the baseline numbers from which the performance targets for the new hospital would be developed. It cost 185 million maloti to operate the old hospital. What did Lesotho get for that sum? How many outpatients were using the hospital every month? What were their health problems, how many needed to be hospitalized, and how many could be treated in an outpatient clinic?

Conducting an accurate baseline study is no easy task, especially in a poor developing country. Theoretical indicators are useless when dealing with the magnitude of health problems. What is the benchmark for patient care, when more than 25% of pediatric patients are malnourished? How do you know how many patients have any

³ Central Intelligence Agency, The World Factbook, <https://www.cia.gov/library/publications/the-world-factbook/geos/lt.html>.

⁴ International Finance Corporation Monitor, April 17, 2009.

⁵ Author interviews with Catherine O' Farrell, August 2012 and Carla Faustino, March 13 and 15, 2012.

specific ailment when diagnostic testing is poor and test records are often missing? One of the indicators of hospital efficiency is “length of stay.” But in many developing countries, including Lesotho, many patients have no suitable family or home to which they can be discharged, and therefore they are often kept in the hospital for much longer than would be the “norm.”

Under the leadership of William Bicknell, Dean of the BU Public Health School, the study exceeded everyone’s expectations both in its thoroughness and recommendations. Some of its findings were alarming, but simple to correct. For example, doctors and nurses rarely washed their hands, in part because there were only two hand-washing stations with hot water in the whole hospital. Primary care clinics were badly understaffed, and there were no criteria or procedure for referring patients to the hospital or treating them as outpatients at the filter clinics, so hordes of patients went directly to the hospital, overwhelming its staff and doctors. There was no tradition of service orientation or training. Customer satisfaction was a foreign concept (see Exhibits 2-4 for more on the quality and character of service).

The idea of a comprehensive PPP in which the private provider would not only build and operate a new hospital, but would also provide clinical services was strongly reinforced by the baseline studies. This spurred two immediate questions: 1) would any private health care provider be willing to make an investment in Lesotho, and if so, would it be willing to invest in both construction—bricks and mortar—and the provision of health care services, and 2) could Lesotho afford to sign a PPP with a private company? A preliminary RFP was released, seeking interest in designing, building and operating the new hospital. Sixteen companies paid \$1,000 to purchase documents. The challenge was to see if any of the sixteen would submit a bid.

The IFC team began a preliminary round of meetings with representatives of the interested companies to explore the market’s response to Lesotho’s needs. The IFC’s approach was designed to overcome the limitations experienced when projects are hastily launched, but then produce mixed results. This may occur when expectations are not clearly defined, costed, or explored and the issues are left to be negotiated after the winning bids are awarded. This scenario often leads to prolonged and continuous negotiations and suboptimal results. The IFC knew that this project required a thorough understanding by all parties in order to successfully move ahead.

The IFC held intensive meetings with government and potential bidders, obtaining their input on issues ranging from the scope of the contract to the list of required services. Every detail of the proposal was discussed and considered prior to being incorporated into the RFP. These meetings demanded that all parties invest significant time and effort in understanding and buying into the project before the RFP was issued in the hope that negotiations after the winning bid was awarded would be minimal.

The Lesotho government was concerned that bringing the private sector into the mix would make the project unaffordable. Therefore the IFC team conducted two efforts in parallel. They asked the potential bidders, —if they were given an annual unitary payment equal to what the Health Ministry spends on the Queen Elizabeth Hospital (185 million maloti), could they build and operate a new referral hospital and clinics, and provide a much higher quality and broader range of health services? The answer from several of the bidders was yes. Simultaneously, the IFC built its own financial model containing each of the proposed RFP requirements and reached the same

conclusion. This projection gave Thahane and Phooko the confidence they needed to sell the PPP model to the Prime Minister and his cabinet. To make the case, they had to give assurances that the annual cost of the new hospital and clinics would not exceed 185 million maloti per annum, plus a 400 million maloti one-time grant. The annual appropriation was referred to as the unitary payment. The second concern was the effect of the project on the local economy and jobs. With national unemployment levels exceeding 25%, the government did not want to see all jobs and profit going to South Africa.

While the companies were willing to make encouraging assertions, it was not assured that they would bid. The IFC team and their colleagues from the Ministries of Health and Finance continued to work with all bidders, the most engaged of which were two South African companies—Life Healthcare and Netcare Ltd.. Both were premier suppliers of health services in South Africa with operations in Europe and other parts of the world.

The Bid

The government's objective was to buy the outputs – high quality health services delivered in a timely way from well-equipped and well-maintained facilities – rather than to pay only for infrastructure. Each potential bidder was therefore presented with a predefined package of services that it would have to supply—including both clinical and facilities management/building services. They would have to build a 425-bed hospital and renovate three filter clinics around the city of Maseru. The government stipulated that the winning bidder must provide for a minimum of 16,500 in-patient and 258,000 out-patient visits per year. Additionally, they would have to agree to provide all services according to detailed standards and meet the list of performance indicators contained in the RFP, as well as any additional services that they might offer. The government's goal was to procure as many services at the specified level of quality for as many people at the hospital and filter clinics, and to do so within its affordability limit.

The bids would be divided into two parts—a financial bid and a technical bid. The latter in turn was divided into three elements: 1) service coverage; 2) patient volumes; and 3) a service delivery plan. Under service coverage, bidders were asked to confirm which services they could feasibly provide within the unitary payment, which included both those mandated by the government (such as orthopedic services or diagnostic imaging) and any additional services they chose to provide as long as they stayed within the affordability limit.

Under patient volumes, bidders were asked how many visits above the government-stipulated minimum, if any, they would agree to within the preset unitary payment. Finally, bidders would be evaluated on their approach to quality, effectiveness, and efficiency of the services they would provide. Bids were to be evaluated by a multidisciplinary team from the Ministry of Health and Social Welfare, the Ministry of Finance and Development, and the IFC team.

Both Life Healthcare and Netcare submitted bids. Life Healthcare embraced the concept of offering clinical services, but were less enthusiastic about taking on some of the other risks inherent in the PPP agreement. Netcare Ltd. and its consortium were willing to enter into a PPP contract and take on all the construction risks. While Netcare Ltd. held both Minister Thahane and the IFC team in high regard, they were also conscious of the

political risks in the deal. Once the hospital and clinics were built, would Lesotho honor their commitments to pay the unitary payment which would provide 96% of the revenue stream for this project? Even if the government intended to honor this commitment, would they be able to afford it? Lesotho was very poor, and their economic prospects in the next 4-6 years were not encouraging. Even within Netcare Ltd., there were doubts about the project. Was this too much of a risk even for them?

Who is Netcare?

Netcare is known for the quality of its private hospitals, but also has experience with operating private and public partnership hospitals, including four hospitals in South Africa. As Victor Litlhakanyane, Netcare's project leader, pointed out, "Netcare sees itself as a company that likes to take risks. We were attracted to this project because it went beyond bricks and mortar. We felt that the model put forth by the IFC and Lesotho could be applicable throughout Africa. If we could make it work in Lesotho, we could expand it throughout the continent."⁶

While worried about the political risks inherent in the deal, Netcare trusted the Lesotho legal system, which was very similar to that of South Africa. Hence, their remaining hurdle was the affordability risk.

To prepare for the bid, Netcare established a consortium consisting of five institutions: Netcare, (40% ownership); Excel Health Services, a group of Lesotho doctors; Afri'n nai Health, a South African health care provider, (20% share each); and two groups from Lesotho—Women's Investment Company and D10 Investments (see Exhibit 5). The consortium formed a Special Purpose Vehicle —Tsepong. Tsepong in turn was prepared to enter into a subcontract with Netcare Hospitals—a wholly owned subsidiary of Netcare Ltd. to provide the clinical services and with RPP Lesotho for the construction. The latter was the same construction company that built the new Ministry of Health building. The ancillary services, such as security, food, laundry, and cleaning were to be subcontracted to a third firm, but negotiations fell apart before a contract could be negotiated.⁷

To fund the project, Netcare held discussions amongst leading banks in the region (Nedbank, Barclays, and the Development Bank of Southern Africa [DBSA]). All the banks were quite enthused about the project and expressed a willingness to be a major lender. In the last few years, the DBSA had been under pressure to increase its lending in the health sector; hence, this project met the bank's immediate political needs. The same was true for the other banks, but to a lesser extent.

With the consortium established and the prospect for financing promising, Tsepong developed a bid to meet the provisions outlined in the RFP, agreeing to the 185 million maloti ceiling on the unitary payment from the government. However, when Tsepong went back to the DBSA, the bank said that global financial markets had deteriorated badly and that subsequently, they would be unable to meet the terms to which they had initially agreed. In addition, the Ministry of Health decided to add a fourth clinic at the entrance to the hospital. These changes required an increase in the unitary payment to 225 million maloti. While this additional 40 million maloti would require significant reallocations with Lesotho's budget, there was too much political momentum for the

⁶ Author interview with Victor Litlhakanyane, March 13, 2012.

⁷ Netcare later subcontracted these services to Botte – a newly established company.

government to scrap the project. In addition, the unitary payment would be adjusted annually by an inflation index pegged to several factors, including increase in medical services and equipment in South Africa.

Performance Clauses

Setting performance clauses for clinical health services is challenging under normal circumstances, but doing so in a developing country, such as Lesotho is even more so. The Health Ministry knew that if a private party offered the services formerly provided by the government, the public would still hold the Ministry accountable for the quality of the service. The government must therefore set clear performance standards and targets that the private party must meet. Much of the value of a PPP is incorporated within these targets, and thus it is not surprising that establishing performance indicators is at the heart of a successful PPP.

Issues included setting the targets themselves, the penalty provisions for failure to meet them, the monitoring and enforcement mechanism to levy the penalties, and a process by which the targets could be amended as new information was received. In a field such as medical care, in which technologies, knowledge, and practices are constantly changing, developing processes for amending the performance indicators and the penalties attached is essential to the sustainability of the project.

Most of the proposed indicators were included in the RFP and had been discussed in depth beforehand, so all of the bidders had a good idea of what performance levels they would have to meet. In most cases, the indicators were drawn from data and information provided by the baseline studies written by Boston University and the Lesotho-Boston Health Alliance. Further, the IFC team reviewed hundreds of contracts for health services and held extensive discussions before finally deciding on the service standards that would be required for the Lesotho project.

The indicators were divided into categories such as clinical services, facilities management, and client satisfaction. Each included a description of the indicator, the target threshold that must be met, and the deduction from the annual unitary payment to Tsepong if they were not met (see Exhibits 6 for a list of the performance indicators). For example, one of the indicators was compliance with the national protocol for the Prevention of Mother to Child Transmission of AIDS. Tsepong was expected to realize 90% compliance with this protocol and would get a 1% deduction in the unitary payment if it failed to do so. For other indicators such as facilities management, deductions were much less —0.05% to 0.4%. Each quarter, the Independent Monitor for the PPP Agreement would assess performance against the full set of performance indicators and then subtract any relevant deductions, which would then be applied to the payments for the following three months. At the end of each three month period, the monitor would issue its findings for the previous quarter. If the service deficiencies that triggered deductions in one quarter were repeated the next quarter, the penalty deduction could increase. The Ministry of Health had the authority to waive a particular penalty if it felt that Tsepong was making a good faith effort to comply. In these cases Tsepong had to submit a remediation plan showing how they would meet the standard in the future.

Since Tsepong was aware of these indicators before it submitted its bid, there was not much disagreement over the specific measures. Services were divided between mandatory requirements such as orthopedic surgery, and optional services, such as hip-joint replacements. The bidders received additional “points” for offering the extra services.⁸ Where there was disagreement was on the overall ceiling for the penalties, i.e., the total amount of deductions that could be leveled in any given year. Tsepong was acutely aware that offering a new line of services in a country such as Lesotho was full of risks. If the total amount of deductions was too high, Tsepong could find its profit margins totally eliminated. Hence, they insisted on a ceiling for the total amount of percentage points that could be deducted from the unitary payments in any given quarter. The parties eventually agreed upon an 8% ceiling—that is, the largest total amount that could be deducted from the unitary payment in any given period was 8%, even if the penalties attached to the service failures were greater.

While there was almost no disagreement over specific performance indicators, the one exception were those related to patient volume. These included the number of annual outpatient visits and the number of inpatient admissions to the hospital. Tsepong argued that if the number of patients arriving at the feeder clinics exceeded a certain number, they would incur additional costs. The government set the annual level at 16,500 inpatients and 258,000 outpatients, and Tsepong’s bid committed to higher levels of 20,000 inpatients and 310,000 outpatients. Under the proposed system, patients would initially go to one of the four new feeder clinics. They would either be treated at the clinic or referred to the new hospital.⁹ If the outpatient visitors exceeded this ceiling, the government would pay Tsepong 50 maloti per patient (\$4.72). If 100,000 patients above the ceiling were treated in one year, the Ministry of Health would theoretically have to pay an additional five million maloti to Tsepong. The cost for each additional inpatient was 8,326 maloti (\$786). These additional funds would either have to be taken from other health services or other ministries. Given Lesotho’s budget constraints, neither option would be easy if Tsepong insisted on the payment.

Both the government and IFC worried that if the new hospital and its feeder clinics met their performance goals, the quality of services would surpass that of any other hospital and clinic in Lesotho and would be better than hospitals in the neighboring regions of South Africa. Since patients only paid a small co-payment, many people who would have sought health services from clinics or hospitals might travel to Maseru to take advantage of the superior medical services. If this happened, there would be pressure to turn people away and establish a more formal allocation process for clinical services. This would be administratively difficult and politically unpopular. Alternatively, the Ministry of Health and the Lesotho government would have to launch an aggressive campaign to upgrade the 180 clinics and hospitals in other parts of the country, retrain the existing staff of doctors and nurses, and in many cases, hire additional medical personnel. Meeting the additional capital expenses would be very expensive, and only doable with help from external donors. However, building the human capital to provide the actual services would be even more challenging.

⁸ Each bid was given points for meeting certain thresholds or proposing to provide certain services. The bidder with the highest point total was judged the winner.

⁹ For certain ailments, such as heart disease or cancer, they would be referred to hospitals in South Africa.

Ironically, the more Tsepong improved the quality of health care at the new hospital, the greater the demand it created for its services—a demand that could not be met if it exceeded a certain, but undetermined threshold. Both Tsepong and the government understood that managing this problem would be critical to their success and that the performance indicators related to patient volumes would have to be revisited within the first few years after the new hospital opened. The outstanding question remained—at what point would Tsepong and the Ministry of Health have to start limiting the number of outpatients, and what process would they use to do this?

While the uncertainty surrounding patient volumes was a cause for serious concern, so too were the relevance and usefulness of the performance indicators. Even under the best of circumstances, medical needs were constantly changing as new diseases and issues emerged and technologies for treatment and diagnosis evolved. For example, what if telemedicine technologies improve or new medicines change the way a certain disease is treated? On the other hand, some performance indicators might be too rigid or expensive. It became clear to all parties that a process had to be set up to periodically revisit these indicators. Such a process would require significant flexibility on the part of both the government and the private providers. Traditionally, concessions between the two sectors took the form of lengthy negotiations, which resulted in a voluminous contract to which both sides would demand strict compliance. In this case, such a rigid contract would not work, so the parties had to develop a process that would allow the performance indicators to be revisited, requiring both the government of Lesotho (and particularly the Health Ministry) and Tsepong to develop a level of trust rarely seen in traditional concessions. Further, whatever renegotiation process was developed might have to be periodically adjusted, since there were no precedents to guide the parties as they struggled to design a process to effectively reassess the performance measures.

To address these problems, the PPP agreement established a joint service committee, including officials from Tsepong and the Ministry of Health and Social Welfare who would meet quarterly. Each side had the opportunity to raise concerns about any part of the contract including the performance indicator. If there was agreement to amend or change a provision or indicator, this agreement would go back to the senior principles to formally adjust and amend the contract. All parties agreed that changes were expected and that on-going renegotiations were essential. Hence, developing a culture of trust between the parties would be critical.

The final issue was how compliance with the performance indicators should be monitored. Should the government of Lesotho establish a regulatory capacity within the government to monitor the provisions and enforce compliance? Would Tsepong have faith that placing both the monitoring and enforcement capacity in a single regulatory body be fair? Would it be wise to have one part of the Health Ministry enforce the contract provisions and have a sister department in the same ministry renegotiate the provisions being enforced? The resolution was to hire a private third party to serve as the monitor. While there were many firms that provided contract monitoring services generically, no firm in Africa had experience in monitoring the provision of clinic-based health care services within the contract of a PPP. Any firm selected would likely have to reach out to other organizations to help it.

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The final contract stipulated that the monitor would be jointly selected by Tsepong and the Ministry of Health, but would be independent of both. It would be paid out of the annual unitary payment. The monitor was required to send a report to the Minister of Health every quarter, assessing the operator's performance against the performance indicators and identifying any performance provisions that Tsepong had failed to meet (see Exhibit 6). Tsepong argued that during the early stages the monitor should allow some flexibility in the interpretation of the indicators, since all parties were trying to provide services under a new structure. There would be obvious startup problems and thus flexible enforcement would be in everybody's interest. **The government disagreed.** It wanted the monitor to take a literal interpretation of the performance goals. How the contract was enforced during the first two years would send an important message to Tsepong that the government expected high quality service. If flexibility was to be granted, it should be granted by the government, not the monitor, and should be done through the waiver process. Both parties understood that in the early years mistakes would be made, but as long as the parties embraced the joint service committee process, these mistakes could be addressed and remedied. As an IFC official remarked, "We had a relative idea of how the monitor should work, but not an absolute idea, since we had never done this before."¹⁰

Local Empowerment Agreement

Unemployment is seen by most elected officials as the most pressing domestic problem for Lesotho. Therefore, when a project arises that entails hiring significant numbers of people to construct and operate a new referral hospital and provide new medical services, politicians want to be sure that the jobs go to their constituents. This imperative resonates stronger when the managing partner is a company from a richer neighboring country and the project is to replace an existing hospital, which employs over 800 people. Finally, hospitals and clinics must purchase drugs, equipment, and a host of support services. The nightmare scenario would be a project that attracted people from South Africa to take these jobs and bought equipment, services, and materials from foreign vendors which could be provided in Lesotho. Hence, employing Lesotho citizens and purchasing local services was a major political concern. In fact, for most local elected officials, it was more important than the health issues. Taking a cue from neighboring South Africa's Black Economic Empowerment (BEE) framework, the project was designed to include Local Economic Empowerment (LEE) requirements, in which bidders would propose specific incremental targets for the levels of local ownership, local staffing at all levels of project operations, and use of local subcontractors. The proposals by the winning bidder would evolve into contractual obligations and be part of the final PPP Agreement. In other words, the bidders were given significant flexibility to decide how they wanted to manage this issue.

To meet the clinical service provisions of the contract, Tsepong subcontracted with Netcare Hospitals, a subsidiary of Netcare, to operate the hospitals and filter clinics. Netcare Hospitals had the ability to import high quality health professionals from throughout the region, if not the world. However, they also understood that there was a growing global shortage of medical personnel and thus they would have a much better chance of training local citizens to take on medical jobs than to convince trained personnel to relocate to Lesotho.

¹⁰ Author interview with Catherine O'Farrell, August 2012.

The RFP contained four core programs to enhance local economic benefits. The bidders were asked to propose a plan (1) to increase the level of local equity participation; (2) to increase the level of local management and employment; (3) to increase the percentage cash flow to local enterprises; and (4) to ensure spillover benefits from the project to the community. Bidders' proposals were not constrained by the RFP. The plans in each of these four areas would be reviewed and scored by the team evaluating the bids. (Exhibit 8 contains the scoring parameters for the LEE portion of the bid.) The provisions submitted by the winning bidder—Tsepong—were subsequently incorporated into the contract. These included the following:

- 80% of the non-medical staff must be from Lesotho.
- 40% of the services subcontracted must be purchased from Lesotho businesses and this percentage had to increase to 60% by year thirteen.
- 35% of all capital equipment must be procured locally.
- The Tsepong partnership agreed that it would be 60% owned by Lesotho organizations or firms by year ten.

Despite the concern about ensuring that jobs went to local citizens, the government did not force Tsepong to retain the staff of the old hospital. In return, Tsepong agreed to interview any current employees that applied to work in the new hospital. Most people at the old Queen Elizabeth Hospital were employees of the Ministry of Health. Hence, under any outcome they would have jobs, but they might be reassigned to clinics or hospitals located in other parts of the country. Further, Netcare Hospitals decided to send only three managers to Lesotho (one of whom is the present director), ensuring that almost all of the employees would be local.

The combination of the local empowerment provisions in the contract and Netcare's commitment to hiring medical and operational staff from Lesotho enhanced local political support for the project. But it worried managers at Tsepong, who had to meet strict performance indicators with a staff that they characterized as unsophisticated and poorly trained. To succeed, they would have to install effective procedures for processing patients, rework all of the record keeping, establish strict sanitation standards, and develop a customer-friendly culture where none had existed—all in a two-year period.¹¹ Inevitably, the combination of strict standards and limited doctor and nursing capacity would strain management's ability to meet both its budgetary and performance goals, requiring Tsepong to retrain hundreds of key personnel.

While the local empowerment requirements might seem onerous to Tsepong's operational team and certainly would make the first several years difficult, the Health Ministry felt that they were critical to building the human capacity needed to develop a sustainable health care system in Lesotho. These requirements were not simply concessions to local politicians, but were essential building blocks to develop the medical personnel and staff, not only for the new hospital, but for other medical facilities throughout the country. Further, Tsepong entered into an agreement with the National Health Training College to serve as the principle training hospital in Lesotho for health professionals and nurses undergoing training. These students will have access to equipment and facilities

¹¹ Under the contract, Tsepong had to be accredited by the Council for Health Service Accreditation of Southern Africa (COHSASA) within two years in order for the PPP to remain valid.

previously not available in the country. The hope was that the men and women trained at the new hospital would form an expanding cadre of health officials who would work in other hospitals and clinics throughout Lesotho, dramatically improving the quality and scope of the country's health network.

Financing the New Queen Mamohato Hospital

Prior to submitting its bid, Netcare had preliminary discussions with the large regional commercial banks, IFC and the Development Bank of Southern Africa (DBSA). The cost of constructing the new hospital and the four clinics was estimated at 1.1 billion maloti or approximately \$101 million. The government agreed to provide a 400 million maloti grant for capital costs, thus reducing the cost of the overall project. After Tsepong was awarded the project, the DBSA agreed to provide a loan of 595 million maloti at an interest rate of 11.6% to be paid back over fifteen years. The sponsors would provide the remaining funds as equity.

The government of Lesotho agreed to pay a 225 million maloti annual unitary payment, minus deductions for failure to meeting the performance indicators, plus additional payments for patient volume that exceeded the 20,000 ceiling for inpatients and 310,000 for outpatients.

Conclusion

The new Queen Mamohato Memorial Hospital and its gateway clinic opened in October 2011, approximately 18 months after the completion of the three filter clinics. The hospital is an impressive building containing 425 beds and is designed to effectively provide multiple services. The crowds of patients still arrive at 6 a.m., but by 11 a.m., all are treated or referred.

Minister Thahane looked at what the government had accomplished and felt justifiably proud, but he also knew that many challenges lay ahead. Would Tsepong and the Ministry of Health be able to develop a close working relationship based on mutual trust which is so essential for a working PPP? Would Lesotho be able to develop other parts of its health system in order to relieve demands on the new hospital and its feeder clinics? Could Netcare acquire the capability to train the hundreds of doctors and nurses that the country would need? Finally, could the country transition from a system that measured inputs, to one that measured outputs?

EXHIBIT 1: Map of Lesotho (1990)



Source: University of Texas Libraries, <http://www.lib.utexas.edu/maps/faq.html#3.html>.

EXHIBIT 2: National Level Data

National Level Data, FY '07 – '08⁶										
Population Statistics	Population	0-4 yrs	5-14 yrs	15-49 yrs	50-64 yrs	65+ yrs	Total	HIV/AIDS (15 to 49 year olds)	Male/Female Ratio	Population Growth Rate
	Number	237,656	418,719	1,006,121	151,417	102,944	1,916,857	236,438	0.97	0.12%
	% of Total	12.4%	21.8%	52.5%	7.9%	5.4%	100.0%	23.5% ⁷		
	Infant Mortality Rate/1000	Maternal Mortality Rate/100,000 Live Births		Life Expectancy: Female		Life Expectancy: Male		Literacy Rate: Female		Literacy Rate: Male
77.4	760 ⁸		39.5 years		41.2 years		95%		75%	
Expenditure Statistics	Health Expenditure per capita⁹		GDP per Capita		Health Expenditure Proportions, FY '07-'08					
	LSM 347		LSM 7,888 ¹⁰		GOL Health as % of GOL		9.6%			
	US\$ 48 ¹¹		US\$ 1,089		MOHSW as % of GOL		9.4%			
	Expenditure as % GOL, FY '07-'08 Budget				Private as % of All Health		19.3%			
	Education		20.2%		Public as % of All Health		80.7%			
	Health		11.6%		All Health as % of GNI		4.4%			
	Military		4.0%		GOL as % of GNI		36.9%			
Utilization Statistics	% Population Hospitalized per year		3.2%	Estimated Total Deliveries		41,727	Population per Physician		8,157	
	Acute Pt. Days per 1000 Population		0.18	Deliveries in Hospitals as % of Estimated Total Deliveries		52%	Population per Basotho Physician		42,597	
	Acute Beds per 1000 Population		1.12	Caesarian Sections as % of Estimated Total Deliveries		5.4%				
	Acute Beds % Occupancy		44%				Low	Mean	High	
				Deaths in Hospital as % of Admissions			2.5%	10.5%	22.6%	
				Caesarian Sections as % of Total Hospital deliveries			2.8%	10.3%	34.8%	
	Visits/Person/Year		1.6							

⁶ Delivery data from LeBoHA inpatient survey data and DHS 2004. Population growth rate, mortality, life expectancy and literacy from the CIA Fact Book 2/4/201 <https://www.cia.gov/library/publications/the-world-factbook/geos/lt.html>

⁷ Lesotho Statistical Year Book 2008 from the 2004 DHS

⁸ UNICEF, same data set shows an adjusted rate of 960, http://www.unicef.org/infobycountry/lesotho_statistics.html

⁹ Excludes annualized costs attributable to principal and interest on GOL health related loans, pension benefits to government employees and Capital expenditures not included in the annual recurrent budget.

¹⁰ Based on GNI from the 2008 Lesotho Statistical Yearbook

¹¹ US\$ 1.00 = 7.2428 for FY -7-08 from <http://www.oanda.com/currency/historical-rates>

Source: Bicknell, W. J., Cunningham, E., Cafaro C. J., Hann, K., Puglisi, R.J., Wilhelm, A.C., "Assuring the Quality & Affordability of National Health Services: A Comprehensive, Quantitative, Utilization and Cost Baseline for the Lesotho Health Sector," Final Report, September 1, 2010, Revision #1, September 21, 2010.

EXHIBIT 3: Admission and Patient Days for QEII

Ward	Number of Admissions	Patient Days
Gynecology	1,672	7,613
Female Surgical	700	6,201
Male Orthopedic	529	6,932
Male Surgical	1,544	10,826
Male Medical	1,263	9,605
Female Medical	1,811	9,882
Eye Male	387	3,772
Eye Female	454	4,346
TB	184	2,865
Private	88	776
Children's Medical	1,175	12,598
Children's Surgical	743	6,865
Maternity	4,915	9,527
Hospital Wide	15,465	91,808

Table 1. Number of admission and patient days for all wards at QE II from April 1, 2006 to March 31, 2007.

Source: Bicknell, W. J., Berman, J., Babich L., Jack, B., "Queen Elizabeth II and the New PPP Hospital: Baseline Study," Final Report, Volume II, prepared for the Ministry of Health & Social Welfare and the International Finance Corporation by the Lesotho-Boston Health Alliance, March 12, 2009.

EXHIBIT 4: Total number of deaths and within 24 hours of admission at QE II

Deaths	
Deaths as % of total admissions	12%
% of deaths within 24 hours of admit	35%

Ward	Deaths within 24 hours of admission	Total number of deaths	% of deaths occurring within 24 hours	Total admissions	Total number of deaths as % of total admissions
Gynecology	21	41	51%	1672	2%
Female Gen'l & Orthopedic	22	39	56%	700	6%
Male Orthopedic	9	16	56%	529	3%
Male Gen'l Surgical	66	127	52%	1544	8%
Male Medical	172	333	52%	1263	26%
Female Medical	175	342	51%	1811	19%
Eye Male	0	0	0%	387	0%
Eye Female	1	2	50%	454	0%
TB Male	10	20	50%	87	23%
TB Female	7	13	54%	97	13%
Private Male	0	0	0%	47	0%
Private Female	0	0	0%	41	0%
Children Medical	136	260	52%	1175	22%
Children Surgical	9	18	50%	743	2%
Maternity	0	2	0	4915	0%
Hospital Wide	628	1781	35%	15,465	12%

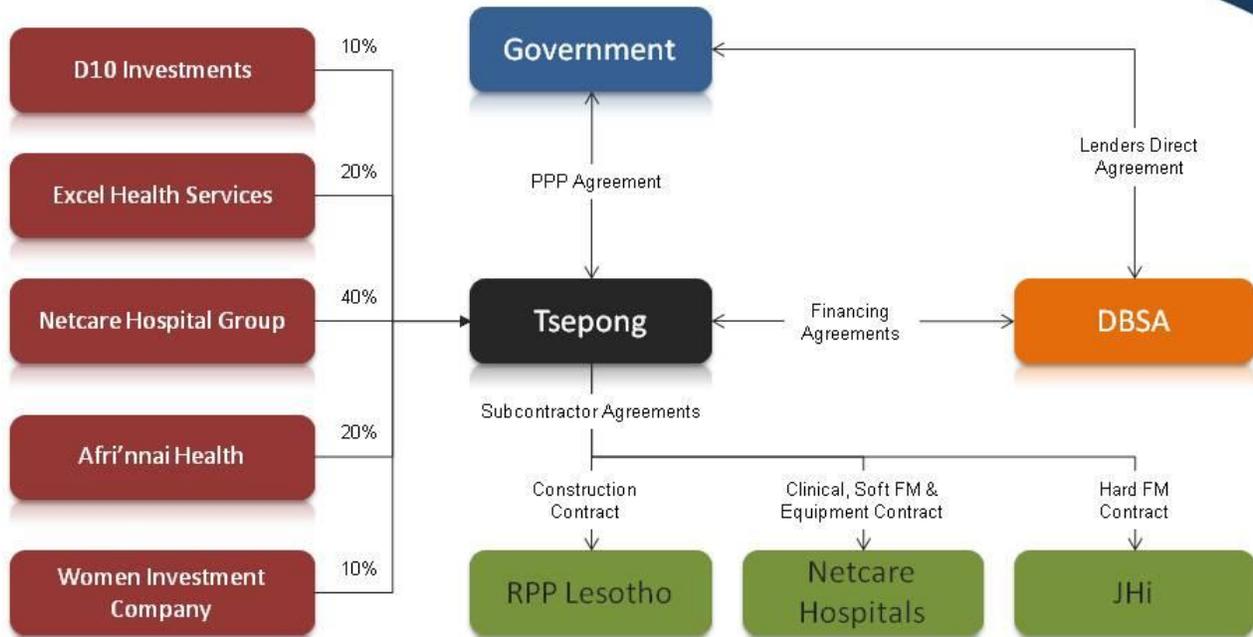
Table 5. Total number of deaths and deaths within 24 hours of admission on all wards at QE II from April 1, 2006 to March 31, 2007.

Source: Bicknell, W. J., Berman, J., Babich L., Jack, B., "Queen Elizabeth II and the New PPP Hospital: Baseline Study," Final Report, Volume II, prepared for the Ministry of Health & Social Welfare and the International Finance Corporation by the Lesotho-Boston Health Alliance, March 12, 2009.

EXHIBIT 5: Agreement Structure

agreement structure

1



Source: Workshop, "Lesotho New Referral Hospital PPP," IFC and Phatshoane Henney Inc., October 2008.

EXHIBIT 6: Schedule 14 Performance Indicators

6.1 Performance Indicators

Ref	Performance Indicator	Application		Description	Pre-Accreditation Quarterly Target Threshold	Post-Accreditation Quarterly Target Threshold	Service Failure Deduction Percentage
		Hospital	Filter Clinics				
A	Clinical						
A1	Emergency surgery times	✓		The time between notification of the operating theatre and the administration of anaesthesia for patients requiring emergency surgery	≤60 minutes in ≥80% of cases	≤60 minutes in 90% of cases	1%
A2	Infection control measures	✓	✓	Compliance with hand washing infection control standards and protocols	≥99% compliance	≥99% compliance	1%
A3	Prevention of Mother to Child transmission	✓	✓	Compliance with national protocol for the Prevention of Mother to Child Transmission (PMTCT)	≥90% compliance	≥90% compliance	1%
A4	Newborns protocol	✓	✓	Compliance with National Government of State protocol for newborns	≥95% compliance	≥95% compliance	1%
A5	Decubitus ulcer rate	✓		Rate of hospital acquired decubitus ulcers (bedsores)	≤10%	≤5%	1%
A6	Myocardial infarction treatment times	✓	✓	Percentage of Patients with provisional or proven diagnosis of myocardial infarction who receive aspirin within 30 minutes of evaluation (locations include casualty, clinics and wards)	≥85% compliance	≥95% compliance	1%

2 years

After 2

Ref	Performance Indicator	Application		Description	Pre-Accreditation Quarterly Target Threshold	Post-Accreditation Quarterly Target Threshold	Service Failure Deduction Percentage
		Hospital	Filter Clinics				
A7	Laboratory Services	✓	✓	Lab test turnaround time for 6 key lab tests the 8 key lab tests listed in .Paragraph 2.1.7 of Part B of Schedule 13. Turnaround time defined as the time from which the specimen is logged into the lab to the time the test result is reported out from the lab by telephone or lab result slip delivery, either physically or electronically.	≤60 minutes in 90% of cases	≤60 minutes in 99% of cases	0.85%
A8	Medical Records: Availability	✓	✓	Medical records that are available	≥75% of cases	≥90% of cases	1%
A9	Medical Records: Accuracy and Completeness	✓	✓	Medical records that are accurate and complete	≥75% of cases	≥90% of cases	1%
B	Patient Volume						
B1	Outpatient visits	✓	✓	Visit = Total ambulatory services provided to a single person in a single day (24 hours)	Depends on bid	Annual Minimum: xxx,xxx outpatients Measured per Contract Year	1%
B2	Inpatient Admissions	✓		Admission = The completion of the full admission procedure and acceptance by the Hospital. The full admission procedure may be defined as the completion of all hospital registration documents including the recording of the Patient's name in the admission registration system.	Depends on bid	Annual Minimum: xx,xx inpatients Measured per Contract Year	1%
B3	Hip Replacements	✓		Total number of hip replacements to be performed by Operator per annum	Depends on bid	Annual number of hip replacements = xxx Measured per financial year	0.5%
C	Client satisfaction						
*C1	Patient & family satisfaction	✓	✓	Overall patient & family satisfaction with facilities and services	≥75% satisfaction rate	≥85% satisfaction rate	0.25%

Ref	Performance Indicator	Application		Description	Pre-Accreditation Quarterly Target Threshold	Post-Accreditation Quarterly Target Threshold	Service Failure Deduction Percentage
		Hospital	Filter Clinics				
D	Local Economic Empowerment						
D1	Local Equity	✓	✓	Levels of Local Equity in the Operator	Compliance with targets as per LEE Scorecard	Compliance with targets as per LEE Scorecard	0.25%
D2	Local Management Control	✓	✓	Levels of Local Management and Local Women Management, Local Staffing and Skills Development	Compliance with targets as per LEE Scorecard	Compliance with targets as per LEE Scorecard	0.25%
D3	Local Subcontracting	✓	✓	Levels of Project capex / opex spend to Local Enterprises	Compliance with targets as per LEE Scorecard	Compliance with targets as per LEE Scorecard	0.25%
D4	Local Community Development	✓	✓	Achievement annually of Local Community Development targets and commitments	Compliance with targets as per LEE Scorecard	Compliance with targets as per LEE Scorecard	0.25%
E	Equipment						
E1	Equipment Audit	✓	✓	Compliance with Service Standards	≥95% compliance	≥95% compliance	1%
F	Facilities Management						
F1	Estate & Maintenance	✓	✓	Compliance with Service Standards	≥80% compliance	≥80% compliance	0.4%
F2	Cleaning Service	✓	✓	Compliance with Service Standards	≥80% compliance	≥80% compliance	0.25%
F3	Catering Service (Patient & Non-Patient)	✓	✓	Compliance with Service Standards	≥80% compliance	≥80% compliance	0.25%
F4	Waste Management & Disposal Service	✓	✓	Compliance with Service Standards	≥80% compliance	≥80% compliance	0.05%
F5	Security Service	✓	✓	Compliance with Service Standards	≥80% compliance	≥80% compliance	0.05%
F6	Help Desk	✓	✓	Compliance with Service Standards	≥90% compliance	≥90% compliance	0.05%
F7	CSSD	✓	✓	Compliance with Service Standards	≥95% compliance	≥95% compliance	0.05%
F8	Mortuary Services	✓		Compliance with Service Standards	≥95% compliance	≥95% compliance	0.05%

Ref	Performance Indicator	Application		Description	Pre-Accreditation Quarterly Target Threshold	Post-Accreditation Quarterly Target Threshold	Service Failure Deduction Percentage
		Hospital	Filter Clinics				
F9	Linen & Laundry	✓	✓	Compliance with Service Standards	≥85% compliance	≥85% compliance	0.25%
F10	Patient Transport	✓	✓	Compliance with Service Standards	≥90% compliance	≥90% compliance	0.05%
F11	Management Services	✓	✓	Compliance with Service Standards	≥80% compliance	≥80% compliance	0.4%
G	Information Management & Technology (IM&T)						
G1	IM&T System Uptime	✓	✓	System uptime based on a three month average period	≥99% over 3 months	≥99% over 3 months	0.2%
G2	Systems	✓	✓	User satisfaction surveys	≥80% satisfaction rate	≥80% satisfaction rate	0.2%
H	Staff Certification and Training						
H1	Staff Certification	✓	✓	Compliance with Service Standards	≥80% compliance	≥90% compliance	0.5%
H2	Staff Training: Registrars	✓	✓	Compliance with Service Standards	≥80% compliance	≥90% compliance	0.3%
H3	Staff Training: Consultants	✓	✓	Compliance with Service Standards	≥80% compliance	≥90% compliance	0.3%
H4	Staff Training: Nurses	✓	✓	Compliance with Service Standards	≥80% compliance	≥90% compliance	0.3%

6.2 Measurement Criteria

The following table contains the Measurement Criteria in relation to each Performance Indicator to determine achievement of the Quarterly Threshold Target:

Ref	Performance Indicator	Measurement Criteria	Measurement Period
A	Clinical		
A1	Emergency surgery times	Compliance with Schedule 13, Part B Section 2.1.1. Measured quarterly by random examination of surgery patients' charts. Chart sampling n≥10	Quarterly
A2	Infection control measures	Compliance with Schedule 13, Part B Section 2.1.2. Measured quarterly by unannounced: (i) inspections of hand washing stations, which may be fixed (i.e. sinks) or mobile (including bedside) proximate to the patient, 100% of which must have appropriate soap, water and/or hand sterilization solution and paper towels; and (ii) observation of doctors and nurses for compliance with 100% hand washing and glove changing (as applicable) between each patient. Observations will be for n≥100 drawn from multiple wards and patient services throughout the Facilities, including both morning and evening shifts.	Quarterly
A3	Prevention of Mother to Child transmission	Compliance with Schedule 13, Part B Section 2.1.3. Measured quarterly by random examination of charts for women admitted who have given birth, without regard to HIV status, for compliance with the applicable intra-partum protocol based on the charted status of mother and child. Quarterly chart sampling n≥100, with deliveries at the Filter Clinics measured in proportion to their share of total deliveries at the Filter Clinics and Hospital.	Quarterly
A4	Newborns protocol	Compliance with Schedule 13, Part B Section 2.1.4. Measured quarterly by random examination of delivery records at the Filter Clinics and Hospital. Quarterly chart sampling n≥100, with deliveries at the Filter Clinics measured in proportion to their share of total deliveries at the Filter Clinics and Hospital.	Quarterly
A5	Decubitus ulcer rate	Compliance with Schedule 13, Part B Section 2.1.5. Measured quarterly by random examination of charts of all patients with a length of stay>10 days. Quarterly chart sampling n=30 or 100% up to 30. If chart does not include a skin assessment completed upon admission, all decubiti will be assumed to have been acquired in Hospital.	Quarterly
A6	Myocardial infarction treatment times	Compliance with Schedule 13, Part B Section 2.1.6. Measured quarterly by random examination of charts of all patients who have proven or suspected myocardial infarction, whether seen in casualty, wards or clinics. Quarterly chart sampling n=10 or 100% up to 10.	Quarterly

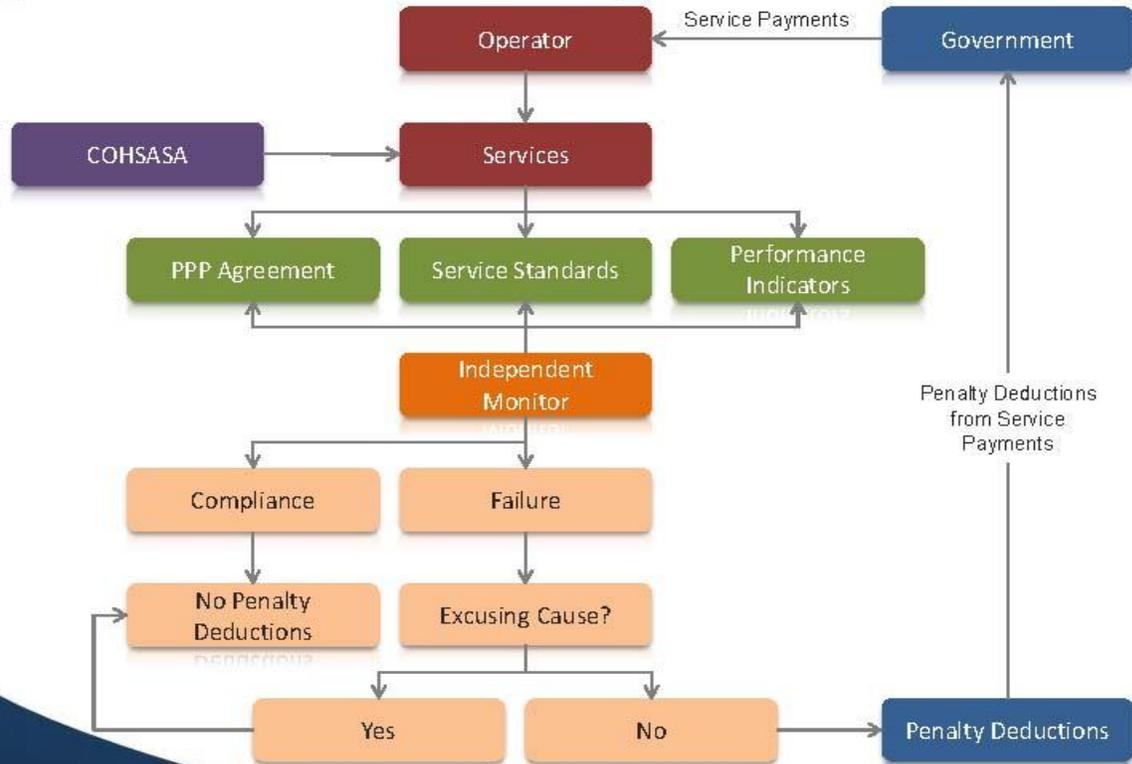
Ref	Performance Indicator	Measurement Criteria	Measurement Period
A7	Laboratory Services	Compliance with Schedule 13, Part B Section 2.1.7. Measured quarterly by examination of stat/emergency tests as documented in laboratory record book, with a 100% sample up to an n=25, with a random sample for n>25.	Quarterly
A8	Medical Records: Availability	Compliance with Schedule 13, Part B Section 2.1.8. Measured quarterly by examination of 100 patient records selected randomly three months after discharge but in proportion to the admissions for each service, with all records being retrievable..	Quarterly
A9	Medical Records: Accuracy and Completeness	Compliance with Schedule 13, Part B Section 2.1.9. Measured quarterly by examination of patient records selected randomly three months after discharge but in proportion to the admissions for each service, with all records having: (i) a complete set of vital signs at least once per day; and, (ii) a physicians note at least once per day, excepting obstetrics (a nurse run service), which must have a nurses note at least once per day, or unless there is a physicians order stating that no note is required due to the patients condition	Quarterly
B	Patient Volume		
B1	Outpatient visits	Compliance with Schedule 18 protocols: Annual measurement with minimum of 258,000	Annually
B2	Inpatient Admissions	Compliance with Schedule 18 protocols: Annual measurement with minimum of 16,500	Annually
B3	Hip Replacements	Compliance with Schedule 13 (Service Standards): Annual measurement of 160, with unused budget applied as per Schedule 13	Annually
C	Client satisfaction		
C1	Patient & family satisfaction	Determine with reference to results of Operator compliance procedure and help desk records implemented in accordance with the Payment Mechanism and Schedule 13, Section 7.1; sampling n≥30.	Quarterly
D	Local Economic Empowerment		
D1	Local Equity	Compliance with Schedule 22, Section A	Quarterly
D2	Local Management Control	Compliance with Schedule 22, Section B	Quarterly
D3	Local Subcontracting	Compliance with Schedule 22, Section C	Quarterly
D4	Local Community Development	Compliance with Schedule 22, Section D	Annually
E	Equipment		
E1	Equipment Audit	Compliance with Schedule 13, Part A Section 13.2	Quarterly
F	Facilities Management		
F1	Estate & Maintenance	Compliance with Schedule 13, Part A Section 2.1	Quarterly
F2	Cleaning Services	Compliance with Schedule 13, Part A Section 3.2	Quarterly
F3	Catering (Patient & Non-Patient)	Compliance with Schedule 13, Part A Section 4.1	Quarterly
F4	Waste Management & Disposal Services	Compliance with Schedule 13, Part A Section 5.1	Quarterly
F5	Security Services	Compliance with Schedule 13, Part A Section 6.1	Quarterly

Ref	Performance Indicator	Measurement Criteria	Measurement Period
F6	Help Desk	Compliance with Schedule 13, Part A Section 7.1	Quarterly
F7	CSSD	Compliance with Schedule 13, Part A Section 8.1	Quarterly
F8	Mortuary Services	Compliance with Schedule 13, Part A Section 9.1	Quarterly
F9	Linen & Laundry	Compliance with Schedule 13, Part A Section 10.1	Quarterly
F10	Patient Transport	Compliance with Schedule 13, Part A Section 11.1	Quarterly
G	Information Management & Technology (IM&T)		
G1	IM&T System Uptime	Compliance with Schedule 13, Part A Section 12.2.2	Quarterly
G2	Systems	Compliance with Schedule 13, Part A Section 12.2.2	Quarterly
H	Staff Certification and Training		
H1	Staff Certification	Compliance with Schedule 13, Part B Section 4.1	Annually
H2	Staff Training: Registrars	Compliance with Schedule 13, Part B Section 4.2 (a)	Annually
H3	Staff Training: Consultants	Compliance with Schedule 13, Part B Section 4.2 (b)	Annually
H4	Staff Training: Nurses	Compliance with Schedule 13, Part B Section 4.2 (c)	Annually

Source: Based on a draft version of Schedule 14 Performance Indicators, State Government, Schedules to the State Referral Hospital PPP Agreement, 27 October 200xx.

EXHIBIT 7: Performance Monitoring

performance monitoring



Source: Workshop, "Lesotho New Referral Hospital PPP", IFC and Phatshoane Henney Inc., October 2008.

EXHIBIT 8: Scoring Parameter for the LEE Portion of the Bid

Core Technical Proposal: Part 3: Local Economic Empowerment		
LEE Element	Indicative PPP Project Target	Total Possible Score
A: Local Equity		20
A1: Local Equity	<5.0% = FAIL 5.0 - 7.5% = 4 7.6 - 10.0% = 6 10.1 - 12.5% = 8 12.6 - 15.0% = 10 >15.0% = 12	12
A2: A credible plan and commitments for increasing the levels of Local Equity participation in the SPV at key milestones in the project term.	poor = 1 acceptable = 3 good = 5 excellent = 8	8
B: Local Management and Staff		30
B1: Local Management Control	<10% = FAIL 10.0 - 15.0% = 2 15.0 - 20.0% = 4 20.1 - 25.0% = 6 >25.0% = 8	8
B2: Local Women Management Control	<10% of B1 = 0 10.0 - 20.0% of B1 = 1 20.1 - 30.0% of B1 = 2 30.1 - 40.0% of B1 = 3 >40.0% of B1 = 4	4
B3: Percentage of Local Staff employed by the Operator;	<25% = FAIL 25% = 2 25.1 - 35% = 4 35.1 - 50.0% = 6 >50.0% = 8	8
B4: Skills Development	< 1% of payroll = 0 1% of payroll = 1 1-1.5% of payroll = 2 1.5-2% of payroll = 3 2% <= 4	4
B5: A credible plan and commitments for increasing the levels of Local Management Participation and Local Employment in the SPV at key milestones in the project term.	poor = 0 acceptable = 2 good = 4 excellent = 6	6
C: Subcontracting		40
C1: Project capex to local enterprises	<10% = Fail	12
	10.1 - 15.0% = 4	
	15.1- 20.0% = 6	
	20.1 - 25.0% = 8	
	25.1 - 30.0% = 10	
	>30% = 12	

Core Technical Proposal: Part 3: Local Economic Empowerment		
LEE Element	Indicative PPP Project Target	Total Possible Score
C2: Project opex to local enterprises	<10% = Fail 10.1 - 15.0% = 6 15.1 - 20.0% = 8 20.1 - 25.0% = 10 25.1 - 30.0% = 12 >30% = 14	14
C3: Local women management control in subcontractors (as a percentage of opex)	<5% of C2 = 0 5.0 -15.0% of C2 = 2 15.1 - 25.0% of C2 = 4 25.1 - 35.0% of C2 = 6 >35.0% of C2 = 8	8
C4: A credible plan and commitments for increasing the percentage cash-flow to Local enterprises at key milestones in the project term.	poor = 0 acceptable = 2 good = 4 excellent = 6	6
D: Local community development		10
A credible, sustainable plan for commitment to ensure spill over benefits from the project to the community.	poor = 0 acceptable = 3.5 good = 6.5 excellent = 10	10
TOTAL		100

Source: Lesotho Ministry of Health and Social Welfare, Final RFP for the Lesotho New Referral Hospital PPP.