Contractual Structures and Risk Allocation and Mitigation in the Context of Public Private Partnerships in the Health Sector

Eric Stemmer

Finance Economics & Urban Department
Finance & Guarantees Group

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1. The Rationale for private participation

   a. Health is important for economic development/poverty reduction

   When looking at the relationship between spending and health status in developing countries, two main patterns emerge. First, among the lowest spending countries, higher spending appears to be associated with significant improvements in health status. Second, even at very low levels of per capita spending, some countries achieve better health than others, suggesting that efficiency and public policy are key when provisioning for health services.

   Therefore, when health is perceived as a poverty reduction strategy, the questions of who pays and who decides for health care for the poor become absolutely critical. These questions have become even more pressing in view of recent trends. While their public health systems are heavily indebted and running deficits leading to restriction of expenditures, developing countries are experiencing rise in chronic diseases such as heart diseases, cancer, diabetes or asthma. This demand further increases the burden on health systems and tension in the available health workforce. Public health systems face constant pressures to improve quality, delivery, adapt to changing healthcare needs, or invest in often expensive medical treatment and technology advances.

   b. Large financing needs but fiscal constrains on government’s side

   Constraints on public funding, combined with rising costs, have forced public hospitals to cut costs wherever possible while rightly seeking to guarantee universal and free access to patients. Governments have used different strategies to address these problems, such as shifting financing from general tax revenue to payroll-financed national health insurance, narrowing the basic package of services available to all citizens, linking hospital funding to outputs and efficiency, amalgamating hospitals into networks, increasing autonomy and incentives for management, and reducing the number of hospital beds.

   However, many hospitals still do not perform their public health functions because hospital buildings are decrepit, there is little or no managerial expertise or financing are inefficiently spent. New solutions deserve to be explored, and Governments are increasingly turning to public-private partnerships to bring private sector efficiency into public hospitals.
c. Private participation benefits

The partnership with the private sector holds various benefits and risks. The presence of a private partner in particular helps deliver improvements in efficiency (better service provision and reduced management costs), service quality enhancements (innovations and investments in infrastructure and new medical equipment), a potential to attract and retain better performing staff, and efficient risk allocation among parties – i.e. the benefit of the PPP approach is that significant risks are transferred from the Government (or Public Authority) and transferred to the private sector. The private partner absorbs and redistributes risks (guaranteeing construction under budget and within timelines, and cost efficient operation) to partners best equipped to deal with them, while the hospital may remain under some various degrees of public control, and with a separation of strategic control from operation ensuring higher health/public policy objectives are properly addressed.

d. Previous PPP experiences in the health sector in (developed) countries.

In most OECD countries Governments have developed or are in the process of developing comprehensive health PPP program, though the extend of these programs vary substantially.

In the UK, the British government has used public-private partnerships for many public hospitals over the past decade with close to a hundred projects currently under contract. In France as of 2007, 40 contracts have been signed and more than 40 transactions were underway for a total of Euro 10 billion under the MAINH\(^1\) program. In this model of public-private partnership, the public sector remains responsible for all medical services: a company – usually in the construction sector, creates a special purpose vehicle to bid for a contract with a health authority to build and provide non clinical services to a hospital, and one with a facilities management company to manage it over the lifetime of the contract (typically 30 years). Similar DBFO\(^2\) models have been developed in Canada.

In Australia both public and private providers deliver health services. The private sector delivers almost all primary and much specialist medical care, and runs private hospitals. As of 2004, one third of hospital beds in the country were run by private operators.

Currently, private hospitals represent just a small proportion of the German hospitals, and they concentrate mainly on the care and rehabilitation of chronically ill patients.

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1 Mission d'Appui à l'Investissement Hospitalier
2 Design Build Finance Transfer
Under the strong financial pressures, however, there is a trend towards the privatization and closure of state owned hospitals.

Under the franchising model, a private company takes over management of an existing public hospital. This alternative has been used in Sweden and Spain for example. In Spain, the 1994 Law for the creation of Private Foundations (not just for hospitals) and its extension in 1996 to cover new hospitals (up to now, half a dozen small to medium sized hospitals). These are all publicly-owned, but managed privately, employing staff according to general labour laws, purchasing supplies on the open market, and using private accountancy rules and with ex-post control of their expenses.

Other models tailored to population needs have been explored, such as the Alzira hospital in Valencia (Spain) where a private company provides healthcare to a defined population in return for a payment per capita.

2. Options for Private Sector Involvement

In these countries, as well as other countries were they have been utilized, private participation in hospitals take many different forms with differing degrees of public and private sector responsibility and risk. The main forms of hospital PPPs can be synthesized as follows:

<table>
<thead>
<tr>
<th>Model</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>Service Contract</td>
<td>Provision of a defined service (e.g., laboratory services, catering): the outsourcing can be for non clinical, clinical or specialized services</td>
</tr>
<tr>
<td>Franchising</td>
<td>Public authority contracts a private company to manage clinical and non clinical services in an existing hospital</td>
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<tr>
<td>DBFO (design build finance operate)</td>
<td>Private consortium designs facilities based on public authority’s specified requirements, builds the facility, finances the capital cost and operates their facilities</td>
</tr>
<tr>
<td>BOO/T</td>
<td>Public authority purchases services for fixed period after which ownership remain with private provider / Reverts to public authority.</td>
</tr>
<tr>
<td>BOLB (build, own, lease back)</td>
<td>Private contractor builds hospital; facility is leased back and managed by public authority</td>
</tr>
<tr>
<td>Alzira model</td>
<td>Private contractor builds and operates hospital, with contract to provide care for a defined population</td>
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</table>

Requirements (supervision, dispute resolution mechanisms)
As hospital PPP initiatives have become more common, so have failures which ended up being damaging and costly for the public.

The first issue for the Government consists in dealing with for profit companies which objectives are the maximization of profit within the contractual framework established under the PPP contract. Hospitals, unlike other types of infrastructure, can provide a wide range of technical services and the adequate mix and mix flexibility over time can be very complex; in addition disruption in operation or inadequate provisions for services can have dramatic consequences. For this reason, they can take a long time and are expensive to establish and monitor, and in many cases may not be the most effective or efficient option available. Careful evaluation, structuring and execution are prerequisites for PPP approaches.

Depending on the country, the extend to which the relationship with the private operator is managed through a corpus of laws, regulations and certifications processes handled internally, though independent government bodies or third parties may vary widely. If such elements are missing, the hospital may be regulated by contract. In all cases, arrangements need to be monitored over the term of the contract which implies a public expertise in this area and institutional capacity or delegation to a reliable third party.

One example of an element unforeseen by the British Government is the sharing of refinancing benefits. The low risk once construction is complete has allowed advantageous refinancing of projects at lower interest rates, with significant benefits to the PFI consortia.
The Norfolk & Norwich University Hospital Refinancing Scandal (UK)

In 1998, the Norfolk & Norwich University Hospital NHS Trust (the Trust) let one of the first PFI hospital contracts to a private sector consortium Octagon. In 2003, just two years after the new hospital opened, Octagon refinanced the project, dramatically increasing its investors’ rate of return to over three times the level Octagon had predicted when bidding for the contract. The Trust only received 29% of the refinancing gains despite taking on substantial new risks following the refinancing.

Octagon achieved this outcome by increasing its borrowings by 53% from £200 million to £306 million. Octagon then used the increased funds to accelerate the financial benefits which the investors would receive from the project. After other financing adjustments, the total refinancing gain was £116 million. £82 million of the gain was retained by Octagon increasing its investors’ internal rate of return, which it had said would be 19% when it bid for the contract, to 60%.

In securing the right to receive £34 million of the gains the Trust accepted that the money it would have to pay to end the contract early could increase by up to £257 million following the refinancing as its termination liabilities are related to the amount of Octagon’s outstanding borrowings. The Trust also agreed to extend the PFI contract from 34 to 39 years and to receive its share of the refinancing gains over the life of the contract, rather than as an immediate payment.

In summary, our conclusions and recommendations are:

The opportunity for large refinancing gains on this early PFI deal does not seem to have been seriously considered as part of the original deal negotiations. Yet, through simply borrowing more, the benefits to Octagon’s investors have soared on refinancing to levels which are unacceptable even for an early PFI deal.

Extract from the British House of Commons Committee of Public Accounts, March 2006 (www.publications.parliament.uk)

Most difficulties which can arise over the project life can be avoided by ensuring that (i) contracts are based on realistic evaluations of the situation and do not transfer unmanageable risks to the private partner or excessively curtail performance incentives (ii) the private partner has financial stability and a proven track record of experience and expertise in the field, (iii) appropriate monitoring and evaluation mechanisms, performance indicators, targets and outputs, as well as any performance bonuses are built into contracts (iv) the public partner has sufficient capacity for oversight (external oversight methods can also be utilized) for the duration of the project.

Hospital PFI schemes have been attractive for Governments because they force the provider of the facility to provide the financing. Whereas it is unlikely that
the private sector will have an advantage over the government of securing the funds in the capital (domestic of international) markets, the government accounts will look better if it is able to put in its accounts only an annual rent rather than the entire capital expenditure amounts. In short, hospital PFIs projects which stem from a desire to circumvent regular budgetary procedures and provide little more benefits than window dressing for conventional public investment are to be avoided. However, the public sector remains the provider of last resort. In cases where the private sector loses money and walks away from a contract the public sector must intervene to maintain services.

The Latrobe regional hospital in Victoria, Australia is an example of a failed BOO where the underestimation of many costs by the private operator and a failure to understand how hospitals in Victoria were funded resulted in serious financial problems. In 1999, after reporting a loss of AU$6.2 million in 1999, the 257 bed hospital which had been owned and operated by private company Australia Health Care (AHC), was handed back to the Victorian government. These boxes or ‘case studies’ are very useful - in this case I think the text is somewhat short to have it in a box – we could expand a bit more on the case

The most common issues which governments have faced so far have been shoddy construction/maintenance and safety problems as well as higher than expected operating costs. There have been numerous examples of hospitals which have experienced quality problems, from poor ventilation, poor drainage, and use of cheap components making it impossible to use wall fixtures and necessitating regular refitting. Linked to inflexible contracts and the obligation by the public partner to pay for operating charges, inflated costs have lead to either cut in services, sometimes to the detriment of other public hospitals.

Competition between privately outsourced and publicly managed hospital is a source of improvements which can also have negative effects if poorly managed. For example, in a resource scare environment, private hospitals can use their managerial flexibility by increasing wages and taking doctors away from public services. In circumstances when medical costs increase under a tight public budget, the contractual obligations with the private sector may be an incentive for the government to arbitrage payments in favor of the latter.

The existence of clear rules does not however remove the risk of a dispute arising from unforeseen events or resulting from failure of one of the parties to abide to the terms of the contract. Clear dispute resolution procedures and processes (including settlement incentives) and access to formal international arbitration if the binding nature of adjudications is questioned are key elements to private sector participation.
Why private investment remains low in developing countries?

Perceived risks of investors in Health PPPs (and more specifically resulting from interactions with Governments), and need for risk enhancement mechanisms. The sharing of risks and rewards is a key driver for a quality private partner to enter into a collaboration/partnership. Project companies are expected to face for hospital projects categories of risks which are very similar in broad terms to those of other PPP projects: for example, construction risk, and operating risks, completion risk or political risk. It is therefore important to highlight the specificities of risk linked to hospital PPPs rather than going through a list of all elements which will be considered by investors.

**Revenue Risk:** Unlike in more advanced countries, patients in LDCs are not expected to be able to pay – or only at a marginal or symbolic level- for the services provided by the hospital, for specific and advanced treatments but also for basic care. This implies that revenue collection can at best be used as an incentive for additional revenue to the operator but that all payments need to take the form of an availability payment to the project company. Such payments will need to cater for operating costs, refurbishments, medical machinery and equipment, which might need to be imported, but also for equity and debt repayments in case of a BTO. The hospital PPP scheme in this case substitutes in effect revenue risk for country/ political risk. Payments from the government can be allocated through an agency or directly from the treasury. However availability payment can be quite large and in order to mitigate potential corruption risk and unproductive overheads, the line of payments should be as direct as possible. In addition, a direct contractual relationship with the budget will reduce the allocation/ frictional risk.

**Regular payments to the private operator also bear a cash flow risk:** Although the private sector is expected to mitigate it through the setting up of a proper operating reserve, it is preferable to provide for some form of reserve on the Government side as well. The setting of a letter of credit for a period of time equal to the contract will prove unfeasible, simply because L/C for 15 years of more are costly and unheard of, but also because an operator would not accept to take the credit risk of the commercial bank providing the credit for such tenors. The best option lies with an escrow account mechanism whereby the equivalent of a certain number of months of availability payments to be negotiated between the public and the private sector is delivered to an escrow agent to be held in
trust, and released should there be non payment to the private operator under certain conditions (contract fulfillment).

The availability payment is expected to be subject to some form of indexation to the country CPI growth, but as for most PPP contracts, this risk is expected to be taken by the private partner.

*Operating risk* Too many patients + no doctors the issue of excess capacity addressed below is also operational Risk.

Other situation-specific risks may also need to be addressed, such as the frequently encountered risk of creating excess capacity or new capacity in the wrong place in the health system. Such risks can be mitigated through an effective planning and licensing system that allows for a needs-based distribution of services. In many situations, an adequate licensing system should not only selectively issue licenses to operate health facilities based on a set of pre-defined criteria, but might also include the option of a special regulation of high-risk interventions, such as, for example, through a so-called certificate of need procedure.

A diligent up-front evaluation is also critical for ensuring financial responsibility and managing fiscal risks for the public partner. Analysis of unsuccessful projects often reveals a hastily or inappropriately designed arrangement that might in effect shift spending off-budget, defer sizeable fiscal costs, obscure higher private financing costs, or excessively shift costs to the public sector. Appropriate fiscal risk mitigation requires that the fiscal costs and risks of the contractual obligations in a partnership or collaboration be identified and quantified upfront.

*Termination risk:* Unlike most infrastructures where upon an event leading to termination, the private operator can almost leave the key to the public entity with limited disturbances, it is virtually impossible for the private operator to quit a hospital operation waiting for the public sector or another operator to step in simply because patients are awaiting treatment, need care etc. For example if upon termination, the public sector does not step right away to administer the hospital the private operator has a very large reputation risk in terminating its operation. Besides, most of the hospital staff would be expected to be reemployed in the same capacity by the public sector.
To ensure that efficiency gains made by the PPP are shared between the public and private partners, contracts may need to include variable payment levels that allow appropriate benefits to be captured by the public sector.

### Lesotho Referral Hospital PPP

Starting in 2006, with the assistance of IFC, the Government examined different financial options to replace the national referral hospital, including public finance only, private finance only, and Public-Private Partnership (PPP). In September 2006, Cabinet approved a PPP based plan to build a new national referral hospital to replace the existing one.

The hospital PPP plan is a Design-Build-Finance-Operate project for a 390 bed hospital to be constructed on a greenfield site in Maseru. Under the PPP plan, the PPP partner, selected by competitive tender, will design, build, partly finance and fully operate the new public hospital, as well as refurbish and re-equip three associated filter clinics. The private sector partners are required to provide a package of clinical services defined in the tender documents and operate and maintain the new hospital to a satisfactory standard. The services delivered to patients at the new hospital and filter clinics will be measured through specific agreed performance indicators and volume targets and monitored by an independent certifier. The PPP contract is anticipated to be for 18 years (including an estimated construction period of 3 years).

The project will serve the hospital’s catchment area, Maseru district, with a population of almost 500,000 people or one third of the country’s population. In addition, the new hospital will continue to serve as the nation’s referral hospital for secondary and limited tertiary care services not offered or not available at the country’s district hospitals.

Due to the general level of poverty throughout the country, where 58% of the population lives on less than $1 per day, primary healthcare services are now provided free of charge, whereas hospital services are 97% subsidized by the Government of Lesotho, with a symbolic 3% co-payment by patients. The same subsidy will be applied by Government for the new hospital, since the overwhelming majority of the population served will be poor.

The Government will be responsible for partly financing the capital cost and will provide monthly unitary payments to the PPP partners. Based on the IFC’s projection, the total estimated cost of the new referral hospital is about M500 million or US$ 71.4 million (including VAT). Out of the total estimated cost, the Government will invest M400 million (US$57.1 million) and the PPP partner will be expected to invest M100 million (US$14.3 million). The unitary payment will cover debt service costs, facility and
equipment replacement and maintenance costs, and operating and staffing costs, as well as reasonable returns for the investors’ equity participation. The gross unitary payment to the private partner is estimated to be M169 (US$ 24.1 million) million per year (based on 2006 values). This unitary payment, on a net basis, is approximately the same amount that Government spends to operate the current hospital. The Unitary Payment will be indexed to the CPI as an appropriate measure of inflation.

GPOBA

The Operator of the Project is eligible to receive a 5 year grant, totaling $6.25m, of output based aid (OBA) from the GPOBA (Global Program for Output Based Aid). This grant is designed to enhance the affordability level set by Government, as a supplement to Government’s budget for clinical services during the first 5 years of the PPP Agreement. The amount of the annual subsidy requested is the estimated difference between the current operational spending for the hospital and filter clinics and that for the expanded and upgraded services to be provided at the new hospital and refurbished filter clinics.

Outputs will be measured through quarterly measurement of specific performance indicators and volume targets, monitored by an independent certifier.

3. Risk Mitigation Instruments and Applicability of PRGs in the Health Sector.

a. Use of a PRG to backstop Government undertakings in hospital projects

World Bank Partial Risk Guarantees help to catalyze private capital flows to emerging market countries by mitigating government performance risks, including political, regulatory and contractual risks associated with infrastructure projects, be they concessions or BOTs. The Bank’s guarantee is generally available in any country eligible for borrowing from the International Bank for Reconstruction and Development (IBRD) or International Development Association (IDA). As with loans, the Bank requires a counter-guarantee from the host government in the form of an Indemnity Agreement. In addition, compliance with the Bank’s policies and due diligence requirements relating to
the project and the sector, including environmental and social safeguards, is required.

Given the Bank’s unique relationship with its member countries and their governments, it is better equipped than the private sector to backstop certain risks, thereby reinforcing the incentives for governments to comply with their performance undertakings. PRGs are particularly relevant in countries where the sector is in early stages of reform and when perceived risks of policy reversals and changes to the regulatory framework are high.

The Bank’s objective when structuring a PRG is always to provide its support only to the extent needed to make a transaction financeable in the commercial markets. Hospital projects are subject to regulatory provisions by Governments, either directly thought the project agreement, or via an established regulatory agency. As discussed previously, hospital projects are typically subject to (i) one or many forms of obligations such as public service obligations, quality of service, minimum level of investments or patients, controlled tariffs and (ii) demand some rights and incentives to operate, such as exclusivity provisions, subsidies in the form of annual payments, or minimum revenue guarantees.

Partial Risk Guarantees Political risk guarantees are necessary to support the private sector’s involvement in health projects in circumstances where investors lack sufficient assurances that a government will not change the policy framework and contractual relationship unilaterally, and will maintain its commitments towards the project for its entire duration. For these reasons, termination clauses in the agreement are essential as they state the formula by which concessionaires will be compensated and reduce a government’s ability to rescind a concession. The problem for governments is that their contractual commitments may not be sufficient to assuage investors’ concerns: developing countries rarely offer a long history of private involvement in health infrastructure or services and where the participatory framework has been used successfully before, and to which investors can relate.

Investors are concerned that the time of a concession being significantly longer than political mandates, government commitment can diminish or change in objectives which can be detrimental to the operations. In the short run, this can cause financial problems for the concessionaires, and in the long run, reduce the interest of other firms in investing in concessions be they potential successors to the operations upon expiry of a mandate, or interested in upcoming projects in the event that multiple tenders are planned. In such instances, a third-party
political risk guarantee, such as a World Bank PRG may be needed for ongoing support as well as to ensure proper termination of the contractual relationship.

b. **Advantages of the PRG**

PRGs support two key objectives for providing risk mitigation for health projects:

*Enhancing Investor Interest:* Risk mitigation through a PRG strengthens investor confidence in a government’s commitment to the negotiated agreements. As a consequence, more firms may be expected to bid for a privatization, concession or a greenfield project, thereby increasing the competitiveness of the tender, resulting in higher bid prices or stronger upfront commitments to invest in asset rehabilitation and upgrades.

*Leveraging Additional Investment:* A PRG improves the risk profile of the project, therefore enabling investors to raise funds in commercial debt markets that may not be available without some form of political risk mitigation. As such, a PRG helps make the health projects financeable by leveraging large amounts of capital typically needed to build ports and airports, and for network rehabilitation and expansion. Catalyzing such investments through the private sector can relieve a government’s fiscal resources for other expenditures.

A PRG offers the following additional benefits through its political risk mitigation:

*Better Risk Sharing:* The risks covered by the PRG would be limited to government-related performance undertakings. In this way, the PRG provides a transparent mechanism for allocating risks between the government and investors. The government is accountable only for its own actions and for the proper implementation of the regulatory framework, while the investors are accountable for all the commercial risks, including demand and collection risks as well as investment and performance risks.

*More Competitive Tariff Structures:* Using the PRG to catalyze commercial debt not only helps to achieve much longer tenors for the debt, but also reduces the cost of financing because of the AAA credit-rating of the Bank. This in turn helps achieve higher economic returns for the project.
No Incremental Government Liability or Costs: The PRG generally does not give rise to any additional contingent liability for the government, as it backstops only the contractual arrangements that the government already makes with the investor. However, mitigation of critical contractual undertakings could enhance the willingness of investors to assume additional risks in other areas. In addition, the government does not incur any cost associated with the PRG, as all guarantee-related charges are payable by the investor.

Reinforcing Regulatory Independence and Credibility: The Bank’s involvement through a PRG signals government’s commitment to achieving a credible regulatory regime as a basis for sustained investment and financial viability in the sector, thereby boosting investors’ confidence in the sector. Thus, a successful project supported by a PRG has a positive demonstration effect by making future projects feasible without the need for political risk guarantees.

c. PRG structures

The World Bank has developed two guarantee structures which can be used to mitigate critical risks in health projects: (i) a Limited Recourse structure (ii) a Deferred Loan structure for ongoing or termination payment. Both these structures are aimed specifically at supporting health projects be they BOTs, concessions or privatizations.

Limited Recourse Structure:

Under the limited recourse structure, the Bank can provide guarantees of commercial debt or shareholder loans to the project company, thereby providing political risk mitigation as well as catalyzing commercial debt in support of the project. Under this guarantee structure, the Borrower could be a health sector operator, and the Bank would cover scheduled debt service payments. The Bank guarantee could only be triggered in the event of a debt service default on the covered loans caused by governmental non-compliance to its contractual undertakings to the company, guaranteed by the PRG. This structure is best suited where there is a need for substantial upfront amounts of debt capital for investments and rehabilitation works. Active commercial banks are usually aware of Project Finance Guarantee structures and reflect the benefits of the guarantee in terms of spreads and maturities available to borrowers.
Limited Recourse Mechanism

- The PRG can be triggered if a debt service shortfall occurs as a result of a default of a government contractual obligation only if the claim is not disputed (if the default does not result in a debt service shortfall, then the PRG can not be triggered, and only dividends on the investor’s equity would be impacted).

- If the claim is disputed, the Bank will pay only if the dispute is resolved in favor of the investor in accordance with the predefined dispute resolution mechanism.

- Payments under the PRG will be limited to the principal and interest payments on the covered debt tranche.

- Any payments the Bank makes to the guaranteed commercial lenders under the Guarantee Agreement give the Bank the right to seek immediate repayment from the host government under the Indemnity Agreement.
**Deferred Loan Structure**

The deferred loan structure is particularly suited to the coverage of termination risks. Under this structure, upon occurrence of an event leading to termination of the project agreement, and should the relevant government (or parastatal) fail to make a required termination payments, the project company would be deemed to have made a loan to the defaulting government in the amount of the non-paid obligation, with a typical maturity of one year. The ‘deemed’ Project Company loan is a deferred payment mechanism for the governments’ contractual payments to the project company because no money would be transferred by the concession companies. The Bank guarantee can be provided for part or totality of the principal and interest of the loan, depending on pre-agreed guarantee amounts.

The deferred loan, implies specific documentation and discussions between the parties to structure than the limited recourse structure, and offers many advantages to project sponsors. It recognizes that mobilizing equity can be as important as lending, and that not only initial investments financed by debt but also ongoing capital expenditures are essential components of health projects.
Deferred Loan Mechanism

- The PRG can be triggered following default of a government to repay the deferred loan in due time or in full subsequent to a breach of the project agreement with respect to government payment obligations in the event of early termination or expiry of the concession.

- Specific guarantee coverage to be negotiated with the project company and can include political risk events, breach of contract, change in laws, force majeure.

- If the payment obligation amount is disputed, the Bank will guarantee the deferred loan up to the maximum guaranteed amount and according to the ruling of the predefined dispute resolution mechanism.

- Payments under the PRG will be limited to the principal and interest payments on the covered debt tranche.

- Any payments the Bank makes to the guaranteed lenders under the Guarantee Agreement give the Bank the right to seek immediate repayment from the host government under the Indemnity Agreement.
This structure can be further considered to cover ongoing payments due under the concession agreement. In this case, each time there would be an unremedied payment default under the Agreement due by the Government to the project company, a deemed loan of such an amount would be crystallized, which would be covered by the World Bank Guarantee, up to the cumulated outstanding guaranteed loans less any payments done under the guarantee. This innovative structure is envisaged to support projects where public service obligations lead to recurring transfers to the project company. In such cases, the amounts could be small enough that the company is not comfortable to call a default under the project agreement, and willing to terminate the contract. The guarantee would therefore act as an additional cure mechanism should there be a temporary default of obligations from a Government under a project agreement.

\[ d. \text{ Using a PRG to support privatizations} \]

The Bank can consider providing a PRG once a client government has embarked on a sound and sustainable reform program. Ideally, the Bank’s involvement should be requested early in the pre-privatization design phase, to ensure that the Bank is in a position to issue an indicative term sheet for a PRG for
incorporation in the Invitation to Bid for the privatization. In this way, the
government is able to extract maximum value of the PRG in the form of
enhanced investor interest, higher price offers, and greater upfront investment
commitments. The Bank’s provision of the PRG would in all cases be subject to
due diligence satisfactory to the Bank, including a review of the sector, industry,
and project structures; compliance with all applicable Bank policies; Board
approval; and satisfactory conclusion of an Indemnity Agreement with the host
government.