Contracting for Health Services with the Private Sector

The Evidence and Experience from Developing Countries

Overview

1. Background
2. Review of global experience of contracting
3. A specific example of contracting
4. Summary of main issues with contracting and some take home messages

Contracting in Context

- 63% of under 5 deaths could be prevented by full implementation of existing interventions
- However, coverage of these services remains frustratingly low in many places
- Public sector, while significant player, is performing inconsistently and poorly in many areas
- Publicly funded services face increasing challenges with HIV, epidemiological transition, etc.
- Growing amounts of contracting on every continent

Potential Advantages – Why Contracting Ought to Work

1. Private sector's flexibility and better morale
2. Greater focus on measurable results
3. Increases managerial autonomy & decentralizes decision making
4. Overcomes absorptive capacity constraints, improves distribution of health workers
5. Uses competition to increase effectiveness and efficiency
6. Allows governments to focus greater efforts on their unique roles

Potential Difficulties

1. Can not be done on a scale that matters
2. More expensive, higher transaction costs
3. Increases inequities, NSPs only interested in "easy" areas
4. Governments cannot manage contracts well
5. Creates opportunities for fraud and corruption
6. Governments and NSPs can't work together
7. Contracting is not "sustainable"

Methodology of Review

- Searched for examples of explicit contracts (not grants) with NSPs to deliver non-hospital services, e.g. PHC and nutrition
- Used personal networks, prior reviews, computerized literature searches
- Included examples had to have some coherent form of evaluation, at least before and after
- Interviewed or sent questionnaires to people with personal knowledge of examples

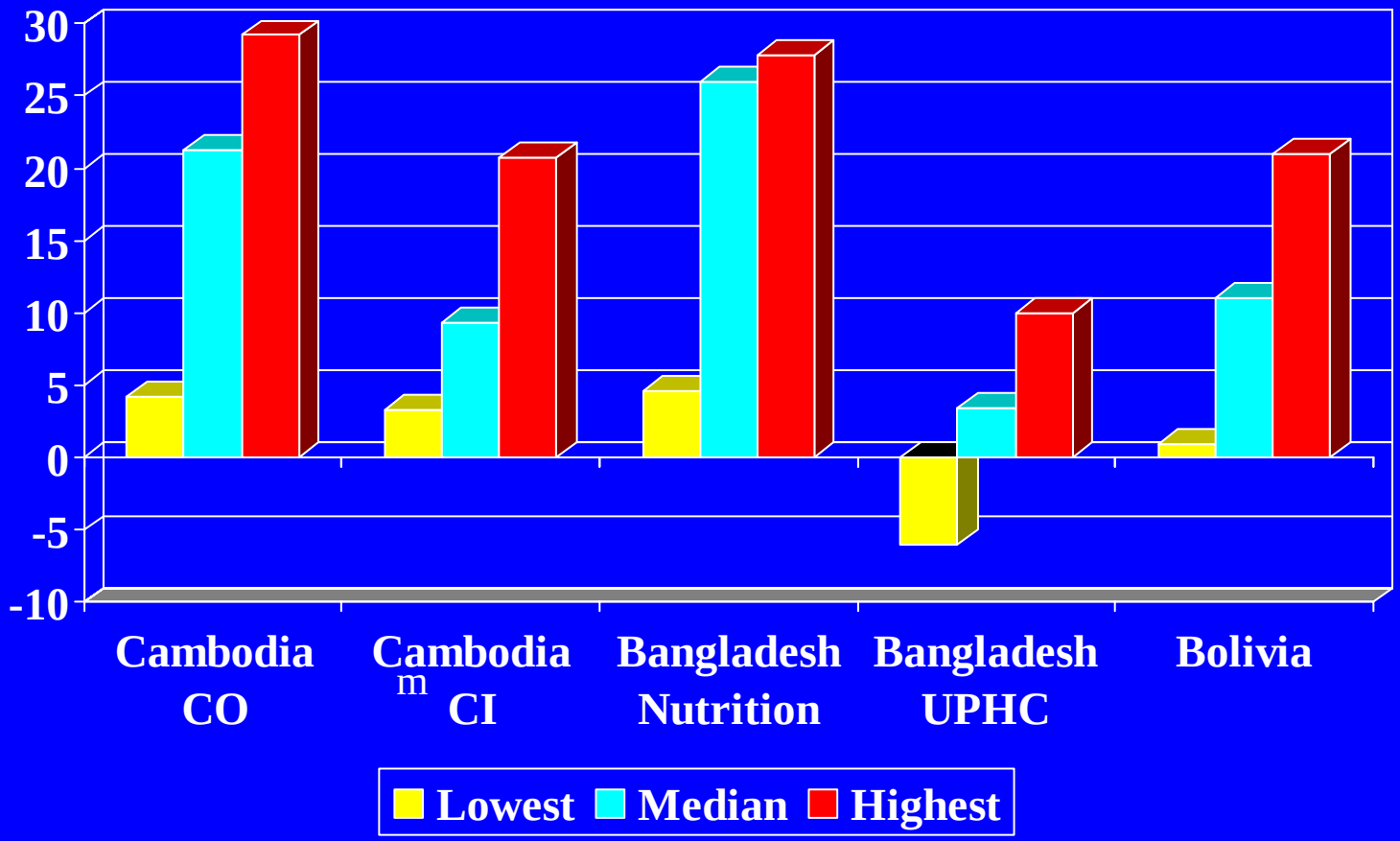
Results of the Review

- 10 studies were found from a variety of countries and settings, all found positive results
- The most rigorously evaluated cases tended to display the largest effects
- In 6 studies where it was possible to compare, NSPs performed better than governments
- In 4 studies with controlled, before and after design, the median double difference ranged from 2 to 26 percentage points

Double Difference – FIC Coverage in Cambodia

Type	Baseline (a)	Follow-Up (b)	(a) – (b)	Double Diff.
CO	25.5%	65.8%	40.3 (c)	21.3 (c-e)
CI	29.9%	54.4%	24.5 (d)	5.5 (d-e)
Control	34.0%	53.0%	19.0 (e)	

Double Differences in Percentage Points



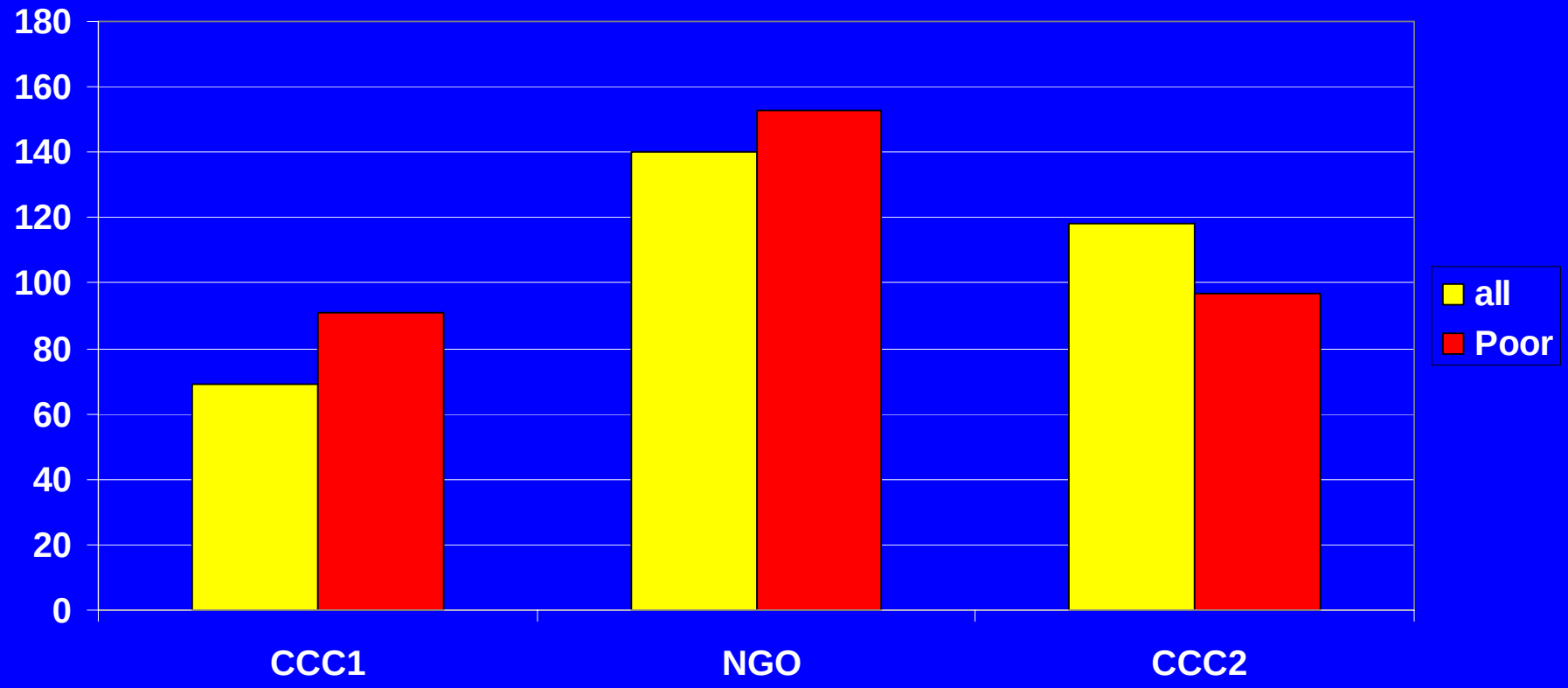
Bangladesh Urban PHC Project – Context

- As in most other large urban settings, health service delivery in Bangladesh is complex:
  - NGOs – patchwork of clinics and outreach
  - MOHFW clinics – limited
  - City Corps. – limited number, little outreach
  - For-profit private sector – clinics & individuals
- Resulted in poor coverage of PHC, (EPI, FP) particularly for the poor and higher IMR, U5MR and lower CPR.

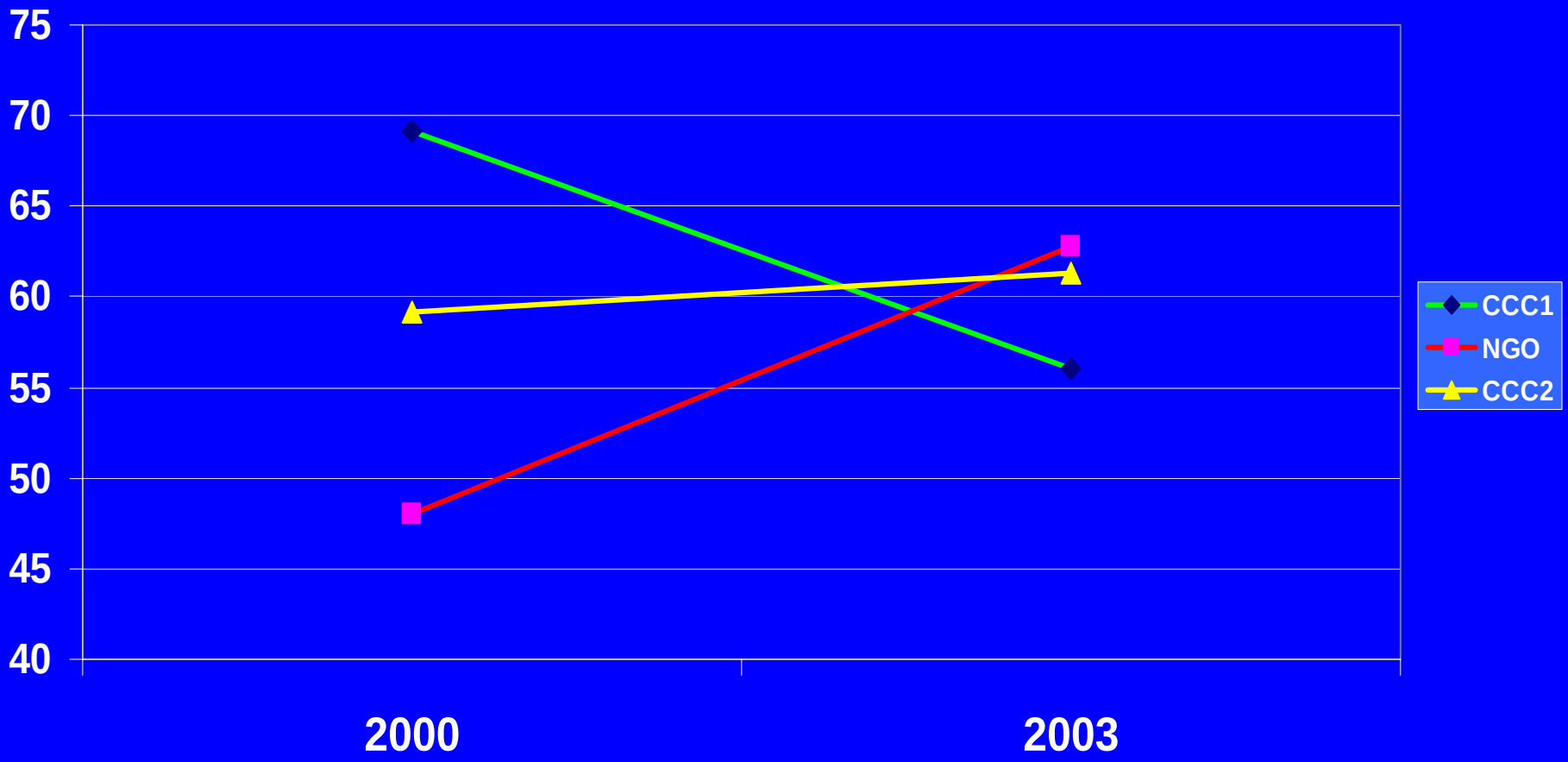
Bangladesh Urban PHC Project - Plan

- Contract with NGOs to deliver PHC services to geographically defined areas
- Parts of 4 large cities divided into PAAs
- 5-7 health centers constructed per PAA
- Two PAAs given to CCC (i.e. local government) to run itself, while another PAA in Chittagong managed by an NGO
- Baseline and mid-term household and health facility surveys carried out

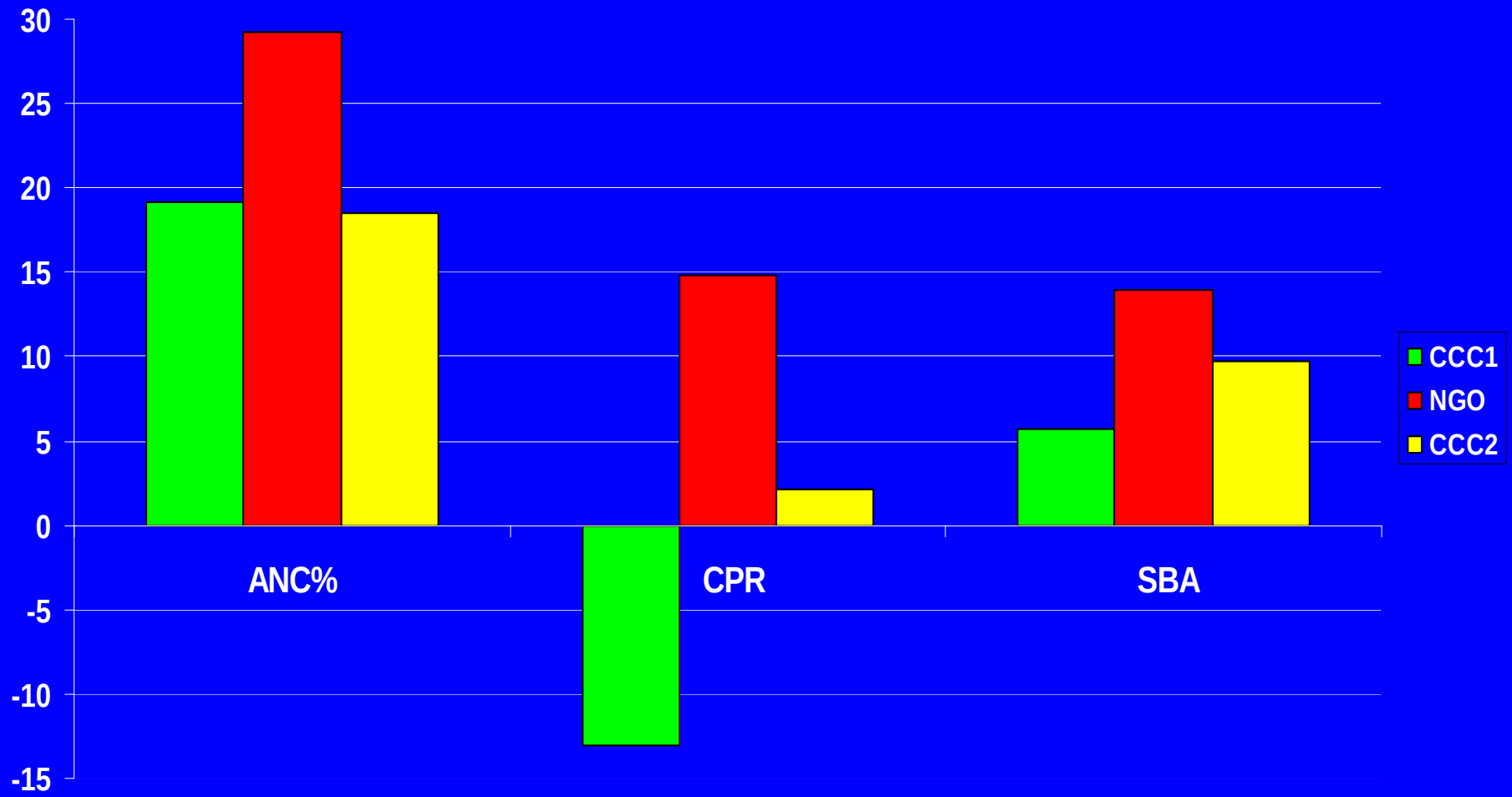
Changes in Performance Index (based on 5 HH survey indicators) from 2000 to 2003 in Chittagong



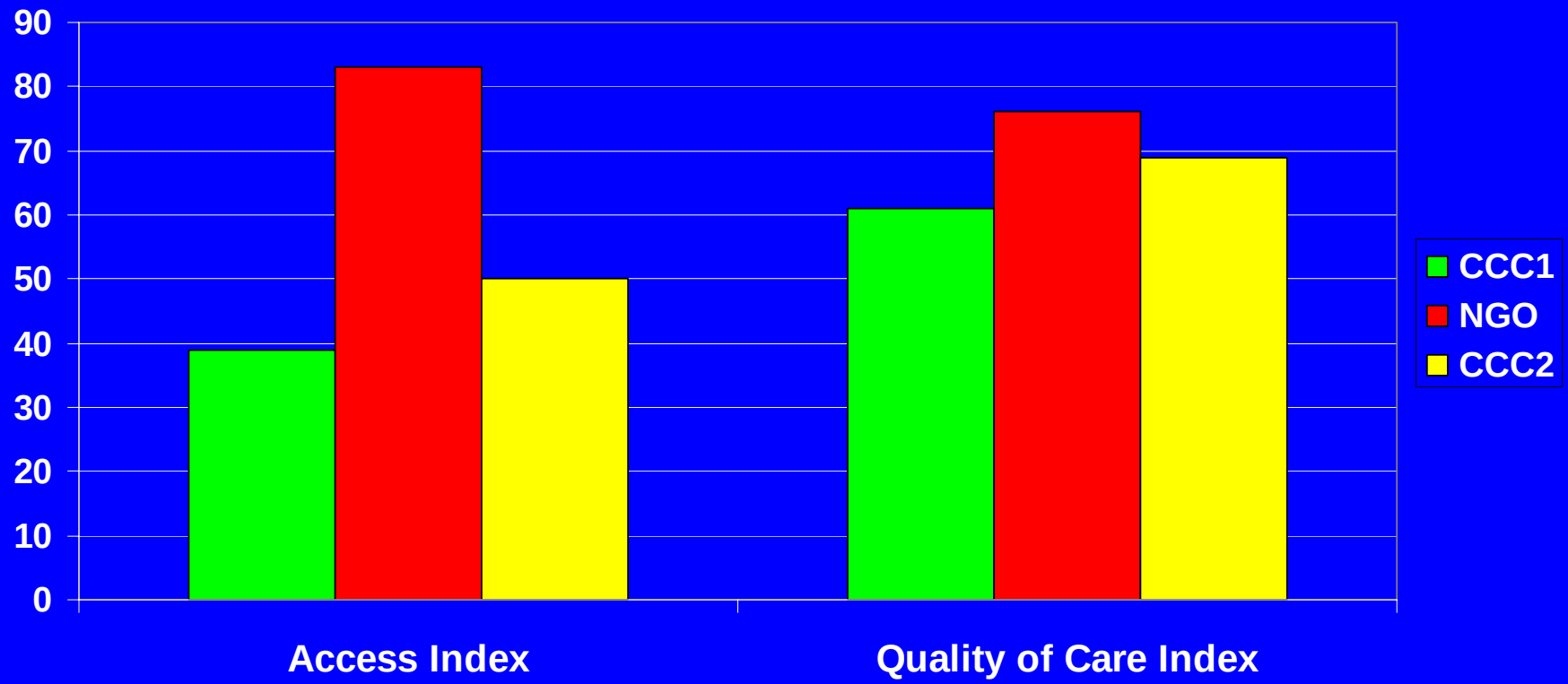
CPR (Modern Methods) in Different Parts of Chittagong



Follow-up – baseline in Chittagong (percentage points)



Quality of Care and Access Indices in Chittagong



Comments on Urban PHC Project

- Improvements in coverage, quality of care, and access for the poor observed.
- Improvements larger in NGO area compared to CCC areas
- NGO performed better in spite of receiving slightly less resources than CCC
- Now expanded to all of 6 city corporation and 5 municipal corporations

Posited Difficulties of Contracting

- Contracting can only be done on **small scale**
  - many examples with tens of millions of beneficiaries, one now covers 30 million people!!
- Contracting **more expensive** than government provision of services
  - Studies in Bangladesh, Pakistan, & India show NGOs do better job at same or lower cost

Posited Difficulties of Contracting

- Contracting **worsens inequities**
  - NGOs willing to work anywhere if provided resources & direction
  - If designed properly contracting can reduce inequities, e.g. Cambodia, Bangladesh UPHCP
- Governments **can't manage** contracts
  - Even if they can't experience in Bangladesh, & Guatemala shows it doesn't matter much
  - Examples from Cambodia & Africa show that governments can manage contracts with help

Posited Difficulties of Contracting

- NGOs and Governments **weary** of each other
  - Contracting makes for more mature relationship, can work together
- Contracting will be a source of **corruption**
  - Needs constant vigilance, difficult to know how serious
  - Involvement of neutral parties important
  - May actually prevent corruption

Posited Difficulties of Contracting

- Contracting will not be **sustainable**
  - In all 8 examples where enough time (>3 years) elapsed, contracting was sustained and expanded.
  - A package of basic services in LICs costs $3 to $6 per capita per year

Take Home Messages

- **It's worth trying to contract**!! Not just a far fetched idea. May make a real difference in achieving MDGs
- **Evaluate –** debate on contracting should be decided by evidence not eminence
  - Evidence is good but not great. Better than other interventions though
- **Practical Issues will determine Success!! –** need to pay attention to contract design & management