The public sector can potentially influence the private sector to provide more cost-effective health care interventions in a number of ways, one of which is through contracting of private providers using public finance. However there are few documented examples of contracting arrangements which focus specifically on the poor.

This paper reviews experiences of social agencies contracting with the private sector to provide health care services, and focuses on the capacity of this mechanism to improve access to services by the poor.

Case studies from Georgia, Cambodia and Surinam are highlighted, among other country experiences which reflect a range of potential methods for using contracting to benefit the poor. Lessons which can be learned from these experiences are outlined and simple guidelines for contracting suggested.

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Experience of contracting with the private sector

a selective review

Roger England

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The DFID Health Systems Resource Centre (HSRC) provides technical assistance and information to the British Government's Department for International Development (DFID) and its partners in support of pro-poor health policies, financing and services. The HSRC is based at IHSD Ltd's London offices and managed by an international consortium of seven organisations: Aga Khan Health Services Community Health Department, Kenya; CREDES-International, France; Curatio International Foundation, Georgia; IDS (Institute of Development Studies, University of Sussex, UK); IHSD Ltd (Institute of Health Sector Development Limited, UK); IHSG (International Health Systems Group, Harvard School of Public Health, USA); and the Institute of Policy Studies, Sri Lanka.

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Title: Experiences of contracting with the private sector: a selective review

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Contents

Abbreviations

ADB	Asian Development Bank
BHSP	Basic Health Services Project, Cambodia
CHSPP	Contracting for Health Services Pilot Project
C/C	control/comparison (Cambodia)
CI	contracting in
CO	contracting out
DHMT	district health management team
DRG	diagnostic related groups
FB-PNFP	facility based not-for-profit organisations (Uganda)
HC	health centre
HII	Health Insurance Institute, Albania
IADB	Inter-American Development Bank
ICAS	Central American Health Institute
JAMC	Jo Ann Medical Centre, Georgia
MoH	Ministry of Health
MPA	minimum package of activities (Cambodia)
NGO	non-government organisation
OD	operational district
ORT	oral rehydration therapy
PCU	project co-ordinating unit (for ADB Project)
PHC	primary health care
PHD	provincial health department
PSR	public sector reform
RH	referral hospital (Cambodia)
SES	socio-economic status
SMIC	Georgia State Medical Insurance Company
STIs	sexually transmitted infections
SWAp	sector wide approach
TA	technical assistance
USAID	United States Agency for International Development

1 Executive summary

This paper reviews some experiences of social agencies contracting with the private sector to provide health care services. It focuses on the capacity of this mechanism to improve access to services by the poor. The term 'private sector' is used to cover both for-profit and not-for-profit providers of health services. The paper draws on these experiences to suggest some lessons and basic guidelines for contracting.

Whilst there are various examples of contracting for health services in low and middle income countries, and there is a growing body of literature (see References), there are few evaluations that look specifically at how and how well the contracting arrangements serve the poor. This paper reviews two of the cases where there has been more thorough evaluation – the contract to provide paediatric cardiac surgery in Georgia (see Annex 1) and the pilot programme of contracting for basic health services in Cambodia (see Annex 2). It also considers the case of Surinam where contracts could be helpful in ensuring better value for the public funding provided for services to the poor (Annex 3), as well as some other examples of contracting.

The options for using contracting to benefit the poor can be summarised as follows:

Approach to targeting the poor	Examples
Providing general subsidy for services in areas where public services are not available (or to replace public provision), assuming the poor will benefit alongside others	Cambodia, Guatemala and Uganda - contracts with NGO providers
Geographic targeting – selecting an area where there are high concentrations of poor residents e.g. urban slums, poor districts	Bangladesh - urban slums project
Subsidising services for those identified as poor, which requires a mechanism to identify those eligible e.g. social security system, individual or household characteristics	Georgia – cardiac surgery; Surinam – health cards for the poor (but contracts not used)
Subsidising specific services related to illnesses that affect the poor or target groups	Nicaragua – vouchers for sex workers

The case study from Georgia indicates that it is feasible to set up a contract for specified services and to target the poor with a larger subsidy than the non-poor. Identification of the poor depended on household characteristics, and households were already identified by the insurance agency. The task was relatively simple to the extent that the range of services provided was quite narrow and specific, so easier to define and cost; there was only one hospital involved, so easier to manage than a country-wide arrangement; there were not competing providers in the public sector; and the insurance scheme already had some capacity and a relatively sophisticated legal and institutional framework.

The case study from Cambodia shows that contracting for basic service provision in a rural district (by transferring public sector facilities and staff to management by international non-government organisations (NGOs)) was feasible, led to increased service use and also resulted in lower health spending by the poorest 50 per cent of households. The poor were not targeted specifically – rather they benefited from improvements in the health services available and from reductions in their expenditure. The experimental design of this pilot scheme indicated better results in the 'contracted out' districts than in the control districts (which remained under public sector management), or 'contracted in' districts (which brought in management while staff stayed within the public service). However the level of funding for the control districts was significantly lower, making it hard to assess efficiency. The use of international NGOs as contractors made it more expensive and the scope was limited (single districts). This approach is now being tested on a larger scale (whole provinces) under the current sector plan in Cambodia, as the Government has accepted that the approach can be tested in remote provinces where Government health services are clearly inadequate.

Key issues that emerge in reviewing the experience to date include:

- Sustainability/scope for contracting – most of the contracting experiences have relied on special funding e.g. project support; this raises questions over how the arrangements can be sustained. It is difficult for governments to re-deploy public funds to private providers when available funds are already committed to public services (mostly for wages and salaries). Also, contracting with private providers requires a substantial political commitment and, typically, more funding if the services are to be of reasonable quality. An exception to this may be post-conflict situations (e.g. Guatemala and proposals for Afghanistan), where flows of public finance are already dislocated.

- Institutional capacity to develop and manage contracts and targeting mechanisms – this needs to be in place or developed. The Cambodia pilot had intensive technical assistance (TA) in developing effective contracts and monitoring arrangements.

- Identifying the poor – the same issues arise as with other mechanisms intended to benefit the poor (e.g. fee exemptions) – the ideal is to use an existing mechanism

for identifying the poor which is reasonably reliable; new systems can be costly. Experience suggests that it should not be left to the providers to decide who should benefit.

- Provider payment methods and other contract terms are key – as in other health financing arrangements, the incentives built into contracts are critical. Specific recommendations on contract scope and content are set out in Section 4.

- Monitoring and evaluation – ideally, contracts should require providers to commission regular consumer surveys as part of their work, otherwise occasional independent surveys will be needed to assess whether the poor are actually benefiting as intended, and to guide remedial steps if not. This includes baseline studies (or other ways) to assess impact and how far the changes are affecting the poor.

2 Context

This paper aims to review some experiences of employing public finance to contract with the private sector to provide health care services. It does not deal with contracting for non-clinical support services (hospital cleaning etc.), which are relatively straightforward and practised with success in many parts of the world already. The "private sector" is used indiscriminately to cover for-profit and not-for-profit extra-government providers of services.

The current strong interest in the private sector arises from, *inter alia*:

- Frustration with lack of real progress in reforming the public sector

  Despite a decade of effort in public sector reform (PSR), public sectors continue to provide poor quality services. Financing and delivery frequently suffer from political interference, structural weaknesses in organisations and institutions, inadequate resources, and labour rigidities often enshrined in legislative rights.

  It is not realistic to expect governments to focus primarily on serving the poor when entire public health sectors are performing so badly.

  Some hope is being placed in private sectors where it is anticipated that service providers can charge viable tariffs and manage their operations free of public service constraints.

- The large sums that are already being spent in the private sector

  More money is being spent out of pocket by individual health care consumers than is being spent through public financing apparatus, even in poor countries. In at least 50 countries, private health expenditures account for 50 per cent or more of total health expenditures. Countries with high shares of private expenditure include: Georgia (90 per cent), India (82 per cent), Nigeria (79 per cent), Sudan (79 per cent), Kenya (78 per cent), Pakistan (77 per cent), Cambodia (76 per cent), Cameroon (75 per cent), Viet Nam (74 per cent), Indonesia (76 per cent), Nepal (71 per cent), Morocco (70 per cent), Bangladesh (64 per cent), Uganda (62 per cent), Paraguay (62 per cent), and Ethiopia (61 per cent).

Much of the care provided may be of low quality and/or low cost effectiveness. Studies throughout the 1990s provide evidence that, for example, private providers are more likely to prescribe antibiotics and anti-diarrhoeals than oral rehydration salts (ORS) when the latter would be preferable (Muhuri 1996; Langsten and Hill 1995; Igun 1994; Ickx, 1996 – all cited in Waters, Hatt, Axelsson, 2002).

Some hope is being placed in the ability of the public sector to influence the private sector to provide more cost-effective interventions. Exercise of this influence is seen to come from four main areas:

- raising consumer knowledge;
- regulating the behaviour of private providers;
- developing approved provider programmes (including franchising);
- contracting with private providers using public finance.

This paper focuses on the last of these.

3 Lessons and observations

A growing number of experiences indicate that contracting mechanisms can raise provider performance in terms of service quantities and quality. Some examples suggest that contracting may also be cost effective. However, there are very few examples of contracting arrangements that focus specifically on the poor or that incorporate significant elements to favour the poor or other vulnerable groups. Section 5 identifies and reviews some of these experiences, this section (Section 3) summarises some lessons indicated by those experiences, and Section 4 suggests what these mean in terms of simple guidelines for contracting.

It has to be said that the evidence base is thin. Although forms of contracting are in place in many countries, and there is a growing literature on contracting experience, few of these experiences have been subject to proper evaluation, particularly concerning their impact on the poor. Much of the literature also tends to lack detail on how the contracts are specified and on how specific provisions are made to serve the poor or other target groups.

Where there has been a favourable impact on the poor, two main mechanisms appear relevant:

- contractual arrangements that *specifically* encourage providers to serve the poor (e.g. the contracting of Jo Ann Medical Centre, Georgia, by the State Medical Insurance Company – see Annex 1);

- a general subsidisation of providers that results in lower out-of-pocket payments by consumers *including* the poor, often located in a relatively poor area (e.g. the Cambodia Contracting for Health Service Pilot – see Annex 2).

Strategy 1 Contractual arrangements that specifically encourage providers to serve the poor

Whilst this may be favoured as a main objective of contracting, it requires a sophisticated context to work. Contracting can improve the performance of providers, but additional mechanisms are necessary to secure the benefits of public finance (subsidies) for the poor. The mechanisms are separate but may be usefully combined. Key elements include:

- availability of a subsidy for the poor handled through the purchasing agency (rather than assuming the provider will cross subsidise the poor) - the availability of funds earmarked for the poor encourages the provider to serve the poor because of

guarantees that the provider will be paid for such services (without such earmarked funding, private providers would favour patients more able to pay);

- a system that clearly and simply identifies who qualifies as poor/low income and that can be used at the point of consumption of services to trigger the release of subsidies;

- contractual conditions that prevent income maximisation by patient churning or over-charging including appropriate combinations of:
  - contracts/payments based on outputs not inputs
  - ceilings for total contract value
  - a set price per case by type
  - monitoring arrangements by the contracting agency;

- an experienced purchasing agency with good information on needs, costs and standards (or the mechanism with which to build this data year on year).

These elements are well illustrated in the case study of the Jo Ann Medical Centre (JAMC) in Georgia provided in Annex 1.

Strategy 2 A general subsidisation of providers including the poor

Essentially, this is what exists in public systems now, and the problem has always been how to target this subsidy. This problem is not solved automatically when contracting with the private sector. If there is no system to identify the poor – and if that system cannot be used to identify the poor at the point of service delivery – subsidies cannot be targeted as in strategy 1 above. Instead:

- subsidies can be targeted by contracting with private providers in areas which are predominantly poor (geographic targeting) – but populations are not always homogenous and in any poor area, there are ranges of poverty and deprivation;

- or by contracting to subsidise only those services of most benefit to the poor – but these are not necessarily the services sought by the poor and it is difficult to offer some services and not others whilst still retaining credibility with consumers.

Nevertheless, crude mechanisms like these may offer the most realistic strategy where more sophisticated financing, institutional and poverty registration mechanisms are not yet developed. An example of the potential and problems of this approach is provided by the Case Study of the Cambodia Contracting for Health Services Pilot Project (see Annex 2).

Whether strategies (1) or (2) are employed, care must be taken not to let policy concerns with the poor create insular delivery systems that prevent the economies of scale, cross

subsidisation, and consumer influence over providers that integration with non-poor segments of the population may help to secure.

3.1 Sustainability

Successful experiences of contracting with the private sector in poorer countries tend to rely on special funding, for example, projects. Unless there is substantial reform of the public sector, all available public finance is tied up paying for public services – mainly for the salaries of public sector workers. This funding cannot be transferred to buy services from the private sector unless employment in the public sector is reduced. So public sector reforms remain essential if significant public finance is to be re-deployed to contract with private providers.

Nor can contracting be used to achieve better performance for private out-of-pocket expenditure – unless that expenditure is channelled through forms of pooling organisations with the muscle to enter into contracts with providers on any meaningful scale.

Without significant financial pooling, the most that may be achievable is that purchasing agencies may use contracting with special funds to leverage private providers to meet defined standards. If a provider accepts this extra funding (thus enabling it to top up wages for example), it has to agree under a contract to provide certain services to certain standards and at certain prices to consumers. The Case Study of the Cambodia Contracting for Health Services Pilot Project presented in Annex 2, suggests that this approach has resulted in reduced expenditure out of pocket by poorer households. Similarly, as outlined in Section 5.10, the Nicaragua Central American Health Institute (ICAS) voucher experience (albeit with high-risk consumers rather than the poorest consumers) has succeeded in ensuring that providers offer and maintain certain standards for services.

3.2 Institutional issues

The question remains of who will instigate and manage any process of contracting private providers for public services? Which public agency has the incentive (let alone the knowledge) to perform the necessary purchasing side of the contracting function? The available experiences (e.g. Bangladesh) indicate that except in extreme circumstances (eg. Cambodia and Guatemala), ministries of health do not embrace the role of diverting public finance to private sector providers with any more enthusiasm than they have worked to reform themselves.

Attempts have been made to establish new services purchasing organisations outside of ministries of health. Again, without substantial sector reforms, these agencies can only be given control of special funds but this can be seen as a step in learning how to contract and, in some cases, as a preliminary to formation of a national health insurance

organisation. In Belize, a special fund was established (with IADB support) for learning how to purchase from private sector primary care providers whilst, simultaneously, a national health insurance operation was being developed as part of the social insurance board. Several small Caribbean states have some experience of purchasing care for their citizens from overseas – for services for which their populations are too small to support a viable service – and proposals have been made to use these funds to build a services purchasing agency as part of reforms (e.g. Turks and Caicos Islands and Anguilla). *Inter alia*, sector wide approaches (SWAps) have also included attempts to consolidate purchasing of services from the private sector. The example of Bangladesh is outlined in Section 5.

3.3 Identifying and reaching the poor

A crucial element in targeting subsidies efficiently is the ability to identify the poorer beneficiaries (or other target groups) and to institutionalise this information so that it is transparent, fair, updated and useable. This process must be within the control of the purchaser or available to the purchaser as a result of some more comprehensive social assessment programme. The task cannot be left to the private provider of services. In countries with large informal sectors, means testing is not feasible. In the Georgia case study (Annex 1) this was replaced by a simple 16-criteria system developed and administered centrally by government as the basis for identifying beneficiaries of the Medical Insurance Policy for the Vulnerable. The criteria included for example: single pensioners, single female head of household, significant disability, persons displaced as a result of conflict etc.

Unfortunately, most documented experiences do not provide much information on how this is done elsewhere, and it appears that in poor countries it may not be done at all. In the Cambodia pilot project (Annex 2) poverty was assessed during household surveys by assessing the quality of housing. Surveys elsewhere (e.g. Tanzania) have used other proxies such as household ownership of a radio, a tin roof, a bicycle, and by the education and occupation of household heads. But these assessments are used for monitoring and evaluating service use and expenditures – not for deciding which individual households are eligible for subsidies or exemptions at the point of service delivery.

Voucher systems are achieving some success but in relatively specific situations. One of the best known examples is the use of vouchers for commercial sex workers to cover health checks and treatment – see the example of Nicaragua in Section 5. Providers redeem vouchers for cash from the central organising agency. Where there is large-scale delivery of services by the private sector based on cost recovery, vouchers may offer a mechanism for the focused use of a subsidy for the poor, effectively exempting them from payment for services but guaranteeing equivalent payment to providers. The privatisation of water in Chile was accompanied by such a scheme. But vouchers do not remove the problems of how to identify the poor nor how to sustain significant financing without public sector reforms.

3.4 Provider payment methods

Provider payment methods under contracting tend to be either:

- population-based – an amount per capita covered by the service provider;

or

- services-based – with payment linked to service volume (fee for service).

Payment methods can have dramatic effects on service standards, cost effectiveness and costs to the purchaser.

Population-based systems can create incentives for the provider to under-provide thus maximising the margin between income and costs. This under-provision may be achieved by treating fewer patients, by not treating expensive cases or by reducing quality of services. In Argentina, the national insurance agency, PAMI, pays care providers on a per capita basis. This resulted in serious under provision. Of course, per capita payment arrangements must be based on realistic costs, and the problems of per capita methods can be reduced if providers are also given output targets to which some of their payment may be geared.

Services-based payment systems may create incentives to over provide in order to maximise income. For this reason, purchasers usually also introduce a maximum number of services to be provided. Because they require data on the number and type of services delivered, service-based contracts invariably incur higher transaction costs. Definitions of service types can also be manipulated by providers by, for example, giving preference to simpler cases within any service category, or by minimising treatment.

Either way, contracting should try to create targets for provider outputs and link payment to the achievement of these so that the provider carries some financial risk and has the incentive to perform. The pilot study from Haiti (Section 5) illustrates one way of doing this.

4 Guidelines for contracting with the private sector

A basic structure and content for contracts is available in an earlier DFID HSRC publication: 'Contracting and performance management in the health sector: guidelines for low and middle income countries', (England 2000).

The contracting experiences reviewed since then suggest a number of key factors should be considered in introducing contracting in poorer countries.

4.1 Political/socio-economic/legal context

Unless a country has undertaken successful public sector reforms introducing a clear separation of functions between payer and provider and including a significant reduction of public sector staff on the state budget, contracting with the private sector can only be based on special and relatively small amounts of public funding.

Where the contracting is of resources at the margin rather than a major reallocation of resources to private providers, it is important to look strategically at what contracting can achieve. For example, the difficulty and costs of setting up an effective targeting system in a relatively poor area may suggest that it will be better to use contracting to leverage better performance for all consumers of the service. This is likely to be more successful when combined with regulation (e.g. licensing) and/or forms of sponsorship (e.g. approved provider schemes).

Another situation where there may be scope for larger scale contracting is the post conflict environment where public services and employment are disrupted. The approach has been introduced in Guatemala (see Section 5) and is gradually evolving there. A similar mechanism of designating NGOs to work in specific areas was used in East Timor at an early stage, but with relatively high costs of the NGO services and inconsistency in services provided. There are currently proposals in Afghanistan to establish contracting closer to the Cambodia model on a geographic basis. However, acceptability to the new government may be a constraint on introducing large scale contracting.

Clear public policy is required on subsidising service provision for the poor as the basis for building an effective mechanism to deliver this subsidy through service providers. Where such a mechanism is not feasible, policy should indicate how public finance for health services is actually to reach the poor in practice.

4.2 Institutional context

Contracting requires the existence or development of a knowledgeable purchaser organisation able to enter into contracts with providers based on information about health needs, services efficacy and costs. It must be a pro-active organisation, not a reimburser after the fact.

There should be a system to identify the poor based on explicit and transparent principles and appropriate to the socio-economic circumstances. This system should be operated by the purchaser (or should be part of a national system) and not left to the provider. Where such systems are not feasible, the use of contracting using public finance should focus on getting better value for money in predominantly poor areas, and/or on ensuring provision of some basic preventive services to those in need and that otherwise would not be delivered.

The purchaser organisation must have the capacity to fulfil its obligations under the contracts it enters into including paying providers properly and on time.

4.3 Contracting context

Contracting arrangements should be discussed extensively with stakeholders and potential stakeholders at an early stage of planning.

Contract design

- the services being contracted for should be specified clearly and contracts should be based on outputs rather than inputs or processes – including quantities of services to be provided and quality to be achieved even if this is in the form of very simple measures/proxies;

- contracts should leave the provider to manage operations – they should not be based on specifications of how services are produced, how the provider allocates resources between inputs, or how those inputs are procured;

- payment mechanisms should be well thought out and preferably tested in advance to ensure that they create a good balance of incentives for the provider;

- contracts should specify how and when payments are to be made and precisely how and when non-performance by the provider could instigate delays or non-payments;

- arrangements for managing the contractual relationship should be planned in advance and where appropriate specified in the contract, detailing which party is to be responsible for what activities (procurement, data generation for contract

monitoring and evaluation (M&E), M&E functions, problem resolution etc.) – sufficient thought should be given to the incentives for the various actors to make the arrangements successful.

Contract monitoring and evaluation

- M&E should be planned in advance and should reinforce the aims of the contract by measuring outputs and costs - indicators should provide clear output targets;
- indicators should also measure the extent to which the poor access services – this may need to be done by intermittent household/consumer surveys rather than by provider record keeping if there is not a purchaser-managed system to identify individual poor patients. Surveys can also be used to see why the poor are not using services and evaluate how well the targeting/identification works;
- M&E should require regular monitoring meetings between purchaser and provider and these should be used to understand implementation problems and solve them.

Contract bidding procedures

- bidding procedures should be explicit, documented and transparent to all stakeholders;
- external, third party assistance should be involved in bid evaluation and the awarding of contracts.

5 The experiences reviewed

Experiences and references

A complete list of projects and references consulted is provided in the reference section of this document. Many of these descriptions are qualitative. There are few substantial and quantitative evaluations of actual contracting with the private sector. What follows below is a selective review of some of the more relevant of these experiences.

Characteristics of selected experiences

This Section provides brief descriptions of some relevant experiences of contracting. Some key elements are captured for selected experiences in the accompanying chart.

5.1 Georgia

The Georgia State Medical Insurance Company (SMIC) is the established social health insurance organisation financing a basic benefit package for the entire population. In 1998, paediatric cardiac care was added to SMIC coverage and a contract was negotiated with the Jo Ann Medical Centre (JAMC). The JAMC had been established as a not-for-profit NGO with foreign technical and financial assistance in recognition of the significant and untreated prevalence of congenital heart abnormalities. It commenced operations in 1996. The resulting experience of this contractual relationship provides good insight into the strengths and limitations of contracting in a relatively sophisticated legal and institutional context where there is an established system for targeting the poor with subsidies. Because this experience is well studied, it has been expanded as a case study and presented in Annex 1.

5.2 Bangladesh

For many years external development partners have directly funded a large network of NGOs to provide health care, particularly in reproductive health. In 1999, a SWAp was introduced in which most major development partners agreed to support delivery of an agreed health strategy led by government. This formed the basis for a five-year sector investment plan. There are two funding mechanisms: pooled funds through which external development partners provide financial support to the government health budget; and a parallel mechanism whereby development partners fund specific activities within the agreed strategy and programme.

For pooled funding, government contracts with NGOs to deliver services (at the design stage, there was considerable opposition to this from the NGO community). To ensure

contracting for services was handled properly, it was planned to appoint a procurement agent but because of delay in contracting such an agent, this function had to be done by Ministry staff who lacked experience. A major problem has been meeting World Bank procurement rules, which are complex and rigid. The capacity building needed for this was underestimated particularly because of the rigidity of the Bank's procurement rules.

However contracts with NGOs were eventually put in place and should offer greater accountability as well as greater government ownership and sustainability. Evaluations will assess if the contracting arrangements have positive effects on delivery performance. A lesson for any similar attempt elsewhere should be to recognise the threat that NGOs will see in the SWAp process and to bring them into the design at an early stage. This will help with capacity building for the contracting process and enable providers to prepare in advance. Secondly, the Bangladesh experience suggests that the volume of contracting needs to be large enough to sub-contract out the contracting process to a professional procurement agent or to justify the inclusion of some technical assistance within the Ministry.

5.3 Haiti

USAID supports NGO service providers in delivering preventive health care services. An intermediary NGO (MSH) is used to contract with the NGOs. Some years into this programme (in 1999) a pilot was set up in which the conventional cost-based funding of the NGOs was replaced with an output-based payment formula. NGOs were paid 95 per cent of their budget under an expenditure-based contract and no more if they failed to meet targets in outputs, but an additional 10 per cent if they met these targets (i.e. 5 per cent more than they would have got).

Targets were set for immunisation, use of oral rehydration therapy (ORT), contraception etc., and an independent survey organisation was used to measure results. The results were mixed but showed significant improvement in immunisation coverage. The pilot highlights the importance and difficulty of using the right output targets. Some of the measures required longer term educational and behavioural change work and results could not be seen in the one-year evaluation period. Perhaps more interestingly, the pilot certainly encouraged the NGOs to innovate in how they delivered services, created incentives for staff, and improved their management.

5.4 Guatemala

In 1996, after the war, 46 per cent of the population (and all the rural population) had no access to medical services. The Ministry did not have the capacity to expand coverage sufficiently so a plan was devised to encourage the private sector to provide a package of services under a form of agreement with government. The target was to achieve universal coverage within five years.

A basic package of services was specified and an agreement (*convenios*) prepared. Any private provider could provide the services and was paid on a catchment population basis, with higher payments for isolated populations. An institutional facilitator (Ministry) organised coverage for 10,000 people (a district), and was supported by a doctor, traditional birth attendants, vector controllers and community workers, each serving 20 families.

By the end of 1999, 84 private providers (NGOs) had extended health services to a further 37 per cent of the population: 2,492 community centres had been established (for training, medical care and distribution of basic drugs); 541 doctors, 24,613 community health workers and 399 institutional facilitators were involved. The MoH spent US$8million on the programme in 1999 (total health budget US$19.5 million). The service provided has not been evaluated so far. A key issue is the extent Government was willing to trade off quality for coverage (many of the NGOs had little health expertise initially).

The programme provides an example of what can be mobilised quickly with political urgency. The approach adopted appears to be to get some form of coverage implemented fast, then improve things. Agreements were virtually given out to anyone, no guarantees were required, little monitoring was done (some financial reporting was required), providers did not have to sign up to targets etc. But over the first two to three years, arrangements began to be tightened as experience and mutual confidence was gained.

5.5 Uganda

Hospitals run by facility-based not-for-profit organisations (FB-PNFP) have long provided over 50 per cent of beds and 60 per cent of hospital services in Uganda. Most of these are church-based NGOs. They depended on high levels of self-financing from user fees but this became insufficient for some to continue.

In recognition that many of the FB-PNFP hospitals were more efficient than most public hospitals, government initiated a scheme to fund them through negotiated contracting. It was agreed that the hospitals would use the funds to freeze user fees, improve services and improve staff wages based on the provision of specific services. Guidelines for the use of funds were drawn up and resources allocated according to an agreed formula. Simple contracts in the form of a memorandum of understanding (MOU) were deployed. Monitoring was contracted out to the medical bureau overseeing the FB-PNFP hospitals.

Limited evaluation indicates that staff salaries have been increased, user fees have been reduced, and there has been increased utilisation of services especially by vulnerable groups and children. However, the funds released by the Ministry have been subject to delays, are lower than anticipated and some have been mislaid. The scheme could also lead to broader reform and benefits to the public sector as the agreements (MOUs) have now been extended to public hospitals.

5.6 Cambodia

Under the Contracting for Health Services Pilot Project, the MoH entered into contractual relationships with not-for-profit NGOs to provide health care services in some districts. The pilot project aimed to compare the results of both contracting for services (contracting out) and contracting external management to run public services (contracting in) with services run by public sector district health teams. The pilot functioned from 1998 to 2002. Significant increases in utilisation of services were achieved in contracting districts and reductions achieved in out-of-pocket expenditure by the poor – as measured by household survey. Additional funding was provided to finance the contracting arrangements. This experience is provided as a case study in Annex 2.

Despite the positive results from the pilot, the Government continued to prefer an approach based on improving public services as the major strategy for health services; however, the approach is being scaled up to cover whole provinces in remote parts of the country where Government has a demonstrably poor record of service provision.

5.7 Albania

Albania succeeded in improving primary care services through the introduction of a national health insurance scheme administered by the Health Insurance Institute (HII). As purchaser, HII contracts with doctors and pharmacists to ensure that services and essential drugs are available to all. New drug registration procedures were introduced and a national committee determined the essential drug list that would be reimbursed by government. Contracts with pharmacists required maintenance of stock levels and specified prices, co-payments and a dispensing fee which helped establish a reliable supply chain for drugs and ensure that everyone has access to drugs at no or low cost.

Analysis of prescribing data has lead to improved prescribing practice and district doctors are now using the data to teach general practitioners (GPs) about evidence-based prescribing (see James 2000).

5.8 Romania

The Romanian Government ran a pilot programme between 1994-96 under which district health authorities contracted with accredited doctors to provide primary care services. The model was an adapted form of the UK capitation system, and about four million people participated. The doctors were paid a capitation amount for each of the patients who registered with them. Patients were allowed to select a doctor as their family physician and to change after three months if they wished. The capitation payment was adjusted with a patient-age weighting, and was increased for rural locations. On top of the capitation payment, doctors were paid a fee-for-service reimbursement for each of about 30 preventive services including immunisations, pre-natal and child development monitoring visits, check-ups and screening etc. The

capitation element was about 60 per cent and the itemised services about 40 per cent of the total payment.

It appears that M&E was not a strong component of the pilot and was not built in, effectively preventing proper evaluation of results. As in many cases of purchaser-provider separation, the purchaser function was weak initially. It appears that the pilot did succeed in raising standards but a key constraint was the fact that the doctors did not really control the input or management of other resources including nursing and physical facilities. In addition, there were no incentives for professional development built into the funding mechanisms. As might be expected, the administrative load of dealing with reimbursement claims was substantial.

Lessons learned from the pilot were introduced as the system was extended nation-wide as a component of introducing a national health insurance programme. These included simplification of the capitation payment, clearer specification of services to be delivered and introduction of practice guidelines and continuous professional development for doctors.

5.9 Latin America

An Inter-American Development Bank (IADB) review of 27 examples of contracting with the private sector (Slack and Savedoff 2001) draws these broad conclusions on key issues:

- the importance of provider payment mechanisms and the incentives they create;
- the degree to which public funding of providers is sufficient to influence provider behaviour;
- the need for adequate quality assurance and M&E systems;
- the impact of factors outside the contract including the level of development of the market, the type of service being contracted for and the involvement of government and community.

Experience from Peru with local health administration committees (not really private but a form of NGO managed by the community and the Ministry of Health and with considerable autonomy in managing health centres) suggests that, in comparison with pure public providers, these CLAS units achieve some improvements in services (see Cotlear 2000).

5.10 Nicaragua

The Central American Health Institute (ICAS) set up a donor-supported voucher scheme in Nicaragua to provide treatment and prevention services for sexually transmitted infections (STIs) to high-risk populations such as commercial sex workers and their partners and clients. ICAS contracts with clinics able to provide these services. Every six months the scheme distributes 2,000 vouchers to vulnerable groups either directly or through community-based organisations. The vouchers, which remain valid for two and a half months, entitle the bearer to a predefined package of 'best practice' sexual health services free of charge at any one of about 10 contracted clinics. To prevent counterfeiting, vouchers are individually numbered, stamped with the ICAS seal and laminated. Their expiration date is printed on them. The ICAS acts as the voucher agency, contracting and monitoring clinical and laboratory services, training clinic staff in handling sex workers in a non-discriminatory manner, defining the service package covered by the voucher, analysing data, and monitoring technical quality and patient satisfaction. Clinics are paid according to the number of vouchers they return (along with data collection sheets).

Clinics compete for contracts on the basis of price, quality and location. The contracts between ICAS and the providers require staff to follow a specified treatment protocol and to participate in training sessions. Contracts are not renewed if the performance is judged to be unsatisfactory. ICAS contracts one laboratory to perform diagnostic tests. By 2001 the programme had contracted 20 services providers at one time or another. Since round four only private and NGO clinics have participated. The public sector clinics did not attract many voucher redeemers and had long waiting times and unfriendly 'gatekeepers'. The voucher scheme is sustained at a cost of US$60,000 a year, reflecting the relatively low cost of patient visits. The scheme has been successful in lowering prevalence of STIs and incidence in repeat users (Sandiford, Gorter and Salvetto 2002).

5.11 Surinam

Surinam provides an example of a complex mixed public-private system with partial purchaser-provider separation where contracting is not used but should be. Purchaser-provider relationships exist between government and social insurance funders and private and public care providers. As is frequently the case, funding arrangements are seen only as means to raise more finance, not as leverage for cost effectiveness through informed contracting. Surinam has a national system to identify the poor and to entitle them to services, but the loose funding arrangements have caused costs to rise without health gain (See Annex 3).

5.12 Other experiences

Contracting with the private sector is becoming commonplace around the world. Many publications have provided lists and brief summaries of examples. Waters *et al* (2002) mention contracting in:

Peru	IPSS contracting with private hospitals for minor surgery;
PAAD	a network of private primary care doctors
Nicaragua	INSS contracts with accredited health care providers
El Salvador	ISSS contracts with private doctors for ambulatory care for children
El Salvador	MOH contracts with FUSAL (NGO) to provide primary care in under-served San Julian
Zambia	BASICS funds NGOs providing services in partnership with MOH
India	USAID funds NGOs providing primary care
Senegal	MOH contracts Agetip (NGO) to run community nutrition centres
Madagascar	PMs office contracts NGO to contract other NGOs to provide nutrition services

Rosen (2000) mentions other examples:

Bolivia	MOH contracts Prosalud (NGO) to provide PHC/RH services
Brazil	MOH contracts over 200 NGOs to provide HIV/AIDS services
Columbia	MOH / SSI contracts Profamilia / other NGOs / private for profit providers for PHC/RH
Haiti	MOH contracts PSI (NGO) to provide RH services
Mexico	SSI contracts FEMAP and MEXFAM (NGOs) for RH services
Kenya	MOH contracts GTZ (NGO) to provide RH services
Mali	Social Fund contracts NGOs for PHC/RH
India	MOH contracts NGOs and private doctors/midwives for RH and MH services

But there are few substantive evaluations or even detailed descriptions of these or other projects (but see Marek, Diallo, Ndiaye and Rakotosalama 1999 for Senegal and Madagascar).

Many African countries have a long tradition of government subvention to mission hospitals (see South Africa and Zimbabwe in Mills and Broomberg 1998) but these have not been based on formal contracting specifying output quantities, qualities or access by the poor.

5.13 Summary of characteristics of case studies

	Georgia	Cambodia	Guatemala
Provider	Jo Ann Medical	NGOs	NGOs: PSS/ASS
for profit			
not for profit (NGO)	yes	yes	yes
national	yes		yes
international	support to set up	yes	yes
Provider regulation	licensing	no	no
Purchaser	State Medical Insurance Company	MOH	MSPAS
MoH		yes	yes
NHI agency	yes		
other			
Services provided	paediatric cardiac surgery	basic primary and hospital care	basic package
Contract type	contracting out	contracting out contracting in control (MOH)	contracting out
Contract specifies			
services types	yes	essential services	basic package
service quantities	expected case mix	prevention targets	not originally
services quality	outcomes	inputs only	performance
budget ceiling	yes	yes	yes
unit prices	yes	per capita	per capita
parties' responsibilities	yes	payment only	payment only
payment schedule	yes	yes	yes - quarterly
M&E arrangements	yes	yes – surveys	no
Focus on poor			
specific funding	yes	no	no
contract specifies	yes	no	no
M&E	yes	yes – surveys	no
system to identify poor	yes	no	no
% poor in location	n/a	high	high
Cost sharing	yes, poor exempt[1]	yes	no?
Contract awarded by			
selection	originally		yes
competition	later but limited	yes	

M&E system / data			
clinical outcomes	yes	yes - prevention	no
PSS	no[2]	no	no
utilisation by age	yes	children	no
case mix	yes	no	no
price per case	yes	no	no
utilisation by poor	yes	surveys only	no
Socio-economic context	favourable – reforms enacted	enthusiasm but limited capacity	post war urgency to reach un-served
Outcomes			
services volumes	increased[3]	increased	increased[5]
services to poor as %	increased[3]	increased	increased[5]
unit costs	n/a	increased[4]	n/a
costs for poor	reduced	reduced	n/a
cost effectiveness	n/a	increased	n/a

PSS Patient satisfaction surveys

1 0-3 age free; 3-14 age 20-25 per cent co-payment for non-poor removed in 2002 for treatment, retained for diagnostics

2 Undertaken by case study, not routinely

3 see table in text, Annex 1

4 earlier expenditure was extremely low

5 originally determined by national surveys (e.g. immunisation rates) and interviews with NGOs, not project M&E; some M&E introduced later.

References

Abramson, W. (1999) *Partnerships between the public sector and non-governmental organizations: contracting for primary health care services, a state of the practice paper*, Washington: Latin America and Caribbean Health Sector Reform Initiative

Barnett, C., Connor, C., Putney, P. J. (2001) *Contracting non-governmental organizations to combat HIV/AIDS*, Bethesda: Partners for Health Reformplus

Bataringaya J. and Lochoro, P. (2001) 'The public private partnership in health (PPPH): the collaborative framework for delivery of health services in Uganda', Inter-country Meeting on Experiences on Contracting Health Services Delivery in Africa, Addis Ababa, 19-22 November

Bennett, S., Mills, A. (1998) Government capacity to contract: health sector experience and lessons, *Public Administration and Development* Vol. 18, no. 4, London: Royal Institute of Public Administration

Bennett, S., McPake, B., Mills, A., (eds) (1997) *Private health providers in developing countries: serving the public interest?* London: Zed Books

Bhushan, I., Keller, S., Schwartz, B. (2002) 'Achieving the twin objectives of efficiency and equity: contracting health services in Cambodia', *ERD Policy Brief Series* Number 6, Manila: Asian Development Bank, http://www.adb.org/Documents/EDRC/Policy_Briefs/PB006.pdf (accessed April 2004)

Connor, C. (2000) *Contracting non-governmental organizations for HIV/AIDS: Brazil case study - Brazil's experiences of contracting out HIV/AIDS services to NGOs*, Bethesda: Partners for Health Reformplus

Cotlear, D. (2000) 'Peru: reforming health care for the poor', *LCSHD paper* series Number 57, Washington: World Bank, http://www-wds.worldbank.org/servlet/WDS_IBank_Servlet?pcont=details&eid=000094946_00102005304192 (accessed April 2004)

Cuellar, C. J., Newbrander, W., Timmons, B. K. (2000) *The PROSALUD model for expanding access to health services*, Boston: Management Sciences for Health, http://www.worldbank.org/wbi/healthflagship/oj_prosalud.pdf (accessed April 2004)

de Silva, S. (2000) *Community-based contracting: a review of stakeholder experience*, Washington: World Bank, http://www.worldbank.org/watsan/pdf/ccpaper.pdf (accessed April 2004)

Edmond, A. H., Paterson, M. A., Sadiq, A. J., Sadiq, L. M., Scribner, S., Terrell, N. (1999) 'Establishing a family health fund in Alexandria, Egypt: the quality contracting component of the Family Health Care Pilot Project', *Technical report No. 42* , Bethesda: Partners for Health Reformplus, http://www.phrplus.org/Pubs/te42fin.pdf (accessed April 2004)

England, R. (2000) *Contracting and performance management in the health sector: a guide for low and middle income countries*, London: DFID Health Systems Resource Centre, http://www.phrplus.org/Pubs/te42fin.pdf (accessed April 2004)

Gotsadze, G. and Jugeli, L. (2003) 'Contracting an NGO to provide non-core specialist services to the population, Georgia', draft report, London: DFID Health Systems Resource Centre

Gotsadze, G., and Jugeli, L. (2003) 'Contracting a private insurance company by the Municipal Health Fund, Georgia', draft report, London: DFID Health Systems Resource Centre

Ickx, P. (1996) *Central Asia Infectious Diseases Program, Simulated Purchase Survey*, Kazakhstan: Rational Pharmaceutical Management

Igun, U. A. (1994) 'Reported and actual prescription of oral rehydration therapy for childhood diarrhoeas by retail pharmacists in Nigeria', *Social Science and Medicine* 39 (6): 797-806

James, J. (2000) *Contracting for primary care medicines management in Albania: lessons learned and transferable principles*, London: Institute for Health Sector Development Limited, http://www.ihsd.org/docs/IN1.pdf (accessed April 2004)

Langsten, R., Hill, K. (1995) 'Treatment of childhood diarrhea in rural Egypt'. *Social Science and Medicine*, 40 (7): 989-1001

Loevinsohn B. (2002) *Practical issues in contracting for primary health care delivery: lessons from two large projects in Bangladesh*, Washington: World Bank, http://rru.worldbank.org/Documents/746.doc (accessed April 2004)

Loevinsohn, B. (2000) *Contracting for the delivery of primary health care in Cambodia: design and initial experience of a large pilot-test*, Washington: World Bank, http://www.worldbank.org/wbi/healthflagship/oj_cambodia.pdf (accessed April 2004)

Marek, T., Diallo, I., Ndiaye, B., Rakotosalama, J. (1999) 'Successful contracting of prevention services: fighting malnutrition in Senegal and Madagascar' *Health policy and planning* Vol. 14, No. 4

McCoy, D., Buch, E., Palmer, N. (2000) *Protecting efficient, comprehensive and integrated Primary Health Care: principles and guidelines for inter-governmental contracting/service agreements*, Durban: Health Systems Trust, ftp://ftp.hst.org.za/pubs/localgov/contracting.pdf (accessed April 2004)

McPake, B. and Hongoro, C. (1995) 'Contracting out of clinical services in Zimbabwe', *Social science and medicine* Vol. 41, No.1

McPake, B., Banda, E. E. N. (1994) 'Contracting out of health services in developing countries' *Health policy and planning* Vol. 9, No.1

Mills, A. (1998) 'To contract or not to contract?: issues for low and middle income countries', *Health policy and planning* Vol. 13, No.1

Mills, A., Broomberg, J. (1998) 'Experiences of contracting: an overview of the literature', *Macroeconomics health and development series* Number 33, Geneva: World Health Organization, http://whqlibdoc.who.int/hq/1998/WHO_ICO_MESD_33.pdf (accessed April 2004)

Muhuri, P. K., Anker, M., Bryce, J. (1996) 'Treatment patterns for childhood diarrhoea: evidence from demographic and health surveys'. *Bulletin of the World Health Organization*, 74 (2): 135-46

Nieves, I., La Forgia, G. M., Ribera, J. (2000) *Large-scale government contracting of NGOs to extend basic health services to poor populations in Guatemala*, Washington: World Bank, http://www.worldbank.org/lachealth/ (accessed April 2004)

Palmer, N. (2000) 'The use of private-sector contracts for primary health care: theory, evidence and lessons for low-income and middle-income countries', *Bulletin of the World Health Organization* 78 (6), http://www.who.int/docstore/bulletin/pdf/2000/issue6/bu0482.pdf (accessed April 2004)

Perrot, J., Carrin, G., Sergent, F. (1997) 'The contractual approach: new partnerships for health in developing countries', *Macroeconomics health and development series* Number 24, Geneva: World Health Organization, http://whqlibdoc.who.int/hq/1997/WHO_ICO_MESD.24.pdf (accessed April 2004)

Rosen, J. E. (2000) *Contracting for reproductive health care: a guide*, Washington: World Bank, http://rru.worldbank.org/documents/Contracting%20for%20RH%20Publication.doc (accessed April 2004)

Sandiford, P., Gorter, A., Salvetto, M. (2002) 'Vouchers for health: using voucher schemes for output-based aid', *Public policy for the private sector,* Note number 243,

http://rru.worldbank.org/documents/OBA_Vouchers.pdf (accessed April 2004)

Slack, K., Savedoff, W. D. (2001) *Public purchaser-private provider contracting for health services: examples from Latin America and the Caribbean*, Washington: Inter-American Development Bank, http://www.iadb.org/sds/doc/slack.pdf (accessed April 2004)

Waters, H., Hatt, L., Axelsson, H. (2002) *Working with the private sector for child health*, Washington: SARA Project and Inter-Agency Working Group on Private Participation and Child Health

Notes

1 USAID RFP M/OP-03-2027, Global Health Private Sector Program, 23.09.03

2 See www.worldbank.org/wbi/healthandpopulation/oj-haiti.pdf

Annex 1

Case study of Georgia State Medical Insurance Company and Jo Ann Medical Centre

The Georgia State Medical Insurance Company is the established social health insurance organisation financing a basic benefit package for the entire population. In 1998, paediatric cardiac care was added to SMIC coverage and a contract was negotiated with the Jo Ann Medical Centre (JAMC). The JAMC had been established as a not-for-profit NGO with foreign technical and financial assistance in recognition of the significant and untreated prevalence of congenital heart abnormalities. It commenced operations in 1996.

1 Socio-economic context

A key factor was the public sector reform context in which a purchaser-provider separation had been implemented. All medical providers were made separate legal entities, first as autonomous organisations as state (Treasury) enterprises, later as corporate entities as limited liability companies or joint stock companies.

Government had an established Programme for the Vulnerable administered by SMIC and based on a number of simple criteria. Using social welfare offices, SMIC regional branches issued a Medical Insurance Policy for the Vulnerable to eligible individuals.

2 The contract

A detailed and quite sophisticated contract was negotiated between the parties. This specified:

- the responsibilities of both parties;
- price per case (fixed by the state for SMIC financed programmes);
- billing and payment terms and procedures;
- annual and quarterly ceilings for the total contract value based on the JAMC database of registered patients from which the expected case-mix for the coming year was derived;
- monitoring responsibilities and the rights of SMIC to carry them out;

- special provisions for the 3-14 year old poor to be financed from the Programme for the Vulnerable.

Under the contract, JAMC invoiced SMIC on a monthly basis. The billing procedures were categorised by two age groups because:

- 0-3 year old children were charged no co-payment for services;
- 3-14 year old patients carried a co-payment of 20-25 per cent of costs.

3 Focus on the poor

3-14 year olds from low income families were exempted from the co-payments and the cost of treatment was covered by the Programme for the Vulnerable. In this way, JAMC had no incentive to refuse treatment to poor people; indeed, it probably had an incentive to prioritise the poor since there was a higher possibility of recovering co-financing from the state purchaser than from consumers directly.

4 Monitoring and evaluation

The billing process defined under the contract provided information allowing SMIC to monitor:

- overall utilisation of services by age groups;
- number and types of conditions (case mix) treated by the JAMC;
- actual cost per case;
- number of eligible 3-14 year olds (whose co-payments were covered by the Programme for the Vulnerable) who received treatment and their share in overall patient load;
- treatment outcomes per case and by age groups.

This information allows SMIC to:

- plan the following year's budget;
- monitor the service utilisation by various age/population groups;
- track the case-mix of JAMC (and in theory to compare this with unmet need data);
- monitor the outcome of the treated cases.

There appears to be no contractual obligation for JAMC to undertake patient satisfaction surveys, and SMIC does not do this either.

5 Outcome

SMIC records indicate that utilisation of services by the poor in the 3-14 year old age group was significant and increased from 55 per cent of total operations in 1999 to 93 per cent in 2000, and 82 per cent in 2001.

Services utilisation by age group and poverty status

Year	Operations performed Total	Operations performed 0-3 years	Operations performed 3-14 years	Operations performed 3-14 years from poor families	Contract value GeL	Average price per case	Case fatality rate
1997	36	N/A	N/A	N/A	N/A	N/A	N/A
1998	99	N/A	N/A	N/A	0.5m	5,050	N/A
1999	119	55	64	35 (55%)	1.3m	10,924	9.0%
2000	113	67	46	43 (93%)	1.1m	9,734	6.0%
2001	137	80	57	47 (82%)	1.1m	8,029	4.8%
2002	225	*	*	*	2.5m	11,110	4.8%

Source: SMIC
N/A = not available
* = In 2002 co-payments for 3-14 year olds were removed and SMIC financed the full costs of treatment for every patient (though the non-poor still pay for diagnostics). It appears that this data is no longer differentiated or reported to SMIC.

It appears that the valuable monitoring of utilisation by the poor has ceased with the withdrawal of co-payments for treatment by the non-poor in 2002.

A consumer satisfaction survey undertaken as part of a case study (see Sources below) indicates a high degree of satisfaction.

6 Key factors for success/failure

Political/socio-economic/legal context:

- successful public sector reforms introducing a clear separation of functions between payer and provider and including the transfer of public sector staff from the state budget to be contracted by providers;
- a system of accreditation and licensing for providers treating public and private providers equally and thus regulating market entry;

- explicit public financing policies to subsidise service provision for the poor, together with an effective national mechanism to deliver this subsidy through providers.

Institutional context:

- the existence of a competent purchaser organisation (in the form of a national health insurance organisation, SMIC) able to contract with providers;
- a national system to identify the poor based on simple criteria and avoiding complex means testing;

Contracting context:

- a (relatively) definable service is being contracted for;
- data was available initially on need and costs of services (from the work of the provider prior to contracting);
- tendering was transparent and based on clear technical criteria (although there was a lack of competition in this case, this still assisted in achieving a clear contracting context);
- a budget envelope was fixed annually in the form of an annual ceiling for the contract amount;
- contracting was based on service outputs (not just inputs) leaving the provider free to manage service provision within a reasonably predictable budget envelope;
- reimbursement was case-based with prices set by the state (a form of diagnostic related groups (DRGs) appears to be used for this) reducing the incentive to admit only uncomplicated cases;
- the record keeping and billing system releases subsidies for the poor and monitors their utilisation of services;
- contracting has built-in monitoring and evaluation.

7 Comments

This appears to be a reasonable balance of incentives for the provider including an incentive to treat poor patients (assuming SMIC payments are actually made as contracted). There may still be some favourable case selection by the provider (within any DRG) to maximise income whilst minimising costs and not necessarily admitting patients by need – certainly in a more competitive situation, this could be more difficult to control.

8 Sources

The above has been prepared by Roger England based on information provided in: 'Private-Public Partnership in Georgia: case study of contracting an NGO to provide non-core specialist services', Gotsadze and Levan, DFID Health Systems Resource Centre, June 2003.

Annex 2

Case study of Cambodia contracting for health services pilot project

The MoH entered into contractual relationships with not-for-profit NGOs to provide health care services in some districts. The pilot project aimed to compare the results of both contracting for services (contracting out) and contracting external management to run public services (contracting in) with services run by public sector district health teams. The pilot functioned from 1998 to 2002.

1 Socio-economic context

Following elections in 1993 and subsequent international recognition of the Cambodian Government, in 1996 the newly created Cambodian MoH developed a Health Coverage Plan specifying the facilities and services to be provided at local and district levels. Public health services were seriously deficient as a result of the continuing challenges of reconstruction following the country's disastrous civil war and its aftermath. Key constraints included a critical lack of health facilities, problems in delivering much-needed outreach, and a large but low-paid, under-skilled and under-managed workforce. A boom in private medical practice since 1993 was staffed mainly by government medical practitioners working after, or instead of their official duties.

Despite considerable subsequent improvements, the Cambodian Demographic and Health Survey in 2000 indicated that Cambodia had the highest levels of infant and child mortality in the region and that those levels were still rising. The maternal mortality rate was 437 per 100,000 live births (and was probably higher); infant mortality was 95 per 1,000 live births. In rural Cambodia, only 39 per cent of children (12-23 months) were fully immunised.

Health coverage plan

The 1996 health coverage plan envisaged the construction or rehabilitation of health centres (HCs) providing services to populations of about 10,000, and referral hospitals (RH) at operational district (OD) level, each covering a population of about 150,000. The plan also defined a minimum package of activities (MPA) to be carried out at HC level. The specified activities consisted of basic preventive and curative services such as immunisation, family planning, antenatal care, provision of micronutrients and other nutritional support, and simple curative care for diarrhoea, acute respiratory tract infection and tuberculosis.

Basic health services project

A basic health services project (BHSP) was designed to support implementation of the Health Coverage Plan. A key objective was to reduce preventable mortality and morbidity, particularly among poor women and children by ensuring the delivery of the MPA. The project was supported by a US$25 million Asian Development Bank (ADB) loan. It had three main elements:

- strengthening physical infrastructure - construction of HCs and RHs, and provision of basic medical equipment, drugs and supplies;
- improving management capacity through training new district health management teams (DHMTs) and developing supervisory systems;
- testing innovative mechanisms to increase the efficiency of health service delivery, with government contracting with private entities to deliver district health services – the Contracting for Health Services Pilot Project (CHSPP).

2 The contract

A MoH Working Group, chaired by the Director General of Health and including line management and specialist representatives, developed detailed terms of reference and guidelines for the CHSPP. The pilot was designed to assess the performance of three approaches:

- Contracting services (contracting out): private contractors have full management control of, and responsibility for, delivery of all district health services in accordance with the health coverage plan and MoH technical protocols, with complete authority over human resources and procurement.
- Management contracts (contracting in): private contractors work within the MoH system providing day-to-day management of the DHMT and district health staff. The initial design envisaged all other inputs (operating costs, salaries, drugs etc.) being provided by the government through normal MoH channels. In practise, a project budget supplement of US$0.25 per capita was introduced (originally intended only for the control/comparison districts (CCs)) to allow contractors to pay some form of staff incentive.
- Control/comparison: DHMTs run district health services as before under customary MOH mechanisms, but with eligibility for a US$0.25 per capita budget supplement dependent on production of acceptable activity plans.

Some of the key characteristics of the different delivery models are shown on page 38.

Key characteristics of the different models in the CHSPP

	CO 2 districts	CI 3 districts	C/C 4 districts
Management responsibilities	Contractors had full management control (replacing DHMT and civil service), and full accountability for service delivery.	Contractors working within MoH system to provide day-to-day management of DHMT and district health staff.	DHMT running district health services as before.
Outputs	Contract specifies required outputs for service coverage and quality, with goals and minimum levels of achievement (identical to CI outputs). CO and CI to comply with health coverage Plan, MoH technical protocols and reporting requirements.	Contract specifies required outputs for service coverage and quality, with goals and minimum levels of achievement (identical to CO outputs). CO and CI to comply with health coverage plan, MoH technical protocols and reporting requirements.	
Human resources	Contractors directly employ health care staff and have complete freedom over structure, hiring, firing, wage rates.	Staff remain MoH civil servants. Contractors could not hire or fire but could request staff transfer.	
Finance	All recurrent costs covered by contract funds paid by government through project co-ordination unit (PCU).	Contract payments cover only specific contractor costs such as training. Operating costs (salaries/ supplies etc.) are paid through provincial health departments (PHDs) and according to government rules. A budget supplement of US$0.25 per capita pa (US$37,000 per district typically) was paid out of project funds direct from PCU, and was at the disposal of the contractor.*	Operating costs paid through normal government channels and according to government rules. CCs eligible for budget supplement of US$0.25 per capita pa (typically US$37,000 per district) paid out of project funds, based on acceptable action plans.
Supplies	Contractor procured drugs and consumables.	Drugs and supplies provided through normal MoH channels.	Drugs and supplies provided through normal MoH channels.

* Note: the budget supplement was originally planned only for control districts (CC) but was extended to contracting-in districts (CI) after baseline surveys showed the actual receipt of operating funds at district level was negligible: only US$0.13 per capita per year.

Selection and survey of participating districts

After excluding districts with a number of biasing factors, the design envisaged each of the CO, CI and Control approaches being tested in four districts, whose populations ranged from 100,000 to 180,000. Household and health facility surveys were undertaken in the twelve selected districts to establish baselines against which subsequent changes could be measured, and were repeated using the same methodology by an evaluation team. The use of an asset consumption index as part of the baseline survey enabled relative poverty to be identified in all districts. The 12 districts were randomly assigned between the three models.

Selection of contractors

Following invitations and notices in local and international media:

- 51 expressions of interest were received and all were invited to bid;
- 16 bids were submitted from 10 different organisations - four international NGOs and six private consulting firms;
- no expressions of interest or bids were received from local organisations, reflecting lack of local capacity.

Contracts for CO and CI were competitively awarded using a two-envelope system, with technical and price proposals being submitted separately:

- eight of the 16 bids were technically non-compliant, leaving no bids for two districts;
- two further bids for one district were eliminated as overpriced;
- contracts for five districts were awarded to four different organisations, all of which were international NGOs (although the design had had for-profit private contractors in mind).

As a consequence, the pilot went ahead with only two CO districts and three CI districts rather than four each as originally intended. The number of participating CCs was left at four, giving a total of nine districts in all.

Despite considerable diversity among individual districts, the three groups were fairly well matched, each containing at least one easily accessible and higher socio-economic status district, and at least one remote and lower socio-economic status district. Overall, socio-economic status was similar between CI and CCs with a higher proportion of the very poor in CO districts.

Planned and actual budget costs

Before the start of the project, the MoH total budget envisaged healthcare allocations of about US$2.0 per capita per annum. The average bid price for CO contractors was US$5.04 per capita pa, and for CI contractors US$1.54 per capita pa (excluding MoH-assumed costs, suggesting an estimated total cost of approximately US$2.50 per capita pa, about half the CO bid price).

Despite operating the pilot in three fewer districts, the actual budget for contracts awarded was more than double that planned. Contributory factors included:

- with no local contractors, expatriate staff costs were incurred;
- inputs (e.g. staff, transport, IT) had generally been underestimated at planning stage;
- the US$0.25 per capita pa budget supplement intended only for CCs had to be extended to CI contractors;
- original estimates for the CC budget supplements were based on population figures shown to be too low by a 1998 census.

3 Focus on the poor

The CHSPP was not specifically a pro-poor project and incorporated no mechanisms for direct subsidy targeted at the poor. However, the design demonstrates a strong concern for the poor inasmuch as the pilot evaluation indicators and the household and health facility surveys were designed to identify changes in various aspects of the health and service utilisation of the poor, relative to the rest of the populations of the selected districts, over the period of the project. Socio-economic status (SES) was measured by the development of an index based on ownership of certain household assets. Households falling within the lowest quartile were regarded as ‘very poor’. In the nine districts within which the pilot was conducted, the percentage of households falling within the lowest SES quartile varied from 18.9 per cent to 41.9 per cent.

Other factors such as the mean number of years of maternal education, geographical accessibility and ethnic and other forms of diversity (which affect the poor disproportionately) were also identified.

4 Monitoring and evaluation

An MoH Monitoring Group monitored progress resulting from household and facility surveys. An external independent evaluation of the whole project was undertaken in 2001.

At the project design stage, and consistent with the overall objective for the BHSP, specific evaluation indicators were developed focusing on preventive maternal-child health care coverage, and on service quality indicators for HCs and RHs:

Specific services evaluation indicators

- child immunisation: percentage of children aged 12-23 months fully immunised;
- tetanus toxoid: percentage of women with a delivery in the past year who had received two or more doses (at least one of which was during the pregnancy), or five lifetime doses;
- antenatal care: percentage of women with a delivery in the past year who received > two antenatal checks during which blood pressure was measured at least once;
- trained delivery attendant: percentage of women with a delivery in the past year whose birth attendant was a qualified nurse, midwife, doctor or medical assistant;
- delivery in health facility: percentage of women with a delivery in the past year who delivered in a health facility, public or private;
- knowledge of birth-spacing (1): percentage of women who gave birth in the past 24 months who knew four or more modern methods and where to obtain them *(all women);*
- knowledge of birth-spacing (2): percentage of women who gave birth in the past 24 months who knew four or more modern methods and where to obtain them (women in households falling within the lowest 50 per cent socio-economic strata);
- use of birth spacing: percentage of women with a living child age 6-23 months currently using a modern method of birth spacing;
- Vitamin A capsule receipt (1): percentage of children aged 6-59 months who had received high-dose Vitamin A twice in the past 12 months (*all children*);
- Vitamin A capsule receipt (2): percentage of children aged 6-59 months who had received high-dose Vitamin A twice in the past 12 months (*children in households falling within the lowest 50 per cent socio-economic strata*);
- utilisation of contractor facilities *by the poorest 50 per cent of households*: of all family members ill in the prior 30 days, percentage who obtained treatment from a district RH, HC, or other service site provided by the government/contractor.

Quality of care indicators

Quality of care at HC is measured through direct observation of the following elements in a structured questionnaire:

- immunisation: equipment, supplies and record-keeping;
- antenatal care: equipment, supplies and record-keeping;
- birth-spacing: equipment, supplies and record-keeping;
- deliveries: equipment, supplies and record-keeping;
- consultation: equipment, supplies and record-keeping;
- presence of functioning health centre (10 points for each HC);
- presence of a documented referral system (up to 10 points for each HC).

Quality of care at RHs is measured through direct observation of the following elements in a structured questionnaire:

- presence of assigned staff;
- drugs, equipment and supplies;
- hygiene/infection control;
- utilisation for maternity;
- utilisation by children under the age of five years;
- utilisation for tuberculosis;
- charting – adult, paediatric, TB and maternity wards;
- correct medical and nursing treatment of paediatric diarrhoea;
- correct medical and nursing treatment of paediatric respiratory infections;
- correct medical and nursing care during labour and delivery;
- management systems for quality control: mortality reviews, medical rounds, nursing shift reports, etc.;
- referral system.

A baseline household survey and facility surveys were conducted before the start of the project in order to establish a baseline against which subsequent changes could be measured. Comparisons were made of the norms in the contracting districts with the national rural norms established by the National Health Surveys. At the outset of the project, the contracting districts were, on the whole, lower performing than the national rural norm. Health facility surveys were conducted in all nine participating districts. No hospital exceeded 34 per cent of the maximum possible score.

Repeat household and facility surveys were undertaken using the same methodology as had been used in the baseline surveys. This enabled changes in the key indicators within and between CO, CI and CCs to be measured. All RHs and HCs were surveyed.

Changes in private health care expenditures were computed from the baseline and evaluation surveys. In addition, regular investigations were conducted in all districts of expenditures from all sources, principally the regular government budget and the Project loan funds.

5 Outcome

Service indicators

For the 11 health service key indicators, the mean increases achieved by the project over a two and a half-year period were 320.4 per cent, 179.7 per cent, and 99.6 per cent for the CO, CI and CCs respectively. In addition to much higher increases in health care coverage, the two CO districts and the one CI district which adopted a “user fee/no private practice” policy achieved substantial reductions in out-of-pocket health care expenditure by the poor. The reduction in out-of-pocket costs was greater among the poor than among the overall population. All CO and CI districts showed large increases in the utilisation of district public health facilities for curative care, as did two of the CCs. The other two CCs showed small decreases in utilisation.

Costs

In total (government, donor and out-of-pocket expenditures), the average annual recurrent health expenditures per capita were US$22.67 for the CO districts, US$26.38 for the CI districts, and US$26.85 for the CCs. The composition of this spending differed (as shown below), with substantially higher spend by donor and government in the contracted out districts, offset by lower out of pocket spending in these districts.

Of the nine project districts, six showed reductions in out-of-pocket expenditures in the poorest 50 per cent of households. The reductions in the two CO districts were particularly marked at 77 per cent and 61 per cent. Only one CI district showed a reduction. This occurred in the district which introduced user fees and used them to pay incentives to staff, allied to a ban on private practice. In the other two CI districts where

it proved difficult to pay staff a living wage (despite the availability of budget supplements), continued extensive private practice and unofficial charging led to increases in out-of-pocket expenditures of 36 per cent. In three of the four CCs, there were significant reductions of 33 per cent, 12 per cent and 11 per cent, but a large increase of 132 per cent in the remaining district led to a small overall average increase.

Cost-effectiveness

Measured as the average percentage change in all services indicators divided by the average total cost per capita over the two and a half year duration of the project, higher cost-effectiveness ratios were achieved by the CO and CI districts (in that order) than by the CCs. In the CO districts this represented a 30 per cent increase in health coverage for every dollar spent per capita throughout the project.

These and other findings of the independent 2001 evaluation are summarised below.

Selected key evaluation findings - 2001

	CO 2 districts	CI 3 districts	CC 4 districts
Services	Mean increase in 11 service indicators over 2.5 years: 320%	Mean increase in 11 service indicators over 2.5 years: 180%	Mean increase in 11 service indicators over 2.5 years: 100%
Costs	Average govt/donor/NGO recurrent expenditure: US$4.50 per capita, pa plus US$18.17 private out of pocket, totalling US$22.67 (15% less than the CCs).	Average govt/donor/NGO recurrent expenditure: US$2.82 per capita, pa plus US$23.56 private out of pocket, totalling US$26.38.	Average govt/donor/NGO recurrent expenditure: US$1.86 per capita, pa plus US$24.99 private out of pocket, totalling US$26.85.
Cost effectiveness	The most cost-effective of the three models, delivering a 30% increase in health service coverage for every dollar per capita spent over 2.5 years.	Less cost-effective than CO but more cost-effective than controls, delivering a 26% increase in health service coverage for every dollar per capita spent over 2.5 years.	The least cost-effective of the three models, delivering a 21% increase in health service coverage for every dollar per capita spent over 2.5 years.

	CO 2 districts	CI 3 districts	CC 4 districts
Cost effectiveness (continued)		2 of 3 CI districts received disproportionately less of their approved budget from PHDs than CCs.	Considerable TA required to develop plans for budget supplement, and actual expenditure overall 36.1% lower than funds available. Main use of budget supplement was for outreach immunisation. Accountability generally poor.
User fees	Both CO contractors had official “no user fees” policies.	Contractor-managed user fee scheme in one CI (Pearaing). No official user fees in two CIs, (though payments reported by patients in Cheung Prey and by a minority at the referral hospital in Kirivong).	Two districts had official MoH user fee schemes, two districts had unofficial pilot schemes.
Human resources	Contractors proved able to ensure the necessary number and type of staff. Most MoH district staff took leave of absence from civil service and were hired by contractor. Those unwilling or unacceptable to contractor were transferred. More highly trained staff were brought in from elsewhere. The Ang Roka contractor posted a Medical Assistant in every health centre. One contractor forbade private practice, the other simply required full working day attendance. Contractors maintained staff accountability and enforced regulations.	Contractors proved unable to exert direct management authority. To motivate staff or enforce staff regulations, all three CI contractors had to pay staff (though civil servants) incentives out of a project budget supplement originally intended for operating costs: i) Cheung Prey: flat supplement not tied to performance, (plus per diems for outreach); total pay still below living wage. Staff worked only mornings and could pursue private practice. ii) Kirivong: flat supplement linked to specific behaviour. Staff worked only mornings and could pursue private practice.	Baseline staff shortages not resolved. Civil service staff salaries minimal and no relocation costs available.

	CO 2 districts	CI 3 districts	CC 4 districts
Human resources (continued)		iii) Pearaing: user fee revenue plus budget supplement funded performance-based living wage for staff. No private practice. CI districts effected significant improvement in staff accountability and regulation.	
Supplies	Procurement of all medical equipment internationally under ADB guidelines led to delays and operational constraints for all districts. Drug procurement procedures proved difficult for small dollar values.	Procurement of all medical equipment internationally under ADB guidelines led to delays and operational constraints for all districts. CIs forced to supplement inadequate MoH drug supplies. Drug procurement procedures proved difficult for small dollar values.	Procurement of all medical equipment internationally under ADB guidelines led to delays/operational constraints for all districts. CCs suffered longest delays.

6 Key factors for success/failure

Political/socio-economic/legal context:

- Government accepted new approaches – the starting point was so low that something significantly different was acceptable;
- there was strong support from ADB (and WHO with support from DFID) to try a contracting mechanism in a controlled experiment.

Institutional context:

- the institutional context was weak – contracting did not fit comfortably into a hierarchical management structure, which was itself still at a relatively early stage of re-development;
- contracting still requires institutional capacity – i.e. an effective, knowledgeable purchaser organisation – and the MoH was stretched to perform this role; there was substantial reliance on international TA to assist;

- effective working relationships between contractors and the central MoH finally emerged but there were continuing tensions between contractors and the provincial and district management levels – not surprisingly, these impacted most severely on the CI contractors who occupied a difficult position in relation to both DHMTs and PHDs;

- contracting bypassed the PHDs resulting in some lack of support and, in the CI districts, some confusion and ambiguity in roles;

- weak national NGO capacity at the time resulted in contracts being awarded to (arguably more expensive) international NGOs albeit with some cost incentives to recruit local staff;

- the contracting NGOs, which normally operate through grants, had some difficulty in adjusting to the disciplines of a contractual relationship with their clients.

Contracting context:

- the contracting arrangements benefited from extensive consultation with stakeholders prior to implementation;

- contract design provided little detail on MoH or contractor roles and did not include a number of disease-specific/vertical programme activities or budgets;

- contracts were fixed-price (based on population) which resulted in containing transaction costs but provided no incentive to fill prolonged staff vacancies – the ADB evaluation recommended that future contracts should be “cost-plus-fee” based for personnel and fixed for other inputs;

- contracts were based on providing a defined minimum package of activities from HCs and RHs but it is not clear from documentation how providers dealt with patients needing other services (this is invariably an inherent failing in the essential package approach);

- the service evaluation indicators provided a good basis for output evaluation and a clear target for providers in delivering their services;

- several of the indicators are focused on the extent to which services are consumed by the poor – monitoring was through household surveys not provider records;

- the simple services quality indicators provided easily assessed measures for quarterly monitoring field visits – and these visits also provided opportunities for purchaser-provider interaction and mutual problem solving;

- contracting resulted in better financial control than that in un-contracted districts (CCs) where audit irregularities continued;

- payments were (to some extent) contingent on performance and the purchaser (MoH Monitoring Group) could and did withhold progress payments (in one case for failing to meet contract provisions on replacement of key personnel);

- procurement of equipment, supplies and drugs was hampered by the ADB procurement rules (which are more appropriate perhaps to costly items) and this had an adverse effect on achieving targets.

7 Comments

Contract payment mechanisms

It is not clear why a 'cost-plus-fee' payment will improve cost effectiveness. It could generate over-staffing unless staffing is defined in the contract, in which case contractors can simply be required to fill posts and this can be monitored – as appears to have happened. Either way would suggest that the purchaser is getting too involved in management of the contractor's operations and it may be better to base contracting only on service outputs rather than inputs.

Contractor staff pay flexibility

A factor in the relative success of the pilot was the flexibility in staff pay and conditions achievable under the contracting arrangements. The CO contractors paid the staff they had recruited from the civil service up to ten times more than their government salaries. In return, one CO contractor required that staff should not be involved at all in private practice; the other simply required staff to be present in the public facilities for a full working day.

The CI contractors were allowed to supplement civil service salaries from a budget supplement, without which it would have been impossible to motivate staff to work. Even with these additional payments, in two CI districts the salaries paid still fell short of a living wage and staff continued to pursue private practice. In the third district, however, a no private practice agreement was enforced following the institution of user fees, which were used to provide staff with a living wage through the payment of performance bonuses (in addition to the budget supplement payments).

CCs were eligible for a budget supplement but only upon submission of acceptable activity plans. The difficulties experienced in meeting this requirement meant that, in the event, actual expenditure was considerably lower than the amounts made available through the pilot and performance suffered accordingly, principally on promoting outreach activities (which attracted bonus payments for staff).

Non-pay management flexibility

Because they employed them directly, the CO contractors had full management authority to use their staff as they thought fit. One innovative approach, for example, was to post higher-trained consultation staff (Medical Assistants) to each HC in a district to increase the quantity and the quality of primary curative care.

CI contractors had no independent authority to hire, fire, transfer or sanction staff without higher approval. They could and did, however, use supplemental budgets to provide some forms of staff incentive.

CCs were bound by normal civil service rules. Very poor government salaries (US$10/month against an estimated minimum living wage of US$80-100) made it difficult for the MoH to persuade staff to accept transfers. Subject to the approval of action plans, however, they received the budget supplement, which they then used for incentive payments to staff to achieve service improvements e.g. for immunisation outreach. Use of the supplement was subject to financial audit and spot checking of the activities involved.

Contractors used innovative approaches to provide HC services by setting up temporary facilities where construction of permanent HCs had not been completed.

Miscellaneous problems

Both contractors and the CCs found their management control undermined to some degree by the existence of vertical national programmes with direct donor funding. Run out of MOH, these allowed District Management Teams, acting with delegated authority, to issue instructions to HC staff.

Scaling up potential

The ADB Evaluation Report recommends an expansion of contracting-out, which it finds to be high performing, cost-effective, and capable of replication. It specifically recommends its continued use because of its potential to increase wider access to services by the poor and to reduce their out-of-pocket expenditure on health care. The recommended next stage is extension of the project to a province or near province-wide area with a large, poor, under-served population where economies of scale and easy monitoring could be looked for: this is planned.

The ADB Evaluation Report recommends the inclusion in future contracts of provisions reflecting the positive lessons learned in the pilot including the setting of user fees, bans on private practice, the need for staff incentives and the interrelationships between these. It recognises the difficulties of choosing suitable payment systems, ensuring clarity in terms of the relationships between the MoH and its contractors and in the arrangements for the procurement and supply of medical equipment.

Though acknowledging too the problems arising for the MoH from the lack of local contracting capacity, it does not address directly the critical question of affordability and sustainability. It recommends that future bid documents should specify a ceiling of US$4.00 per capita for recurrent costs but this is still twice the expenditure from public funds at the start of the pilot.

8 Sources

This summary case study has been prepared by Karen Caines and Roger England based on information provided in:

'Contracting for the delivery of primary health care in Cambodia: design and initial experience of a large pilot test', Benjamin Loevinsohn, December 2000

'Achieving the twin objectives of efficiency and equity: contracting health services in Cambodia', Asian Development Bank Policy Briefing No. 6, March 2002

Annex 3

Case study on covering the poor in Surinam

Surinam provides an example of a complex mixed public-private system with partial purchaser-provider separation where contracting is not used but should be.

1 Socio-economic context

Surinam has a population of about 400,000 of which 85 per cent live on the relatively urban coastal plains and the remaining 15 per cent in scattered rural villages in the interior. Estimates of poverty vary from 28 per cent to 54 per cent of the total population. It is a former Dutch colony, and Dutch support comprises technical input (as negotiated with the Ministry of Planning) and tertiary services in Holland provided on an agreed case by case basis. Public and private expenditure is fairly evenly split at around 45 per cent, with the remaining 10 per cent of expenditure coming from the Dutch tertiary care support.

The Government established insurance coverage for civil servants (including retirees), administered by a quasi-independent organisation, the SZF. Civil servants and their families represent about 28 per cent of the total population. Contributions are shared and set at 11 per cent of the salary bill, with employee contributions deducted at source by the Ministry of Finance. The SZF benefit package is for curative services only, and assumes that the MoH continues to fund the full cost of preventive health services and public health. The package is relatively comprehensive, but limited in practice by what care is available in country, and results from negotiations between the Ministry of Internal Affairs and the Civil Servants Labour Union. With an SZF card, civil servants are allowed to use private or public providers. They must register with a GP who is meant to act as the clinical gatekeeper to the rest of the system. Recently, the SZF has begun to offer the same benefit package to the public, at a fixed premium cost (not percentage of salary). Private individuals and families now represent about 10 per cent of the SZF membership.

The three public hospitals, including the teaching hospital, are managed autonomously and allowed to levy charges and retain them. In the heavily populated coastal areas, primary curative care is provided by independent GPs working mostly in solo practices, and by GPs working for the public primary care provider, the RGD. The RGD provides preventive and public health services mostly focused on maternal and child care, free of charge to the public, and delivered by the nursing profession.

For the people of the interior regions, primary care is provided by an NGO, the MZPHC, which also manages the emergency referral to hospital services provided by a private

mission hospital in the capital city, Paramaribo. MZPHC is also supported in infrastructure development by the Ministry of Regional Development.

2 Focus on the poor

Government has an established registration programme for the poor, administered by the Ministry of Social Affairs (SoZA) based on a number of simple criteria. Using social welfare offices, SoZA issues a health card, which entitles the bearer to free care at hospitals and from the GPs at government primary care facilities (RGD). Non-GP related services are provided free of charge. Small co-payments are permitted at hospital level as a deterrent for inappropriate care.

3 The contract/funding mechanisms

No contracts exist in the system, from any of the public or private payers to any of the providers. The MoH continues to fund public providers predominantly on an historical basis to cover salaries and fixed overhead costs. This includes a budgetary allocation to MZPHC, which is in practice negotiated and managed (paid) directly by the Ministry of Finance. About 90 per cent of MZPHC's budget is funded by government.

For their membership, SZF pays GPs on a capitation basis, whether private or public whereas specialists are paid on fee-for-service basis, and hospitals on a per diem basis regardless of case complexity. Diagnostics and pharmaceuticals are reimbursed on a fee for service basis. Bills are submitted monthly to SZF by the providers. Private sector and private insurance, for the most part, also follow these provider payment mechanisms.

SoZA is billed monthly by public providers for services to the poor who have a card. Payment vouchers are authorised and then paid directly by Ministry of Finance for all services - except those for primary care and specialist outpatient care which are assumed to be provided free of charge by the RGD and MZPHC under their MoH budgetary allocations. Also, SoZA authorises payments to the Mission Hospital for all inpatient care and related costs for the people of the interior regions who in lieu of a card, are deemed indigent by virtue of being referred by MZPHC.

4 Monitoring and evaluation

Without some sort of contracting process, very little M&E is done in terms of quality, outputs, outcome or value for money. The checks and balances are mostly focused on monitoring inputs i.e. ensuring financial probity and compliance with rules and regulations. The MoH has not been engaged in the funding or payment mechanisms outlined above and does not see its role as monitoring overall system performance on behalf of the key ministries and other stakeholders (e.g. employers) who are acting as purchasers for distinct population groups. The situation has been described in recently

completed studies on the financing system as one where there are 'no active purchasers but rather many passive payers'.

5 Outcome

The fragmented payment system and lack of contracting has resulted in a high overall rate of hospital admissions coupled with long lengths of stay, a high rate of services from specialists, and a heavy focus on curative primary care with only an estimated 4 to 5 per cent of total expenditure spent on public health and preventive care.

Total expenditure now represents 9.4 per cent of GDP (about US$180/capita) which is high for the Caribbean Region where spend varies from 4 per cent to 8 per cent of GDP. Also, SoZA is reporting an increasing number of individuals applying for health cards to cover the increasing costs of health care. There has been no significant health gain in the last ten years in terms of life expectancy, infant and maternal mortality. Efforts are underway now to introduce contracting arrangements in order to address the rising levels of health expenditure and improve quality and access issues for the poor.

6 Key factors for success/failure

Political/socio-economic/legal context:

- strong attraction to insurance or pre-paid care and strong tradition of employer provided health care or coverage;
- coalition and consensus-style government lends to covering groups based on characteristics rather than population approach;
- high levels of poverty.

Institutional context:

Weak public administration system with attendant problems of:

- inadequate budgeting;
- slow and inadequate payments;
- weak record keeping or information systems;
- lack of proper accountability mechanisms;
- lack of a performance management culture.

The fragmented financing and provision of services creates beneficiary pools too small to manage risk efficiently and with no effective regulation of the system including referral.

Contracting context:

Contracting was not considered a priority at the time of establishing the other payment systems for health care. The issues were more about increasing revenue for health care and expanding access and coverage.

7 Source

Prepared by Jennifer Sancho, IHSD, from first hand experience.