



## PRIMER FOR POLICYMAKERS

### Contracting-out Reproductive Health and Family Planning Services: Contracting Management and Operations

Increasingly, governments in developing countries seek to offer more accessible, higher quality and cost-effective health services to their target populations by contracting with private providers—both not-for-profit and for-profit—to deliver care. Reproductive health and family planning (RH/FP) services<sup>1</sup> have been contracted out either individually or bundled with other essential health services. Governments have contracted virtually all areas of RH/FP services (see Box 1).

While contracting-out for RH/FP services is widely documented, few reports have presented cross-country experiences or been targeted to country-level decision makers and contract operation managers, who are of key importance to the success of contracting-out initiatives.

This primer introduces key aspects of contracting and summarizes lessons from countries' experiences in contracting-out. In doing so, it is intended to serve the practical needs of contracting practitioners in developing countries that are considering contracting as a way to deliver RH/FP services. Intended users include country-level decision makers, contract operation managers, and mission officers and advisers from donor agencies.

<sup>1</sup>The focus of this primer is on contracting-out of RH/FP services. Although it is theoretically possible to contract out the production and distribution of products (e.g., condoms, contraceptive drugs), there are no reports on such of which the authors are aware.

#### Box 1. Contracting-out RH/FP services

Many countries have contracted out for RH/FP services. An illustrative list includes:

- *Family planning* – Bangladesh, Brazil, Cambodia, Colombia, Costa Rica, Guatemala, India, Peru, Korea
- *Maternal health* – Mali, Senegal, Bangladesh, Indonesia
- *Abortion-related care* – Bangladesh
- *Emergency obstetric care* – Colombia

Source: Rosen (2000)

Following sections describe the concept of contracting-out, discuss its rationale and process, and summarize three cases of contracting-out programs. The primer closes with general conclusions from these experiences and recommendations on how to ensure the effectiveness of design and implementation of future contracting-out initiatives. Readers should, however, note two caveats to this guidance: First, because the contracting-out context (e.g., legal framework, level of private sector development, nature of services to be contracted) varies across countries and initiatives, contracting arrangements should be tailored to fit specific needs. Second, in covering many topics, the primer may contain insufficient detail to meet specific needs of individual contracting practitioners. Related topics of interest might include the costing of the



RH/FP services to be contracted out, measuring provider performance in contracting for RH/FP services, monitoring and evaluating contracting for services, and payment mechanisms in contracting for services. Additional readings therefore are provided in the Bibliography.

## I. WHAT IS CONTRACTING-OUT?

Contracting-out is one of the contractual arrangements by which a government enters into partnership with a private provider<sup>2</sup> for the delivery of RH/FP services. This section presents the generic definition of a contract, defines outsourcing and contracting-out, and provides a typology of contracting-out.

### Definitions

A contract is basically an agreement between two or more parties that creates an obligation to do, or not do, something. If it is made formal, the agreement creates a legal relationship of rights and duties. If the agreement is broken, the law provides certain remedies.

Several contractual arrangements are relevant to public/private partnerships in the delivery of RH/FP services (see Box 2). One of them is outsourcing, in which the government purchases services from the private sector, rather than providing these services in-house using its own employees. Outsourcing has two forms: contracting-out and contracting-in.

Contracting-out, the most common contractual arrangement in the health sector and the focus of this primer, is defined as a contractual arrangement by which the government (purchaser) compensates a private provider (contractor) to deliver a defined set of health services to a defined target population. This contrasts with contracting-in, by which the government contracts with private entities to provide services (e.g., administrative and logistics

<sup>2</sup> Contracting can be done with any independent entity, for example, public providers with autonomy as well as private providers. Because this primer considers contracting-out as a mechanism for public/private partnership, the concept of contracting-out is limited here to the relationship between governments and the private sector.

## Box 2. Five types of contractual relationships

*Contracting-out:* A contractual agreement by which the government pays a contractor to provide goods and/or services to the government or to a designated third party(ies) on behalf of the government. Provision/production takes place *outside* public facilities.

*Contracting-in:* A contractual agreement by which the government pays a contractor to provide goods and/or services to the government or to a designated third party(ies). Provision/production takes place *inside* public facilities.

*Grant:* A contractual arrangement by which the government awards financial assistance to a private entity (usually a nongovernmental organization). The grantee is required to account for spending the money in the manner specified by the grantor.

*Franchising:* A contractual arrangement by which the government (franchisor) confers the right or privilege to a private provider (franchisee) to provide specified health services to a particular population. It differs from contracting-out in that the government here is not the purchaser and is not responsible for paying for the services provided.

*Leasing:* A contractual arrangement by which the government secures the use, but not ownership, of facilities or equipment by a private entity in exchange for a payment or commitment to provide certain services.

services) in public facilities to support public provision of health care.

### Typology

Contracting-out (like other contractual arrangements) can be classified into various forms depending on the formality of the contract, competition in contractor selection, existence or absence of a subcontractor, and basis of reimbursement (payment).

In regard to contract formality, a contract can be a *classical contract* or a *relational contract*. The former is legally binding, law enforceable, and includes quantifiable performance targets and specified terms. The latter is informal, not law enforceable, and is used when contractor performance is difficult to quantify and costly to monitor. A relational contract is usually

supported and sustained by trust, mutual benefits, and the value of future relationship. Between classical and relational is a range of contract types that combine elements of the two.

Depending on how the contractor is selected, a contract can be classified as *competitive* or *sole source*. In the former, the contractor is selected using competitive bidding (tendering) and predetermined technical and cost criteria. In the latter, contractor selection is done without competitive bidding and is based on the contractor's capacity, as perceived by the purchaser, to deliver the specified services.

Depending on the existence or absence of subcontractors, a contract can be classified as a *single-tier contract* or a *multi-tier contract*. The former refers to a contractual arrangement between the purchaser and a single contractor. The latter is when the contractor also serves as a purchaser, entering into a subcontract with another contractor.

According to the basis of reimbursement, a contract can be:

- *Cost-based*, by which the contractor is reimbursed based on costs incurred;
- *Output-based*, by which the contractor is reimbursed based on the quantity of services provided;
- *Outcome-based*, by which the contractor is reimbursed based on the improvement in outcome (for our purposes, health outcome);
- *Performance-based*, by which the contractor is reimbursed based on the contractor's performance, measured by the achievement of predetermined objectives and targets.

## 2. WHY CONTRACT OUT?

The drive toward contracting-out of RH/FP and other essential health services has been largely influenced by the assumption that government provision of services is inefficient (World Bank 1993) and the fact that public providers do not reach some under-served regions.

The increasing popularity of contracting-out in the health sector is based on the premise that the efficiency, quality, and cost-effectiveness of health service delivery can be improved through contracts that set clear expectations for providers and tie payments to achievement of the predefined objectives. It has been found that the public sector in many developing countries does not define the performance expected of public providers in return for their funding, resulting in insufficient responsiveness and financial accountability. Developing countries and the international development community have struggled to determine how to deliver and target public services in ways that improve health system performance by promoting accountability for health service delivery. One policy option is to shift the government's role from both financing and provision of care to solely financing, and entering into contract/partnership with private providers for the delivery of priority health services.

The second rationale for contracting-out is lack of access to essential services due to unavailability or shortage of public providers. Rather than build public sector providers in under-served areas, which would be costly, engaging the private sector is an effective and efficient means to ensure equitable access to services.

Contracting-out can be used to achieve RH/FP service delivery objectives (see Box 3), through the following mechanisms:

- Partnerships with the private sector
  - Available private sector resources (e.g., human resources and capital assets) can be mobilized to fill the resource gap in the public sector, avoiding government capital investment (which may be substantial at start-up) and allowing government funds to cover recurrent spending. Roles can be clearly divided with the government focusing on financing and supervision and contractors focusing on provision.
- Incentives – Contracting-out links payment with provider performance. This linkage

### Box 3. Common RH/FP service delivery objectives

*Access:* availability, utilization, and coverage of RH/FP services

*Quality:* ensuring necessary capacity of the providers, adherence to clinical protocols for patient care, and improved health outcomes

*Equity:* fairness in access to and financing of RH/FP services

*Efficiency:* the attainment of the above objectives at the least cost

provides strong incentives for the providers to meet the predetermined performance targets.

- Competition – Through competitive bidding, contracting-out promotes competition among providers, thereby creating strong downward pressure on costs and positive incentives to improve performance. Contracts tend to yield the greatest efficiency of production when the contracting process rewards the highest quality bidder at the lowest cost.

### 3. WHAT IS THE PROCESS OF CONTRACTING-OUT?

Various guidelines and handbooks describe the steps of the contracting-out process differently (see Bibliography). Further, documentation of the contract may vary by country and by contract, depending on the nature of the services being contracted out and the legal environment. This primer divides the contracting process into five steps. While the steps are generally sequential, there often is overlap between them; they may be modified according to the needs of an individual contract or the context of a particular country.

#### Step 1: Deciding to contract out

First, the government must decide if it will contract out for RH/FP services. To do this, policymakers need to assess the political and technical feasibility of contracting-out, and justify why contracting-out is the preferred approach.

- Political feasibility – assessment of whether the current legal framework and political situation

support or oppose contracting-out (e.g., does existing legislation prevent contracting-out?; do political concerns about redundancy of public providers outweigh benefits of contracting-out?);

- Technical feasibility – assessment of the availability of qualified private providers (the market situation and possibility of competition), the contract management capacity of both government and private providers, and the *contractibility* (see Box 4) of the designated RH/FP services;
- Comparison between contracting-out and in-house provision – assessment of whether contracting-out is better than public provision for achieving the objectives of RH/FP service delivery.

### Box 4. Concept of contractibility

Contractibility has three dimensions: measurability, monitorability, and contestability.

- *Measurability* refers to whether the quantity and quality of services being considered for contracting-out can be easily specified.
- *Monitorability* refers to whether the quantity and quality of services can be observed at a low cost.
- *Contestability* refers to the likelihood that new providers can enter into the market to compete with existing providers for the provision of the contracted services.

Services with a higher level of contractibility are more suitable for contracting-out and more likely to achieve desired results.

#### Step 2: Preparing the terms of a contract

Both technical and managerial preparations must be made for contracting-out; this includes preparing draft documents on the following topics:

- Scope of services – This specifies the type/s of services (what) to be carried out under the contract, objective of each service (why), volume of services (how many), geographic areas (where), and target populations (whom).
- Performance standards – The performance

of the specified RH/FP service delivery needs to be defined in operational terms, including how the performance is measured, and what performance targets will be expected from contracted providers.

- **Payment methods** – In deciding how much the contracted providers are paid, it is essential to link their performance with payment. A document should be prepared specifying the methods of payment, including the basis of payment (e.g., per capita, per unit of service provided), payment schedule, upfront pay, reward for good performance, and penalty for poor and nonperformance. It is essential for the government purchaser to estimate the costs of providing the defined services and incentives for attainment of specified performance targets in order to decide how much the providers should be paid.
- **Capacity building** – It is often necessary to strengthen the contract management capacity of both government and private providers, including the formation of a contract management team/unit, acquisition of needed expertise (contract management, performance evaluation) through training and staffing, and workshops for private providers to strengthen their capacity for bidding on and managing contracts.

### Step 3: Selecting a provider (contractor)

The objective of this step is to select a qualified provider (or multiple providers) that possesses the capacity and commitment to deliver the defined RH/FP services efficiently. The activities include:

- **Deciding the process of provider selection process** – competitive bidding or sole-source. This decision will be based on the market analysis of the private providers, including their quantity, distribution, and qualifications.
- **Request for proposal (RFP)** – This includes RFP preparation (see Box 5) and dissemination to all potential and qualified bidders.
- **Proposal evaluation** – This should be done by a proposal evaluation committee. The process

### Box 5. General format of a request for proposal (RFP)

*Introduction:* background and the objectives of the RFP

*Scope of services:* objectives of service delivery, what, how many, where, and to whom

*Payment methods:* how the contracted providers will be reimbursed

*Qualification:* characteristics of providers qualified for submitting a proposal

*Proposal format:* specify the contents that should be included in a proposal

*Others:* proposal selection criteria, definition of terms, time schedule and contact person, etc.

includes checking the completeness of each proposal and the qualifications of each bidder, scoring the proposals, and generating a short list of contractor candidates ranked according to the predetermined evaluation criteria, which may include technical and management capability, soundness of technical approaches for delivering services, and costs.

- **Selecting the provider from the short list** – After further questions, clarifications, and comparison, the selection committee chooses the provider in a transparent process (e.g., voting).
- **Contract negotiation** – Final terms of the contract must be agreed upon by the purchaser and winning bidder. This takes place immediately after the winner(s) of the award is informed. Negotiations are usually limited to a small number of specific technicalities (e.g., performance targets, payment methods and schedule, reporting procedures, and responsibilities). If the purchaser is not able to reach agreement with the bidder after a good faith effort, the purchaser may exercise the option to terminate negotiations and begin discussions with the second highest-ranked bidder.
- **Preparation and signature of the contract** – Once an agreement has been reached, the

## Box 6. General format of a contracting document

Generally, a contracting document can include the following:

1. *Front page*: Title of contract, contracting parties, date when the contract becomes effective.
2. *Table of contents*: List of contract contents (below).
3. *Preamble*: Purpose of the contract, parties involved, and key points of the contract.
4. *Authorized persons and signatures*: The contract is signed by a legal representative from each party, and is dated.
5. *Contract period*: Time period covered by the contract and the arrangement for the contract renewal.
6. *Service specification*: Service delivery objectives, definition of services (what), volume of services (how many), target populations (to whom), and geographic locations (where).
7. *Performance specification*: Definition of performance, performance targets, methods of performance measurement, and strategies for performance assurance.
8. *Payment methods*: Specification of how, how much, and when the providers are paid.
9. *Monitoring and evaluation (M&E)*: Responsibilities of data gathering and record keeping, M&E types and schedule, and the use of a third party to perform M&E.
10. *Variations to the agreement*: The procedure for making variations, normally in writing and mutually agreed.
11. *Best endeavors*: Both parties have a duty to resolve matters without arbitration if possible.
12. *Arbitration*: Who the arbitrator will be and how he/she will be appointed.
13. *Statutory regulations*: Noting that both parties must be acquainted with and act in accordance with all relevant legislation and national policy.
14. *Others items*: Conflict of interest, confidentiality, patent, etc.

contract (see Box 6) should be prepared by the purchaser and signed by both parties in the most timely way possible, to complete the provider selection process.

### Step 4: Implementing the contract

After the contract is signed, details of implementation are specified and then carried out and monitored to ensure the attainment of the predetermined performance targets. Contract implementation includes the following activities:

- Developing and executing a contract implementation plan – Once the contract is signed, the contractor must develop a detailed implementation plan for approval by the purchaser and then implement the agreed-upon activities on day-to-day basis.
- Negotiating and managing contractual modifications – Often a contract will need to be modified during the process of implementation to respond to unforeseen circumstances. Modifications may include addition of new services, provision of services in new sites, and changes in obligations and contractual terms.
- Maintaining the purchaser/contractor relationship – Successful implementation relies on an ongoing good relationship between the two parties to the contract. Strategies to achieve this include regular communication, prompt response to ad hoc requests, and good management of disputes.
- Paying the contractor – To ensure achievement of contract objectives and avoid potential conflict, payment should be based on contractor performance, and should be timely. (See also Step 5.)

## Step 5: Monitoring and evaluating contractor performance

Doing monitoring and evaluation (M&E) helps to ensure that the contract is implemented as planned and performance targets are achieved, to document successes and failures, and to analyze the determinants of contract success. While M&E activities and methods may vary, the process should be guided by the following principles:

- Developing and executing a contract M&E plan – The M&E plan should be included in the contract implementation plan or developed immediately after the implementation plan is completed, and carried out as part of contract implementation.
- M&E conducted externally by a third party is encouraged to ensure neutrality – However, if the contract is small (in terms of services and cost) or/and the parties to the contract have a close relationship, M&E can also be done by the two parties.
- Monitoring of contract implementation should be ongoing – The frequency of more formal M&E reviews should be decided based on size, length, and technical needs of the contract and the affordability of M&E. For example, M&E in a multi-year contract should do annual and overall reviews, that is, focus on the year that is ending but also evaluate overall contract performance to date. M&E can also be conducted on a monthly and quarterly basis.
- M&E should be linked to the payment cycle – M&E activities should be able to generate timely and valid information that forms the basis for payment of providers.

## 4. WHAT CAN WE LEARN FROM COUNTRY EXPERIENCE?

A look at RH/FP contracting-out that has taken place in different countries reveals some general trends across countries. What is also apparent, however, is that rigorous evidence is limited; as a result, strong conclusions about the impact of contracting are difficult to formulate.

A broad overview of contracting literature conducted by Loevinsohn and Harding (2004) discusses numerous contracting interventions around the world. Only eleven included before-and-after or controlled experimental designs that measured quality of care with tangible outputs. Of the eleven interventions, seven were contracting-out of health services, and four were contracting-in for private management of public health service delivery. More than half of the interventions involved providing some combination of primary health care services, including maternal health, child health, and treatment of high prevalence diseases. Although some interventions explicitly mentioned the inclusion of RH/FP in contracted services, none was a RH/FP-specific contract, and it was unclear how extensive the coverage for such services was.

Generalizations about the effects of contracting on quality and efficiency are difficult to make considering non-comparable policy objectives and data. Nevertheless, results tend to demonstrate that contracting can be an effective tool in improving overall access and equity in access to health services by increasing the private provision and coverage of these services, and targeting the services to vulnerable and disadvantaged populations (Liu, Hotchkiss, Bose et al. 2004). The cases presented below illustrate the evidence and lessons learned from some of the most often-cited field experiences.

### Country case 1: Guatemala<sup>3</sup>

**Background** – Less than 50 percent of the Guatemalan population had access to essential health care at the end of the civil war in 1996. This lack of access contributed to the poor health status of the population: life expectancy at birth was 65 years; infant mortality was 46 per 1,000 live births; and maternal mortality ranged between 200 and 400 per 100,000 live births. These national averages masked the even greater plight of the rural poor. In 1998, the Guatemalan

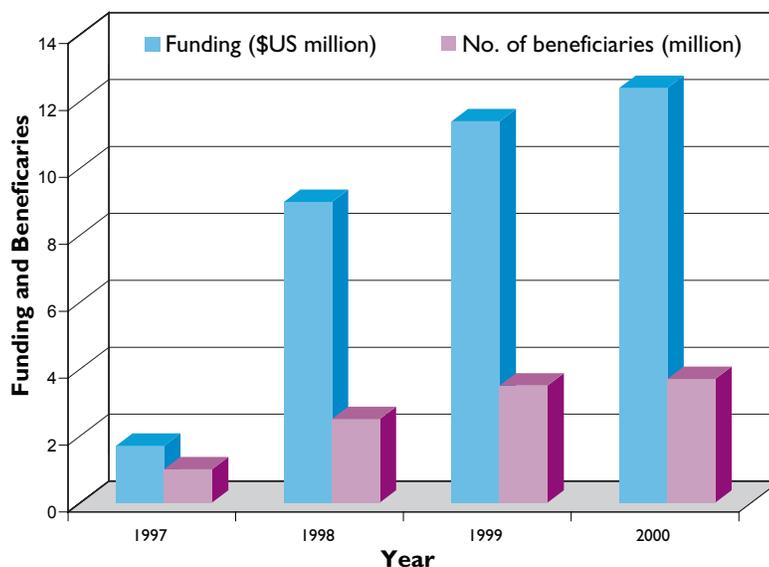
<sup>3</sup>This case is based mainly on LaForgia, Mintz, and Cerezo 2004.

Congress approved a new regulatory framework that empowered the Ministry of Health to contract nongovernmental organizations (NGOs) to deliver health services. The overall goal of this initiative was to achieve maximum impact on maternal and infant mortality and morbidity while keeping costs at a sustainable level. More immediate objectives were to increase overall access to basic health services and improve equity in access to these services for poor populations.

**Contract and services** – The contracting programs were designed to deliver a basic package of health services that gave priority to prevention, maternal and child health care, and basic curative services. Under a relational contract, that is, an informal agreement between the government and NGOs, the private providers were paid on a per capita basis, with higher payments for services provided to isolated populations. By the end of 1999, 84 contracted NGOs were providing services to 37 percent of the population on behalf of the government. In 1999, the government spent \$8 million on the program out of a total health budget of about \$19.5 million.

**Evaluation and evidence** – There is little evidence on whether the overall goal of the contracting-out initiative – to maximize impact on health while keeping cost at a sustainable level – was achieved. Furthermore, it is not shown that, given the great lack of coverage prior to roll-out of the contracting program, private providers did better at expanding coverage than public ones would have. It is evident that access was improved overall due to rapid expansion of coverage of basic health services; between 1997 and 2000, the number of beneficiaries increased from 1 million to approximately 3.7 million. However, insufficient capacity of providers and lack of dependable providers in rural areas, where availability of services on a particular day depended on whether

**Figure 1. The funding and number of beneficiaries in contracting with NGOs in Guatemala (1997-2000)**



volunteers came to work, adversely impacted both the quality of care and equity of access to care.

No proper comparative evaluation was conducted regarding the cost of rapidly expanding coverage, particularly to the rural poor. Data show that, in the 1997-2000 period, government funding for NGO provision increased from \$1.7 million to \$12.4 million. The aforementioned increase in beneficiaries (from 1 million to 3.7 million) indicates an increase in cost per beneficiary.

It is unclear whether these issues were associated with the lack of formality in the agreements between the government and NGOs. What seems apparent is that Guatemala's mandate to expand health service coverage resulted in policies that sacrificed both quality and equity in favor of achieving widespread coverage. One of the major reasons for this failure was that the program did not develop a key set of performance indicators according to which providers would be monitored and reimbursed. This resulted in provider behavior that was not aligned with the policy goals outlined in the program; in particular, the contracting initiative

<sup>4</sup>This case is summarized based mainly on Bhusan, Keller, and Schwartz 2002, and Soeters and Griffiths 2003.

failed to ensure service of acceptable quality to improve maternal and child health. Further, communication and management structures were not effective in orienting NGO contractors to provide the stated services to under-served population. While maternal and infant health was identified as a priority, the actual delivery of services was inconsistent from region to region. This was attributable to a number of factors, including lack of program flexibility to address region-specific health concerns. Furthermore, needed capacity building was not provided to NGOs. As a result, early in the program, NGOs failed to provide the comprehensive set of services, selecting only those services in which they were most experienced.

**Lessons learned** – The Guatemalan experience demonstrates that (1) for a contracting program to be successful, it is important to develop flexible programs and provide services that reflect regional variations in priority problems and service needs; (2) effective service provision requires capacity building for service providers to ensure that services provided are consistent with regional priorities; (3) contracting programs must institute clear performance indicators by which providers are monitored to ensure the effective provision of defined services to target populations; (4) well-designed contracts, as opposed to informal agreements, are integral to overall program success.

### **Country case 2: Cambodia<sup>4</sup>**

**Background** – Health indicators in Cambodia are among the worst in the Asia Pacific region. Average life expectancy at birth was estimated in 1996 to be only 56.4 years, 54.4 for males and 58.3 for females. High rates of infant mortality and maternal mortality were also a cause of concern for health officials. Poor health indicators mismatched with high levels of health expenditure for a low-income country (US \$19 per capita per year or approximately 8 percent of gross domestic product [GDP]). Public expenditure on health was low; private out-of-pocket expenditure

accounted for upwards of three-quarters of total expenditures on health (WHO 2002). Much of these out-of-pocket payments were informal fees for low quality services, creating significant equity and efficiency concerns. Though public health services were supposedly free prior to the establishment of contracting reforms in 1996, practice free services did not reach the poor and largely benefited those in higher income strata, further exacerbating inequities in the system. High levels of expenditure were not translating into high quality or effective service. A root cause of poor performance of public institutions was low (US \$10–30 per month) and irregularly paid salaries that forced health workers to seek alternative sources of income. As a result, many health workers opened private clinics, which earned them supplemental salaries.

**Contract and services** – To address these issues, the Ministry of Health in 1996 devised a coverage plan, supported by a loan from the Asian Development Bank, that involved the construction or rehabilitation of health centers, each designed to provide services to a population of about 100,000. The coverage plan defined a minimum package of services and activities that would be carried out at the health center level. The package included basic preventive and curative care, such as immunization, family planning, antenatal visits, provision of micronutrients and other nutritional support, and basic treatment of diarrhea, acute respiratory tract infections, and tuberculosis. The plan was also used to test the effectiveness and efficiency of contracting with NGOs and the private sector for the delivery of the essential health services. Nine districts with populations ranging from 100,000 to 180,000 were selected for the pilot test, with two districts in a contracting-out group, three in a contracting-in group, and four in a control group. Performance indicators and targets were developed and used for monitoring contracted providers. Incentives for improving service delivery performance were provided by linking the level of pay with achievement of monitored results.

**Evaluation and evidence** – Cambodia provides an example of how contracting health services can achieve the twin goals of efficiency and equity. During the study, coverage indicators improved across the board; the contracting-out program achieved the greatest improvement, doubling the rate of increase in coverage of contracted services relative to areas where no contracting intervention was initiated. Contracting-out districts also experienced marked increases in use of RH/FP services, almost tripling the increase found in control districts.

Contracting-out programs not only significantly expanded coverage overall, but also lowered costs and improved equity and access. One factor that contributed to improved coverage was the proximity of health facilities to consumers, particularly in rural areas. Reduced transportation costs and thus increased effective demand for health services positively impacted equity, as demonstrated by the fact that the increase in health care utilization in contracting-out districts was concentrated among low-income households.

Equity gains were also brought about by fundamental regulatory and financing reforms that increased public expenditure on health services and formalized user fees at a level lower than the pre-reform usual and customary informal payments. Lower out-of-pocket payments significantly reduced the financial burden on poor consumers; out-of-pocket health care expenditures by the poorer half of the households fell by 70 percent during the contracting period.

**Lessons learned** – Contracting health services was an effective component of an overall reform process initiated within the Cambodian health sector. The initiative demonstrated that (1) contracting-out can be an effective policy tool for improving access and equity, and thus have a positive impact on equitable use of maternal health and child health services, as well as of RH/FP services; (2) government-financed and -monitored contracted health service delivery can

be more efficient and equitable than traditional government-provided services; (3) contracting-out can be more effective if it is implemented with other policy innovations, such as reforms in the fee structure and increased government financial support to purchase essential services, as well as assured, reasonable incentive payment to contracted providers.

### Country case 3: Bangladesh <sup>5</sup>

**Background** – In 1999, less than 40 percent of the population had access to basic health care and government services were poorly utilized. Expenditure on health in 1996/7 amounted to \$10.5 per capita or 3.9 percent of GDP. An informal payment system existed along with official user fees, making basic health services difficult to afford for poorer segments of the population. In the 1990s, many donor agencies questioned the effectiveness and integrity of government institutions and thus channeled funds to NGOs, which had traditionally played an important role in delivery of various social services in Bangladesh. A number of larger-scale health care projects were initiated during the late 1990s, geared toward improving the effectiveness of service delivery through the contracting-out of services to NGOs. This discussion draws on the experiences of two such arrangements where the government was charged with contracting health services to NGOs for the purposes of improving service delivery and expanding coverage, namely, an initiative managed by the Bangladesh Population and Health Consortium (BPHC) to deliver child health and RH/FP services to rural areas through contracting with NGOs, and an initiative implemented by the Ministry of Health and Family Welfare (MOHFW) to deliver community nutrition services.

**Contract and services** – In the case of BPHC, the contracting process invited NGOs to bid for funds to deliver a basic set of maternal health and RH/FP services to agreed-upon geographic areas. The process included submission of separate financial and technical proposals that were evaluated by both BPHC and a set of external reviewers. BPHC did not impose a fixed model

<sup>5</sup>This case is summarized mainly based on Mercer et al. 2004, and Loevinsohn 2002.

for local service delivery on the selected 27 NGOs, but rather encouraged its partners to develop service delivery approaches that were appropriate to the local context. The competitive bid process and flexible contracting framework for service delivery were important features of this contracting-out program. The MOHFW contracting arrangement initially selected NGOs based on their track record and offered sole-source contracts (though this process was later replaced with competitive bids). Winning bidders were offered fixed-price contracts.

**Evaluation and evidence** – In either case, there is little quantifiable evidence of efficiency gains through contracting. It is difficult to conduct a comparative cost analysis of public and NGO service delivery due to lack of data and differences in contracted services and target populations. Both programs did demonstrate improvements in access to contracted services.

Basic data from BPHC indicates that the program improved delivery of basic services, albeit on a much smaller scale than the public sector. Evidence from survey data indicates that women and children from the poorest households now have service coverage rates almost as high as their wealthier counterparts, and that infant and child mortality in poor and wealthier areas are converging. In 1999 in NGO-serviced areas, neo-natal mortality was 36.8 per 1,000 in the poorest areas while it was 30.6 in other areas. In the same year, infant mortality was 52.8 in the poorest areas and 41.6 in other areas. By 2002, neo-natal mortality declined to 15.1 in the poorest areas and 16.5 in other areas, and infant mortality dropped to 28.3 and 28.2 respectively. The poorest areas either matched or out-performed other areas, indicating that the equity mandate of the contracting-out initiative was achieved. The evidence demonstrates success in reducing the service delivery gap between poorer and less-poor populations.

In the case of MOHFW, key indicators demonstrated that the contracting-out program did positively impact some performance

indicators. Before-and-after data show that, compared to control groups, program areas experienced a 27.8 percent higher increase in women attending antenatal checkups, a 26.8 percent higher increase in children who received vitamin A capsules, a 4.3 percent higher decrease in the number of moderately to severely underweight children, and a 25.5 percent higher increase in initiation of breastfeeding immediately after birth. However, these outcomes were achieved at high cost. Fixed-price contracts restrained the ability to use contracting as a tool for driving efficiency gains. In several instances, NGOs were not afforded the flexibility to undertake cost savings measures without prior approval or were directed to take on additional responsibility without taking cost considerations into account. This was coupled with significant delays in payment to a number of NGOs during

#### **Box 7. Ten mistakes to avoid in contracting-out for RH/FP services**

1. Transaction costs are not considered or are underestimated when making contracting-out decisions
2. Viewing contracting-out solely as a cost reduction exercise rather than a strategy to improve service delivery performance
3. Weak contract management capacity from both purchasers and providers
4. Competitive bidding is not used when alternative providers are available
5. Provider selection is not transparent and is based on individual preference
6. Performance measurement is not operationally defined, and performance targets are not specified
7. Providers' performance is not well monitored and evaluated at the right time, using appropriate methods
8. Payments do not link to the results of performance evaluation
9. Lack of trust, probity, partnership and cooperation from both parties
10. Contract does not allow flexibility to tailor services to local needs

the program period. Stringent government controls as well as lack of management capacity limited potential efficiency gains.

**Lessons learned** – These two contracting-out programs demonstrated that (1) contracting interventions can be effective in achieving access and equity objectives; (2) if achieving greater efficiency is not an explicit objective or if there is little incentive to improve efficiency, performance targets may be reached without desired efficiency gains; (3) fixed price contract and stringent government control of the contracted providers may limit the effectiveness of contracting-out initiative and (4) contracting is more feasible and likely to be successful in countries (such as Bangladesh) where the NGO sector is well established.

## 5. HOW TO ENSURE THE EFFECTIVENESS OF CONTRACTING-OUT?

To ensure that contracting-out programs for RH/FP services achieve expected and desirable results, participating managers need to have essential contract management capacity, follow the contracting-out steps proposed above, learn from experiences of both successful and failed contracting programs, and be innovative in the use of competition and incentives to promote service delivery performance objectives. Particular attention should be paid to the following key points (also see Box 7, for mistakes to avoid):

- *Transaction costs should be minimized.* Transaction costs are costs incurred for establishing contracts, contract management, M&E planning and implementation, contract enforcement, and efforts to avoid and resolve conflicts. Transaction costs are an important consideration when determining whether the services should be contracted out, because they can escalate, particularly when contracts are overly complex and/or large numbers of providers are engaged in contract negotiation. To avoid cost escalation, it may be necessary to adopt transaction cost reduction strategies, including limiting bureaucratic procedures for handling management activities, avoiding long-
- *running contracts, keeping contracts simple, sharing standard forms of documentation, focusing M&E on what is the most important, and avoiding micro-management.*
- *Competition should be used to the extent possible.* When there is more than one potential provider, the purchaser should use competitive bidding to reduce cost and to improve performance under the contract. In instances where the initially targeted provider market is monopolistic, the government may attempt to: (1) privatize or provide autonomy to public providers and allow them to compete for the contract; (2) relax policies or legal regulations to allow additional private providers to enter into the market; and (3) allow the government purchaser to cover larger populations so as to open up more provider competition.
- *Make full and appropriate use of economic incentives.* Providers' performance must be operationally defined and targets of performance explicitly specified; providers must be monitored and evaluated against those performance targets; and they must be paid based on the results of performance evaluation. Failures in the above areas can create perverse incentives for providers to maximize their income or to minimize inputs (e.g., to see more patients, but deliver poor-quality service), putting purchaser objectives at risk.
- *Contract management capacity should be ensured.* Contracting-out represents a shift of the role of government from both financing and provision to only financing, from service delivery to purchasing, and from micro-management to macro-stewardship. Government purchasers need ideological transformation as well as the improvement in key capacities that support these functions, including the capacity to undertake population needs assessment; to perform provider market analysis; to design, negotiate, and manage the contracts; and to manage and monitor the performance of contractors.

- *Maintain partnership and cooperation constantly.* Ensuring the performance of health care delivery requires coordination and collaboration between purchasers and providers. A confrontational contract is likely to increase the likelihood of conflicts. Partnership should be used for preventing disputes from occurring. Under this concept, the contracting process should create a “buy-in” to the overall goal of satisfactory performance on time, within budget, and without claims. The purchasers and providers need to meet and communicate regularly

to discuss their mutual expectations and issues. The parties should mutually develop performance goals, identify potential sources of conflict, and establish cooperative ways to resolve problems that may arise during contract performance. Contracting parties should avoid relying on claims and litigation to resolve disputes because it is costly, time-consuming, and often ineffective. Both parties should try to seek less confrontational resolutions through dialogue, communication, and openness.

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