

Contracting for Health Care Service Delivery

A Manual for Policy Makers

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INTRODUCTION

The last decade has seen a number of important changes in the mix of public and private services in the health sector and in the organization of those services throughout the developing world. Governments are looking for ways to increase efficiency in the use of public sector resources, improve the quality of health care, and extend health services to underserved populations. Public-private partnerships can help government agencies deliver more cost-effective health services to target populations. This guide offers a brief overview of the benefits—and limits—of using contracts for service delivery, and describes some of the steps that are key to good contract management. Although there exist a wide range of types of contracts, this guide focuses on performance-based contracting.

Things to consider:

- 1) What objectives do each party have in seeking a contract?
- 2) Are the political environment and legal framework conducive to contracting?
- 3) How able is each party to meet its responsibilities, given the complexity of the contract?
- 4) Once the decision has been made to proceed with a contract, how do the parties go about developing it?

What is a contract?

A contract is a written agreement between two parties, usually enforceable by law. A contract might, for example, authorize the transfer of funds from a government agency to a contractor, in return for the goods or services defined in the contract. A contract can be negotiated with a sole provider or awarded through a competitive bidding process. It can allow the contractor a great deal of liberty as long as its objectives are met, or it can establish standards and conditions of work to be evaluated and enforced by the purchaser. There is no single rule to determine how specific a good contract should be; rather its form will depend on a number social, political, and legal issues, some of which are described below (see OECD 1999, Abramson 1999).

Why contract?

Public agencies may use contracts to:

1. Extend coverage to underserved sectors of the population and provide priority services to targeted groups.
2. Provide services that the government does not have the infrastructure (human or technical capacity) to provide.
3. Improve the quality of health care.
4. Encourage competition among health care providers.
5. Control costs and improve the efficiency of public health expenditures.
6. Improve government's ability to focus on public health planning, financing, and oversight.

Nongovernmental organizations (NGOs) and commercial health care providers have many different reasons for entering into contracts with public sector agencies. NGOs may wish to ensure their financial sustainability, extend their social mission, or achieve greater public recognition and a more prominent role in the marketplace. Commercial health care providers may wish to increase their profits or market share.

What are the advantages and disadvantages of contracting?

How contracting works—how it helps agencies meet objectives like those mentioned above—is described throughout this guide. Contracting increases government’s accountability to the public. As the use of contracting increases, government gains authority in its regulatory and oversight roles. Contracting encourages innovation among government agencies, and it requires government and the private sector to develop new ways of working together as they evolve from regarding each other as competitors (see Carrin 1998) to collaborators.

Possible Advantages

- Meets the health care needs of the population.
- Improves the quality of health care and extends coverage (increase access).
- Increases oversight of the private sector.
- Enlists private sector support for public priorities.
- Increases efficiency in the use of public sector resources.
- Offers greater flexibility in personnel management to hire, fire, and relocate staff members and to offer them with performance-based incentives.
- Introduces market tools and market-like incentives, such as links between results and costs, demand-based service provision and monitoring of customer satisfaction, service definition and calculations of unit costs, and accountability of personnel for performance.

Possible Disadvantages

- Demands a high level of supervision and monitoring.
- Incurs higher administrative and transaction costs, for example, the costs of negotiating, seeking legal advice, and creating adequate information and reporting systems.
- Decreases direct control over the use of public funds while maintaining public sector accountability over the use of government funds.

WHAT DIFFERENT CONTRACTING OPTIONS ARE AVAILABLE?

There are basically two contracting options—contracting in and contracting out—and within these options falls many variations. The type of contracting arrangement and the contract’s level of specification should be determined on a case-by-case basis, depending on the national political environment and the goals of the contract. There is no prescription, however, nor is there a template. Both contracting in and contracting out are done in a variety of countries. However contracting out to private providers is often times easier to implement, due to public sector management issues and political environment, and will be the primary focus of this guide.

Contracting in

Contracting for Service Delivery

In

A mechanism whereby the public sector contracts with either another level of government or public facility.

Out

A tool used by the public sector to employ private providers to deliver specified services in exchange for payment.

One option often explored by the public sector is contracting in: that is, when one level of government or a public institution—for example, the central Ministry of Health—contracts with a lower level of government facility—say, a district, a province, or another facility to deliver services. Contracting in serves as a way to introduce private sector concepts and business strategies into public sector management in an unthreatening way, as only public providers are involved. This document introduces contracting in but will serve primarily as a guide to contracting out.

For example, contracting in can introduce market-inspired mechanisms such as competition and performance-based incentives into the public sector health care system. The goal might be to promote greater efficiency, improve the quality of care, extend coverage, or motivate the public sector workforce. Performance-based contracts between two levels of government will not be effective or efficient, however, if it is difficult to enforce contract compliance.

Contracting in was the approach used in the 1980s in **Great Britain** under the National Health Service Reform. This strategy has also been adopted by developing countries. For example, in 1995 the Government of **Chile** established contracts between the Ministry of Health and select Regional Health Service Administrations (Sojo 1996). In **Costa Rica**, the Social Security Institute has signed contracts with its own social security hospitals. Nicaragua has developed contracting in agreements whose objective is to motivate public service health care workers to improve their performance. In **Zambia** and **Cambodia**, agreements have been signed between the central Ministry of Health and Health Districts.

Contracting out

Contracting out presents many options to the public sector in its role as purchaser, including the opportunity to work with a wide array of potential partners, from nonprofit NGOs to for-profit private commercial providers, in order to meet public sector health care needs. A variation of the contracting-in model exists whereby a NGO is contracted to improve upon public sector management practices to run government clinics while working under the framework of civil service law. In **Cambodia**, for example, the contractor has authority over Ministry of Health staff to

manage service delivery within the district and may establish internal staff regulations as long as they are not in conflict with civil service law (Fronczak et al. 2000).

Under a donor-financed project, Cambodia also employs a contracting out model, in which a private sector contractor has authority over the project staff and budget, as well as autonomy within the service delivery system (Fronczak et al 2000). Since the early 1990s, when **Colombia** enacted a series of laws explicitly allowing public agencies to contract out to the private sector for the delivery of health services, that country has signed a wide range of public-private contracts for service delivery. There, competition among providers—including public agencies, private for-profit providers, and, especially, NGOs—has been created in order to extend access to care, as well as improve the management, efficiency, and quality of care (Abramson 1999).

The decision to contract is not the inevitable result of a straightforward process, nor is there a “recipe” to follow. Rather, contracting responds to a country’s particular needs at a particular time.

At the local level, municipal governments in **Brazil** have been contracting out with BEMFAM—Brazil’s International Planned Parenthood Federation affiliate—to provide education and technical assistance in planning and implementing health services, supervise local activities, produce educational materials, and strengthen information systems on utilization and stock controls. Of a total of 3,339 municipalities, 996 (29.8%) have contracts with BEMFAM.

In choosing whether to contract for service delivery and whether contracting should be done within the public service delivery system or with private providers of health services, the purchaser must consider the national legal framework and political environment, and the capacities of the public sector to manage the contracting process, as well as the goals and objectives of contracting. The decision to contract is not the inevitable result of a straightforward process, nor is there a “recipe” to follow. Rather, contracting responds to a country’s particular needs at a particular time. Nevertheless, there are issues that policymakers, health authorities, and providers should consider before negotiating and implementing a contract (Abramson 1999).

WHAT FACTORS ARE IMPORTANT TO CONTRACTING?

Before entering into a contractual arrangement, it is important to ask whether the political environment and legal structure of the country are conducive to contracting.

Several kinds of documents make up the legal framework for contracting:

Laws: general and binding legal rules enacted and published by a legislative body.

Decrees and orders: binding rules adopted and published by executive agencies of the government.

Rules & regulations: written instructions made available to the public by ministries or independent agencies of the government, used to apply and interpret laws, decrees, and orders.

National legal framework

Laws and other legal documents can help or hinder contracting and private sector participation in health service delivery. Many countries in the developing world face legal barriers to contracting, and in most developing countries the legal framework is not geared to public contracts.

In countries where the legal framework is not particularly conducive to contracting but not explicitly against it, public sector agencies have been able to contract either through projects or by careful attention to legal language and concepts. This was the case of **Costa Rica** where the National Social Security Institute was able to initiate contracting under the auspices of an international donor-supported project in spite of national legislation non-conducive to contracting. Where barriers to contracting are more difficult to surmount, health care agencies have had to find alternative approaches to meet their goals.

Political and social environment

The roles of the public and private sectors in a society—for example, the traditional role of civil servants—impact on government’s success in contracting. In addition, the history and culture of the contracting institution must be taken into consideration.

Agencies must ask:

1. Is the public sector the primary provider of health care coverage? Are the majority of health expenditures incurred within the public sector?
2. Are there strong professional and medical associations or unions that generally benefit from the status quo? Can changes in the system offer union members new opportunities?
3. What political forces outside the health sector may oppose or support contracting?
4. Will there be resistance to the introduction of traditional private sector management concepts into the public realm? Will contracting be misunderstood as “privatization” of public health functions?

On the other hand, some social factors may support contracting. Examples include changes in government administration, and an organized community that supports increasing access to services through alternative providers. Calling public attention to the goal of strengthening public health financing and regulatory oversight, rather than presenting contracting as a way for government to get out of the business of providing direct services, may help deter opposition.

Choosing a provider

Ideally, when considering options for health service delivery including the option of contracting out to the private sector, the purchaser will compare the costs of each option, the quality of services offered, and the ability of each approach to reach target populations.

A private provider is one that has legal status as a private entity. A private provider has full responsibility for its sources of income and control over its budget—that is, it has control over its assets and is responsible for its debts and claims on its revenues.

In simple terms, there are two basic types of private providers: nonprofit providers, generally referred to in this document as nongovernmental organizations (NGOs), and for-profit commercial providers. In the health care industry it is often difficult to distinguish between the two. What the commercial sector calls earnings or profits, for example, NGOs may call reserves. However, these reserves, if any, are not distributed to owners or investors, as business profits are; instead, they are generally used to advance the organization's mission—to subsidize health promotion or education services, for example, or to offer services to target populations who are unable to pay market prices for them (World Bank 1997).

Below is a more detailed description of these two types of providers.

- **Nongovernmental Organizations (NGOs)**

NGOs can range from community-based grassroots service delivery organizations to large service delivery organizations dependent upon international donor funding. Some NGOs are formally constituted; others are informal. They all, however, operate independently of government. Most are characterized by humanitarian or cooperative missions and values. NGOs promote the interests of the poor, for example, and do relief, development, and advocacy work.

When considering an NGO as a potential contractor, the purchaser of health services should become familiar with the types of services delivered, the organization's sources and types of funding, as well as its mission, role in the community, and ties to other local groups. An organization that receives funding from international sources, for example, whether in the form of grants or contracts, will have to maintain special accounting systems to track its use of these funds and will have experience meeting reporting requirements. An organization that does not receive international funds may be used to having greater autonomy to execute tasks and report on them.

- **Commercial sector**

The for-profit sector is generally characterized by commercial objectives. It is important to note that accounting and reporting experience and practices can vary widely within the private sector—in different countries and among publicly traded and private or closely held companies.

WHAT CAPABILITIES DOES THE PUBLIC SECTOR NEED IN ORDER TO CONTRACT?

Contracting for health care services is a complex process, one that affects not only the public health care system, but also health care market structures. In order to contract successfully, the purchaser must be able to manage contracting processes properly: that is, to define contract objectives, negotiate contract terms, prepare and implement contracts, and monitor and evaluate performance. This section describes some of the key capabilities that the public sector needs to develop in order to manage the contracting process, including regulation; procurement, administration, and financial systems; information systems; cost determination; and bill paying.

By definition, the use of public funds to contract out to private providers requires the purchaser to ensure that those funds are being used properly. This focus on accountability of public funds, through contract management and oversight, is one of the principal benefits of contracting.

Regulation

As Ministries of Health evolve from providing direct service delivery to financing, purchasing, and oversight of the health care sector, regulation of the health sector should, as a consequence, become a major public sector responsibility. Three areas are key to this regulatory function: **accreditation, enforcement of national treatment standards for health care providers**, and **quality assurance** to provide adequate levels of care.

Although many developing countries enter into contractual relations without first establishing an accreditation process, the establishment of an accreditation process for health care facilities—either public sector facilities, in the case of contracting in, or private providers, when contracting out—can facilitate the contracting process. Accreditation makes clear the basic requirements a health care provider must meet in order to be considered for a contract. These requirements will vary depending on the type of contract in place. For example, a performance-based contract may require the provider to have a specific type of financial system, follow certain clinical protocols for service delivery, maintain a given ratio of physicians to nurses or nurse's aides, and have appropriate licenses and certain basic equipment or infrastructure. Another factor that may be considered in the process of accreditation is the existence of a quality of care program, including provisions for client satisfaction surveys, education and training of service delivery staff, etc.

Regulation also involves the oversight or supervisory functions the public sector undertakes to ensure that providers comply with national health care standards and treatment protocols. Directly related is the issue of quality assurance—performance standards expected of service providers and procedures to ensure that the standards are met, and that care is as safe and effective as possible.

After the government has decided what qualifications providers must meet in order to be considered as contractors, it should determine which aspects of the care to be provided it should regulate and how it will regulate them. Developing management

skills in health, administration, and finance and strengthening the health information systems of both purchasers and providers are indispensable next steps (Bennett 1997, Mills 1998, Sojo 1999).

Information systems

Information systems essential to contracting include programmatic information, financial information, administrative information, information flows, and communications. As information is a two-way street, the purchaser must have its own administrative information structures, procedures, and mechanisms in order before entering into contracts.

Although Ministries of Health generally keep records of epidemiological and administrative information, few countries have created the formats and records needed to monitor contractor compliance with financial and programmatic terms. In the case of health care contracting, relevant information includes specific services to be provided, the quality of those services, the personnel and materials used in providing services, and the costs of public and private health care. Once the government knows the cost and quality of public health services, this data can be entered into an information system. The government will then have sufficient data to decide which services they should contract out for and which services would be better provided in house.

After a contract is in place, information systems enable its flexible and appropriate supervision. For example, information systems provide patient records that help the purchaser review the quality of care delivered (programmatic information). They also make it possible to process and review contractor invoices (financial information).

Cost determination

In order to determine the benefits of contracting services out to the private sector, the purchaser must know what its unit costs are, either for individual services or for packages of services. Information about costs is also important to ensure that services are appropriately priced in the contract.

On the basis of an analysis of demand and of the needs of the population covered under the contract, the public sector purchaser should estimate the number of services to be offered. The purchaser should then estimate both its costs and the commercial sector's costs for those services. Once the public agency has determined the type and volume of services to be contracted for and its unit cost per service, it can establish a basis upon which to evaluate bids and negotiate with contractors. For more on this aspect of contracting, see the table of definitions below.

Payment

As a purchasing agent, the government is responsible for ensuring that it has payment procedures in place for the timely disbursement of funds. It is a good idea for a payment schedule to be outlined in the contract. Whether the government contracts with public sector facilities, not-for-profit NGOs, or private commercial firms, its

financial and administrative capacity to disburse funds on time is pivotal to building trust between purchaser and contractor.

Many small commercial providers and NGOs depend on timely payment for their financial survival. Some health service delivery NGOs charge user fees to patients, but others do not. In most cases, the fees alone are not sufficient to support these organizations for an extended period of time. A significant delay in payment from the government can have a devastating effect on the provider's cash flow, preventing it from carrying out the services to which it is committed by contract. In some cases, providers who do not have the financial means to cover upfront expenses or to cushion themselves against possible delays negotiate advance payments with the government as part of their contracts.

One option available to public sector purchasers is to contract out accounting and payment functions to a third party. This eliminates the need for the purchaser to develop accounting and invoice tracking systems and helps ensure the timely disbursement of funds.

Definition of Terms

Term	Purchaser	Provider	Consumer/End User
Cost	The value of an input; generally used to determine the level of investment required to produce a service or treat a case.	The value of an input; generally used to determine the level of investment required to produce a service or treat a case.	What is paid or disbursed in order to receive a service or treatment.
Price	What the provider asks to be paid in exchange for service or treatment.	What the purchaser is asked to pay in exchange for service or treatment.	What is paid for a service.
Payment	What is disbursed to the provider in exchange for service or treatment.	What the purchaser disburses for service or treatment.	What is disbursed in exchange for service or treatment.
Rate	Similar to price, what the purchaser pays the provider in exchange for service or treatment.	Similar to price, what the purchaser is asked to pay in exchange for service or treatment.	Consumers generally do not use this term.

WHAT ARE THE STEPS INVOLVED IN CONTRACTING?

Once a government agency has decided that it will contract for services, there are a number of steps to the contracting process. Ideally purchasers should follow these steps, although the process can vary.

Steps in Contracting

- 1) Carry out needs assessment.
- 2) Identify contracting objectives.
- 3) Develop statement of work.
- 4) Decide on contract type and payment mechanism.
- 5) Decide whether to competitively bid out contract.
- 6) Send out Request for Proposals (if competitively bid).
- 7) Review proposals.
- 8) Award, negotiate and design contract.
- 9) Monitor contract implementation.
- 10) Evaluate contract performance.

When is it best to bid contracts competitively?

The competitive bidding process, commonly referred to as a call for tenders, has the advantage of requiring potential contractors to analyze and cost out the services they are being asked to provide. Below is a list of steps needed to contract for services. It is important to remember, however, that when the public sector moves from providing services in-house to purchasing them through a competitive process, market structures are altered.

Competitive bidding works inherently to ensure that services are provided at the lowest price the market can sustain (Domberger 1998). Few comparative studies have been done on the quality of health care services delivered under competitively bid contracts versus non-competitively bid contracts. In the non-health sector, however, research has shown that the highest quality services are provided at the lowest possible cost when driven by market forces.

When considering whether to solicit competitive bids for a contract, the purchaser should bear in mind that preparation for a competitive bidding process is both time-consuming and costly. Competitive bidding requires the preparation of requests for proposals, organization of an evaluation committee, and development of criteria for ranking proposals as they come in. These and other procedures such as the pre-qualification of bidders all come at a cost—in time, as well as human and financial resources. Of course, competitive bidding should be reserved for cases in which more than one acceptable service provider is available.

There may be instances where there really is only one provider who can meet the needs specified under contract. In these instances, contracts may also be negotiated directly with a single provider without going through a formal competitive process. This alternative—called sole source contracting—is appropriate when the purchaser has enough information about the demand for services and the cost of providing them to be able to negotiate a fair and workable contract directly with a single provider without soliciting competitive bids.

What are the administrative costs contracting can incur?

In order to improve efficiency—often an objective of contracting—the purchaser should ensure that each component of the contract offers maximum added value and that administrative costs are kept to a minimum. In addition to the costs of preparing, managing, and supervising a contract, administrative or transaction costs involved in contracting include creating sufficient incentives for key health care staff, such as physicians and nurses, to enter into the contract. Contracts in which payments are closely linked to contractor performance tend to incur higher administrative costs than do subsidies or block grants. Similarly, creating appropriate record keeping systems may involve high start-up costs, but in the long run good record keeping will facilitate contract management, a benefit to both parties to the contract.

It is in the purchaser's best interest to structure a contract so that the greater administrative burden falls upon the provider. Contracts often allocate a fixed amount for administrative costs. In this way, cost containment—tracking and controlling costs in order to maintain them below the contract ceiling—results in net savings for the provider. Should costs exceed this fixed amount, the provider must cover them out of pocket. This offers the provider a powerful incentive to control costs.

Contracting for services through a competitive process encourages contractors to propose the best possible technical approach at the lowest possible cost. However, this process involves greater transaction costs than sole-source contracting. It is important to recognize that the selection process involves costs up front, even before a contract is tendered. Nevertheless, negotiating and drawing up terms for sole-source contracts also have costs attached to them.

Public sector requirements for the procurement of goods or services through contracts, as well as the development and maintenance of government contracts, more often than not demand that the public sector develop a separate management unit. Procurement divisions or units are generally responsible for preparing, negotiating, and assessing contracts and for establishing contracting policies. These offices also handle technical and administrative information used for contract management.

WHAT ARE THE COMPONENTS OF A CONTRACT?

All the terms used in a contract, including beneficiary, enrollee (in the case of insurance plans), health care services, provider, etc., should be defined early on in the body of the contract. The type of contract or contracting vehicle should also be clarified up front. All contracts should specify each party's responsibilities for provision, compensation, data collection and information systems, reporting requirements, quality assurance, monitoring and evaluation. Key components of contracts include:

A. Output specifications and contract deliverables

The outputs or services to be provided under a contract and the population eligible to receive those services need to be included in the body of the contract. They may also be attached to the contract as an annex. Depending upon the type of contract and payment mechanism (see below) negotiated under the contract, the target population, and the volume, types, and complexity of services will be defined in the contract. If the contract specifies that a particular target population will be eligible to receive services then this population is identified. If, for example, the contract is part of an insurance plan, then only the enrolled population will receive services.

The services to be provided under the contract will be specific public health services that the purchaser has determined to be a priority and that the provider offers. The government's priorities in contracting may be to improve the quality of primary care or reproductive health and family planning services or to extend access to basic services to targeted or underserved groups. Or the government may have determined that certain services can be better provided by a contract provider, for example, dental care, ophthalmology, or other specialized care.

B. Price setting, compensation, and billing

Setting prices and determining compensation for services are two of the most difficult parts of the contracting process. Not only must the government agency estimate its current and future unit costs, but providers must also determine their costs to provide services. Based on their calculations of those costs, providers will offer to sell their services at set prices that enable them to fully recover their costs (in the case of not-for-profit entities) or earn a surplus (in the case of the commercial sector). See the section on payment mechanisms below for further details.

Unless some sort of block grant arrangement is chosen, provider prices will be specified under the terms of the contract. Pricing options include payment exemptions for target populations, user fees established according to sliding scales, and other types of subsidies. Providers may also ask the purchaser to consider setting prices that subsidize services that the provider believes are important or that add value to the care delivered. Under insurance plans or subsidized arrangements, too, pricing may vary. Insurance plans, both public and private, have set prices for services, which will be referred to under contract if it is funded as such.

If consumers are asked to pay for health services then an agreement will need to be reached about how fees will be collected and revenues will be allocated. In this case, how prices are set between the provider and the end user—the consumer—is another area that needs to be defined in the contract. There is a range of pricing options, from free market supply and demand (using cost recovery mechanisms), to exemption policies that provide services free of charge. Service prices must be made clear in the terms of the contract. If prices are to be adjusted in accordance with variations in the market or economic fluctuations in inflation rates, this too must be spelled out in the contract. The purchaser and the provider will negotiate whether services will be provided free of charge or user fees charged, or if there will be a sliding scale for certain target populations. Their decision will be included under the terms of the contract.

Just as compensation needs to be spelled out in the contract, billing procedures must also be specified. How often will the provider submit invoices for reimbursement? How long does the purchaser have to disburse funds? How will delays in late payments be compensated?

C. Length of time

It is important to consider the advantages and limitations of short-term (one year or less), medium-term (from one year to five years), and long-term (five to ten years) contracts. The start up costs—including design and implementation of information and monitoring systems, administrative systems, and tracking systems—are similar for all contracts. However, the relative costs are greater under short-term contracts than under medium or long-term contracts, since new systems may need to be developed or current ones altered when contracts near expiration and are renegotiated or extended.

On the other hand, although long-term contracts (five to ten years) may be less costly to administer over the long run, they can also foster complacency and undermine the positive effects of competition among contractors.

D. Information systems and record keeping

As discussed above, appropriate information systems are critical to the success of an integrated contracting process. In the case of health care contracting, relevant information includes the services to be provided, the quality of those services, personnel and material resources used, as well as accounting and financial records. Once a contract is in place, information systems enable flexible and appropriate contract supervision; for example, they can generate patient records essential to reviewing the quality of care delivered. Information systems also review and process contractor invoices. Bennett and Mills (1998) describe the essential requirements for an information system that can assist in developing, awarding, and supervising contracts.

Most contracts stipulate that providers will maintain their own accounting records and meet all requirements for clinical, financial, and administrative information. However, the content and form of these reports need to be agreed upon by both the purchaser and the provider. Despite these information demands upon the provider,

the purchaser must keep accurate records and information systems and be accountable to constituents for the use of public funds. The purchaser is also responsible for developing oversight mechanisms to measure performance and progress toward contract goals. The purchaser must be able to monitor service volume and payment for services provided. If, for example, the purchaser finds that the provider does not follow established protocols or meet performance targets, then payment may be withheld.

E. Supervision, monitoring, and evaluation

The more specific the contract is in terms of performance expectations and monitoring, the less risk on the part of the purchaser. Even when expectations for performance are explicit in a contract, however, performance should be measured. Ultimately that measurement should be used in rewarding the contractor and structuring future contracts (Abramson 2000).

Once the objectives of a contract are clearly defined, it is important to develop specific performance indicators to measure progress toward achieving them. Tracking health service information as well as administrative and financial information helps inform the purchaser on contractor performance. If the government has strict rules and standards for accreditation of facilities, they may obviate the need for explicit, contractual performance monitoring to assure quality. In the majority of cases, however, for the contract to meet its objectives, it will need to specify how performance will be monitored, including what the target indicators are and how performance will affect payment under the contract's terms.

Indicators developed to measure contract performance should also be directly related to the purchaser's contracting objectives. Before determining the indicators that will be monitored under a contract, then, the purchaser should determine its contracting objectives: to increase efficiency, improve quality of care, increase coverage to target populations, etc.

Indicators must be objective, quantifiable, and easy to measure in order to reduce the administrative burden on the purchaser. In addition, they should measure outcomes the contractor can act upon—or that are within the contractor's control. A contract may also include indicators to measure administrative standards, customer service standards, and quality standards, depending upon how complex the contract is and how closely the purchaser wishes to supervise it. One caveat to bear in mind when discussing performance indicators, however, is that the more complex and detailed the contract's indicators, the greater the burden on the public sector to monitor contract performance.

The purchaser may choose to conduct periodic contract supervision and evaluation in-house or contract out these functions to a third party. Supervision and evaluation of contract performance by a third party may help ensure objectivity of results. Independent contractor assessments of performance, especially when performance is linked to results, may also be directly linked to payment.

The list on the left gives examples of indicators that can be used to supervise the performance of primary health care units and hospital outpatient services.

Illustrative Performance Indicators

- ◆ Volume of services: availability of services, coverage
- ◆ Quality of services: end-user surveys to gauge customer satisfaction, medication errors, staff rotation, absenteeism, waiting time for patient admission, percentage of cases referred to higher-level health facilities
- ◆ Financial measurements: cash flow, expenses versus revenues
- ◆ Productivity: nursing hours per patient, number of patients received or treated

FUNDING AND PAYMENT MECHANISMS

In order to discuss funding and payment mechanisms it is important to discuss the incentives and risks associated with them.

Incentives and risks

All contracts contain incentives and risks. In other words, they can induce certain behaviors, either positive or negative, in the parties involved. In contracting for services, the government purchaser is distributing risk and responsibility between itself and the contracted provider (Walsh 1995). The contract terms, price levels, administrative costs, and costs of supervision determine the risk distribution. Presumably, the higher the provider's risk is, the more compensation the provider will seek.

Risk for the purchaser refers to whether the results sought, contracted, and paid for are actually obtained—that is, whether and how well the provider supplies the goods and services agreed upon in the contract.

Financial risk involves the prospect that the actual cost of services provided will exceed the amount of funds provided in the contract. How the contract covers the cost of services determines the distribution of financial risk between the purchaser and the provider. Such risk can be mitigated in several ways, such as through consumer co-payments or by limiting coverage to a defined package of services with ceilings on expenditures or volume (the number of patient visits). Financial risks to the provider include the risk that in negotiating or bidding on a contract the provider may underestimate the cost of services and not be reimbursed for all costs it incurs. Provider incentives include the possibility that the cost of services provided will not reach the level estimated, and the payment it receives under the contract may exceed its costs.

Different payment mechanisms offer varying distributions of risk between the purchaser and contractor. The following section briefly covers some of the payment mechanisms available to purchasers and contractors and their corresponding incentives. For example, fee-for-service plans charge set rates for different services; providers receive this rate for each service rendered, and it is the purchaser who assumes the greater share of financial risk. Under a prospective payment system such as capitation, which pays the provider a set amount for each person enrolled in the health plan regardless of the number of services rendered, financial risk is transferred to the provider. The provider and purchaser can share risk, such as with case-based payment, which pays a fixed amount for all services related to a specified case or illness.

Studies have shown that the performance of health systems is linked more closely to the method of resource allocation—how health care providers are paid—than to the size of the overall budget. Purchasers can pay for services in a variety of ways, individually or in combination: by case, day, person, year, or type of service (Wouters 1998). Again, the payment method will determine the degree of risk placed upon the purchaser. Each payment mechanism has a corresponding set of positive

and negative incentives, resulting in specific behavior by the provider in terms of the type, quality, and quantity of service provided. When considering contracting for service delivery, the public sector needs to determine, first, what the payment method will be and, second, what incentives will be created through this type of payment (Wouters 1998, Bennett 1998).

Once the price for a service or a package of services is decided, payment can be determined in two ways: either before services are rendered, prospective payment, or after services are rendered, retrospective payment. Capitation is one type of prospective payment; another is global budgeting. Because prospective payment puts the provider at greater financial risk, it acts as an incentive to the provider to employ greater efficiency. Fee-for-service is one the most common kinds of retrospective or cost-based reimbursement payments (Maceira 1998). The text box below describes four of the main payment methods for health services. Additional information on payment mechanisms and incentives can be found in the Partnerships for Health Reform primer for policymakers, *Alternative Provider Payment Methods: Incentives for Improving Health Care Delivery* (Wouters 1998).

Payment mechanisms

Prospective payment mechanisms

Global amount or block grant

Under a global amount or block grant payment, the purchaser pays the provider an agreed-upon fixed amount on a regular basis—e.g., monthly, quarterly, or yearly (Wouters 1998). This type of payment involves the transfer of funds from the government to a provider to fund a budget line item, cover high priority health services, or finance the general operations of the organization or company.

Capitation payment

Under capitation, the provider is paid an amount in exchange for a predetermined set of services for the population targeted. The size of the population and the geographic area of coverage determine the volume, and the purchaser and provider agree to a contract on the basis of their coverage target in relation to the two variables for volume. Under this type of payment mechanism, the provider receives per capita payments each month, quarter, or year, regardless of the actual demand for services. Capitation creates a high degree of financial risk to the provider since revenues will not vary by number of services provided or cases attended. This mechanism offers strong incentives to the provider to control costs. In their efforts to economize, however, providers may undercut the quality of care.

Case-based payment

Under case-based payment, the provider is paid a fixed amount for each case. The cost per case is based on diagnosis and procedure classifications and determined before the contract is signed. One problem with this type of payment is that the procedures to be performed for a given case may be minimized in an effort to contain costs. This incentive to increase efficiency may undercut the quality of care, so case-based payment requires a system for monitoring and evaluation that will enable the purchaser to review the level and quality of the services provided closely.

Retrospective payment mechanisms

Reimbursement for services provided

Under fee-for-service reimbursement, payments are made only for services provided. As the volume of services increases provider costs will decrease due to economies of scale. This method encourages providers to increase the volume of services they provide, potentially to the point of providing unneeded services. In order to curb risk, the purchaser may want to establish the maximum volume of services covered by the contract. A system of supervision and evaluation is recommended to enable the purchaser to collect information on the volume of services claimed and compare the result with the volume of services from other providers (public, private, or NGO). These comparisons can also be used to develop national projections of service volume for targeted populations or areas, and ultimately to control costs. (Source: Abramson 1999)

CONCLUSION

This guide serves to aid the public policymaker in assessing and understanding the essence of contracting. With this information the policymaker will be able to approach performance-based contracting as a tool to achieving public sector objectives.

Contracting is an important tool that can be utilized by public-sector policymakers to meet the health care needs of target populations. Some of the opportunities that contracting can bring include extending coverage to underserved populations and increasing the provision of priority services to targeted groups, improving the quality of health care delivery, and increasing efficiency in the use of public-sector resources. There are, however, certain prerequisite conditions that need to exist before the public sector contracts. The public sector must have the capability to gather and utilize programmatic, administrative, and financial data in order to properly regulate service providers—particularly private providers under government contract. Information systems and data collection processes need to be functioning in order to ensure proper contract supervision and monitoring. An analysis of unit costs by the public sector is essential in order for the government to act as an informed purchaser of services. The national legal framework and political environment need to be considered prior to contracting. In addition, the availability of service delivery providers as potential contractors needs to be measured. Contracting with private providers serves to utilize existing health resources to service the public sector and decrease coverage gaps and improve the efficiency of public resources.

CONTRACT PLANNING CHECKLIST

Political environment, legal framework, and contract objectives

1. What are the country's health policy goals?
2. What are the country's health policy objectives?
3. Can the goals and objectives be achieved through contracting? If so, how?
4. Is there legislation conducive to contracting? If so, what laws support contracting?
5. What are some potential political constraints to contracting (for example, fear of privatization, strong labor unions, etc.)?
6. Would it be better to begin by contracting within the public system or contracting out to private providers? Why? If contracting out to private providers, would it be better to contract with a not-for-profit provider or with the commercial sector? Why?
7. Would it be better to contract through a competitive or semi-competitive bidding process or to sole source a contract? Why?
8. Is there a strategy in place to educate the public on what contracting is, its advantages and benefits?
9. Have potential stakeholders in the decision to contract been identified? If so, who are those likely to be opposed to contracting, and who are those likely to be in favor of contracting?

Opposed:

Supportive:

Analysis of the public sector's capacity to purchase health care services

1. Is there an accreditation process in place for private providers?
2. Are there structures in place to monitor and evaluate contracts?
3. Is there a system in place to regulate health care providers under government contract? Explain
4. Is there a division within the public sector contracting agency that will administer and monitor contracts? Explain.
5. Are there sufficient information systems in place—administrative, financial, and programmatic—to allow the public sector to use data generated by the contractor?

Entering into contract negotiations

1. Can the contract's expected outputs be clearly stated?
2. What would be the most appropriate length for a contract?
3. Is there a plan to sensitize key stakeholders to the purpose, advantages, and expected outcomes of contracting? If so, how will this plan be implemented?
4. Have the various contract types and payment mechanisms been analyzed? Is the purchaser ready to discuss these options with the contractor?
5. Is it clear what risks the contract contains?
6. Is it clear who will be responsible for monitoring the contract and how evaluations will be conducted? Are indicators to measure contractor performance clearly identified?

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