Chapter 1.

Contracting out Health Services in Post-Conflict and Fragile Situations: Lessons from Cambodia, Guatemala and Liberia

Wendy B. Abramson

Abstract

There are numerous experiences of contracting out in the health sector throughout the developing world as well as in post-conflict and fragile states. The health sector has provided leadership at the global level of government contracting out services to the non-government sector, and is an excellent starting point for fragile states in the process of rebuilding their country’s infrastructure and workforce and regaining the confidence of their citizens.

Executive summary

A number of post-conflict states – including Afghanistan, Cambodia, the Democratic Republic of Congo, Rwanda and South Sudan – are using performance-based contracting to increase access to basic primary health care services. Similarly, countries like Bangladesh, Guatemala and Haiti are using contracting to target geographically and/or culturally difficult-to-reach populations.

This study presents case studies from Guatemala, Cambodia and Liberia of public agencies contracting NGOs or private for-profit companies in the health sector. The cases also serve as examples from which other post-conflict or fragile countries may draw lessons.

Under a loan agreement with the Asian Development Bank, the Ministry of Health (MoH) of the Royal Government of Cambodia implemented a project for managing and delivering a basic package of health services through NGO contracting. To understand the most cost-effective approach, two different pilot models of district-level contracting (contracting in the management of MoH staff, and contracting out the complete health service) were set up in order to compare results with control districts (which remained under MoH management). The contracts were performance-based and had penalties for failing to achieve targets. The results showed a large positive effect on contracted service utilisation rates with both contracting in and contracting out districts, on use of public facilities.
There was little effect on non-targeted service use rates, and negative effects on the perceived quality of care and the incidence of reporting an illness and diarrhoea. While contracting reduced private out-of-pocket costs per capita, it increased public spending per capita, and consequently there was no overall change to total health spending. In addition, there was an increase in access to basic health care and lower per capita private spending by the underserved. Since the pilot phase ended in 2005, the government has moved to a hybrid model focusing on “internal contracting” or performance-based contracting among different levels and entities of government.

With over 25 diverse indigenous groups dispersed across its mountainous terrain, Guatemala presents a number of formidable geographic, cultural, and language barriers to accessing health services. Its central government and Ministry of Health adopted contracting in the late 1990s to expand access to and improve the quality of health services for the country’s rural and indigenous populations. This reflected commitments made in a series of peace agreements, ratified by Guatemala and four other Central American countries that ended Guatemala’s decades-long civil war. Since the ministry lacked adequate infrastructure it turned to civil society, including community-based NGOs, to provide a package of basic health services to the poorest sectors of society. Community-based NGOs have a long history of providing social services to low-income indigenous communities. The Ministry of Health was receptive to this approach because the legal framework authorises it to sign agreements with health sector NGOs. Support from both NGOs (who were sceptical of becoming “employees” of the government) and the government was critical to the contracting approach, especially because certain other sectors, particularly medical labour unions, opposed the change. Initially funded under an International Development Bank (IDB) loan, there are now contracts with over 100 NGOs across the country for integrated primary care with an emphasis on services (the “Basic Package of Health Services to Rural Populations”). Performance measures look at service, activity, quality and productivity. Efforts required for management and administration are low since data collection and monitoring are already provided by the health ministry. Monitoring takes place every two months and a contract evaluation occurs every year.

In post-conflict Liberia the Ministry of Health and Social Welfare (MoHSW) initiated a massive health reform effort that included a new public-private partnership model for health service delivery. Although it received strong support from the international donor community, impetus for the performance-based contracting (PBC) programme came from within MoHSW itself. To initiate the process, MoHSW contracted an outside consulting firm to help its Planning Division and Finance team assess Liberia’s capacity to contract NGOs to deliver a basic package of health services. Based on the assessment, MoHSW developed a contracting policy, strategy and operational plan. An important element was the ministry’s approach to engaging stakeholders and gaining their support from the very beginning. Although sceptical at first, NGO partners warmed to the concept as they learned more. A pool fund was established as a tool for aid effectiveness in order to increase ownership and alignment of funding to the Liberian health sector. Several European donor agencies worked with MoHSW to finance the pool fund, which was to be responsible for managing most of MoHSW’s future contracting. MoHSW’s PBC policy, procedures and processes guide the efforts of other donors, such as USAID, which is also supporting PBC activities in Liberia. By working with key stakeholders throughout the process, MoHSW has ensured a relatively smooth transition from humanitarian relief to development. The fact that the impetus for contracting came from the Government of Liberia and is supported by its stakeholder partners bodes well for the future sustainability of contracting.

Key lessons learned from the three experiences include the following:

- Government leadership and stakeholder involvement are critical for success.
- Contracting out should be a true partnership between the public and private sectors.
It is important to assess the private market when deciding to contract and design health services contracts with private providers.

- The need for basic health care systems should not be underestimated.
- Strong management of both purchaser and provider is essential.
- Management contracting works best when there is a basic functioning health infrastructure base.
- Information systems and record keeping, along with contract oversight and evaluation, are often difficult hurdles to overcome in contracting.
- With some assistance, governments can effectively design, manage and monitor health service delivery contracts.
- Finally, although there is no conclusive evidence as yet, contracting out may help to foster confidence in the governments of fragile states.

Introduction

This paper explores performance-based contracting (PBC – see definitions below) and the factors that have led up to PBC between either the international donor community or host-country government and the non-government sector (i.e. NGOs and/or the commercial sector). The actual process of contracting and managing private services is the cornerstone to the success of PBC. In the health sector, experience has shown that in post-conflict or fragile states that are trying to rebuild core public services (e.g. Afghanistan, Cambodia, Guatemala, Liberia and South Sudan), ministries of health are not naturally enthusiastic about using public finances to purchase private services – whether they are commercial for-profit or not-for-profit services – since this is very different from how core public health services have been delivered in the past.

In some countries attempts have been made to establish new service purchasing organisations external to ministries of health. However, without substantial sector reforms (e.g. Liberia), frequently these agencies can only be given control of special funds through international financing institutions or donor grants/loans (e.g. Cambodia and Guatemala), which can be seen as an initial step in contracting.

The particular interest of the OECD is to describe three different types of public sector contracting: (i) a full service delivery package; (ii) facility management contracting; and (iii) contracting of technical assistance to help inform policy development. This paper describes three examples of government PBC of the non-government sector:

- Contracting out full implementation of a service delivery package of healthcare in Cambodia and Guatemala.
  
  i) Contracting in for the management of civil servants at the facility level in Cambodia.
  
  ii) Contracting out technical assistance to help inform the Ministry of Health and Social Welfare’s development of a PBC policy in Liberia.
  
  iii) Subsequently this paper also describes the Liberian-led PBC initiative, including assessment, stakeholder buy-in, policy development, and contract design and implementation.

The paper was developed through a desk review of pertinent literature, including journal articles, technical papers and grey literature on the subject. Data were collected through guided and semi-structured interviews – either in person, by telephone or by email – of key informants with knowledge and experience of the subject in Cambodia, Guatemala and Liberia.
While the cases presented here are not unique, they were chosen because they represent a range of scenarios in terms of contractor type (e.g. indigenous or local/international NGOs or community-based organisations) and goal (policy development, management or implementation).

**Definition of terms and rationale for contracting out in fragile states**

As a country rebuilds itself after civil strife, relationships that were once *ad hoc* and informal at best among the public and private sectors become more formally structured. Contracting out and performance-based financing are linked. Contracting is a tool used to operationalise performance-based financing, which is closely linked to the “incentive theory” which states that the environment brings out behaviour.

- **Contracting** is the purchasing mechanism used to acquire a specified service, of a defined quantity and quality, at an agreed-on price from a specific provider for a specified period.

- **Contracting out** (CO) is the design and implementation of a documented agreement by which the government (purchaser) provides compensation to another party outside of the government (provider) in exchange for a definite set of services for a specific target population.

- **Contracting in** (CI) is where the national or central level of government contracts local government in a decentralised setting.

- **Performance-based contracting** (PBC) is a specific form of contracting and can involve either contracting out or contracting in. PBC involves transferring competencies for a defined period of time based on a formal written agreement (contract). Payment is made by a government authority (the state) or a donor or donor-funded project to a contractor (provider) and is based upon achieving predetermined results. In other words, the transfer of money or material goods is linked to a concrete and measurable action or to achieving a target; rewards are provided for reaching or surpassing targets.

Broadly defined, there are three categories of contracting out:

i) International donor agency to government. This is based on a model of “conditionality” formally used in the 1980s and early 1990s by the international financing institutions as requirements for loan disbursements, as well as some of the present day methods for paying for performance used by the Global Alliance for Vaccines and Immunizations and the Global Fund for Malaria, AIDS and Tuberculosis.

ii) Within the public sector from one level of government to another. Examples include the Costa Rican Social Security Institute’s model of contracting between levels of care and the model implemented in Brazil with budget transfers from central government to municipal level.

iii) Between any “purchaser” and “provider”, for example between an international donor agency and non-government provider or between government and non-government provider (this is the more common model seen in Afghanistan, Colombia, Guatemala, Haiti, Nicaragua, Rwanda and, most recently, Liberia). Another example is between government provider or private provider and health worker. Examples include Cambodia CO and CI models, Rwanda, and, in the future, Liberia.
Governments have a much greater need to link health service expenditure to performance objectives. Contracting out sets specific targets that ideally will reflect the public sector’s health policy and objectives. To gauge results, these contracts should include a variety of indicators to measure areas such as coverage, quality and efficiency (Abramson, 1999).

In the health sector, public sector contracts with non-governmental organisations (NGOs) to deliver health services are increasingly being used in the developing world and, most recently, in post-conflict or fragile states. Contracts with NGOs are an effective way to expand services quickly to the most marginalised and underserved. Thus, there is increasing interest in developing countries in contracting NGOs and the for-profit private sector to deliver a wide range of services in the health sector, including:

- facilitating stakeholder involvement in health reform policy development;
- health policy development;
- delivery of key public health goods or services such as supply chain management;
- procurement of medicines or medical supplies; and

conducting specific public health services, such as training in technical norms and service delivery protocols and, most recently, for a package of essential health care services, particularly primary health care.

Experience from other sectors, and from the health sector in both industrialised and developing countries, suggests that health services delivered through these mechanisms can be more effective than publicly-provided health services, which are often inefficient. Even with the potential advantages of contracting health services, there have been few evaluations of how well contracting works in practice in developing countries though many lessons and conclusions can be drawn upon examination of experiences in the field. This paper aims to provide lessons on those experiences.

Cambodia

**Rationale and institutional arrangements**

During the 1960s and 1970s Cambodia experienced massive, traumatic social upheaval from war and the murderous policies of the Khmer Rouge regime. At the end of 1979 that regime was removed, but Cambodia’s health system infrastructure had been severely damaged, particularly in rural areas. Health indicators in Cambodia were among the worst in the Asia Pacific region, with an average life expectancy at birth in 1996 of only 56.4 years and high rates of infant and maternal mortality (Loevinsohn, 2001).

Many years of war and political upheaval left essentially no functioning health centres, district hospitals, or ministry of health (MoH), and only an estimated 50 medical doctors in the entire country. Though public health services were supposedly free prior to the contracting reforms in 1996, they often did not reach the poor and largely benefited the wealthy, further exacerbating inequities in the system. Eighty percent of the population lived near or below the poverty line and private out-of-pocket expenditure accounted for upwards of three-quarters of total expenditures on health, with much of these out-of-pocket payments being informal fees for low quality services (Bloom and Choynowski, 2003).

As in many developing countries, a root cause of poor performance of public institutions was low and irregularly paid salaries (USD 10-30/month), forcing health workers to seek alternative sources of
income. As a result, many health workers opened private clinics to supplement their salaries (USAID, 2006). There was often poor management at the district level. This resulted from the appointment of managers on the basis of political connections rather than ability, and exacerbated the low morale of the workers. All these issues resulted in a primary health care system that was unable to deliver an adequate level of services. In addition, there were very few NGOs operating in Cambodia at that time.

**Types of contracts: service delivery implementation and management**

To address these issues, in 1996 the Ministry of Health devised a plan to increase access to and coverage by essential health care services. This was supported by a loan from the Asian Development Bank (ADB). The plan was to test the effectiveness and efficiency of two different contracting models. Twelve districts (of a total of 77) were randomly chosen, with populations ranging from 100 000 to 180 000, were selected for the pilot test. Health centres would offer a minimum package of basic preventive and curative care – such as immunisation, family planning, and treatment of respiratory tract infections – and one referral hospital would offer a complementary package of activities. The following three approaches were tested:

i) **Contracting out (CO):** a complete service delivery contract whereby the contractors have absolute responsibility for service delivery, including hiring, firing and setting wages; procuring and distributing essential drugs and supplies; and organising and staffing health facilities.

ii) **Contracting in (CI):** commonly known as a management contract. The external contractors work within the MoH system to strengthen the existing district structure through a management contract. The contractors cannot hire or fire district health workers although they can request their transfer. Drugs and supplies are provided to the district through the normal MoH channels. The contractor receives a yearly budget supplement of USD 0.25 per capita to spend on incentives for staff, operating expenses, etc.

iii) **Control/comparison (CC):** the management of services remains in the hands of the district health management team (DHMT) and drugs and supplies continue to be provided through normal MoH channels. As with the CI, the DHMT receives a budget supplement of USD 0.25 per capita per year to spend on incentives for staff, operating expenses, etc.

The initial contracting project under the ADB loan ran from 1999 to 2003 and covered a total population of about 1.26 million people, or about 11% of Cambodia’s population (Bloom, et al., 2006). The 12 districts were randomly assigned into three groups of four districts (Table 1.1): (i) those eligible to receive CI bids; (ii) those eligible to receive CO bids; and (iii) a comparison group. Both the CI and the control districts received their operating costs and goods from the national budget and were also able to receive a subsidy of USD 0.25 per capita per year paid for by the ADB based upon submission of a plan. The CI managers were permitted to use the USD 0.25 subsidy to augment staff salaries. The control districts used the subsidy to improve immunisation coverage. After this pilot, contracting was expanded to additional districts, but not as a randomised pilot (Bloom, et al., 2006).

Bidding and forming a contractual relationship were new to many NGOs, with some feeling that the principles behind contracting were contrary to their charitable philosophy. Meetings were held with NGOs in-country to elicit input when developing the bidding documents and contracts; this allowed bidding and contract conditions to be revised, where appropriate, to meet the NGOs’ concerns and to encourage their participation in bidding.
I. CONTRACTING OUT HEALTH SERVICES IN POST-CONFLICT AND FRAGILE SITUATIONS

To ensure adequate understanding and buy-in to the process of formalising relationships between the state and the NGOs, the contracting process took place over a two-year period from the initial decision to contract to the actual signing of the contracts. An international competitive bidding process was used to select contractors after advertising in the international press and sending letters to consulting firms registered with the ADB. To alert organisations without a presence in-country of the upcoming project, an advertisement for expressions of interest was published several months before actually calling for bids.

A “two envelope” system comprising separate technical and financial proposals was use for evaluating bids. A committee was formed to analyse and rank the proposals (Loevinsohn, 2001). During 1997 and 1998 the groundwork for contracting was prepared, and bidding and award of contracts completed. There was a total of 10 bidders from 14 organisations (8 NGOs already working in Cambodia, 4 consulting companies and 2 university groups). Since there were very few indigenous NGOs working in Cambodia in 1997, all the awardees were international NGOs. Two CO and three CI contracts were signed, and in January 1999 contractors began work (Fronczak et al., 2000).

**Contracting out and the state**

It is not clear whether contracting out to NGOs had a negative impact on state legitimacy. What is known is that the pilot phase in the contracting model (prior to 2005) was designed and seen by the government as a temporary measure to rapidly improve service delivery in pilot districts and improve contracting pilot phase of increasing government capacity for contract management, the move from CO to a hybrid NGO contracting model after 2005 is a clear indication of the government’s desire to regain ownership of contracting arrangements.

It is important to note that although the initial phase of contracting was a pilot, contracting has always been a part of government strategies and plans. Contracting was an indicator in the First

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Table 1.1 Characteristics of programme districts

<table>
<thead>
<tr>
<th>Treatment Status</th>
<th>Staffing</th>
<th>Procurement</th>
<th>Budget Supply</th>
<th>TA &amp; MGMT Training</th>
<th>Contract Project Payments</th>
<th>Number of Districts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contracting out-full-service delivery contract</td>
<td>Hired at market rates, MoH staff could take leave of absence</td>
<td>NGO</td>
<td>No</td>
<td>No</td>
<td>USD 3.98</td>
<td>2</td>
</tr>
<tr>
<td>Contracting in-management contract</td>
<td>MoH staff on government salary, usually given performance-based bonus</td>
<td>NGO, through MoH system</td>
<td>Yes</td>
<td>No</td>
<td>USD 1.05</td>
<td>3</td>
</tr>
<tr>
<td>Comparison control district</td>
<td>MoH staff on government salary, often given supplement from user charges</td>
<td>MoH, through MoH system</td>
<td>Yes</td>
<td>Yes</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>Not successfully contracted</td>
<td>MoH staff on government salary, given supplements from user charges</td>
<td>MoH, through MoH system</td>
<td>No</td>
<td>No</td>
<td>0</td>
<td>3</td>
</tr>
</tbody>
</table>

Define a package of key policies and develop implementation tools, including a policy on contracting supported through royal sub-decree on special operating agencies (SOA), and including both internal and external contracting.

Institutional development and capacity strengthening at all levels to implement the above policy packages, including contracting in the initial pilot operating districts (OD).

Implement defined policy packages and prepare for scaling up.


Service delivery versus long-term capacity development

Monitoring and evaluation: measuring and paying for performance

All providers under the CO and CI models applied performance-based incentives to staff. In the CO districts these incentives included a fixed salary supplement above government salaries as well as a performance-based bonus. Staff in these districts could be fired for underperforming. Interestingly, two of the five CO districts attempted to restrict double employment in private practice while the other three tried to restrict outside employment by forcing staff to be present during their assigned hours in the health facility. At the same time, the CI managers found that it was difficult to improve morale and performance in their districts without monetary incentives (Bloom et al., 2006).

During project design and implementation, there were extensive discussions among the MoH, NGOs and other stakeholders about how the contracting process should be evaluated. The contracts provided for a MoH monitoring group to evaluate progress in the contracted districts towards meeting targeted goals and allowed the MoH to withhold payments to the contractors if progress was not satisfactory. Structural, process and health indicators were measured at both health centres and referral hospitals and covered immunisation, family planning, antenatal care, provision of micronutrients and other nutritional support, simple curative care (access, quality, efficiency), and quality of primary health care. A baseline survey was carried out in 1997 (Xingzhu Liu, et al., 2008).

Results

During the study, coverage indicators improved across the board; the CO programme achieved the greatest improvement – doubling the rate of increase in coverage by contracted services compared to areas with no contracting (Figure 1.1). In CO districts improvements in service delivery became evident quite quickly, with marked increases in the use of reproductive health and family planning services. An in-depth assessment of the contracting experience showed that districts with health services contracted out to NGOs delivered care more efficiently and equitably than those that
remained under government control (Loevinsohn and Harding, 2005). Data showed that not only did the CO and CI facilities increase primary health care coverage but that the control districts also increased coverage rates, perhaps due to a trickle-down effect.

Equity

CO programmes not only significantly expanded coverage overall, but also lowered costs for users and improved equity and access. Equity gains were brought about by fundamental regulatory and financing reforms that increased public expenditure on health services and formalised user fees at a level lower than the pre-reform informal payments. One factor that contributed to improved coverage was the proximity of health facilities to consumers, particularly in rural areas. Reduced transportation costs – and the resulting increased effective demand for health services – improved equity. CO reduced the financial burden of health care on the poor; private out-of-pocket health care expenditures by the bottom half of the population fell by 70% over the contract period. The reduction in out-of-pocket costs was greater among this population than among the overall population, indicating the successful targeting of the poor (Bloom et al., 2006).

Contracted services were more costly to the government than direct provision. On a per capita basis, CO increased public health spending by a significant and very substantial USD 2.93 per capita in 2003, against a comparison mean of USD 1.59 (Table 1.2). However, some scholars have concluded that total costs per capita did not increase from a societal perspective, largely because the intervention reduced household out-of-pocket expenditures. They also argue that contracted NGOs performed better than public institutions with similar amounts of total financial input due to the former’s stronger management policies and practices (Xingzhu Liu, et al., 2008).
Table 1.2. Average annual recurrent expenditure per capita (in USD)

<table>
<thead>
<tr>
<th>EXPENDITURE CATEGORY</th>
<th>CONTRACTED OUT</th>
<th>CONTRACTED IN</th>
<th>GOVERNMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>NGO technical assistance</td>
<td>1.28</td>
<td>0.77</td>
<td>0.0</td>
</tr>
<tr>
<td>Staff salaries(^a)</td>
<td>1.32</td>
<td>0.55</td>
<td>0.53</td>
</tr>
<tr>
<td>Drugs, supplies, operating expenses(^b)</td>
<td>1.28</td>
<td>1.08</td>
<td>1.12</td>
</tr>
<tr>
<td>TOTAL</td>
<td>3.88</td>
<td>2.40</td>
<td>1.65</td>
</tr>
</tbody>
</table>

\(^a\) Salaries, bonuses, other allowances.
\(^b\) Drugs, medical supplies, travel, fuel, per diems, office supplies, communications, building and vehicle maintenance and repair, utilities.


Despite not being obliged to do so, contractors in CO districts hired most of the paramedical staff working there and increased their previous government salaries, in some cases up to 10 times more. This may account for the better results from the CO districts. Hence, the difference in cost between CO and CI reflects the increased salaries paid to staff. This new salary was fixed and the possibility of dismissal included in their contract (versus traditional public sector employment which does not base continuation of staff on performance and whereby dismissal for poor performance is difficult). One of the negative effects of the CO model was that in order to work for a contractor, MoH staff had to take leave of absence from their government jobs, which most of them did (Loevinsohn, 2001).

In the CI districts progress was not as rapid, although there did appear to be some improvement in service delivery. The relationship between contractor and MoH staff was less clear; therefore, it took longer to implement changes. Although staff received some incentive payments from the budget supplements and user charges, they expressed concern that contractors’ expectations would interfere with the time they had available to earn money from private practice (Hill, 2007). In addition, some senior district staff requested transfers to other districts in order to continue to work double shifts in government facilities as well as in private practice.

There was considerable concern that neither CO nor CI is sustainable in Cambodia, given the extra costs involved in both models, particularly CO. It is possible that costs will decrease in future contracts if there is greater competition. As more indigenous NGOs become involved, the administrative costs of international non-governmental organisations (INGOs) could significantly decrease. That said, the Cambodian experience did not necessarily have a clear vision for long-term implementation; rather, it was an initial pilot project to see how these two models could positively increase primary health care coverage. It is important however to reiterate that external contractors were required to transfer management capacities and responsibilities to MoH district managers before the end of the contract period to support long-term capacity-building.

In Cambodia there were numerous discussions at the highest level of government as to whether to continue with contracting, and if so, what type. In 2005, a decision was made to revert to performance-based management within the public sector involving different levels and entities within the government. This shift was initiated by two important reforms: (i) the decentralisation and de-concentration of health services; and (ii) the introduction of special operating agencies (SOA) to provide community or civil society oversight of government services, initiated through a Royal Decree in 2008 with the objective of increasing effectiveness of public service delivery. Therefore, CO officially ended in 2005 and the state shifted ownership and control over contracting through a “hybrid” model of contracting, to be implemented in 11 districts between 2005 and 2009. The MoH is
箱1.2。健康和2000年危地马拉和平协议

和平协议于2000年达成，要求危地马拉政府承诺以下内容：

- 增加公共健康支出，占GDP的50%，与1995年的支出相比。
- 将至少50%的政府支出分配给预防性护理。
- 将婴儿和母亲的死亡率减少到现有19%的50%。
- 鼓励社会参与健康。
- 维持根除脊髓灰质炎的认证，并实现麻疹的根除认证。

最初，政府考虑通过向卫生部增加人员，以建立卫生基础设施，并填补这些设施的空缺等。然而，这是一个漫长的过程。因为政府任期相对较短，所以不可能实施这种策略。因此，政府转向社会参与，以扩大覆盖范围到最贫穷的群体，并提供基本的卫生服务包。

非政府组织和社区为基础的组织（CBOs）在冲突期间提供了基本的生存服务，通过救济和紧急努力。但是，这种情况发生在孤立的条件下，并且以最好的方式是零星和断断续续的。武装冲突阻止了任何协调或与政府的合作。社区对政府的内在不信任在战后，以及需要接触的地理上和文化上都难以接触的人群，意味着纯粹的公共部门卫生服务提供模式在2009年之前不会实现。

### 戈麦塔

**政策和机构安排**

戈麦塔最初在危地马拉通过一系列的和平协议，结束了危地马拉长达30年的内战（见箱1.2）。1996年和平协议要求危地马拉的卫生部（卫生部）迅速扩大覆盖范围，以达到最贫困人口——贫困、农村和土著人口。存在巨大的差异，西班牙语的城镇和半城镇人口与非西班牙语的土著农村人口。6这一群体将是政府努力的重点。1997年中美洲和平协议为正式化与社会（NGOs）的安排提供了动力。但是，在总统的领导下，财政部和卫生与社会福利部在国家卫生法和内部卫生部条例第23条（规定初级保健覆盖将通过卫生诊所和社区中心实施）。

<table>
<thead>
<tr>
<th>Box 1.2. Health and the 2000 Guatemala peace accords</th>
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<tbody>
<tr>
<td>表1.2。健康和2000年危地马拉和平协议</td>
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<tr>
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<td>- 增加公共健康支出，占GDP的50%，与1995年的支出相比。</td>
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<tr>
<td>- 将至少50%的政府支出分配给预防性护理。</td>
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<td>- 将婴儿和母亲的死亡率减少到现有19%的50%。</td>
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</table>

最初，政府考虑通过向卫生部增加人员，以建立卫生基础设施，并填补这些设施的空缺等。然而，这是一个漫长的过程。因为政府任期相对较短，所以不可能实施这种策略。因此，政府转向社会参与，以扩大覆盖范围到最贫穷的群体，并提供基本的卫生服务包。

非政府组织和社区为基础的组织（CBOs）在冲突期间提供了基本的生存服务，通过救济和紧急努力。但是，这种情况发生在孤立的条件下，并且以最好的方式是零星和断断续续的。武装冲突阻止了任何协调或与政府的合作。社区对政府的内在不信任在战后，以及需要接触的地理上和文化上都难以接触的人群，意味着一个更传统模式的纯公共部门卫生服务交付将不会实现。
Therefore, the ministry decided to formalise its relationship with NGOs to expand access to and improve the quality of health services for rural and indigenous populations, mainly in remote areas. In 1997, with initial funding from an Inter-American Development Bank (IADB) loan, the Program to Extend Coverage of Basic Health Services was adopted, involving formal agreements in three pilot departments with four NGOs. The original agreement called for a three-year pilot project that would be evaluated and subsequently expanded. Although the increase in expenditure was significant, just six months after the original agreement was signed, the government saw a dramatic increase in the extension of coverage as the pilot was applied nationwide. Within three years this pilot had successfully been scaled up to include 137 agreements with 90 NGOs. Presently there are 85 NGOs contracted by the ministry to offer basic health services in 20 departments and 424 jurisdictions across the country, reaching 4.3 million people in rural Guatemala.

Under agreement with the central government, all donations and loans for the new coverage programme were to be put into a single fund along with Ministry of Health national funds. The only exception to this was the United States Agency for International Development (USAID), whose funds were administered by the United Nations Development Program (UNDP) and administered and managed by Plan International. Since 1997, all recurrent costs have been covered by the ministry. In 2008 the IADB budget support ceased, and World Bank funding was added.

Types of contracts: full service delivery implementation

In Guatemala, the ministry’s role is to oversee and develop norms and protocols for service delivery. The NGOs are responsible for delivering health services in accordance with pre-established performance indicators.

Ministry payments were made to NGOs as budgetary transfers from two ministry budget lines. Contracted NGOs were each responsible for delivering a basic package of primary health care to a geographically targeted population of approximately 10,000. Under agreements made between 1997 and 2004, NGOs were paid prospectively (up front or in advance), through a global payment mechanism, a fixed amount through capitated payments based on population estimates each quarter for a total of four yearly instalments. The only prerequisite for payment was proof of expenditures of at least 75% of total advanced payments. The payment covered the direct cost of the basic package plus administrative expenses, as well as expenditures related to institutional strengthening.

Contracting out and the state

Guatemala’s contracting scheme has fallen under the government’s legal framework for over a decade, with implementation supported by the ministry’s technical teams. Tangible results have been achieved in terms of reaching the most remote populations. The government accepted complete ownership of this model from the beginning, demonstrated by (i) its decision to support it financially; (ii) the ongoing legal framework which supports contracting third parties; and (iii) strong leadership and vision from the ministry to continue to implement and solidify this strategy.

Like Cambodia, the private provider community in Guatemala was sceptical about formalising relationships with the government. When the programme was initiated, NGOs mostly felt that they provided higher quality services to the community than did the public sector. They were initially opposed to being contracted by the government since they were uncomfortable with having to feel obligated to perform in accordance with government rules and regulations or to be in a subordinate role to the government. In addition, there was huge mistrust on the part of civil society and the NGOs which represented civil society. The NGOs’ primary concern was that
contracts could not and would not be transparent and that the ministry would not be able to make timely payments to the organisations. To help ease their financial situation and mitigate the latter concern, the NGOs were able to negotiate payment in advance, including start-up costs (Abramson, W., 2000).

At the time, although there were not many indigenous health service delivery NGOs in Guatemala, there were many grassroots organisations in the indigenous communities. Part of the ministry’s strategy was to use international NGOs to help build the capacity of local NGOs to provide health services. The idea was to create a multiplier effect whereby government agreements would be expanded to include local Guatemalan community groups. There was quite a bit of political concern at the community level and among the NGOs that “contracts” or formal agreements would be construed as “privatisation” of government services. Likewise, at the other end of the spectrum, it was also necessary to obtain internal stakeholder buy-in for this programme in light of misperceptions about agreements or contracts as a form of “privatisation”, especially because certain sectors, particularly medical unions, opposed the change.

To really manage these perceptions and promote partnerships between the community and the government, the ministry decided to implement an intensive promotional campaign targeting communities. The campaign was designed to support NGO autonomy in this process. In addition, the ministry invited organisations with experience in health to attend meetings on the new model. Advertisements on regional radio stations and written and oral invitations were among the variety of communication modes chosen. Unfortunately, some local and smaller NGOs did not receive letters and therefore felt excluded from the process. The government did not advertise the new model in national newspapers in order to mitigate potential fallout from the labour unions, which were already wary of using NGOs under this new mechanism.

It was determined early on that a number of NGOs might not be willing to accept agreements that committed them to delivering measurable results. NGOs were particularly uncomfortable with being asked to deliver concrete results that even the public sector was not able to deliver, for example increasing immunisation coverage or prenatal visits. So, in the first round of negotiations, the ministry did not push performance indicators in the agreements; rather, the agreements stipulated that the NGOs would comply with processes and schedules and “deliver health services” (Nieves et al., 2000). In addition, during the initial round of contracts in 1997, all seven of the proposals submitted were accepted. The ministry then worked diligently to distribute guidelines to all NGOs and gave them technical assistance for preparing future proposals. The following year a similar mechanism, an “open contract”, was applied. This essentially allowed for any acceptable NGO proposal to result in an “agreement”; 117 “agreements” were signed that year.

Around the same time that the pilot project was scaled up, elections took place (1999) and a new government entered office. The new government saw that the extension programme was functioning well and opted to further solidify it by aligning the ministry “agreements” with the Guatemalan Public Contracting Law. There was no need to align these contracts with a particular health plan or policy since this public contracting law enabled the new government to allow the ministry to use national budget line items for contracts with NGOs. This would further institutionalise and legitimise the newly elected government and contracting as a tool to extend coverage via NGOs. Thus, the original “agreements” were transformed into specified and formalised “performance-based contracts” under the national legal framework. Table 1.3 illustrates the differences between the two.

It is widely recognised that the government does not have the capacity to accomplish what the NGOs are achieving in extending coverage in the short to medium term. Although contracting with NGOs
Table 1.3. A comparison of agreements and performance-based contracts (PBC) in Guatemala

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Agreement</th>
<th>PBC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Competitive bidding</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Specification clauses (for contractor)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Beneficiaries</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>• Services</td>
<td>Mainly by service type</td>
<td>Yes</td>
</tr>
<tr>
<td>• Personnel</td>
<td>Yes (in manual)</td>
<td>Yes</td>
</tr>
<tr>
<td>• Performance requirements</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>• Incentives</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>• Posting of performance bond/guarantee</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>• Reporting requirements</td>
<td>Yes (but not specific)</td>
<td>Yes</td>
</tr>
<tr>
<td>Responsibilities of MSPAS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Payment and payment procedures</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>• Performance review procedures</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>• Monitoring procedures</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Provisions for contract change</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Dispute resolution</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>• Unanticipated work or events</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Provision for contract duration</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Provisions for contract non-compliance</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Provisions for contract termination</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Authorised signatures</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>


Box 1.3. The objectives of social auditing in Guatemala

Allow for supervisory audit of services provided by the health ministry through NGOs.

► Promote community participation.

► Use the results of social auditing committees to reach consensus on incentives for providing basic health services.

► Train the community in their rights to basic health services.

► Inform families about basic health services.

► Analyse challenges and develop solutions to the delivery of basic health services at the community level.

has been underway for over a decade and has survived three different administrations, some actors in the health sector still refer to it as “privatisation” or in other negative terms. In order to ensure accountability to the community as well as transparency over the use of government funds, a new mechanism called auditoría social or “social audit” was devised. This social audit was partly put into place in order to ensure community participation in health care services, but mainly to provide a type of community oversight of the use of government funds in the health sector via contracted NGOs (Box 1.3).

Service delivery versus long-term capacity development

Government and provider capacity were prioritised by the Guatemalan government early in the pilot phase. Numerous procedures were developed for nearly every task related to contracting and training, and supervision was adequately budgeted for under the contracting model. This was particularly important given the high turnover of personnel. A management unit, the Integrated Health Care System (Sistema Integral de Atención en Salud, SIAS), was created within the ministry to oversee and monitor contract funds. The SIAS received technical and administrative support from both the IADB and the UNDP to support contract management and oversight systems.

The IADB loan included a line for capacity-building at all levels of the public health care system – central and regional ministry staff as well as NGOs. Other donor agencies, including UNICEF and USAID, also provided funding to support capacity-building for this model. In 2007/08 the IADB provided additional funding for monitoring by assigning personnel at the central and regional levels to be charged with contract negotiations, monitoring, and strengthening information systems. However, this funding ended in 2008, and there remains a gap in human resource capacity for this function, highlighting the importance of putting in place a sustainable exit strategy.

NGO capacity was an issue in Guatemala. The contracts stipulated that payments could be withheld if there were irregularities in the use of resources or poor productivity on the part of the NGO. Although contracts involved a lump sum payment up-front to reduce NGOs’ costs, any payment delay due to administrative or procedural bottlenecks within the ministry was a huge problem, particularly for indigenous NGOs, which were small and lacked a strong financial base. Any payment delay could impede their operations and ability to deliver health services (Abramson, 1999). When delays in payment occurred, many of the NGOs had to resort to other funding sources, such as bank credits, to continue operations. Fortunately, many of the NGOs had immediate access to overdraft protection credits on their bank accounts. However, the NGOs that did not have such access, lack of funds for medical supplies and general operations could have prevented them from providing services to the community.

Monitoring and evaluation of performance

During Phase I of the extension programme, teams from the ministry, together with regional appointees in the District Directorate offices, were deployed to monitor the agreements. Monitoring visits focused primarily on the use of funds, verifying that services were actually being delivered, and capacity-building efforts by the NGOs. In late 1999 the ministry hired external auditors to perform monthly audits of providers’ financial systems, make recommendations and issue warnings to contractors, and identify technical assistance needed to strengthen systems.

However, the quality of services delivered and the adherence to government treatment standards and protocols were not monitored. A 1999 evaluation by the IADB showed that although access to essential primary health care services rapidly expanded under this new model, service quality was sub-standard. In most instances, only one-third of the essential services contracted to be delivered
were actually delivered. This highlighted the need for further capacity-building of NGOs and more stringent monitoring of the agreements.

Since the ministry did not have the capacity to monitor contract performance, it hired two private companies to monitor programmatic and technical implementation of the agreements. After two years of implementation and data collection, the ministry developed an internal computerised system for monitoring performance, which included report preparation by contractors, surveillance data and service delivery data. This system enabled the collection, organisation and aggregation of key indicators, including immunisations by age group, prenatal controls by mobile physicians, delivery of iron sulphate packages to pregnant women, and treatment of new patients for selected illnesses. Data were then used in the renewal of agreements and the move to formalise “performance-based contracts” with NGO providers in 1999 (Nieves et al., 2000).

From 2005 a full-scale automated monitoring and evaluation system was created involving indicators to allow the ministry to evaluate performance quarterly. An automated system generated a quarterly report using information that came directly from the service delivery point (clinic) in their financial and programmatic reporting forms. District personnel from the ministry, together with the NGOs in each corresponding jurisdiction, verified the information. The report, which includes both technical (e.g. programmatic) and financial information, links payment to performance.

Presently, there is one contract per jurisdiction of 10 000 people, totalling 424 contracts. Each contract contains a set of indicators and targets, and performance is measured both by financial expenditure and results. Monitoring and supervising the performance of 424 jurisdictions have proved challenging, and the capacity of the ministry at the department and central levels remains somewhat weak. The contracting strategy/model had always been designed to be implemented and monitored at the departmental level, but it was not until 2007 – a full ten years after this process was initiated – that each department in Guatemala had authority over the provider selection process, contract management and supervision, monitoring and evaluation, and fund distribution. This process presents quite a few bottlenecks and difficulties but is clearly helping to fulfil the vision of the Guatemalan Health Ministry.

Liberia

Rationale and institutional arrangements

Since its democratic elections in 2005, Liberia has taken bold steps to evolve from an emergency relief model of health service delivery to a functioning, decentralised health system. Under this system, counties are responsible for the operational management of health services with support from the central Ministry of Health and Social Welfare (MoHSW) and a diverse set of partners. During Liberia’s 14-year war, approximately 80% of health services were provided by international and national NGOs. Thus, when the war ended in 2003, health care service delivery was fragmented, uneven and heavily dependent on donor-funded programmes and international NGOs, and the policy platform was eroded and virtually non-functional. During the initial recovery phase after the new government took office, the country was unfortunately left with the potential for a huge service delivery gap as the international community was slow to design, develop and commit funding.

The MoHSW announced its vision for a national health system in January 2007 through the National Health Policy and a five-year National Health Plan (2007-2011). The plan defines a framework for shifting from emergency humanitarian relief to development and from vertical programmes to an integrated health system. The health sector has decentralised authority to the county health teams...
The 2007 Revised National Health Policy and Plan states that it is MoHSW’s policy to use contracts with partners. Liberia’s poverty reduction strategy includes several key health targets taken from the National Health Plan. These targets, which will be achieved in the short to medium term (by 2011) by implementing PBC, include:

- ensuring 70% of health facilities are providing the BPHS;
- deploying midwives, physician assistants and lab technicians nationwide;
- training traditionally-trained midwives in home-based life saving skills;
- establishing emergency obstetrics care services in every district; and
- placing 6,000 health workers on “standardised incentives” (however, only a fraction of this will be achieved through contracting).

United Nations Children’s Fund (UNICEF), by providing funds to the MoHSW, who in turn directly contracted a United States consulting firm to conduct the assessment (MoHSW, 2008a). The assessment helped lay the groundwork for the ministry’s performance-based contracting (PBC) policy (Box 1.4). All aforementioned studies reports that were commissioned by the MoHSW were approved by MoHSW and vetted both within MoHSW and amongst key external stakeholders before payment was made.

When MoHSW began its contracting process, it was clear that the full implications of PBC for Liberia’s health system were not immediately understood by all the stakeholders. As a result, the process initially raised concerns among both internal and external stakeholders that the ministry would implement an approach to PBC that had not been thoroughly discussed or vetted. However, MoHSW quickly engaged with its stakeholder partners through information meetings and workshops as part of its assessment and planning processes. The situational assessment was posted on its website and shared widely with stakeholders. MoHSW’s transparency reassured partners about the contracting process, although many NGOs and faith-based organisations (FBOs) still had reservations.

MoHSW is now reforming most of the essential systems within the Liberian health sector for successful NGO contracting for basic service delivery. These systems include finance and administration, human resources, supply chain management, regulation and quality assurance, and health information. In this post-conflict transitional health system, these key systems are being simultaneously developed while the country begins to implement PBC.

Donors quickly offered support to MoHSW’s contracting plans, and several European donor agencies worked with MoHSW to establish a pool fund for managing most of MoHSW’s future contracting. The fund has already begun contracting out BPHS services in areas of critical need. MoHSW’s PBC policy, procedures and processes also guide the efforts of other donors, such as USAID, which is also beginning to support a large volume of PBC activities in Liberia. By working with key stakeholders throughout the process, MoHSW was able to ensure a relatively smooth transition from humanitarian relief to development. The fact that the impetus for contracting came from within MoHSW and is supported by its stakeholders is critical to the continued success, not only of contracting, but the delivery of health services.

**Contracting out and the state**

In 1972, under the Act to Amend Chapter 30 of the Executive Law, the government of Liberia approved the provision of subsidies to civil society and faith-based organisations (FBO). This sets a historical foundation for providing funding to NGO partners. This discrete subsidising of partners reflects the value that the government places on their services, such as those provided by the faith-based Phebe Hospital in Bong County and five similar hospitals in Lofa County.

Few other national governments have directly assessed their country’s capacity to undertake PBC or designed service delivery contracts (with plans to manage, monitor, evaluate and pay NGOs for services). This demonstrates progressive, strong leadership and thoughtful planning. Fortunately, the international donor community has expressed its willingness to support and finance this effort. This helps ensure the political sustainability of contracting in Liberia in the short and medium term, as MoHSW and CHTs strengthen their capacity to manage long-term health service delivery.

**Service delivery versus long-term capacity-building**

MoHSW intends to use contracting to strike a balance between directly supporting health facilities and providing indirect financial support through partners or county health authorities in the form
of PBCs. The alternative to contracting would have been to increase the number of facilities that MoHSW is managing through traditional support. However, as in Cambodia and in Guatemala, this option was not chosen because MoHSW's capacity to scale up quickly was low. Ultimately, MoHSW's long-term goal is to return to the traditional government-managed approach – contracting is being used to achieve that goal. Along with its contracting policy, MoHSW is reforming its human resource policies to establish parity in the pay scales for both the public sector and NGOs. This rate varies by geographic location and living conditions.

Thus partner agencies, particularly local and international NGOs, are being temporarily contracted by the MoHSW to support the roll-out of the BPHS and the CHTs in resuming functional responsibility for health service provision in their counties. In other words, contracting is being used as a tool to increase service delivery and build MoHSW capacity at the county level. Service delivery contracts with NGOs also provide for discrete activities that will support the government's return to managing and fully staffing health facilities in the long term.

The contracting process

As previously stated, the initial exposure to the concepts and practicality of being contractors rather than grantees caused anxiety and concern among NGO partners. The first step for MoHSW was to tackle stakeholders' sensitivity and then to build stakeholder support for the use of PBC.

Shortly thereafter, MoHSW’s Pool Fund Steering Committee approved the provision of bridging grants to NGOs to avoid a transition gap in service delivery and to allow the NGOs to continue supporting health facilities. When, in January 2009, MoHSW presented the contracting policy to the Health Sector Coordinating Committee (HSCC) for endorsement, it was already funding three NGOs to support over 50 health facilities to avoid gaps in service provision.

In February 2009, after HSCC endorsed the policy, MoHSW established a performance-based financing (PBF) working group which included a committee on performance-based contracting. The PBF working group then presented its contracting policy and implementation plan to CHT and NGO service delivery partners at the March 2009 quarterly review of BPHS implementation. Six members of MoHSW’s PBC committee went to Rwanda for a two-week on-the-job training to study the Rwandan experience in PBC implementation.

Stakeholder anxiety began to abate at the annual National Health Plan review conference in July 2008; however, there was still a great deal of concern among civil society partners, NGOs and internal MoHSW stakeholders over what PBC meant for Liberia. In the spirit of collaboration and of ensuring that contracting implementation works well, MoHSW (with a small seed grant from the World Bank) planned a series of two-day workshops with partners, CHTs, local and central government, and private sector groups in late May 2009. This process was designed to build understanding about contracting and solicit their input into the design of MoHSW's request for proposals in July 2009.

The MoHSW also plans a rapid scaling up, beginning with the July 2009 request for proposals, along with an eventual exit strategy based on CHT capacity building. Liberia is using the performance-based contracting of NGOs as a tool to build capacity and support for ministry CHTs to eventually resume health facility management. For the pool funds, MoHSW carries out a capacity assessment of all fund recipients and provides for capacity enhancement as required. At the CHT level, the ministry is currently doing a thorough assessment of county capacity in various areas, giving special attention to counties expected to be potential test cases for “contracting in”.

I. CONTRACTING OUT HEALTH SERVICES IN POST-CONFLICT AND FRAGILE SITUATIONS
Why fragile or post-conflict countries choose to contract

A number of institutional issues on the part of the government need to be considered when deciding whether to contract out services or products. The decision to contract out depends on several factors, including political preferences and the efficiency of service production by non-government contractors compared to government (OECD, 2008). If a public agency’s capacity to perform a function is weak, or a contractor can provide the service more efficiently or effectively than the public entity, then the decision to contract out may be taken.

All three of the examples examined in this paper initially chose contracting out for similar reasons, including:

- The desire to instil confidence and rebuild trust in the state after civil or political unrest.
- The need to rapidly extend coverage to underserved sectors of the population and provide priority services to targeted groups.
- The need to provide services for which the government lacks the infrastructure (human or technical capacity).
- The need to encourage competition among health care providers.
- The desire to improve government’s ability to focus on health policy, planning, financing and oversight.

Why the non-government sector accepts contracts from the government

Not-for-profit NGOs and commercial providers generally enter into contracts for one or more of three reasons: to fulfil a social mission, to sustain themselves financially, or to gain recognition from the government. A contract may allow an NGO to realise one or more of these motivations. In the case of service delivery NGOs in Guatemala, Cambodia and Liberia, contracts were seen primarily as mechanisms to strengthen ties with the communities and fulfil the NGOs’ social mission of providing services to underserved populations. Many of the NGOs in all three countries were accustomed to operating in emergency relief situations and were not prepared to become instruments in “development” work. The service delivery NGOs also wanted to obtain the formal government recognition that a contract would bestow upon their organisation.

Lessons learned

- High-level government leadership and stakeholder involvement are essential for successful contracting out to the non-government sector. Both Guatemala and Liberia were guided by a clear vision from both presidential and ministerial levels of government of how they wished to partner with community-based NGOs. For Liberia, the development of a health policy on PBC reflected MoHSW leadership and innovation in a post-conflict and resource-poor setting. This was done in a participatory manner with extensive involvement of key stakeholders in the community, including donors, providers (NGOs) and MoHSW staff. Liberia is the first and only country that has actually conducted a situational assessment of its capacity to carry out PBC before deciding whether and how to contract NGOs. This demonstrates progressive, strong leadership and thoughtful planning. Likewise, the Guatemala experience is an example of what can be mobilised quickly when there is a sense of political urgency. A lesson learned early on in the Liberian experience is that if stakeholders are not managed well and information is not shared in a transparent manner, contracting could be misconstrued and cause unrest amongst stakeholders, especially in the early stage of policy development.
Contracting out, especially performance-based contracting, is an iterative process. As a country gains in experience, it starts to strengthen its contracting model. In Guatemala the model became institutionalised in peacetime and has expanded greatly to include more service providers and more service delivery functions. Initially, in an effort to rapidly scale up this model, agreements were signed with few criteria for basic service delivery infrastructure or staffing, there were no guarantees made to the provider, there was limited monitoring of performance, providers did not have to set to targets, etc. However, after the first two years of implementation, agreements were gradually formalised and contracts included performance measures. As experience was gained, mutual confidence was strengthened, making this model widely accepted throughout the country.

Contracting out, especially performance-based contracting of public health services, should be a true partnership between the state and non-state sector. In other words, although clear performance measures and incentives are built into PBCs, it is important when delivering a public good that both parties work together to achieve contract objectives. For instance, in Cambodia and Guatemala, performance was measured through careful monitoring of key indicators, and sub-standard contract performance led to sanctions and the non-renewal of contracts. This strongly motivates the contractor to ensure it meets the contract's performance goals. A word of caution, however: by linking payment to the performance of specific indicators, there is a risk that the provider's efforts may be diverted from overall performance to ensuring that output relates more directly to the specific indicators to be measured. Performance targets should be set that reflect the health system that is being measured; in other words, the overall functioning, organisation and management of the NGO's delivery system. Indeed, if, in the case of either service delivery or facility management PBC, the purpose of the contract is to extend services to difficult-to-reach populations, it is important not to create negative incentives for provider performance by being too stringent or rigid in setting performance targets unless access to difficult-to-reach populations becomes an indicator of performance.

The supplier market and the capacity of private providers, particularly NGOs, to serve as government health service delivery contractors in post-conflict or fragile states are important to consider when designing contracting out models in which contractors are paid for performance. As non-profit organisations with relatively informal organisational structures, particularly those accustomed to working in emergency relief or conflict situations, NGOs have to adapt their financial and administrative systems to meet the needs and requirements of their contracting clients, in this case the public sector. This research did not attempt an in-depth analysis of the capabilities that an NGO contractor should have, but the success of a contract certainly depends on the capabilities of both parties. This merits investigation before contracts are signed. For example, in post-war Guatemala at the time of the peace accords and initial agreements with NGOs, there were very few NGOs in operation. Existing NGOs had limited capacity to manage their cost structures and weak organisational and management capacity. Most of the NGOs and CBOs in post-conflict Guatemala were dubious about entering into any type of contractual relationship with the government. In order to give NGOs and CBOs time to develop their capacity to serve as contractors the government moved gradually from formal “agreements” to performance-based contracts with NGOs and CBOs. Although the initial agreements were not fully developed performance-based contracts, they served a similar purpose in that access to basic health care services was quickly increased and the NGO market changed substantially. Underperforming NGOs did not have their agreements renewed and new NGOs were created which, in turn, fostered a more competitive environment.
Contracting out to the non-government sector can instil greater confidence in the state in post-conflict environments. By rapidly increasing access to priority services for the underserved in a transparent and participatory manner, people who have lived through years of conflict, turmoil and corruption can begin to regain trust in the state. Even though there may be concerns about the high transaction costs of contracting; government’s capacity to draft, manage, and monitor the contracts; and its expense compared to the direct public provision of services, contracting can be an effective tool to expand access rapidly to basic health services in fragile states. A model that would bear further examination is the “social audit” in Guatemala, a country with a long history of corruption, particularly during the war period. This approach can give civil society oversight in the use of government funds for contracting out NGOs and can fortify transparency and ensure accountability to the community. This model could very well be adapted to other sectors beyond health.

Management contracting generally works well where there is health infrastructure and a system already in place that functions at least minimally. Where strong managers can be recruited and hired on a contractual basis (either within or external to government) and can be held accountable for results, health facility performance can be improved. That said, when designing a management contract it is important to make sure that managers have enough authority and autonomy to make a number of management decisions. Key areas that managers should be given the authority over include how to use the allotted budget and how to provide incentives to health staff that would, for example, dissuade them from working in private practice on the side. For example, a manager with budgetary authority could have a large impact on civil service absenteeism by paying higher salaries to physicians to oversee specific facilities in exchange for an agreement of no outside employment and rigorously enforcing regular employment hours. Likewise, depending on the civil service regulations and laws, it would be ideal if the contracted manager could have the autonomy to hire and fire staff in accordance with performance.

With some initial assistance, governments can effectively and efficiently design, manage and monitor contracts. Financial support and targeted technical assistance can support post-conflict fragile states to develop policy and design, implement and monitor contracts to non-government providers. This should be done carefully and methodically, paying special attention to the inclusion of key internal and external stakeholders throughout the process from contracting policy formation through contract design, implementation and monitoring. Once a decision has been made to use contracting out as a mechanism to strengthen health services, a new management model needs to be built into the service delivery system that encourages behaviour change and provides performance incentives. It is especially important to focus any new contracting scheme on strengthening the institutional capacity-building of the systems, processes and procedures necessary for a government to be an informed purchaser of outside services.

Essential systems and support need to be in place to ensure success of performance-based contracting, especially in fragile states. Basic requirements include buy-in from key stakeholders from civil society, community-based NGOs and the government; government leadership and political will; strong contract management and oversight systems; and reliable health management information systems and reporting based on appropriate and flexible performance measures. Challenges include inadequate information systems; difficulty in reporting and record keeping; and contract oversight and evaluation (Box 1.5).
Box 1.5. Advantages and challenges to contracting out in fragile states

**Advantages**

- May increase confidence in the state as a provider (purchaser) of essential public services.
- Can be an effective policy tool to increase access to priority services to targeted populations (e.g. improves quality and extends coverage).
- Allows for rapid expansion of health services.
- Draws on non-government sector expertise by providing services that the government does not have the infrastructure (human or technical capacity) to provide.
- Increases oversight of the non-government sector.
- Enlists non-government sector support for public priorities.
- Increases effectiveness and efficiency in the use of public resources through competition.
- Offers greater flexibility in personnel management to hire, fire, and relocate staff members and to offer them performance-based incentives.
- Encourages competition among health care providers.
- Allows a greater focus on measurable results.
- Introduces market tools and incentives such as links between results and costs, demand-based service provision, monitoring of customer satisfaction, service definition and calculations of unit costs, and accountability of personnel for performance.
- Allows governments to focus on other roles such as planning, standard setting, financing, oversight and regulation.
- Can be more efficient and equitable than traditional public provision of services.

**Challenges**

- Demands a high level of supervision and monitoring on the part of the purchaser.
- Management costs may wipe out efficiency gains. Incurs higher administrative and transaction costs, for example, the costs of negotiating, seeking legal advice, and creating adequate information and reporting systems.
- Requires cost containment strategies. Contracting can be more effective if it is implemented with other policy innovations, such as civil service reform, reforms in the fee structure and increased government financial support to purchase essential services, as well as reasonable incentive payments to contracted providers.
- Decreases direct control over the use of public funds while maintaining public sector accountability over the use of government funds.
- Leads to confusion over the roles and responsibilities of government and potential institutional dependency on non-state providers.
- Reduces incentives for the ministry of health to strengthen its own systems and processes for becoming a direct provider of health services (service delivery vs. capacity-building dilemma) unless built in, as in Liberia.
- May be affected by the fact that governments with weak capacity to deliver services may also be weak in a stewardship role.
- May fragment the health system.
Recommendations for contracting out in fragile states

Although there is no conclusive evidence as yet, it seems that when contracting out is implemented on a large scale with proper stakeholder participation, it may serve to quickly instil greater confidence in the governments of fragile states by rapidly increasing access to priority services for the underserved and decreasing out-of-pocket private expense. The implicit understanding is that by applying flexible solutions such as variations of contracting out schemes to health service delivery needs, a newly-constituted government may be able to effectively and seamlessly transition their focus from emergency and humanitarian relief to a longer-term, more permanent and sustainable service delivery model. The following recommendations can guide the process:

1. Ensure there is stakeholder involvement in all stages of the contracting process – policy and strategy development, contract design, knowledge-sharing and capacity-building, competitive bidding and selection process, contract implementation, and monitoring and evaluation – in order to foster partnerships, trust, transparency and co-operation.

2. Clearly consider contracting objectives in the design of contracts.

3. Consider transaction costs (the cost of doing business) when making contracting decisions.

4. View contracting as a strategy to improve or increase service delivery access and performance, not just as a way to reduce costs, which is not always the case.

5. Consider public sector capacity-building needs in the contracting process.

6. Ensure providers develop the capacity to serve as contractors.

7. Consider a competitive bidding process if more than one viable provider is available.

8. Ensure transparency in the contracting process, including ensuring that provider selection is apparent.

9. Specify performance targets and how performance will be measured.


11. Link provider payments to performance results.

12. Ensure that the contract allows flexibility to tailor services to local needs.

13. Since contracting for health services is an iterative process, ensure it is adapted to country-specific conditions.

14. Ensure government can perform its new role as a regulatory and oversight body for all service providers and processes to provide strong supervision, monitoring and evaluation, and administrative and financial tracking.
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Bibliography


I. CONTRACTING OUT HEALTH SERVICES IN POST-CONFLICT AND FRAGILE SITUATIONS


Endnotes

1. In the business world, Incentive Theory is essentially that company owners, in this case Ministry of Health purchasers, should structure employee compensation in such a way that the employees' goals are aligned with the owners' or Ministry's goals. Likewise, in psychology, Incentive Theory basis its beliefs on the theory that a person’s actions always have social ramifications such as: If actions are positively received then people are more likely to act in that manner or if actions are negatively received people are less likely to act in that manner. Thus, if you build incentives for performance into formalised agreements then contractors will naturally perform.

2. Adapted from Eldridge and Palmer (2009).

3. Ibid.


5. 3,700 households were visited both for the baseline survey in 1997 and the evaluation survey in 2003. A separate health facility survey of 140 facilities was conducted in 2003.

6. Although Spanish is Guatemala’s official language, 25 different languages are spoken throughout the country.

7. Further information can be found on the ministry website: www.mspas-sias.gob.gt

8. The “standardised incentives” are a package of incentives that the MoHSW’s newly created office of Human Resources is putting together to ensure parity in compensation and pay.

9. In Guatemala the principal motivation was to strengthen ties with indigenous non-Latino communities.

10. Therefore, capacity-building to support NGOs is necessary under a PBC model as their role evolves from relief to development entities responsible to either international donors or national government.

11. The pilot contracting project did create incentives to focus on the targeted indicators and helped to curtail dual employment among the CO and CI staff.

12. Generally, performance measures that reflect the functioning of a health system would include immunisation rates, numbers of trained birth attendants, number of properly treated cases of malaria, etc.
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