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Filling the Gap:
Lessons for Policymakers and Donors on Contracting Out Family Planning and Reproductive Health Services

PRIMER

SHOPS
Strengthening Health Outcomes *through* the Private Sector

Summary: This primer is an update of *Contracting-out Reproductive Health and Family Planning Services: Contracting Management and Operations*. Focusing on the demand-side (governments and donors) of contracting out with the private sector, the primer describes the concept of contracting out, discusses its rationale and process, and summarizes three cases of contracting out programs. It closes with general conclusions from these experiences and recommendations on how to ensure the effectiveness and sustainability of design and implementation of future contracting out initiatives. Readers are encouraged to learn about the supply side of contracting out with the private sector in the complementary primer *Addressing the Need: Lessons for Service Delivery Organizations on Delivering Contracted-Out Family Planning and Reproductive Health Services*.

Keywords: contracting out, health financing, family planning, reproductive health, private sector health

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Project Description: The Strengthening Health Outcomes through the Private Sector (SHOPS) project is USAID's flagship initiative in private sector health. SHOPS focuses on increasing availability, improving quality, and expanding coverage of essential health products and services in family planning and reproductive health, maternal and child health, HIV/AIDS, and other health areas through the private sector. Abt Associates leads the SHOPS team, which includes five partners: Banyan Global, Jhpiego, Marie Stopes International, Monitor Group, and O'Hanlon Health Consulting.

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Filling the Gap: Lessons for Policymakers and Donors on Contracting Out Family Planning and Reproductive Health Services

The drive toward contracting out of family planning and reproductive health (FP/RH) and other essential health services has been largely influenced by the assumption that government provision of services is inefficient and the fact that public providers do not reach some underserved regions (Loevinsohn 2008).

Developing countries and the international development community have struggled to determine how to deliver and target public services in ways that improve health system performance by promoting accountability for health service delivery. Under pressure to cut budgets while offering accessible, high-quality health services to target populations, many overburdened governments do not have the capacity to monitor or even define the performance expected of public providers in return for their funding. As a result, governments then appear to be providing services without well-established and reachable targets, which can lead to insufficient responsiveness and financial accountability. Increasingly, contracting out is being implemented as a solution. The rising popularity of contracting stems from the premise that the efficiency, quality, and cost-effectiveness of health service delivery can be improved through contracts that set clear expectations for providers and tie payments to achievement of the predefined objectives.

Donors and governments increasingly support contracting out projects due to the breadth of literature documenting it as an efficient means of increasing access to services to target populations. In terms of FP/RH, governments reach target populations by providing these services individually or bundled with other essential health services. In fact, governments have contracted virtually all areas of FP/RH services (see Box 1).

Box 1. Contracting Out FP/RH Services

Many governments in developing countries have contracted out for FP/RH services. An illustrative, but not exhaustive, list includes:

Family planning: Afghanistan, Bangladesh, Brazil, Cambodia, Colombia, Costa Rica, Democratic Republic of Congo, Guatemala, Haiti, India, Liberia, Peru, Korea, Rwanda, Southern Sudan

Maternal health: Mali, Senegal, Bangladesh, Indonesia, Bolivia, Afghanistan, Rwanda, Pakistan

Abortion-related care: Bangladesh

Emergency obstetric care: Afghanistan, Colombia

Source: Eichler et al. 2010, Loevinsohn 2008; Rosen 2000

Despite this high level of interest, few reports have so far presented cross-country experiences or targeted country-level decisionmakers and contract operation managers, who are of key importance to the success of contracting out initiatives. This primer intends to fill this gap by introducing key aspects of contracting and summarizing lessons from countries' experiences in contracting out. In doing so, the primer also aims to help countries implement effective measures to reach the Millennium Development Goal 5b of achieving universal access to reproductive health by 2015.

By focusing on the demand side of contracting out, this paper complements the SHOPS project publication *Addressing the Need: Lessons for Service Delivery Organizations on Delivering Contracted Out Family Planning and Reproductive Health Services*. To support the capacity of service delivery organizations to contract out, that primer offers insight on how to bid on, implement, and manage contracts to deliver FP/RH services.

The following sections describe the concept of contracting out, discuss its rationale and process, and summarize three cases of contracting out programs. The primer closes with general conclusions from these experiences and recommendations on how to ensure the effectiveness and sustainability of design and implementation of future contracting out initiatives.

Readers should note two caveats to this guidance: First, because the contracting out context (e.g., legal framework, level of private sector development, nature of services to be contracted) varies across countries and initiatives, contracting arrangements should be tailored to fit specific needs. Second, in covering many topics, the primer may contain insufficient detail to meet specific needs of individual contracting practitioners. Related topics of interest might include costing the FP/RH services to be contracted out, measuring provider performance in contracting for FP/RH services, monitoring and evaluating contracting for services, and using payment mechanisms in contracting for services. The primer also recognizes the need for rigorous evaluation to analyze the impact of contracting on the efficiency, equity, and quality of care. Additional readings are therefore provided in the bibliography.

What Is Contracting Out?

Contracting out is an arrangement in which a government enters into a legal partnership with a private provider[1] for the delivery of services. Similar to the principal-agent theory in economics, the government acts as the principal who purchases services through an agent, such as a nongovernmental organization or private provider, to meet predetermined targets. This section presents a definition of a contract and its various components, defines contracting out within the health context, and provides a typology of contracting out approaches.

[1] Contracting can be implemented with any independent entity, such as public providers with autonomy as well as private providers. Because this primer considers contracting out as a mechanism for public-private partnerships, the concept of contracting out is limited here to the relationship between governments and the private sector (nonprofit and for-profit entities).

Definitions and Typology

A contract is an oral or written agreement between two or more parties—a purchaser and at least one contractor—that creates an obligation to provide a set of services at an agreed-upon price over a set period of performance. Contracting can be classified into various forms depending on the formality of the contract, contract duration, competition in contractor selection, existence or absence of a subcontractor, and basis of reimbursement (payment).

In regard to contract formality, arrangements can take the form of a *formal contract* or a *relational contract*. The former is legally binding and enforceable, and includes quantifiable performance targets and specified terms. The latter is informal, not legally enforceable, and is used when contractor performance is difficult to quantify and costly to monitor. A relational contract is usually supported and sustained by trust, mutual benefits, and the value of maintaining the relationship.

A contract is an oral or written agreement between two or more parties that creates an obligation to provide a set of services at an agreed-upon price over a set period of performance.

In terms of duration, a contract can be *short term* (up to 1 year), *medium term* (1–5 years) or *long term* (more than 5 years). The length of the contract depends on several factors, including the relationship (that is, trust) between the public and private sectors, the capacity of the private sector, and contract formality.

Depending on how the contractor is selected, a contract can be classified as *competitive* or *sole source*. In the former case, the contractor is selected using competitive bidding (tendering) and predetermined technical and cost criteria. In the latter, contractor selection is done without competitive bidding and is based on the contractor's capacity, as perceived by the purchaser, to deliver the specified services. The decision to competitively bid or sole source contracts depends upon the capacity and market of local or international private providers, as well as the relationship between governments and private providers.

Depending on the existence or absence of subcontractors, a contract can be classified as a *single-tiered* or *multi-tiered* contract. The former refers to a contractual arrangement between the purchaser and a single contractor. The latter describes the relationship in which the contractor also serves as a purchaser, entering into a subcontract with another contractor.
According to the basis of reimbursement, a contract can be:

- *Cost-based*, by which the contractor is reimbursed based on costs incurred
- *Output-based*, by which the contractor is reimbursed based on the quantity of services provided
- *Outcome-based*, by which the contractor is reimbursed based on the improvement in outcome (for the purposes of this primer, the improvement in FP/RH health outcomes)

- *Performance-based*, by which the contractor is reimbursed based on the contractor's performance, measured by the achievement of predetermined objectives and targets

Each contract type creates different incentives for the contractors, which in turn has different implications with regard to the quality, quantity, cost-efficiency, and equity of contracted services (see Table 1). With appropriate levels of contract management and monitoring, contracting out can be a low-risk venture for all involved parties.

Table 1: The Advantages and Disadvantages of Contractual Reimbursement Types

Type of contract	Advantages	Disadvantages
Cost-based	Accurately reimburses providers for services offered	Little incentive for providers to offer cost-effective services; could result in the overutilization, or unnecessary utilization, of expensive services; could result in high transaction and administrative costs
Output-based	Incentivizes contractors to achieve service targets; contracts can easily be terminated if targets are not met	Requires a high degree of monitoring capacity on both sides to accurately capture the volume of services provided; quality might suffer as the provider increases the quantity of services for an increase in payment
Outcome-based	Promotes achieving long-term public health goals and meeting service needs	The immediate impact on outcome may be difficult to determine; strong monitoring capacity is required; quality might be overlooked with mounting pressure to improve outcomes
Performance-based	Maximizes target achievements and incentivizes providers to offer cost-efficient, high-quality services; contracts can easily be terminated if targets are not met	Financial incentives may promote the excessive use of services

Although several contractual arrangements are relevant to public-private partnerships in the delivery of FP/RH services, this primer focuses on contracting out.[2] The most common contractual arrangement in health, contracting out sees the government (purchaser) compensate a private provider (contractor) to deliver a defined set of services to a defined target population either in the provider's facility or at another agreed-upon private location. This contrasts with contracting in, under which the government contracts with private entities to provide services (e.g., administrative and logistics services) to support public provision of health care in public facilities only.

Box 2. Rising Interest in Performance-based Contracting

Purchasers should select the contract type (e.g., cost-based, output-based) based on the targets the contractor is expected to achieve. If improved health outcomes and quality care are the desired results, increasing evidence suggests that a performance-based contract may be an appropriate mechanism. This is based on the premise that performance incentives best align the interests of both parties. A long-time proponent of performance-based contracting, the United States Agency for International Development Office of Federal Procurement Policy states that "[performance-based contracts are] designed to ensure that contractors are given freedom to determine how to meet the government performance objectives, that appropriate performance quality levels are achieved, and that payment is only made for services which meet these levels" (Reynolds 2002).

All contract types are similar in the sense that the public sector is relieved of the administrative and logistical burden of service delivery through contracting and the private sector is able to exercise innovation and make decisions in terms of delivering services. Performance-based contracting differs from other arrangements because the contractor's reimbursement is dependent upon meeting agreed-upon targets. The performance targets can include factors such as health coverage or patient knowledge. In such an agreement, the performance risk is shifted to the contractor, who is encouraged to develop efficient and high-quality service delivery planning.

Purchasers may want to be careful to balance verifiable indicators with reasonable incentives so as to avoid excessive services; for example, paying for additional cesarean sections could result in a profligate number of services. To achieve an appropriate balance, the contract must clearly define the scope of service needs within the given indicators, without dictating how services should be delivered.

One example of performance-based contracting took place in Haiti. After a competitive procurement process, USAID awarded a three-phase project to Management Sciences for Health (MSH) in 1995. MSH was charged with strengthening the capacity of NGOs over a 12-year span, primarily through the utilization of output-/performance-based payment mechanisms. To assist in the transition of payment mechanisms, MSH also provided substantial technical assistance and monitoring support. Three NGOs were selected to participate in the

[2] The original primer includes a text box defining the five types of contractual relationships: contracting out, contracting in, grants, franchising, and leasing.

1999 pilot program and new contracts with incentives across seven performance indicators were negotiated; out of the seven indicators, two were specific to FP/RH and contributed to 40 percent of the negotiated bonus value: 1) Reduction in the level of discontinuation rate for injectable and oral contraceptives; 2) Number of institutional service delivery points with at least four modern methods of family planning and number of outreach points with at least three or more modern methods.

A baseline evaluation study (conducted by an independently contracted research firm) revealed mixed results on the first target: although the availability of modern contraceptives increased substantially, one NGO in particular did very poorly at lowering the discontinuation rate for oral contraceptives and injectables. NGOs performed much more successfully against the second target: the number of institutional service delivery points increased substantially (although the sustainability of those points cannot be determined). Despite not meeting all of the targets, all three NGOs generated more revenue than under the reimbursement scheme, which increased their demand for technical assistance to further improve their programmatic results. In review of the entire 12-year project, NGOs under performance-based contracts performed considerably better than those not under such contracts. For further information on the Haiti example, including an example of performance benchmarks, targets, and payment links, see Eichler, et al. 2007.

Source: Eichler et al. 2007; Johannes et al. 2008; Loevinsohn 2008; Reynolds 2002

Why Contract Out?

There are several reasons for governments to consider contracting out for FP/RH services.

First, contracting shifts the government's role as both a financer and provider of care to that of a steward, whereby the government enters into contracts/partnerships with private providers for the delivery of priority health services. This shift in responsibility further fosters relationships between the public and private sectors. As one form of a public-private partnership,[3] contracting out encourages the two sectors to work in tandem, rather than on parallel tracks. In addition, governments that are more open to contract selection and evaluation criteria promote communication and build trusting relationships with the private sector.

Second, contracting out could solve a lack of access to essential services due to unavailability or shortage of public providers, as in the case of Bangladesh and Cambodia. Rather than build public sector facilities in underserved areas, which would be costly, engaging the already established private sector is an effective and efficient means to promote equitable access to services. With potentially lower administrative burden, the private sector is able to exercise greater flexibility and innovation in service delivery approaches, for instance, through a better distribution of health workers.

[3] In the international health community, the definition of public-private partnerships varies widely, and includes subsidized drugs to public providers and information sharing between the two sectors.

Third, governments may see contracting out as an appealing method to maintain stewardship and allow for contractors to independently scale up service delivery and quality in a decentralized manner. As seen in the exceptional case of Colombia, the government underwent substantial regulatory reform to promote the contracting out of services and address dissatisfaction with public sector health services.

Fourth, using market-like incentives such as competition could stimulate the private sector landscape, especially if barriers to entry are low, and more organizations would be available to scale up access to FP/RH services.[4]

Fifth, governments in developing countries may want to confront the issue of transparency—or rather lack thereof—in the provision of services. Though contracting through competition is no silver bullet, it encourages the public sector to be more open about the allocation and utilization of funds. By encouraging transparency and accountability, the government then grows in its role of a steward, guiding the vision of providing health services.

Box 3. Common FP/RH Service Delivery Objectives

Access: availability, utilization, and coverage of FP/RH services
Quality: ensuring necessary capacity of the providers, adherence to clinical protocols for patient care, and improved health outcomes
Equity: fairness in access to and financing of FP/RH services
Efficiency: the attainment of the above objectives at the least cost

All five rationales motivate the public sector to implement contracting out to achieve FP/RH service delivery objectives (see Box 3), through the following mechanisms:

Partnerships with the private sector: Available private sector resources (e.g., human resources and capital assets) can be quickly mobilized to fill the resource gap in the public sector, avoiding government capital investment (which may be substantial at start-up) and allowing government funds to cover recurrent spending. In some cases, the private sector might already be reaching the public sector's target populations. In this partnership, roles can be clearly divided between the contracted parties: governments maintain the role of steering health systems and policy, while the private sector takes on the responsibility of service delivery.

Incentives (applicable only to performance-based contracts): Under this mechanism, payment is conditional upon meeting predetermined health targets. This linkage provides strong incentives for the public sector to define and determine goals for health outcomes and for providers to meet said goals (see Box 3). In addition, this contractual relationship

[4] This is assuming that the market is competitive in that many sellers offer a differentiated product and no barriers to entry exist. Ideally market conditions would maintain a healthy level of competition and prevent any issues of crowding out.

motivates both the public and private sectors to increase their respective monitoring capacity. By paying for performance, the government promotes accountability and transparency within the contracting entity; rewarding results with incentives can promote positive behavior change in institutions that have struggled with implementing effective, quality programs (Eichler et al. 2010). When offering incentives, however, purchasers should take caution to maintain voluntary selection of FP/RH services (see Box 4).

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

Box 4. Precautions When Providing Performance-based Incentives

- If the contract is sponsored with United States government funds, all parties should be familiar with the Tiahrt Amendment, which promotes the principles of voluntarism and informed choice of FP methods. Specifically, the amendment stipulates that no specific method should be forced on a client, and voluntary and informed consent of clients choosing sterilization should be verified with written documentation and a client signature. To directly connect the Tiahrt Amendment with contracting out with the private sector, a performance indicator can target contraceptive prevalence rate (of modern methods) for women in the targeted population; it cannot be a quantifiable target for new acceptors of certain methods. Further information on the Tiahrt Amendment is available here: http://www.usaid.gov/our_work/global_health/pop/voluntarism.html.
- All parties involved should regularly provide updates on monitoring and ensure that monitoring systems are in sync. When payment is linked to performance, measures should be taken to prevent any fraudulent reporting and verify if contractor performance targets are being met.
- If contractors offer to reimburse patients for transportation, communications about these offers need to be clear and demonstrate that it is not a payment to accept a certain method.
- The social value and moral importance of delivering FP/RH services should be emphasized, as providing financial incentives may negatively affect provider behavior. Rewarding contractors based on performance may cause providers to lose sight of the customer service side of medicine and reduce the amount of time allotted to each patient in order to see as many patients as possible in one reporting period.

Source: Eichler et al. 2010

What Is the Process of Contracting Out?

Various guidelines and handbooks describe the steps of the contracting out process in a nonprescriptive manner (see Abramson 1998; Liu et al. 2004; Loevinsohn 2008; Loevinshon and Harding 2004; and Rosen 2000). Further, documentation of the contract may vary by country and by contract, depending on the nature of the services being contracted out, the legal and regulatory environment, and the capacity of the private sector. This primer divides the contracting process into six steps.[5] These steps, which are consistently mentioned in relevant literature, by no means represent a fixed methodology for contracting. Rather, they can be used as a guide to help governments contract out. Although the steps are generally sequential, they often overlap. As previously mentioned, purchasers are encouraged to tailor the steps to best suit the needs of an individual contract or the context of a particular country.

Step 1: Deciding to contract out

First, the government must decide if contracting out is the best approach to deliver FP/RH services. To do this, policymakers need to assess the feasibility of contracting out and justify why contracting out is the preferred approach. The following factors should be evaluated, keeping in mind immediate and long-term goals, before deciding to contract out:

Technical feasibility: Assessment of the availability of qualified private providers (the market situation and possibility of competition – comparing the landscape of local and international NGOs), the contract and monitoring management capacity and mechanisms of both government and private providers, and the contractibility of the designated FP/RH services (see Box 5).

Health service needs: Assessment of the need, or unmet need, for FP/RH services within target populations; evaluation of FP/RH services the target population accesses (including whether the service is purchased, subsidized, or provided for free from a public or private source); and review of the allocated budget to address the needs of the current and future target populations.

Comparison between public and private provision: Assessment of whether FP/RH service delivery objectives are better achieved by the private or public sector (an evaluation against the objectives outlined in Box 3).

Political feasibility: Assessment of whether the current legal framework and political situation support or oppose contracting out (e.g., do political concerns about redundancy of public providers outweigh benefits of contracting?), the country has or intends to draft a national contracting policy, and donor agencies are politically and financially invested in contracting methods.

[5] The original publication describes five steps of contracting out. This version separates the monitoring and evaluation step into two steps.

Box 5. Contractibility

Prior to making any commitments, governments should first evaluate if the services to be offered can actually be contracted. Contractibility has three dimensions—measurability, monitorability, and contestability.

Measurability: whether the quantity and quality of services being considered for contracting out can be easily specified.
Monitorability: whether the quantity and quality of services can be accurately observed at a low cost (functioning information and monitoring management systems are required on both the purchaser and contractor side).
Contestability: the likelihood that new providers can enter into the market to compete with existing providers for the provision of the contracted services.

Services with a higher level of contractibility are more suitable for contracting out and more likely to achieve desired results. The level of contractibility also depends upon the type of services offered, single vs. multiple (see Liu et al. 2007).

Assessing the feasibility of contracting out should be an interactive process. The above factors are recommended talking points when potential purchasers consult with government health officials, government health workers, nongovernmental organizations, community-based organizations, donor agencies, private for-profit providers, and the target community. Doing so assists in establishing strong relationships and program designs, which could greatly assist in minimizing implementation problems.

Step 2: Preparing the terms of a contract

Both technical and managerial preparations should be made for contracting out; this includes drafting documents on the following topics:

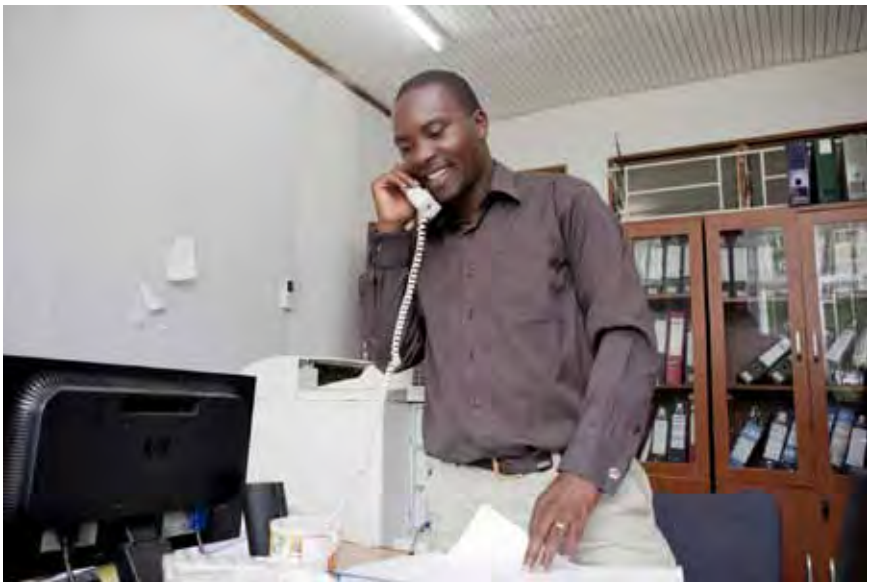
Scope of services and deliverables: This specifies the type/s of services (what) to be carried out under the contract, objective of each service (why), volume of services (how many), geographic areas (where), target populations (whom), and the length of time (when) the services are to be delivered. The main focus should be on stating what services need to be covered, not dictating how they should be delivered.

Indicators/performance standards: This section applies specifically to performance-based contracts. The performance of the specified FP/RH service delivery needs to be defined in operational terms, including how the performance is measured and what performance targets will be expected from contracted providers. Indicators should feature clearly defined numerators and denominators. The type of indicators may

vary—topics include customer satisfaction, quality, and access—but all indicators should be objective, quantifiable, and measurable so as to limit the purchaser's administrative burden. Both indicators and targets should be mutually agreed upon, and the purchaser should be responsible for developing a system or hiring a third party to monitor and measure a contractor's performance against the performance standards. Another key factor is determining how information from the contractor is integrated with the local MOH plans. For instance, how will target data be incorporated into regional target planning?

Compensation requirements and payment methods: Depending on the type of contract, payment will be decided upon by a number of factors. For example, in a firm-fixed price a contractor is reimbursed at a previously agreed-upon price; in an output-based contract, a contractor is reimbursed on a per-unit cost. Language concerning reimbursement for performance-based contracts should clearly state within the contract how payment is to be determined. A section in the contract should specify the amount, method, and timing of payment, including the basis of payment (e.g., per capita, per unit of service provided), how performance is measured (linked with the payment standards), payment schedule, upfront pay, reward for good performance, and penalty for poor performance and nonperformance. In order to best calculate financial compensation, the purchaser should first estimate the costs of providing the defined services and appropriate incentives for attainment of specified performance targets (see Box 2 on performance-based contracting).

Capacity building: In support of developing a successful initiative, the purchaser should ensure that both public and private sector staff are capable of monitoring and meeting the stipulated performance standards. Consequently, both parties may need to undergo capacity-building/strengthening exercises, including the formation of a contract management team/unit, acquisition of needed expertise (contract management, monitoring, evaluation) through training and staffing, and workshops for private providers to strengthen their capacity for bidding on and managing contracts.



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Officials at the Ministry of Health in Malawi manage multiple contracts with the private sector and reporting requirements to donors.

Step 3: Selecting a contractor

The objective of this step is to select a qualified contractor that possesses the capacity and commitment to efficiently deliver the defined FP/RH services. Necessary actions include:

Determine provider selection process: The contract can be awarded through a competitive bidding or sole-source process. This decision will be based on the market analysis of the contractors, including their quantity, distribution, and qualifications. Sole-source selection should be avoided, so as to maintain transparency and promote innovation and efficiency, unless the market is not large or competitive enough. If the market is competitive, governments should maintain transparency when selecting and announcing the chosen provider.

Advertise a request for proposal (RFP): This includes RFP preparation (see Box 6) and broad dissemination to all potential and qualified bidders. To ensure a highly competitive process, the purchaser should consider advertising the RFP through media outlets such as newspapers and websites (for example, dgMarket, a procurement website run by Development Gateway) and by holding "pre-bid conferences."

Box 6. General Format of a Request for Proposal

Introduction: background and objectives of the RFP
Scope of services and deliverables: objectives of service delivery, what, when, how many, where, and to whom
Payment methods: how the contracted providers will be reimbursed
Qualifications: characteristics of providers qualified to submit a proposal
Proposal format: specific sections or issues that the contractor should include or address in the proposal
Other sections: proposal selection criteria, performance indicators, definition of terms, and contact person

Evaluate proposal: Proposals should be evaluated by a committee that has no conflict of interest with bidders or their organizations. The evaluation process includes checking the completeness of each proposal and the qualifications of each bidder, scoring the proposals, and generating a short list of contractor candidates ranked according to the predetermined evaluation criteria, which may include technical and management capability, soundness of technical approaches for delivering services, and costs.

Select the provider from the short list: After further questions, clarifications, and comparison, the selection committee chooses the provider in a transparent process (e.g., voting). Doing so limits the possibility or accusation of selection bias (either through personal preference or bribery) and promotes the idea of institutional trust.

Negotiate contract: Final terms of the contract must be agreed upon by the purchaser and winning bidder. This takes place immediately after the winner of the award is informed. Negotiations are usually limited to a small number of specific technicalities (e.g., performance targets, payment methods and schedule, reporting procedures, and responsibilities). If the purchaser is not able to reach agreement with the bidder after a good faith effort, the purchaser may exercise the option to terminate negotiations and begin discussions with the second highest ranked bidder.

Prepare and sign the contract: Once an agreement has been reached, the contract (see Box 7) should be prepared by the purchaser and signed by both parties in the timeliest way possible to complete the provider selection process.

Box 7. General Format of a Formal Contracting Document

Typical formal contracting documents include the following:

1. Front page: Title of contract, contracting parties, date when the contract becomes effective.
2. Table of contents: List of contract contents (below).
3. Preamble: Purpose of the contract, parties involved, and key points of the contract.
4. Authorized persons and signatures: Signatures of a legal representative from each party, including the date signed.
5. Contract period/period of performance: Time period covered by the contract and options for contract renewal.
6. **Service specification**: Service delivery objectives, definition of services (what), volume of services (how many), target populations (to whom), and geographic locations (where).
7. **Performance specification**: Definition of performance, performance targets, methods of performance measurement, and strategies for performance assurance.
8. Payment methods: Specification of reimbursement type, payment amount, payment schedule with associated deliverables, and ramifications for unsatisfactory performance (if the contract is performance-based).
9. Monitoring plan: Responsibilities of data gathering and record keeping, data collections schedule, definition of quantifiable and measureable indicators, and the use of a third party to monitor contractor performance.
10. Evaluation plan: Guidelines or plans for assessing the project (possibly in terms of quality, efficiency, effectiveness, and equity) through baseline, midline, and endline surveys. To ensure neutrality, a third party should be used to conduct the assessments.
11. Variations to the agreement: The procedure for making variations (including renegotiating performance indicators, if applicable) normally in writing and mutually agreed upon.
12. Best endeavors: The duty of both parties to resolve matters without arbitration if possible.

13. Arbitration: Who the arbitrator will be and how he/she will be appointed.
14. Statutory regulations: The responsibility of all parties to be acquainted with and act in accordance with all relevant legislation and national policy.
15. Others items: Conflict of interest, confidentiality, patent, quality assurance plans, reporting formats, and timelines.

Source: England 2000; Reynolds 2002

Step 4: Implementing the contract

After fully executing the contract, parties should specify the details of an implementation monitor activity to ensure the attainment of the predetermined performance targets. Contract implementation includes the following activities:

A strong monitoring plan is a critical element of a successful contract.

Developing and executing a contract implementation plan: Once the contract is signed, the contractor must develop a detailed implementation plan for approval by the purchaser and then implement the agreed-upon activities on a day-to-day basis.

Negotiating and managing contractual modifications: In response to unforeseen circumstances, a contract will need to be modified during implementation. Modifications may include the addition of new services, a period of performance extension, provision of services in new sites, and changes in obligations and contractual terms.

Maintaining the purchaser-contractor relationship: Successful implementation depends on a trusting relationship between the contracted parties, based on a clearly defined contract management structure. Strategies to achieve this include regular communication, prompt response to ad hoc requests, and efficient dispute resolution management.

Paying the contractor: To ensure achievement of contract objectives and avoid potential conflict, payment should ideally be based on contractor performance and should be timely.

Step 5: Monitoring contractor performance

A strong monitoring plan is a critical element of a successful contract. Monitoring contractor performance assists purchasers in assessing programmatic progress, pointing out areas needing improvement, and showing signs of targets being met. The resulting evidence helps inform decisionmaking, reinforces accountability, and provides valuable insight on contract management and implementation for potential contracting parties. While monitoring activities and methods may vary, the process should be guided by the following principles:

A contract monitoring plan should be developed and executed: At some point in the contract process (the proposal stage, program development

stage, or prior to implementation) a monitoring plan should be developed and rolled out as part of contract implementation. The plan should include a specific set of quantifiable and objective indicators linked to contract performance and a reporting schedule. Both parties should monitor performance and regularly share data, especially at the local level.

Monitoring of contract implementation should be ongoing: The frequency of formal monitoring reviews should be decided based on size, length, and technical needs of the contract and the affordability of the exercise. For example, monitoring in a multiyear contract should be implemented through annual and overall reviews (that is, focusing on the year that is ending but also overall contract performance); monitoring can also be conducted on a monthly and quarterly basis.

Results should be linked with the payment cycle: Monitoring activities should be able to generate timely and valid information that forms the basis for payment of providers.

Step 6: Evaluating program performance

While monitoring efforts assess progress, rigorous evaluations provide a macro-level assessment of the program. Analyses can cover different aspects of the program and can include implementation, process, impact, and cost-benefit analyses. Drafting an evaluation plan includes the following:

Designing and implementing an evaluation plan: Rigorous evaluation plans include clearly defined research questions, objectives that correspond with programmatic objectives, a data collection and analysis timeline, and a strong management plan. Solid programmatic evaluations require a rigorous baseline survey in order to establish benchmark data points.[6] A midline survey and periodic spot checks are recommended, but an endline survey is necessary to help provide a thorough evaluation. When feasible, randomization should be considered to take into account selection bias.

Ensuring appropriate funding: The associated budget should be sufficient to cover the following costs: third-party reviewer (if applicable), sufficient number of surveys, and level of effort for dedicated staff within the contract management unit.

Contracting a third party: As when monitoring contractor performance, contracted parties should try to ensure neutrality to the fullest extent. Depending on the financial sponsor of the contract, certain programs may be required to hire a third party to conduct the evaluation.[7]

Assessing and utilizing results: Depending on the type of evaluation method—focus group, interviews, client surveys—evaluators will have a range of qualitative and quantitative data to assess impact. In order to analyze the collected data, appropriate statistical tools–STATA, SPSS, NVivo—should be used.

[6] A baseline survey is critical for performance-based contracts, as it collects the data against which the contractor's performance is to be measured and guides implementation strategies.

[7] For example, refer to USAID's Evaluation Policy: http://www.usaid.gov/evaluation/

Disseminating results: Once completed, the evaluation report should be distributed among contracting stakeholders to help them make informed decisions on programmatic next steps. Quantifiable evidence will greatly supplement the primarily anecdotal evidence that currently supports contracting out. Success stories and lessons learned can inform future contracting out users on appropriate management and implementation strategies.

What Can We Learn from Country Experience?

A cross-country examination of contracting arrangements to deliver FP/RH services reveals some general trends. Such an examination also reveals that a limited number of rigorous evaluations have been conducted to assess the impact of contracting out.

Contracted private providers with explicit targets to reach the poor show greater equity than in public facilities.

A broad overview of contracting literature conducted by Loevinsohn and Harding (2004) discusses numerous contracting interventions in the delivery or management of primary health care services in developing countries. Only 11 interventions included before-and-after or controlled experimental designs that measured quality of care with tangible outputs; seven of these examined contracting out of health services and four evaluated contracting in efforts for private management of public health service delivery. More than half of the interventions involved provided some combination of primary health care services, including maternal health, child health, and treatment of high prevalence diseases. Although some interventions explicitly mentioned the inclusion of FP/RH in contracted services, none was an FP/RH-specific contract, and it was unclear how extensive the coverage for such services was.

It is difficult to generalize about the effects of contracting out on quality and efficiency. One specific reason lies in the design of contracts; addressing quality and efficiency needs might not be objectives of the contractual indicators, and therefore cannot be measured. For example, Loevinsohn notes that contracted private providers with explicit targets to reach the poor show greater equity than in public facilities (Loevinsohn 2008). Nevertheless, results tend to demonstrate that contracting out can be an effective tool in improving overall access and equity in access to health services by increasing the private provision and coverage of these services and targeting the services to vulnerable and disadvantaged populations (Liu et al. 2004).

Country experiences touch upon the various levels of success that governments face when deciding to contract out. Although the level of impact varies, evidence suggests that more successful initiatives feature collaboration between parties, objective and quantitative indicators, and performance requirements. The cases presented below illustrate the evidence and lessons learned from some of the most often-cited field experiences.

Case Study 1: Colombia[8]

In 1993, the government of Colombia approved new regulatory frameworks that revolutionized its approach to health financing and service delivery. Together, Public Laws 80 and 100 laid the foundation for universal access to health care through decentralization and contracting with the private sector for health care provision.[9] In addition to these laws increasing health care coverage, the government of Colombia hoped that an open market for health care would improve the quality, management, and efficiency of care. The timing of these laws coincided with a gradual reduction in donor funding for the local International Planned Parenthood Federation affiliation, PROFAMILIA. This newly enabling environment encouraged PROFAMILIA, the NGO with a near monopoly on sterilization services, to strengthen operations and management in order to pursue contracts.

Contract and services: Because of PROFAMILIA's dominance in the marketplace and its excellent reputation, the contract between the NGO and the Ministry of Health in the Department of Antioquiá was awarded noncompetitively. The contract was designed to deliver a package of health services that gave priority to educational activities on violence and sexual reproductive health, health promotion and disease prevention, outpatient services (e.g., pap smear, mammogram), and counseling. The payment mechanism for these contracts had a hybrid form: 50 percent was a prospective per capita payment based on an estimated volume of services, and the remaining 50 percent was reimbursed on a case-by-case basis. In addition to this payment agreement, PROFAMILIA charged copayments to patients on a sliding scale depending upon the patient's income, the social security system under which the patient was classified, and the services rendered.

Evaluation and evidence: Relevant literature discusses the impact of contracting out on PROFAMILIA's management and funding portfolio rather than conducting a rigorous impact evaluation. Such a review still provides important information on how contracting can affect the marketplace for RH services as well as the delivery of services.

The extensive expansion of services and decentralization of regulation placed financial and structural pressure on the government of Colombia. Rapid roll-out of decentralization resulted in miscommunication between the federal and municipal levels of government. For example, revisions to central Ministry of Health reporting standards were not implemented at the local level, the level at which the contracts were awarded and reviewed for reimbursement. Because the contracts stipulated that payment could not be released without compliance of central standards, payment was withheld for a significant amount of time as local authorities worked to amend the discrepancy between reporting systems and verified contractor services. As a result, the government was unable to reimburse PROFAMILIA on a timely basis, and the NGO subsequently faced difficulties in complying with the various invoicing demands and in maintaining a steady cash flow.

[8] This case is summarized from Abramson 1999; Lopéz and Pérez 2003; and Rosen 2000.

[9] Public Law 80, the Public Administration General Statute on Government Contracting, set in place the regulatory framework for contracting with private entities. Public Law 100 guaranteed payment for health services through three options: private health insurance, the Social Security Institute, and the government-subsidized complementary health plan (only available to the wealthiest 10 percent of the population). As defined by Public Law 100, universal access also included sexual and FP/RH services.

Overall, contracting with the government of Colombia significantly diversified the NGO's funding portfolio. Prior to the enactment of Public Laws 80 and 100, 30 percent of PROFAMILIA's budget came from international grants; by 1999, the international grants constituted only 5 percent of the NGO's budget, and the organization had entered into 250 contracts with governmental departments worth $5 million.[10]

The emphasis on contracting led to new competition for the NGO with quite a stronghold on the FP/RH marketplace in Colombia. Although PROFAMILIA did see a decrease in the utilization of some services, the NGO still maintained its influence by maintaining quality standards and offering new revenue-generating services such as urology. The NGO increased efficiency by changing its spending habits, updating its technology, and undergoing intensive organizational restructuring (Lopéz and Pérez 2003).

Lessons learned: The Colombian experience demonstrates that (1) political will and supportive legal and regulatory frameworks can have significant influence on the success of contracting programs; (2) complex reimbursement systems can delay the delivery of services and possibly expose the contractor to financial risk; (3) contracting with the private sector can stimulate competition in the health services market place, by either introducing new providers or encouraging providers (including those in the public sector) to expand services, but quality of services depends on government regulation; (4) local government stewardship can decrease dependency on international funding streams; and (5) contracting can encourage indigenous NGOs and other private entities to ensure financial sustainability through diversified sources of income.

Case Study 2: Cambodia[11]

Health indicators in Cambodia are among the worst in the Asia Pacific region. Average life expectancy at birth in 1996 was estimated at only 56.4 years: 54.4 for males and 58.3 for females. High rates of infant and maternal mortality were also a cause of concern for health officials. Such poor health indicators were not consistent with the relatively high levels of health expenditure observed in this low-income country ($19 per capita per year or approximately 8 percent of gross domestic product). Public expenditure on health was low; private out-of-pocket expenditure accounted for more than three-quarters of total expenditures on health (WHO 2002). Much of these out-of-pocket payments consisted of informal fees for low-quality services, creating significant equity and efficiency concerns. Though public health services were supposedly free prior to the establishment of contracting reforms in 1996, in practice they did not reach the poor and largely benefited those in higher income strata, further exacerbating inequities in the system. Relatively high levels of expenditure were not translating into high-quality or effective service. A root cause of poor performance of public institutions was low ($10−30 per month) and irregularly paid salaries that forced health workers to seek

[10] PROFAMILIA also signed a fee-for-service contract with the Office of the Mayor of Bogotá for the provision of FP services (including postpartum FP services) and prenatal, postpartum, and postnatal care.

[11] This case is summarized on the basis of Bhusan et al. 2002, and Soeters and Griffiths 2003.

alternative sources of income. As a result, many health workers opened private clinics in order to earn supplemental income.

Contract and services: To address these issues, in 1996 the Ministry of Health devised a coverage plan, supported by a loan from the Asian Development Bank, which involved the construction or rehabilitation of health centers, each of which was designed to provide services to a population of about 100,000. The coverage plan defined a minimum package of services and activities that would be offered at the health center level. The package included basic preventive and curative care, such as immunization, family planning, antenatal visits, provision of micronutrients and other nutritional support, and basic treatment of diarrhea, acute respiratory tract infections, and tuberculosis. The plan was also used to test the effectiveness and efficiency of contracting with NGOs and the private sector for the delivery of the essential health services. Nine districts with populations ranging from 100,000 to 180,000 were selected for the pilot test, with two districts in a contracting out group, three in a contracting in group, and four in a control group. The contracting out groups were given control over management and delivery systems. The contracting in groups provided management support to staff, and the government provided funds with a supplement of $0.25 per capita through the loan. Performance indicators and targets were developed and used for monitoring contracted providers. Incentives for improving service delivery performance were provided by linking the level of pay with achievement of monitored results.

Contracting out programs not only significantly expanded coverage overall, but also lowered costs and improved equity and access.

Evaluation and evidence: Cambodia provides an example of how contracting health services can achieve the twin goals of efficiency and equity. Over the 2.5-year trial period, coverage indicators improved across the board (see Table 2); the contracting out program achieved the greatest improvement, doubling the rate of increase in coverage of contracted services relative to areas where no contracting intervention was initiated. Contracting out districts also experienced marked increases in use of FP/RH services, almost tripling the increase found in control districts.

Contracting out programs not only significantly expanded coverage overall, but also lowered costs and improved equity and access. One factor that contributed to improved coverage was the proximity of health facilities to consumers, particularly in rural areas. Reduced transportation costs and the consequent increased demand for health services had a positive effect on equity, as demonstrated by the fact that the increase in health care utilization in contracting out districts was concentrated among low-income households. Overall, recurrent costs of contracting out amounted to $22.70, as compared to $26.40 for contracting in and $26.90 for the control group.

Table 2: Average Change in Health Service Coverage Indicators (Percent)

Indicator	Control	Contracted-in	Contracted-out
Antenatal Care	160.1	233.3	401.5
Trained Delivery	26.0	0.0	0.0
Facility Delivery	0.0	255.1	142.0
Antenatal Tetanus Immunization	149.1	148.6	400.0
Family Planning Knowledge – all	307.4	317.4	599.5
Family Planning Knowledge – lower 50% SES*	271.0	301.4	559.5
Contraceptive Prevalence Rate	93.4	104.5	122.6
Child Immunization	55.7	81.8	158.1
Vitamin A Capsule Receipt – all	-25.1	18.1	20.9
Vitamin A Capsule Receipt – lower 50% SES*	-24.1	29.9	23.9
Percent of Illnesses Treated in Public Health Facility – lower 50% SES*	81.7	490.5	1096.0

**socioeconomic status*

Equity gains were also brought about by fundamental regulatory and financing reforms that increased public expenditure on health services and formalized user fees at a level lower than the pre-reform usual and customary informal payments. Lower out-of-pocket payments significantly reduced the financial burden on poor consumers: out-of-pocket health care expenditures by the poorer half of the households fell by 70 percent during the contracting period. As the lower socioeconomic groups gained more benefits from the less expensive services, demand for services among this population began to rise.

Lessons learned: Contracting health services was an effective component of an overall reform process initiated within the Cambodian health sector. The initiative demonstrated that (1) contracting out can be an effective policy tool for improving access and equity, and thus have a positive impact on equitable use of maternal health and child health services, as well as of FP/RH services; (2) government-financed and -monitored contracted health service delivery can be more efficient and equitable than traditional government-provided services; (3) contracting out can be more effective if it is implemented along with other policy innovations, such as reforms in

the fee structure and increased government financial support to purchase essential services, as well as assured, reasonable incentive payment to contracted providers.

Case Study 3: Bangladesh[12]

In 1999, less than 40 percent of the Bangladeshi population had access to basic health care and government services were poorly utilized. Expenditure on health in 1996/1997 amounted to $10.5 per capita or 3.9 percent of GDP. An informal payment system existed along with official user fees, making basic health services difficult to afford for poorer segments of the population. In the 1990s, many donor agencies questioned the effectiveness and integrity of government institutions and thus channeled funds to NGOs, which had traditionally played an important role in delivery of various social services in Bangladesh. A number of large-scale health care projects initiated during the late 1990s were geared toward improving the effectiveness of service delivery through the contracting out of services to NGOs.

This discussion draws on the experience of the government of Bangladesh through the aid of a $40 million loan from the Asian Development Bank for the Urban Primary Health Care (UPHC) project. Under the management of the government of Bangladesh, 16 NGOs, private sector groups, and professional associations were contracted to deliver basic services: immunization, micronutrient support, family planning, prenatal care, basic curative care, health education, and assistance for female domestic abuse victims. By implementing the project in Chittagong, Dhaka, Khulna, and Rajshahi, UPHC targeted the lowest wealth quintiles of the Bangladeshi population. The project took a four-pronged approach to align project interests with the government's major population health priorities and the five principles of the bank's health and population sector strategy for Bangladesh: (1) improvement in the management of the health system; (2) greater private sector involvement; (3) increase in the resources devoted to recurrent costs; (4) improvement in the skills of health workers; and (5) increase in the use of cost-recovery mechanisms (Asian Development Bank 2007).

Contract and services: Although the loan became effective March 30, 1998, delayed assignments to city officials and partnerships with the private sector resulted in activities starting close to two years later (the project was therefore given a 24-month extension). At the end of a competitive bidding process, the government entered into 16 contractual partnerships with nine local NGOs and the Chittagong City Corporation, each covering about 300,000–400,000 people in one of the four regions. The range of services were grouped into the following categories: (1) FP/RH; (2) maternal child health; (3) vaccinations; (4) common and minor diseases/injuries; (5) endemic diseases; (6) diagnostic services; (7) nutrition; (8) emerging diseases (AIDS, dengue fever); (9) health education and behavior change communication; (10) violence against women; and (11) deliveries. Although services were provided at subsidized rates, the

[12] This case is summarized on the basis of Asian Development Bank reports. To learn more about Marie Stopes Bangladesh's own experience in the management of the contract, read *Addressing the Need: Lessons for Service Delivery Organizations on Delivering Contracted-Out Family Planning and Reproductive Health Services.*

project attempted to recover some costs. As the contracted organizations delivered services, the government of Bangladesh worked on strengthening the UPHC infrastructure and provided financial and technical capacity-building support for all partner organizations and the four city corporations, especially in the health departments.

Evaluation and evidence: Baseline and endline data revealed a significant increase in access to services and improved health knowledge due to the utilization of contracted services at affordable, reduced, or no cost. In reviewing the UPHC project results, the Asian Development Bank stated that the project had a significant impact on the health of targeted populations.

Overall, the project reached over 6.16 million recipients (including 3.02 million poor and disadvantaged people) with 16.35 million services. Project completion surveys reveal that each center served an annual average of 85,550 patients, a majority of whom reported satisfaction with the quality of services. In terms of FP/RH, data show highly satisfactory improvements. The modern contraceptive prevalence rate of married women (15-49 years old) increased from 38 percent in 2001 to 88.6 percent in 2006, and the percentage of married women who knew at least three modern contraceptive methods increased from 34 percent in 2001 to 84 percent in 2006. Statistics for maternal and child health also show significant improvement. The percentage of pregnant women who received antenatal care by a doctor at least once increased from 18 percent in 2001 to 97.8 percent in 2006, while the percentage of mothers attended at least once by a trained health worker after delivery increased from 22 percent in 2001 to 90.5 percent in 2006.

Out of the $40 million loan, only $24.14 million was utilized by the project. The Asian Development Bank attributes this result to the low bids received from local organizations and the fact that partner organizations provided most of the commodities such as vaccines and contraceptives. While this is cost-effective on the donor side, *Addressing the Need: Lessons for Service Delivery Organizations* reveals the dangers of bidding low and disbursing payments inconsistently.

Lessons learned: The UPHC project demonstrated that (1) sustainability requires supportive government policy for private sector engagement, along with actual government commitment and partnership with the private sector; (2) budgetary discussions on drugs, vaccines, pharmaceuticals, and medicines should take place during contract negotiations to avoid financial strain on contractors; (3) subsidized services increase access for poorer populations, but this program might not be sustainable without donor funding; (4) concurrent capacity building of local stakeholders and partner organizations greatly increases project efficiency.

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A nurse conducts prenatal counseling in Bangladesh.

How to Ensure the Sustainability and Effectiveness of Contracting Out

Purchasers of contracted services should be aware of two types of sustainability. The first type relates to *management sustainability* (can the contract be successfully managed without donor funding or technical assistance?) while the second relates to *programmatic sustainability* (can the contractor continue providing the services without interruption?). In fragile or developing countries, donors may see contracting out as an effective method to increase service delivery. If the difficulty lies in the government's availability of funds or technical capacity to manage contracts, donors may choose to channel funds through the public sector and provide guidance on appropriate oversight techniques. Prior to withdrawing their support, donors must ensure that a strong management and advisory government team has sufficient budgetary allocations for the service delivery contracts.

Contracting out has received criticism regarding programmatic sustainability. Although evidence on sustainability is still growing, Loevinsohn suggests that out of 14 case studies, the contracting efforts observed in 12 of them (some of which have been in place for 12 years) have been expanded, and that in at least 10 cases the size of the original scope has more than doubled. He concludes that in order to ensure the sustainability of contracting out programs, all parties must take the appropriate measures to ensure the effectiveness of programs. Such measures include maintaining health expenditures at efficient levels and obtaining political will to improve access to health services such as FP/RH.

In fragile or developing countries, donors may see contracting out as an effective method to increase service delivery.

To ensure that contracting out programs for FP/RH services achieve expected and desirable results, participating managers need to have essential contract management capacity, follow the contracting out steps proposed above, learn from experiences of both successful and failed contracting programs, and be innovative in the use of competition and incentives to promote service delivery performance objectives. Doing so not only increases the effectiveness of contracting organizations, but will also build the capacity of contracting NGOS or providers to help them develop into highly functioning entities that are essential to progress toward sustainable development. Particular attention should be paid to the following key points (see Box 8 for mistakes to avoid):

Transaction costs should be minimized. Transaction costs are incurred for establishing contracts, contract management, planning and implementation, contract enforcement, and efforts to avoid and resolve conflicts. These costs are an important consideration when determining whether the services should be contracted out, because they can easily escalate—particularly when contracts are overly complex and/or large numbers of providers are engaged in contract negotiation. To avoid cost escalation, it may be necessary to adopt transaction cost reduction strategies, including limiting bureaucratic procedures for handling management activities, avoiding long-running contracts, keeping contracts

simple, sharing standard forms of documentation, focusing monitoring efforts on main objectives, and avoiding micro-management.

Box 8. Ten Mistakes to Avoid in Contracting Out for FP/RH Services

1. Transaction costs are not considered or are underestimated when making contracting out decisions.
2. Contracting out is viewed solely as a cost-reduction exercise rather than a strategy to improve service delivery performance.
3. Purchasers and contractors possess weak contract management skills.
4. Competitive bidding is not used when alternative providers are available.
5. Contractor selection is not transparent and is based on individual preference.
6. Contractor's performance is not well monitored and evaluated at the right time, using appropriate methods.
7. Performance measurement is not operationally defined, and performance targets are not specified or amended after being evaluated.
8. Payments do not link to the results of performance evaluation, or are delayed to the extent that the contractor cannot deliver services without payment.
9. A poor relationship between the parties fosters a lack of trust, probity, partnership, and cooperation to the point of frustration.
10. Contract does not allow the contractor flexibility to tailor services to local needs.

Competition should be used to the fullest extent possible. When more than one potential contractor exists, the purchaser should use competitive bidding to reduce cost and to improve performance under the contract. In instances where the initially targeted provider market is monopolistic, the government may attempt to (1) privatize or provide autonomy to public providers and allow them to compete for the contract, (2) relax policies or legal regulations to allow additional private providers to enter into the market, and (3) allow the government purchaser to cover larger populations so as to open up more provider competition.

Make full and appropriate use of economic incentives. If the parties enter into a performance-based contract, the contractors' performance must be operationally defined and targets of performance explicitly specified, providers must be monitored and evaluated against those performance targets, and they should preferably be paid based on the results of performance evaluation. Failures in the above areas can create perverse incentives for providers to maximize their income or to minimize inputs (e.g., to see more patients, but deliver poor quality service), putting the purchaser's objectives at risk. All parties should also recognize that original indicators may have been misconceived or future cultural or economic events may cause the indicators to change. The contract should have a clause allowing for renegotiating and amending performance indicators.

Contract management capacity and autonomy should be ensured. Contracting out represents a shift of the role of government from both financing and provision to merely financing, from service delivery to purchasing, and from micro-management to macro-stewardship. Government purchasers need to be prepared and willing to change roles from provider to steward of health services, as well as to support the improvement in key capacities that support these functions, including the capacity to undertake population needs assessment; to perform provider market analysis; to design, negotiate, and manage the contracts; and to manage and monitor the performance of contractors. Contracting out also represents an increase in the government purchaser's trust of a private entity: evidence shows that autonomy entrusted to contractors improves performance. To avoid bureaucratic barriers, contractors should be given autonomy and authority in areas such as personnel and procurement of subcontractors. These role shifts may require focused support and training in one area, such as a needs assessment, or fundamental capacity building in all aspects of a contract to monitor and attain contractual objectives and performance targets.

Maintain a coordinated effort at all levels. While a contractual relationship usually involves two parties—the purchaser and the agent—multiple actors can be involved, and relationships can become complex as a result. For example, the federal government may contract an NGO to provide service in different districts, but district health officers or decisionmakers are not involved during contract negotiations or implementation. Such a situation could lead to an overlap of services, which contracting hopes to avoid. To best ensure the delivery of quality services, performance and target data should be shared with the local health department in addition to donors if applicable, and contractors should regularly communicate with all relevant health offices—at the district and national levels. In addition, as learned in the Bangladesh case, staff turnover and a lack of a contingency plan or communication between parties can greatly hamper project progress. To prevent any interruption in services, it is advised that each contracting party appoint employees especially dedicated to maintaining communication and discussing staff transition plans if necessary.

Jessica Scranton

A couple learns about family planning techniques at a private hospital in Kenya.

Constantly maintain partnership and cooperation. Cooperation is a crucial element of a successful public-private partnership. Ensuring the performance of health care delivery requires coordination and collaboration between purchasers and providers. A confrontational relationship could lead to irreconcilable conflicts. Partnership among the parties involved will help prevent disputes from occurring. Under this concept, the contracting process should create a "buy in" to the overall goal of satisfactory performance on time, within budget, and without claims. The purchasers and providers need to meet and communicate regularly to have a clear understanding of mutual expectations and issues. The parties should mutually develop performance goals, identify potential sources of conflict, and establish cooperative ways to resolve problems that may arise during contract performance. Contracting parties should avoid relying on claims and litigation to resolve disputes because these can be costly, time-consuming, and often ineffective. Instead both parties should try to seek less confrontational resolutions through dialogue, communication, and openness.

Jessica Scranton

Private providers help extend access to family planning services which can benefit the entire family.

CONCLUSION

Together, this primer and its companion piece offer a comprehensive view from both the demand and supply sides of contracting out. By targeting a variety of audiences, the authors hope to promote the benefits of contracting while providing concrete examples of past challenges and how to create successful contracting programs.

While the evidence on the benefits of contracting out with the private sector increases, the key lessons for donors and governments interested in contracting are to (1) prior to contracting, conduct a thorough review of the country's political, regulatory, health services, and private sector landscape; (2) provide an enabling political and regulatory environment that provides concrete guidance and mechanisms for contracting with the private sector; (3) promote open competition in the private sector by soliciting bids in response to an RFP; and (4) maintain clear communication channels with contractors, especially in regard to monitoring progress of implementation. Contracting out is not a silver bullet for development, but it creates levels of accountability for both the private and public sectors. By relieving the public sector of the dual responsibilities to finance and provide FP/RH services, contracting out allows the public sector to increase its stewardship and ownership of policy while the private sector implements programs to complement and expand upon the existing public health structure. In developing countries, progress still needs to be made in increasing the capacity of both sectors to manage and implement contracts. However, the evidence to date shows reasons to be optimistic about the future of contracting.

As seen in the country case studies, contracting out with the private sector was used to mitigate a number of public health concerns, including access to services, affordability of services, dependency on foreign donor assistance, and efficiency of service provision. Overall, evidence reveals that contracting out is an efficient procedure that allows the public sector to define clear FP/RH health goals so that the private sector can help achieve public health objectives through its innovative and extensive reach.

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