Performance-Based Contracting for Health Services in Developing Countries

A Toolkit
Performance-Based Contracting for Health Services in Developing Countries

A Toolkit
Performance-Based Contracting for Health Services in Developing Countries

A Toolkit

Benjamin Loevinsohn
# Contents

<table>
<thead>
<tr>
<th>Boxes, Figures, and Tables</th>
<th>vii</th>
</tr>
</thead>
<tbody>
<tr>
<td>Why and How to Use This Toolkit</td>
<td>xi</td>
</tr>
<tr>
<td>Outline of the Toolkit</td>
<td>xiii</td>
</tr>
<tr>
<td>Acknowledgments</td>
<td>xv</td>
</tr>
<tr>
<td>Abbreviations</td>
<td>xvii</td>
</tr>
</tbody>
</table>

## 1. Summary of the Toolkit

- Background: What Is Performance-Based Contracting? 1
- How to Contract 2
- Whether to Contract 6

## 2. What Is Performance-Based Contracting?

- Introduction 9
- What Is Contracting? 10
- What Is Performance-Based Contracting? 11
- What Kinds of Health Services Can Be Contracted? 11
- How Is Contracting Different from Other Approaches to Organizing Health Services? 12
- What Approaches to Contracting Work Best in Common Situations? 15
- How Is Contracting Related to Pay for Performance? 16

## 3. How to Contract

- Step 1: Conduct Dialogue with Stakeholders 20
- Step 2: Define the Services 26
- Step 3: Design the Monitoring and Evaluation 37
- Step 4: Decide How to Select Contractors and Establish the Price 44
- Step 5: Arrange for Contract Management and Develop a Contract Plan 52
- Step 6: Draft the Contract and Bidding Documents 55
- Step 7: Carry Out the Bidding Process and Manage the Contract 64
Boxes

3.1 Establishing Worker-Controlled Health Cooperatives in Costa Rica 24
3.2 Paying for Performance in Haiti 32
3.3 Accuracy of the Routine Administrative Records Part of the HMIS 40
3.4 Lot Quality Assurance Sampling 41
3.5 Collaborating with Private Practitioners to Treat Tuberculosis 46
3.6 Results of a Government Maintaining Control of Staff Assignments 57
3.7 Attracting Health Workers to Underserved Areas 57
3.8 Decentralizing Drug Procurement in Afghanistan 59
5.1 Contractor versus Government Performance in Industrial and Middle-Income Countries 73

Figures

1.1 The Seven Steps of Contracting 3
3.1 The Seven Steps of Contracting 20
5.1 Median Double Differences in Coverage Rates from Studies with Controlled, Before-and-After Methodology 72
C.1 Coverage of Prenatal Care by Approach Used 127
C.2 Change between Baseline and Endline Surveys 128
C.3 Scores on a Broad Index of Quality of Care 139
C.4 Use of BHU by Respondents Reporting Illness in the Last Month 156
C.5 Change in the Average Number of Outpatient Visits to BHUs per Month, Compared with Same Month of Year before in NGO (PRSP)-Managed Districts and Government-Managed Districts 157

Tables

1 Toolkit Appendixes xiv
2.1 Typology of Service Delivery Arrangements 14
2.2 Types of Contracting to Consider in Some Common Situations 15
2.3 Types of Pay for Performance and Their Relationship to Contracting 17
3.1 Reasonable Performance Indicators in a Contract for Primary Health Care 27
3.2 Some Less-than-Ideal Indicators in a Contract for Primary Health Care 28
3.3 Examples of Input, Process, Output, and Outcome Indicators 29
3.4 Examples of Indicators for a Performance-Based Contract 38
3.5 Means of Data Collection 39
5.1 Summary of Evaluated Contracting Experiences 74
5.2 Some Common Concerns about Contracting and the Global Experience 86
5.3 Financing and Provision of Services 91
5.4 Common Concerns about the Environment for Contracting 94
A.1 Key Performance Indicators and Targets 99
A.2 Next Steps for Agreement Implementation 106
AA.1 Key Performance Indicators and Targets 109
B.1 Procurement Approaches to Use in Different Situations 120
C.1 Changes in the Concentration Index of Health Services, Follow-Up Minus Baseline 129
C.2 Annual Total Health Expenditures per Capita, 2003 129
C.3 Changes in Key Indicators from Baseline to Endline in Project and Control Upazilas 132
C.4 Changes in Coverage, 2000–03 134
C.5 Changes in Coverage among the Poorest 50 Percent, 2000–03 135
C.6 Changes over Time in NGO and Publicly Managed Districts in El Alto 137
C.7 Reported Data on Service Delivery in Butare Intervention Area Compared with the Rest of the Country (Rural Areas) 142
C.8  Before-and-After Results of Household Surveys in Cyangugu  142
C.9  Comparison of Cooperatives and CCSS-Managed Clinics, 1990–99  144
C.10 Characteristics of the Areas Implementing the Different Approaches Used in Guatemala  148
C.11 Results of the Different Approaches to Service Delivery in Guatemala  149
C.12 Performance of NGOs in Haiti as Use of Bonuses Increases  151
C.13 Results from 14 Evaluated Initiatives  153
C.14 Change in Private Provider Behaviors  160
D.1  Key Performance Indicators and Targets  163
E.1  Targets for the PBA  171
E.2  Management Indicators for the PBA  172
E.3  Impact, Output, and Process Indicators for FSW HIV Prevention Services Contract  178
Why Use This Toolkit? This toolkit provides practical advice to anyone involved in, or who is interested in becoming involved in, performance-based contracting of health services with nonstate providers in the context of developing countries. It addresses many of the issues that may be encountered. Input from experienced contracting professionals will give newcomers increased confidence as they go forward. Experts directly involved in contracting on a large scale have contributed to the development of this toolkit.

What Is Contracting? Contracting is a mechanism whereby a financing entity procures a defined set of services from a nonstate provider.

What Is This Toolkit About? Performance-based contracting is a type of contracting with a clear set of objectives and indicators, systematic efforts to collect data on the selected indicators to judge contractor performance, and consequences for the contractor, either rewards or sanctions, based on performance.

Intended Audience. This toolkit has been developed for individuals working for government agencies, other purchasing entities (such as insurance companies and social insurance funds), nongovernmental organizations, faith-based organizations, private (for-profit) health care providers, World Bank staff, and development partners.

Where to Start. The short summary gives an overview of the toolkit. Readers can then delve into increasing levels of detail by working through the various sections and appendixes.
Limitations of the Toolkit. The actual task of contracting is more of an art than a science. Although a reasonable amount of evidence suggests that contracting works (see section 5), many of the “how-to” issues are a matter of experience rather than systematic evidence. As we learn more about contracting, some of what we believe now may change. Keep in mind that contracting occurs in different contexts. Some issues raised in the toolkit are not relevant in certain situations but may be crucial in others.

Don’t Panic! A number of issues have to be considered in contracting, but everything need not be exactly right on the first try. Beethoven scratched out more than a few musical ideas as he was writing his Ninth Symphony, and scientific scans of Leonardo da Vinci’s Mona Lisa show that he changed his mind about her more than once. Just like creating great art, every detail doesn’t have to be perfect every time, and certainly not right off the bat.

Other Useful Materials. Additional materials including key documents, such as a contracting plan, draft contract, terms of reference, and checklist, are included in the toolkit and are available in MS Word format at http://www.worldbank.org/hnp/contracting.
Outline of the Toolkit

Section 1: Summary of the Toolkit. This overview is useful for reference and for quick refreshers later. It will be helpful to read the summary before moving on to the main part of the toolkit.

Section 2: What Is Performance-Based Contracting? This section provides background on contracting, including definitions of key terms, the types of services that can be contracted, how contracting relates to other ways of organizing health services, and which contracting approaches work in different settings.

Section 3: How to Contract. This section provides a systematic way of thinking about contracting and how to do it in practice. It looks at seven aspects of the contracting process from initial dialogue with stakeholders through carrying out the bidding process and managing contracts. This framework will help ensure a systematic consideration of the choices and challenges (see figure 1.1).

Section 4: Checklist for Contracting. This checklist contains tasks and issues to address while designing and implementing a contract. The checklist can also be used to review an existing contract to see what is missing or could be improved.

Section 5: Whether to Contract. This toolkit assumes that the reader has an interest in contracting, but it is useful to keep asking questions. This section reviews the evidence for contracting in developing countries, explores why contracting appears to work, and addresses concerns that have been expressed about contracting.
Table 1 outlines the five appendixes to this toolkit, the purpose of each, and when they should be used.

<table>
<thead>
<tr>
<th>Appendix</th>
<th>Purpose</th>
<th>Point of use</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Contracting Plan: Strengthening Primary Health Care Services in Country X</td>
<td>Example of a contracting plan or contracting manual, which should be developed for all contracting efforts</td>
</tr>
<tr>
<td>B</td>
<td>World Bank Procurement Approach</td>
<td>Guidance for World Bank clients and staff on the procurement methods to use in different contexts</td>
</tr>
<tr>
<td>C</td>
<td>Description of Evaluated Contracting Experiences</td>
<td>Real-world experience that can be used to see what others have done</td>
</tr>
<tr>
<td>D</td>
<td>Terms of Reference for Third-Party Evaluation</td>
<td>Example of TORs for an independent evaluation of a contracting effort</td>
</tr>
<tr>
<td>E</td>
<td>Terms of Reference Examples</td>
<td>Examples of TORs for primary health care service that lays out objectives, scope of work, roles, and responsibilities</td>
</tr>
</tbody>
</table>

Note: TOR = terms of reference.

Your Suggestions and Comments Are Welcome. Please send us your suggestions about how this toolkit can be made more useful: http://www.worldbank.org/hnp/contracting or healthpop@worldbank.org.
Acknowledgments

This toolkit was written by Benjamin Loevinsohn with the support and insights of many people, including Anabela Abreu, Silvia Albert, Asha Ayoung, Patricia Baquero, Bernard Becq, Indu Bhushan, Sekhar Bonu, Emanuele Capobianco, Sadia Chowdhury, Mariam Claeson, Laura Coronel, Agnes Couffinhal, Tania Dmytraczenko, Rena Eichler, Phoebe Folger, Nancy Fronczak, Pablo Gottret, April Harding, Peter Harrold, Zafrul Islam, Barbara Kafka, Vijay Kallavakonda, Shaknaz Kazi, Zahed Khan, Kees Kostermans, Gerard La Forgia, Mattias Lundberg, Jean-Pierre Manshande, Tonia Marek, Alison Micheli, Patrick Mullen, Homira Nassery, Barbara O’Hanlon, Patrick Osewe, Toomas Palu, Aakansha Pande, Miyuki Paris, Harry Anthony Patrinos, Plan International (Shehlina Ahmad, Josef Decosas, Sandy Fortuna, Tom Miller, Sovannarith Sok), John Roome, Robert Saum, Julian Schweitzer, Yolanda Taylor, Inaam ul Haq, Joseph Valadez, Jacques Wangata, and Abdo Yazbeck. Special thanks to the World Bank Institute.
Abbreviations

ARI  acute respiratory tract infection
ARV  antiretroviral
BF   breast fed
BHC  basic health center
BHU  basic health unit
BINP Bangladesh Integrated Nutrition Project
BPHS basic package of health services
BPS  basic package of services
BWP  Bahawalpur
CBO  community-based organization
CCC  Chittagong City Corporation
CCSS Centro Costaricense de Seguridad Social
CHC  comprehensive health center
CHW  community health worker
CI   contracting in
CIDA Canadian International Development Agency
CMU  contract management unit
CO   contracting out
DP   development partner
DPT3 diphtheria, pertussis, and tetanus (vaccine, 3 doses)
EPI  expanded program on immunization
FBO  faith-based organization
FSW  female sex worker
GOX Government of Country X
GS government with support
HFA health facility assessment
HHS household survey
HIV human immunodeficiency virus
HMIS health management information system
IBBS integrated behavioral and biological surveillance
LFA local fund agent
LQAS lot quality assurance sampling
M&E monitoring and evaluation
MC management contract (contracting in)
MCH maternal and child health
MOH Ministry of Health
MOHFW Ministry of Health and Family Welfare
MOPH Ministry of Public Health
MSW male sex worker
NGO nongovernmental organization
NSP nonstate provider
NSSP new sputum smear positive
NTP national tuberculosis program
P4P pay for performance
PAA partnership agreement area
PBA performance-based agreement
PHC primary health care
PHCC primary health care center
PHD provincial health director
PLWHA people living with HIV/AIDS
PPA performance-based partnership agreement
PPHCC Provincial Public Health Coordination Committee
PPP public-private partnership
PubMed U.S. National Library of Medicine
Abbreviations

RFP  request for proposal
RYK  Rahim Yar Kahn
SDC  service delivery contract (contracting out)
SSS  single-source selection
STI  sexually transmitted infection
TB   tuberculosis
TOR  terms of reference
UNICEF United Nations Children’s Fund
USAID U.S. Agency for International Development
VCCT voluntary confidential counseling and testing
WHO  World Health Organization

All dollar amounts are U.S. dollars unless otherwise indicated.
Summary of the Toolkit

Background: What Is Performance-Based Contracting?

Contracting is when a financing agency (government, insurance entity, or development partner), also known as a “purchaser,” provides resources to a nonstate provider (NSP, such as a nongovernmental organization [NGO] or private sector firm), also known as a “contractor,” to provide a specified set of services, in a specified location, with specified objectives and a set of measurable indicators of success, over a defined period.

Performance-based contracting is a form of contracting that explicitly includes a clear definition of a series of objectives and indicators by which to measure contractor performance, collection of data on the performance indicators, and consequences for the contractor based on performance such as provision of rewards (such as performance bonuses or public recognition) or imposition of sanctions (such as termination of the contract or public criticism).

Many different types of health services have been successfully contracted, including offering primary health care (PHC) services in rural or urban areas, providing HIV prevention services among high-risk groups, establishing health insurance systems, acting as an intermediary with many for-profit providers to strengthen the management of tuberculosis patients, managing hospitals, and operating diagnostic services within health facilities.
Contracting is different from providing grants because it is the purchaser, not the NSP, who determines which services will be delivered, where, and how performance will be measured. Contracting is also different from internal contracts between one level of government and another, in part because the sanctions that can be used against local governments are usually limited (for instance, they cannot generally be “fired” for poor performance). It is difficult to be prescriptive, but there are some situations that are more conducive to specific forms of contracting than others. For example, in areas in which existing government services are not achieving adequate results, there may be an opportunity to contract in management services. Contracting is often a form of “pay for performance” (P4P) and has been used sometimes to introduce P4P for individual health workers.

How to Contract

If you believe that contracting may be an approach worthwhile to try in your situation, then you need a systematic approach. Contracting is robust and has worked well even in difficult circumstances, so don’t worry excessively about making everything perfect. Contracting is more of an art than a science, but a systematic approach can avoid some of the most common mistakes. The “contracting cycle” shown in figure 1.1 can help in this regard, as can the checklist in section 4, which summarizes in two pages most of the issues that need to be addressed.

Step 1: Conduct Dialogue with Stakeholders

Designing and implementing an effective contracting system requires close consultation with stakeholders, such as government health workers, government health officials, local politicians, NSPs, development partners, and the community. After initial discussions about contracting, it is worthwhile to draft a contracting plan (see the example in appendix A) and then go back to stakeholders with concrete proposals to discuss. There is usually a need to identify “champions” among the stakeholders to support contracting efforts and overcome resistance. A few common stakeholder concerns are frequently encountered that can be addressed in a number of creative ways. For example, resistance
from government health workers may be overcome by paying higher salaries or providing performance bonuses.

**Step 2: Define the Services**

The process of designing a contract may involve thinking about many issues, but five are usually of central importance:

1. Defining the objectives of the contract and selecting the indicators of success
2. Ensuring that equity and quality of care are addressed
3. Ensuring that contractors (and purchasers) focus on achieving the stated objectives, possibly through the use of paying for performance
4. Defining the size and location of service of each contract “lot”
5. Defining the scope of services to be delivered.

The process of contracting must start with a clear definition of objectives and indicators. Indicators should focus mostly on outcome and outputs, be measurable, be defined as precisely as possible, and be few in number (generally fewer than 10). It is worthwhile to include indicators that ensure that the poorest people and other marginalized groups receive high-quality services. Ensuring that purchasers and contractors pay attention to the key indicators can be accomplished by P4P (for example, by using bonuses or linking payment to the number
of services provided). Paying for performance is attractive, but indicators must be independently verified and perverse incentives must be avoided. For example, paying for each additional cesarean section may lead to an excessive number being performed.

The purchaser needs to define each contract “lot,” that is, the size and location of service of each individual contract. The lots should be relatively large to achieve economies of scale, facilitate management and monitoring, and increase competition among bidders. The scope of services needs to be defined in sufficient detail so that contractors know what is expected, although the terms of reference (TORs) should generally avoid telling contractors “how” they should deliver services except to ensure compliance with national technical standards.

**Step 3: Design the Monitoring and Evaluation**

Considerable argument is often given to which indicators should be used, but little time or effort may be given to deciding how data will be collected, for instance, through the use of a routine health management information system, household surveys, health facility assessments, or supervisory checklists. A schedule for data collection needs to be established with particular attention to collection of baseline data. It needs to be clear who is responsible for implementing the monitoring and evaluation (M&E) plan, and a sufficient budget should be allocated to ensure that the plan can actually be implemented.

**Step 4: Decide How to Select Contractors**

**Competitive Selection Process.** The best way of selecting a contractor is through an open competition, according to clear selection criteria developed in advance, that uses a transparent and independent evaluation process. An independent and diverse bid evaluation committee comprising experts from various institutions is an important part of the process. The number of interested bidders can be maximized in a number of ways, including carrying out consultations with potential contractors before the selection process and advertising widely.

**Selection of Contractors under World Bank Guidelines.** There are two distinct methodologies for selecting contractors. When the output is an easily measured physical result (for example, maintenance of equipment or cleaning), the contractor should be selected using a
wide, competitive process in which the contract will be awarded to the bidder with the lowest price who meets the technical criteria established by the purchaser. When the output is of an intellectual nature (for example, managing a hospital or providing treatment to people living with HIV/AIDS), the contractor should be selected in conformity with procedures normally used for the selection of consultants. There are three methods that can be used in this case: selection based on quality and cost among short-listed firms, fixed budget, and single-source selection. Hybrids of these approaches exist that can also be useful. Although open competition is the preferred approach, circumstances that will be described later in the toolkit may justify the fixed budget and the single-source selections.

**Step 5: Arrange for Contract Management and Develop a Contracting Plan**

Managing contracts requires full-time attention by a clearly defined, reasonably sized team with explicit responsibilities and authority. To function effectively, such a team requires people with a variety of skills and a sufficient budget to cover salaries, equipment, and transportation. When the number of contracts is large, consideration should be given to using contract management software. Effectively implementing a contracting effort requires a written contracting plan (most issues can be dealt with in six or seven pages, as can be seen from the example in appendix A).

**Step 6: Draft the Contract and Bidding Documents**

**Maximizing Managerial Autonomy and Accountability.** There is increasing evidence that autonomy improves contractor performance. Maximizing managerial autonomy also allows purchasers to hold contractors accountable. Safeguarding autonomy can be accomplished by clearly defining the respective authority of the contractor and government officials, using lump-sum budgets rather than line-item budgets, giving contractors control of personnel functions (such as hiring, firing, posting, and handling pay and benefits), and leaving procurement of various supplies up to the contractors.

**Protecting the Interests of Both Parties.** Contract duration should be at least four to five years to allow both parties to get used to
the contractual relationship. To facilitate implementation of the contracts and to reduce opportunities for corruption, clear procedures must be in place for processing both mobilization payments and ongoing payments. Enforcement of a contract requires a clear process for termination, use of other sanctions, and a practical mechanism for resolving disputes.

**Reporting and Other Obligations.** Contracts should specify the content of the contractors’ regular progress reports and may mandate independent financial audits. The TORs should also address whether and how contractors can levy user charges, what their responsibilities for building health worker capacity are, and who is responsible for maintenance, repair, and rehabilitation of physical infrastructure.

**Formulating a Request for Proposals.** On the basis of the considerations above, a request for proposal (RFP) or similar document should be drafted that includes instructions to the bidders on how to prepare their bids and the criteria by which contractors will be selected, the TORs, and the draft contract.

**Step 7: Carry Out the Bidding Process and Manage the Contract**

In almost all situations, it should be possible to complete a competitive bidding process in six months. Long delays should be treated with suspicion. Because contracting involves complex relationships, the contract management unit should meet regularly with contractors and regularly report to major stakeholders. During the implementation of the contracts, the contracting plan and the contract should be reviewed regularly.

**Whether to Contract**

A review of global experience with contracting for health service delivery is described in section 5. Fourteen evaluated examples of contracting were found; it appears that in developing countries contracting with NSPs to deliver primary health or nutrition services can be very effective and that improvements can be achieved rapidly. These results apply for a variety of services and settings. All of the studies found that contracting was successful. Ten of the 14 studies compared contractor
performance with government provision of the same services, and the contractors were found to be consistently more effective. The current weight of evidence indicates that contracting with NSPs will provide better results than government provision of the same services. Future contracting efforts still deserve to be evaluated rigorously.

The advantages of contracting include the following:

• Ensuring a greater focus on the achievement of measurable results
• Tapping the private sector’s greater flexibility and avoiding bureaucratic “red tape” and unhelpful political interference
• Reducing important aspects of corruption, such as absenteeism, selling of positions, and theft of drugs
• Using constructive competition to increase effectiveness and efficiency
• Overcoming “absorptive capacity” constraints that often plague government health care systems
• Improving the availability and distribution of health workers
• Broadening the autonomy of managers on the ground
• Allowing governments to focus on other roles that they are uniquely placed to carry out, such as planning, standard setting, financing, and regulation.

The review provides some information on the concerns that have been expressed about contracting, including:

• There is a concern that contracting is unlikely to enable service delivery on a large scale. However, four of the examples studied involved populations of tens of millions of beneficiaries, and one now covers 30 million people. It does appear that contracting can be conducted successfully on a large scale.

• There has also been concern that contracting might be more expensive than government provision of the same services. Six studies provided an opportunity to test this hypothesis, and each found that NSPs performed better even when public institutions were provided similar amounts of resources.
Sustainability also does not appear to be an issue. Twelve of the 14 examples of contracting have been continued and expanded. Six cases have been sustained for seven years or more. Provision of a basic package of primary health care by contractors costs between $3 and $6 per capita per year, an amount that should be affordable even in low-income settings. Thus, financial sustainability does not appear to be a serious threat.

There is a concern that contracting will decrease equity. Three of the cases studies explicitly examined this issue; two found that NSPs were able to significantly improve health services for the poor and did a better job than government provision. The other case found no difference.

A number of observers have been concerned that ministries of health have limited capacity to manage contracts. This review found that contract management was a significant issue in at least three of the examples studied; however, it did not prevent contractors in those instances from being successful. In addition, there were at least six examples in which contract management was done reasonably well, which suggests that the problem can be overcome.

According to the global experience so far, it appears that contracting is a practical means for improving health service delivery. Its use should be expanded, but continuing evaluation is warranted. Many concerns have been raised about contracting, but the experience so far suggests that few are so serious as to render it ineffective. The concerns that seem most serious are the following: first, contract management capacity is often weak and needs attention; second, tenders and contract management may create opportunities for fraud and corruption (even if they reduce other forms of corruption that afflict the public sector); and, third, bureaucratic opposition to contracting is sometimes deep-seated.