The Rockefeller Foundation–Sponsored Initiative on the Role of the Private Sector in Health Systems in Developing Countries

Technical partner paper 11

Provider Purchasing and Contracting Mechanisms

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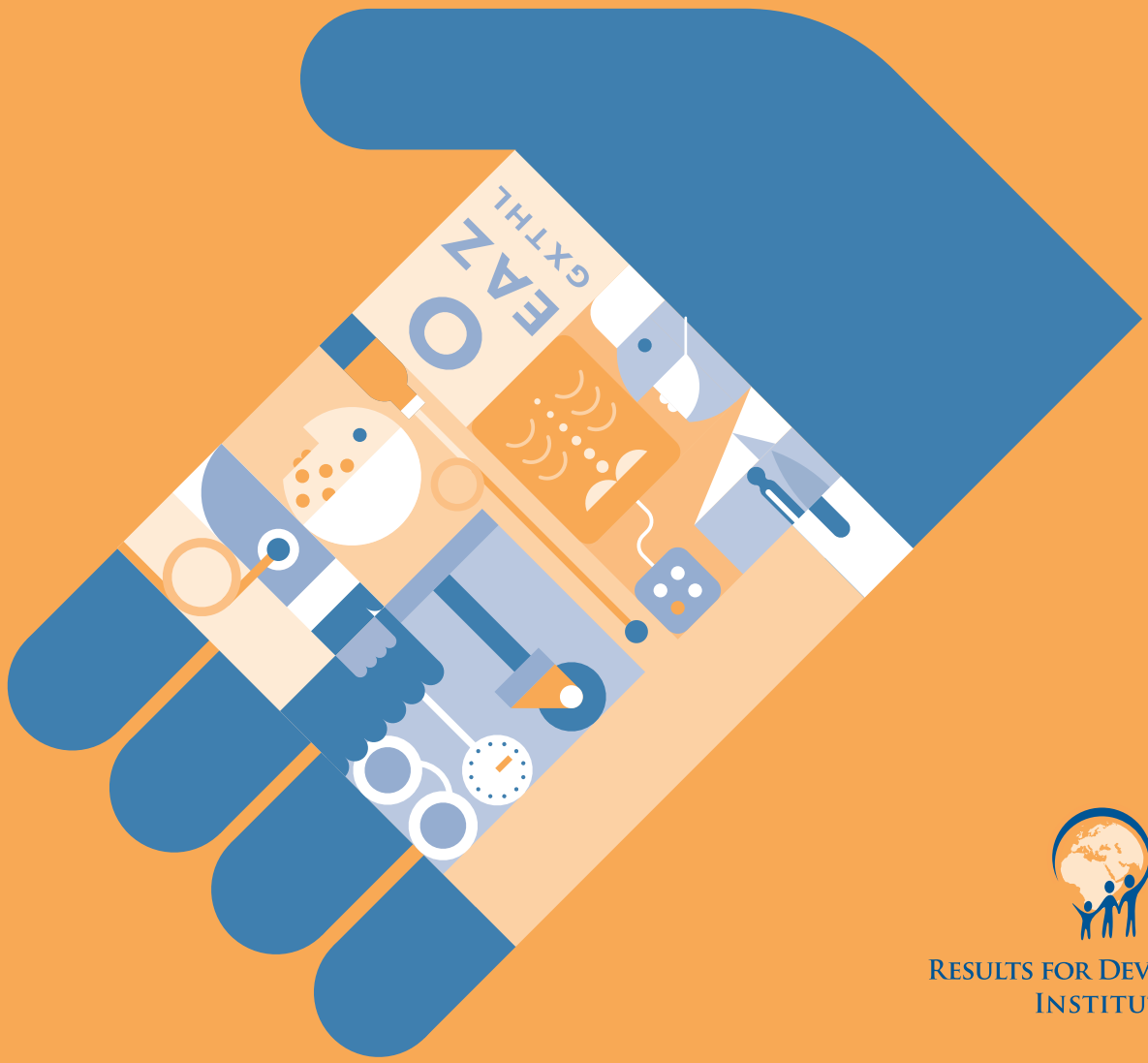

Results for Development Institute

The Rockefeller Foundation

Provider purchasing and contracting mechanisms

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1. The Sector Reform Context for Purchasing

The private (or non-state) sector holds tremendous opportunities to provide health care for those in need. De facto, in poorer countries, many of the poorest obtain their care from mission hospitals and individual independent providers. Often this is the only care available. Major challenges for governments and their development partners should be to raise the quality of that care and to reduce the financial barriers and adverse financial impact on poorer households using it. Purchasing by a knowledgeable organization on behalf of these consumers offers great potential for this.

To achieve this potential, purchasing must be a significant part of resource allocation in the health sector, not just a mechanism for small, aid-funded projects using contracting to buy additional services with additional money. There is no doubt that these can work in terms of producing outputs from inputs efficiently. But they are not the solution to maximizing health results and equity from available resources on a national scale because they do not achieve the structural change needed to do this or even address the constraints on achieving it. For the most part, they remain parallel "experiments" that do not induce the big organizational development changes necessary if available budgets are to be redirected to more efficient service producers. They do not create new incentives for providers, payers, and consumers on a national scale. If we were starting from a clean slate, competitive contracting from the private sector would be a relatively straightforward mechanism for producing public services. But, except in some post-conflict countries, we are not. We start from

- An entrenched public service that absorbs almost all of the money governments make available, mostly in the salaries and wages of public service workers, and that is largely inefficient, unresponsive, and unaccountable to consumers,

- An extensive private sector that, typically and for the most part, consists of unregulated small and individual providers, offering good access but low-quality services—with some notable exceptions,

- Badly informed consumers, and

- An unhelpful aid environment that continues to fund projects rather than structural change and that now delivers much funding off-budget and for specific diseases, creating parallel administrative structures and much disruption for those governments struggling to align their resources to national strategies and planning processes.

Many countries have initiated sector reform programs aiming to overcome the systemic problems of the traditional public sector by separating the function of payer from the function of provider of services. This includes some decentralization programs that give

more autonomy to smaller public provider units like regions, districts, and major public hospitals, introducing opportunities for the payer to purchase proactively in pursuit of quality improvement and cost efficiencies, although these opportunities are not always taken advantage of in practice.

While small-scale contracting may serve to demonstrate its potential to governments and thereby encourage thinking about larger scale reforms based on separating purchaser from provider functions, it cannot cause needed reforms. It is structural reforms that could drive purchasing on a national scale—not contracting that could drive reforms—and it is structural reforms that open the door for significant purchasing from non-state providers of all kinds if these can produce and deliver services more cost effectively than can state providers.

In post-conflict countries, where there is no longer an entrenched public service, contracting of non-state providers has developed rapidly and on a substantial scale as in Afghanistan, Cambodia, Guatemala, and Rwanda, and now planned for Liberia. The risks are that, as stability returns and opportunities for political and financial patronage reemerge, government services get reinstated in the traditional mold, squeezing budgets for contracting just as aid funding declines.

The traditional public health service and the need for reform

In modern times, most developing countries had or have a ministry of health through which government pays for and directly manages services provided by staff that government employs. Although expenditure by consumers on private providers typically now exceeds government expenditure on public providers, neither governments nor most donors have paid much attention to the private sector.

Through a combination of internal and external pressures, many governments have engaged in forms of organizational restructuring or health sector reform aiming to achieve a degree of separation between the basic functions of (1) raising and spending finance for public health services and (2) producing and delivering health care. Mostly, these have taken the form of decentralization, making public service provider units more independent, but some have incorporated purchasing from non-public providers, and some have introduced a social insurance organization as purchaser. The hoped-for benefits include the following:

- More effective management of human resources when provider staff are outside of public service regulations and protections, and incentives can be introduced

- More localized and responsive management rather than management from the center

- More accountability for performance by defining responsibilities and measuring results

- Cost efficiencies and cost containment by setting budget ceilings for providers that cannot be overspent as easily as those within the public sector

- Opportunities to reward providers for quality and performance

- In the case of social insurance, establishing a more independent purchaser, thus bypassing the political allocation process to some extent

Our reviews suggest that three broad types of reform are occurring. The most common is when government retains the role as payer but reduces its role in providing services directly.

Government becomes the payer/purchaser and reduces its direct providing

This is illustrated in the figure below, in which the horizontal axis represents the extent to which government provides services directly, and the vertical axis the extent to which government pays for services directly. Segment 1 represents the traditional public sector that pays for everything and provides everything. Segment 2 represents where governments have reduced their direct provision of services but retain their funding or purchasing role. Providers may range from private to quasi-public bodies with semi-autonomy or full autonomy. Countries have moved from segment 1 to 2 in varying degrees. For example:

- Cambodia, where services for five pilot districts were contracted to nongovernmental organizations—later expanded to cover some 20 percent of the national population—but where government still employs and directly manages most services, would remain close to segment 1.

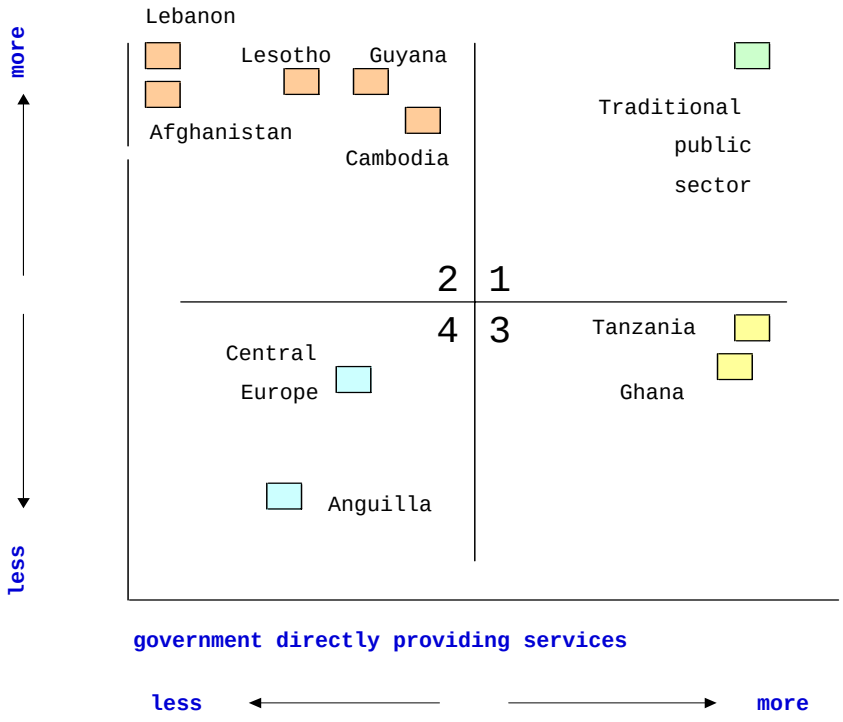
- Guyana, which is devolving responsibility for providing services to semi-autonomous regional health authorities covering the country and to a semi-autonomous national referral hospital, would be located further from segment 1.

- Lesotho, where the national hospital function is being tendered to a private company to rebuild and operate but where the government will continue to operate other services, would be located in a similar position.

- Lebanon, where almost all hospital care is provided by the private sector reimbursed by the government, would be located further from segment 1, as indeed would Afghanistan where over 80 percent of the population has been covered with basic primary care services contracted from nongovernmental organizations.

Appendices 1 and 3 provide more details on these and other examples.

A framework for health sector reform



Countries operating functioning sector-wide approaches (SWAps) might be located in segment 2 if the result of the SWAp is to direct more money to private or more autonomous providers. But most would remain in segment 1 because in practice money still tends to flow through government channels to government-employed providers.

A distinctly different situation arises when a government reduces its role in paying or purchasing but retains its role in directly providing services.

Government ceases part or all of the purchaser function and remains provider

This occurs where a new independent purchaser body is created to contract for services including those provided by the public sector. The creation of national social health insurance can represent this type of reform. A national health insurance organization becomes a major purchaser. Segment 3 of the figure illustrates this with the following examples:

- Tanzania, where NHIF contracts with public and private services but covers only public workers, leaving the government paying function not much reduced, would remain close to segment 1.

- Ghana, where NHIS purchases through district mutual insurance bodies (DMHIS) contracting with public and private providers and covers more of the population, would be located a bit further from segment 1.

See appendices 1 and 3 for more details.

Government ceases both provider and purchaser functions

Segment 4 of the figure illustrates this. A new independent purchaser body (or bodies) is established, and the government divests public services to autonomous provider organizations, retaining only an oversight and regulatory role. Examples include the following:

- Anguilla, where an independent national health fund is being established to handle all sector funds from government and employment contributions, and will contract services from a semi-autonomous (ex public sector) provider and from private providers in country and overseas. (For details see www.healthsystemsworkshop.org/anquilla.html.)

- Several Central European countries where, for primary care, social health insurance has been created as prime purchaser contracting independent providers.

Several poorer countries are discussing the merits of a common health fund for pooling domestic and aid finance. If the fund is run independently of the government, this can create a potentially powerful purchaser driving quality improvements in public and private providers.

2. Actual and Potential Issues with Reform Strategies

This framework has obvious limitations. Many countries are hybrids. Tanzania, for example, has moved from segment 1 toward segment 3 by establishing NHIF but has also moved towards segment 2 by making the national referral hospital autonomous. Many countries have decentralized to regions or provinces without actually giving them independent provider status. Some are established as independent bodies by law but, in effect, manage staff still in the public service because the government has not been willing or able to take the step of demanding their transfer or termination. Regions, provinces, or districts may be relatively autonomous as providers but may themselves be purchasers to make up their care packages.

Nevertheless, the framework may be useful to order and discuss developments in sector reform and the potential for purchasing. A number of issues are identified below using this framework.

Government becomes the purchaser and reduces its direct providing (Segment 2)

Dismantling a big part of the public service is not easy and, invariably, governments' plans to do this are opposed by staff and their unions. Public employees have significant protections under law and will demand substantial compensation for redundancies or transfers to other employment. Pension entitlements also present problems and give rise to resistance to leaving public employment unless future losses are fully compensated. These costs are beyond most governments which, instead, may resort to maintaining staff as public employees while creating semi-autonomous agencies to manage them hoping that transfer of employment will come later. But this does not overcome the management problems of the traditional public service, because staff retain their rigid employment terms and conditions.

Governments are not able to purchase services from the private sector on any significant scale because all the available budget is committed to public sector services, mostly salaries and wages, and much of this cost remains payable even if the government is also purchasing services from new autonomous agencies or private providers. Pilot contracting schemes do not change this fact and are not replicable nationwide unless fully aid funded with additional money.

Frequently, there are insufficient private providers to purchase from, especially in rural locations or, where there are private providers, these tend to be traditional healers, medicines sellers, or individual trained health care workers, all presenting big problems for contracting by public or social purchasers.

Governments do not necessarily make good purchasers. Purchasing requires new skills. Moreover, just as the traditional public sector lacks incentives to provide quality and satisfy consumers, a public sector purchaser may lack incentives to purchase well. There may be resistance to buying services from the private sector, and the temptation for political interference at the management level remains—for personal or party advantage politically, or worse. There is a strong case for the purchaser function to be placed at arm's length from government, and this is discussed in the following subsection in considering structure and governance for social insurance.

Possible implications of this strategy for reform include the following:

- Large additional sums of money are needed to facilitate the transition from a directly managed public service to one contracting services from the private sector (including autonomous ex public providers). This requires development bank support on a significant scale, but donors might consider providing matching funds to public purchasers starting this process.

- Countries could try to do this in steps, and some have:

    - Starting with establishing the national referral hospital as an autonomous body under contract (e.g., Kenya, Nigeria, Tanzania) and encouraging public staff to transfer employment—in practice this is often the only step taken

    - Putting specific services out to tender to the private sector ranging from specialist diagnostic services to a whole district or region (e.g., anti-retroviral treatment services are widely tendered in Africa; family planning and reproductive health services are tendered in Brazil, Colombia, and elsewhere; maternity services in Gujarat; see box)

    - Encouraging primary care providers, midwives, or other staff to leave public employment and contract their services to the government as private providers (e.g., this was attempted with local midwives and nurses in Indonesia)

Box 1: Chiranjeevi Yojana, Gujarat, India

In April 2005, faced with an acute shortage of public sector obstetricians in rural areas, the Government of Gujarat started a program of contracting private specialists. Known as Chiranjeevi Yojana, the program covers below-the-poverty-line families entitling them to free delivery services. It was launched in five districts with a population of 10.5 million but later expanded to the whole state (55 million).

Private providers are accredited, contracted, and paid a fixed rate per 100 deliveries to iron out case mix differences in terms of complications. The payment method and formula aims to encourage providers to reach a certain volume of work, to avoid complicated transaction costs, and create a disincentive for unnecessary Caesarian sections.

Below-the-poverty-line families are identified by the state at the primary care level and issued with cards entitling women to maternity services at their selected provider. About 800 providers are enrolled in the program and, from December 2006 to September 2007, covered 107,000 deliveries.

Government ceases part/all of purchaser function and remains provider (Segment 3)

The most common form of this strategy is through the introduction of national health insurance assuming the function of purchaser, contracting services from a combination of public and private providers. The national health insurance organization as purchaser may be more inclined to purchase from the private sector than is government as purchaser and, indeed, may have real incentives to do so.

Where national health insurance coverage is extensive, this model could avoid the problems of large-scale transfer of staff from public employment mentioned above. Public service staff remain in the public service but would gradually have to compete with private providers to attract national health insurance funding. This could create incentives for better performance and value for money, and even present staff with opportunities to go independent or to join contracted private providers.

In most cases where insurance has been introduced, however, its coverage is partial, often serving only the formally employed or even only public sector employees, and contributing only a small part of total sector expenditure. In Tanzania, for example, only 4.5 percent of total on-budget expenditure goes to the NHIF, and much less than this is actually claimed and reimbursed: total national health insurance contributions were 24 billion Tanzanian shillings in 2005, but only 4.9 billion was claimed by providers and only 86 percent of this paid. Only 3 percent of the population was covered.

Where a national health insurance organization with partial coverage is purchasing from public services, public staff are getting paid anyway through the public service channel, and national health insurance money is a very small part of a service unit's income, so there is no incentive to perform better (or even to bother to claim reimbursement in the case of Tanzania). Leverage over performance increases as coverage increases and, therefore, as national health insurance money increases as a proportion of provider income, especially if providers have discretion over how new funding is spent.

Typically, a national health insurance organization will be obliged to purchase from public services and can have little influence over performance if there is not a thriving private sector in competition. In Tanzania, Ministry of Health services were automatically accredited to provide services and, elsewhere, often the accreditation process is superficial. This raises the question of whether social insurance purchases are in fact still government, and subject to the same constraints raised earlier about their real incentives, and the question of their freedom as purchasers to buy value.

National health insurance usually implies raising funding through contributions based on income in order to be progressive: those earning more pay more. Membership contributions are not so able to do this. But income contributions have disadvantages in practice:

- They are essentially a tax on jobs risking negative effects on employment and competitiveness.
- The burden falls on the formally employed whose contributions can be collected.

A national health fund may offer alternatives suitable for some circumstances, if it is funded significantly from selected consumption taxes. It has been argued that a tariff on electricity bills, for example, may be a fairer and cheaper mechanism, at least in countries where electricity access is widespread, and may have minimum substitution effects. (See www.healthsystemsworkshop.org/anquilla.html.)

Possible implications of this strategy for reform include the following:

New purchaser organizations like national health insurance or a national health fund must have sufficient coverage for the contracting process to have influence over quality or prices.

- In practice, it is not feasible for national health insurance to be financed entirely from contributions from earnings: there are too many poor and informally employed. Governments must contribute for the indigent and, if anything like universal coverage is to be reached, this requires substantial sums while government is still paying the costs of the public service. In theory, as these contributions increase and as national health insurance population coverage increases, public providers can receive an increasing share of their income from national health insurance allowing reductions in direct payments from the government.

- Ghana is developing an NHIS that will inform this strategy. It is operated through district mutual health insurance schemes (DMHIS) as purchasers from public and private providers. DMHIS collect contributions from those able to pay and receive government subsidy for those who are not, the latter funded by a new national health insurance levy on selected goods and services and a slice of the social security contributions paid by the formally employed. It has reached coverage of around 40 percent, although many of those covered are those exempt from contributions. More information is needed about the dynamics of this shift, about how coverage can be increased further, and about its impact on government and household expenditure.

The corporate structure and governance of social insurance programs are crucial to their success.

- National health insurance is usually established as forms of statutory authority, and these may not be sufficiently removed from government to avoid political interference at the micro level. Invariably, board members are appointed by ministers (usually of finance), for example, and appointments may have more to do with patronage and control than with needed leadership, experience, and skills.

- Alternative forms of national health insurance are needed. While there may be some advantages in allowing private insurers to take on this function, the essential regulatory environment thereby needed may be beyond most developing countries to provide. In certain circumstances, forms of mutual fund may be appropriate in which all contributors and beneficiaries are voting members. Where national health insurance receives donor support—which has clear advantages and is likely to be a development in health aid (see point below)—donors could appoint local representatives to sit on boards to represent their interests, that is, the interests of value for money for consumers and reaching poorer families with coverage.

National health funds created as national purchaser organizations could make a strong case for receiving and pooling all external health aid.

- A national purchaser organization receiving combinations of funding from the government health budget, dedicated health taxes, and contributions from earnings or membership fees, provides a good vehicle for the harmonization and alignment of external aid. Donors could encourage these developments, participate as shareholders in the purchaser body, and help finance the transition costs of reforms.

Countries pursuing a strategy of devolving the purchaser function should consider how to encourage the development of a private sector, and what is holding it back.

- In deciding whether to enter into contracts to provide public services, private providers will consider the potential for increasing their business or using spare capacity to improve return on capital invested. They will need to feel confident that they will receive a regular revenue stream from a reliable purchaser and on-time payments, and that providing services to public patients enhances rather than detracts from their reputation with private patients if the latter will continue to constitute a significant share of their income. Private providers will need advance warning of available purchasing strategy and contracts so that they can gear up to compete for them.

Countries must develop ways to purchase from small and individual providers that make up the bulk of the private sector.

- Individual independent doctors, nurses, medicines sellers, midwives, and traditional workers are where most or many people go for care and spend their money. The quality of care they receive and the value for money is invariably low, but often it is the only care available. A fundamental question for sector reform is how the performance of these providers can be raised. Intermediary organizations are needed. One strategy that is gathering momentum is quality-driven networks, including franchising.

These usually involve an NGO franchisor franchising individual care providers, but there is no reason why a public or social body could not assume the franchisor function, as in Gujarat. Also, public or social purchasers could contract with independent franchisors that are themselves achieving the networking of individual service providers.

- Even where services are contracted to NGOs, administration can be complex and time consuming, as in the Bangladesh Urban PHC project, with only 28 NGOs under contract.

- Another approach is to promote and commission as intermediaries private organizations of the health maintenance organization type and leaving it to them to contract with end providers. One example is Hygeia in Nigeria, a health maintenance organization commissioned by an insurance fund to assemble and contract numerous small providers.

Government ceases both provider and purchaser functions (Segment 4)

There is little actual experience of this happening comprehensively. In theory, combining the strategy of government reducing its role in providing with that of reducing its role in purchasing will combine the potential advantages and difficulties outlined above for each.

In Anguilla, the public sector was made autonomous. The Health Authority of Anguilla (HAA) was created by act of parliament with its own board and management, and public service health workers transferred employment. The HAA has operated under contract to the government for some years now. It has been able to improve the quality of care delivered and increase patient satisfaction. The next step planned is an act of parliament to create an independent national health fund as the national purchaser organization, purchasing from the HAA, private providers on the island, and specialty care from overseas (Miami and Puerto Rico).

This direction for reform highlights the issue of the role of government when other parties undertake traditional provider and payer functions. Depending on particular country circumstances this role might include the following:

- Setting legal and regulatory frameworks for purchaser and provider functions

- Monitoring the health of the population and the performance achieved with public finance (including national audit office functions)

- Maintaining international relations with donors and development partners

- Ensuring protection of the poor and the provision and use of subsidies

- Possibly, the contracting of a semi-independent purchaser body or bodies, acting in public interests

3. Issues with the Purchasing Mechanism

In addition to the issues associated with the different broad directions for reforms outlined in section 2 above, our reviews of purchasing experiences identify a number of issues with the mechanics of purchasing itself and applicable across all approaches. These are considered under the following headings:

- Contract specifications
- Provider payment methods
- Services purchased
- The contracting process

Contract specifications

Few countries practicing forms of purchasing are doing so with quantified contracts. Many are simply transferring public finance subventions to private providers, much as they have done with mission hospitals for decades, or reimbursing providers fees for services delivered in response to demand from consumers.

Some have acknowledged the need for the accreditation of providers particularly as they have created new purchasers in the form of national health insurance. Often the accreditation process is perfunctory, however, as in Tanzania where all government facilities were automatically accredited at the start up of NHIF, although this could be tightened over time. But accreditation is not contracting: it establishes only a minimum competence to undertake the task. The potential power of contracting is proactive in specifying provider performance in terms of the quantity, quality, and price of the services to be delivered. Incrementally, contracting can drive improvements in meeting target utilization, quality, and value for money.

Few countries appear to have the capacity to purchase effectively, including specifying service volume, performance, payment methods, and prices, or to monitor constructively through a joint review process (see the subsection on the contracting process below). It is not a simple matter to contract a hospital, requiring projections of service needs and volumes to be targeted (see appendix 3, the contract for GPHC Guyana, particularly section 5.1.3 of that contract). Key issues here are how purchasing can set target utilization levels and prices to maximize health improvement within available budgets and, at the same time, avoid creating incentives for providers to over-provide or for

consumers to over-consume, and how the capacity constraints on purchasers and providers can be overcome in practice.

Moreover, not many management information systems are adequate to generate data to set appropriate service targets for providers or to monitor performance. In addition, many private providers, especially smaller NGOs attracted by new aid funding, have little management capacity.

Provider payment methods

Purchaser payment methods are typically fee-for-service reimbursement or simple block grants, neither creating incentives for appropriate utilization and treatment. Fee-for-service payment can lead to over-provision, and block grants can lead to under-provision and case avoidance or case shifting to save costs. Fee-for-service reimbursement also generates excessive transaction costs in claims assessment, processing, and payment, and can lead purchasers and providers to seek sophisticated information technology with its high risks of failure.

For primary care, better alternatives include a capitation payment for the population covered plus incentive payments for results, especially for prevention, with a ceiling on total outlay. Afghanistan is making some use of per capita payments plus a performance incentive.

For hospital services where the provider cannot be contracted so easily for prevention, techniques are available to project target inpatient and outpatient caseloads by clinical specialty for a given population using empirical data from health systems elsewhere that achieve good value for money in terms of outcomes, and allowing for major variations in epidemiology. Staffing and non-staffing norms and costs can then be used to estimate the fair price of the contract. However, as noted above in the subsection on contract specifications, this is not a simple process.

The issue emerging is the feasibility of basing purchasing on these more appropriate provider payment methods, and the implications for the capacity of purchasers to do this.

Services purchased

Purchasing is usually from providers offering primary or hospital services. This may be the wrong approach because it offers no incentives to provide care at the right level. A health maintenance organization model covering both primary and secondary care might offer better incentives. Purchasing a wider spectrum of care from one provider may create incentives for a provider to prevent and contain expensive utilization and maximize the care provided out of hospitals. Although health maintenance organizations have not been without problems in the U.S. context, the concept deserves more exploration in countries where simple prevention and early treatment could make a huge difference to outcomes and costs. A provider spending a big proportion of its budget on treating malaria cases might think about providing its population with insecticide-treated nets, for example, or

ensuring the local drug shops are stocked with subsidized artemisinin-based combination therapy, and similar logic might apply to control of childhood diseases.

To what extent is this model feasible for a private sector start up, and at what levels of income? Can this principle be used when contracting districts or regions have been made semi-autonomous, and how can pricing strategy reinforce this behavior? In Nigeria, a health insurance fund is using an intermediary health maintenance organization, Hygeia, but this is for primary care and covers very limited secondary care.

The contracting process

Purchasing is a process, not just a contract. Some key elements have been outlined above, but a vital element not much in evidence in our studies is that of joint review. Both purchaser and provider have an interest in a successful outcome and the renewal of purchasing arrangements year on year, and it is essential that they communicate regularly and constructively even if there remains a healthy underlying tension.

Few countries appear to be employing a formal constructive process of performance evaluation through joint reviews. Guyana has started a process of quarterly joint reviews between the Ministry of Health as purchaser and regional health agencies (and the national referral hospital) as providers. These joint reviews focus on achievements and problems, and they may result in modifications to current contracts or inform the subsequent contracting round. Guyana also runs a joint annual review meeting attended by all major providers and by donors. This process helps purchasing to improve targets incrementally and make them realistic, and to understand more about cost structures.

Effective contracting will introduce a new transaction cost, but this must be weighed against the hidden costs of weak human resource management and typically low output in directly managed public systems.

Another emerging issue, then, is what review, learning, and improvement processes can be employed effectively and efficiently as purchasing is introduced.

4. Key Issues to Be Addressed

This section distills some of the key issues that are emerging from this study and that must be addressed if purchasing from private providers on a significant scale is to be part of health sector operations. We then use these to start looking for project support opportunities.

Sector reforms that will facilitate purchasing

At this stage, five key issues are highlighted:

1. Can a country that is not yet purchasing from the private sector much, or at all, be helped to evaluate the potential for doing so and to start implementation as part of its mainstream reform program? At the same time, how can the private sector be encouraged to engage and contract with a public purchaser?

2. What can be done to sensitize donors and international agencies to the needs for engaging with the private sector as well as the public sector, and to help them understand how aid can be used to make this happen constructively? The implication here is that it will be difficult to convince countries to incorporate purchasing if their donors and technical support agencies do not understand and encourage this.

3. What are the prospects for creating national health funds as major purchasers, and can they attract all or most external aid funding as well as domestic expenditure? Can SWAps be the base for this in aid-receiving countries, and move toward becoming funding institutions? What is the role of government if purchasing is transferred to an independent or semi-independent body?

4. Can social health insurance be expanded to become a major purchaser in poorer countries, and can it improve performance in the private and public sectors? Can this facilitate shifting government expenditure away from direct provision and through the insurance fund operating as a knowledgeable purchaser? What are the appropriate structure and governance arrangements to create purchaser incentives? This applies to 2 above as well.

5. Can purchasing be a successful vehicle to engage with the many small and individual private providers who make up the bulk of the private sector (and provide most people with their care) and to improve the relevance and quality of their services?

The fundamental concern running through all of these issues is whether and how purchasing from the private sector can raise the quality of services received by consumers—by buying better performance from private providers and/or by inducing improvement in public providers either by the contracting mechanism itself through internal contracting (under decentralization for example) or by introducing a degree of competition for funding with the private sector.

Improving the mechanics of contracting

In addition, a number of issues specific to the contracting process appear to constrain the performance of purchasing. These may cut across the major reform issues identified above. Four such issues are highlighted:

6. How can the specifications of contracts be improved to set realistic service targets and prices, and how can this be done within the capacity constraints of countries?

7. What are the needs for capacity development of purchasers and providers for the purchasing process to be successful, including effective joint review and learning by both parties, and how can these be developed cost-effectively?

8. What provider payment methods are most appropriate, in different circumstances, to create the right balance of incentives under purchasing? What role might performance-related payments have? (Performance-based incentives are discussed in the background paper prepared by the Center for Global Development under this Rockefeller Foundation initiative—*Performance Incentives in Provider Purchasing and Contracting Arrangements: Rationale and Experiences*.)

9. Can purchasing broader service packages create incentives for prevention and early intervention—for example, by purchasing care from autonomous districts, or by contracting for mission hospitals to take on community prevention and primary care (not necessarily by providing it but through innovative quality-driven networks), or by promoting and contracting with organizations similar to health maintenance organizations as intermediaries with end providers?

5. Opportunities for Program Support and Action Research

At this stage, we have tried to identify possibilities for future program support that would address and inform some of these issues. These could be elaborated and further explored with the relevant governments and other parties during the final stage of this work.

Guyana health sector reform program

Guyana offers possibilities for program support focusing on key issues 1 and 3 above, but also exploring issues 6 through 9. The country is undertaking a significant health sector reform program under which delivery of health care is devolved to autonomous health regions and the national referral hospital. To date, the first region (Region 6) and the referral hospital (Georgetown Public Hospital Corporation) are established and operate under contract with the Ministry of Health through its Health Sector Development Unit, which also manages external assistance programs including those funded by the World Bank, IDB, and Global Fund. Other regions are being established this year and next.

Initiating purchasing from the private sector

A distinct possibility is that both the established region and the national hospital could purchase services from the private sector to make up the package of services they are contracted to deliver. These could range from rural primary care to specialist diagnostics and care. Purchasing primary care would be a suitable solution to explore for the hinterland, a large and sparsely populated region away from the main coastal population, and badly served at present. Potential advantages include improving access and quality for public patients where public capacity is low, particularly for target groups in need. Also, purchasing specialist care could bring new services to public consumers and, at the

same time, avoid duplicating expensive investment by GPHC in the capital city. And, by raising standards, the contracting process could also raise standards for private consumers.

The opportunity would be to work with the Ministry of Health, Region 6, and GPHC to investigate the potential for purchasing from the private sector and to support initial implementation. The objective would be to make purchasing from the private sector a routine component of producing services.

The steps involved would be:

- Evaluating the existing private sector and its potential.
- Assessing what encouragement the private sector would need to improve supply to the public sector, including advance warning of contracting requirements, whether this would cover those services really needed, and what it would cost.
- Identifying specific possibilities for contracting from the non-state sector, designing and supporting the contracting process including monitoring and joint reviews.
- Funding additional costs for two years (for example) while building those costs into routine budgeting and expenditure processes.

Guyana experiences a particularly acute shortage of public sector health staff, a result of outward migration, and this may encourage the use of non-state providers, especially given the fact that the country is in receipt of substantial external aid with which to commence this.

Other possibilities may arise during design and implementation including staff groups opting for independence and contracting their services to the regional health authority.

This potential program support has been discussed with the minister of health in Guyana, and there is enthusiasm to take it to the next step. We anticipate this could be done during the final stage of this work if Rockefeller decides this could be a possible project.

Creating a national health fund

Guyana has also initiated a process of joint annual reviews with the Ministry of Health, providers, and donors, and is investigating the potential for a SWAp and a national health fund pooling all domestic and aid finance. We think there is potential to support this process that, if successful, would create a national purchasing organization directing all sector funding to autonomous regional providers on the basis of need and through a performance-linked contracting process.

Information for donors and health development agencies on including the independent sector in health systems strengthening support

Health Systems Workshop (HSW) is planning a project to produce a publication, a communications campaign, and a conference, providing information for donors and other development partners on how non-state providers can contribute to public health goals, and how aid can influence this. The project will be undertaken in collaboration with a number of other organizations and individuals with experience and interest in the non-state sector, and an international advisory group is being established to guide and review the process and products.

The project will focus on key issue 2 (section 4 above) but, through this, will cover almost all other issues listed. It will address possibilities, advantages, and disadvantages, and try to identify practical ways that donors can stimulate the non-state sector in the public interest within the context of strengthening country processes and mechanisms for aid harmonization and alignment to national strategy and priorities. In terms of services, the focus will be on how the independent sector may provide a broad spectrum of primary care services, rather than disease-specific or intervention-specific services.

Rockefeller may wish to collaborate with or support this project, and a separate project note is available providing more detail. It could be a focused, high-visibility, and effective vehicle for Rockefeller to enter the field and could identify key partners (e.g., KfW has already expressed strong interest) and possible support programs leveraging donor support.

Kenya SWAp

Kenya offers the potential for program support focusing on key issue 3 above, and also investigating issues 6 through 9. Initiation of the health SWAp has raised issues and possibilities for significant purchasing from the private sector, particularly from the faith-based organizations. While these have traditionally had public subventions, further development of the SWAp raises the possibility of transferring larger sums through contracting arrangements.

Kenya has a well-established network of faith-based organizations providing health care through mission hospitals and health centers in remote rural areas. These are faced with funding difficulties as their sponsors have reduced support, and have to rely on user fees to finance their services. But with widespread poverty in the rural areas, the capacity to generate revenues through charges is low.

Faith-based organizations have petitioned the Ministry of Health to guarantee support to them under the SWAp, but the difficulty is how to structure the support. The debate is ongoing between the ministry and representatives of faith-based organizations on justification and modalities, but the situation is right for a contracting approach based on aligning all external and domestic funding to the national sector strategy and plans. This will be informed by cost studies now being undertaken with GTZ support.

Building on SWAp arrangements to contract with private providers and to develop national health funds as national purchasers is of great interest to many countries. Can SWAps be institutionalized in this way? Mozambique and Rwanda have made some progress in directing Global Fund support through the SWAp, but there are problems. Kenya may not be the easiest country in which to study SWAP evolution and support developments, but we are making enquiries through our Kenya office as to what could be done.

We have not yet discussed this directly with the relevant authorities in Kenya.

Tanzania and Ghana national health insurance

Ghana and Tanzania offer the potential for program support focusing on key issue 4 above. Both face problems of how national health insurance organizations with partial coverage can drive quality and cost containment through purchasing from a combination of public and private providers. Can they develop the power to do this when they remain minority funders of the providers? How can more of the government budget be allocated through national health insurance instead of directly funding public providers? As coverage is extended, improvement in purchasing mechanisms becomes important, and any support program would also have to investigate issues 6 through 9 outlined in section 4 above.

As yet, we are only at the stage of trying to contact individuals who could help us evaluate the potential here and who could introduce the idea to the relevant authorities. Several other countries have similar situations, Kenya included.

Purchasing from small providers

In practice, the private sector is very fragmented. Large-scale purchasing for the benefit of consumers means contracting with lots of small and individual providers. This presents organizational challenges, but solutions could improve quality and access, and must go hand in hand with developing the purchaser function. We know that franchise operations run by NGOs can operate successfully as intermediaries and are doing so particularly in reproductive health. Some of these have achieved large-scale operations. A relatively recent summary of the better known quality-driven networks, including franchises, is available.[1] It must be said, however, that little quantified external evaluation is available on these operations.

A quality-driven network for primary care

Franchises have been developed mainly to provide reproductive health services but appear to have the potential to provide other services. CFW Shops in Kenya operates a micro-financing business model supporting and networking small drug shop owners providing quality drugs for common illnesses. It is run by an NGO, the HealthStore

[1] [ref England]

Foundation. The model appears to be a good one, but the franchise has been slow to grow. It is highly desirable to know why this model has not been able to expand faster, because it could form the basis for significant coverage of rural populations elsewhere.

Tanzania has an established network of accredited drug shops (*duka la dawa baridi*) from which most Tanzanians seek their first-line treatment. They are forming the basis of rolling out subsidized artemisinin-based combination therapy for malaria through a pilot project in Kongwa and Maswa districts with Clinton Foundation support. What are the prospects for building on some of this network to offer a broader primary care and reproductive health package from the dukas? Would the government or the NHIF be interested in developing this through a purchasing arrangement, and how could this work?

PSI has created and operated several franchises that also appear to offer opportunities for learning and reproduction elsewhere.

We have no particular inside information or connections in these quality-driven networks but would be keen to pursue them further during the final stage of this work. They would focus on key issue 5 in section 4 above, but would inevitably also cover aspects of key issues 1 through 4 concerning the nature of the purchaser and the operating environment, and key issues 6 through 9 concerning issues of the specifics of contracting.

Gujarat maternity services quality-driven network, India

There is little experience with public bodies assuming the role of franchisor, or in purchasing from private franchises with public finance. Models with the potential for this should be explored urgently and supported on a large scale.

Chiranjeevi Yojanna is one of the few examples of a government-organized quality-driven network, contracting private providers without external funding. The state contracts with some 800 private obstetricians/gynecologists to provide delivery services to poorer women. The provider is reimbursed a flat rate per delivery, paid in batches of 100 deliveries to smooth the costs of complications. The poor—below the poverty line—beneficiaries are identified and issued with cards entitling them to the service.

The public sector is acting as network coordinator here and, rather like a franchisor, is demanding standards and uniform pricing from individual providers, and promoting the scheme to the consumer. At the same time, target beneficiaries are being subsidized to gain access to the services.

We have been in very preliminary contact with the Gujarat Health & Family Welfare Department and with the Indian Institute of Management, which has undertaken several studies of the scheme, but we do not think this quality-driven network needs support. Rather it may provide a vehicle for learning if and how this principle could be expanded to cover other services, and if this model could be employed elsewhere.

Appendix 1: Matrix Summary of Selected Examples of Purchasing

Country / Program	Purchaser	Funding	Provider	Nature of Contract and Payment	Population Covered	Services Provided	Competition	Review Mechanism
Afghanistan	Donors directly (WB, USAID, ADB, KfW, EC) MOPH for 3 provinces	Donors	17 international NGOs 10 national NGOs	Basic package of services Performance based agreements	82% of population by WB estimate	Primary care	Varies—but mostly competitive tender	Third party appointed for surveys, not much regular monitoring
Anguilla	MOH Planned to transfer to a National Health Fund	Government Dedicated income tax	Autonomous health agency Overseas hospitals Planned to include national private providers	Specification of service levels and quality Fee for service (for overseas care) Capitation with incentives	100%	Primary and secondary care Tertiary care (overseas) Primary care	No, agency derived from ex public sector Yes Yes	Quarterly joint reviews Medical review case by case Quarterly review

Bangladesh UPHCP	Local government	Government External aid (ADB, DFID, SIDA, UNFPA)	NGOs	Minimum package of activities and quality measures Performance incentive payments	About 28 contracts covering urban population of 10 million	Primary care plus STI/HIV	Yes, tendered	Project review twice a year Monthly monitoring reporting (appears project based rather than institutionalized)
Cambodia BHSP	MOH through PCU	External aid (ADB, DFID, WB) User fees	International NGOs Government may now be looking to revert to internal contracting	Minimum package of activities and quality measures Performance incentive payments	Originally 5 districts each with 100-200k Expanded program now covers 20%	Primary care	Yes, tendered	MOH monitoring team (appears project based rather than institutionalized)

Ghana NHIS	NHIS through district mutual health insurance schemes or private schemes	NHIS receives from social security contributions of formally employed, and from a national consumption tax DMHIS collect membership contributions from informally employed, and from NHIS for those exempt	Public and non-state providers, predominantly public and mission (CHAG)	Not specific for quantity, quality Fee-for-service reimbursement MOU between NHI and accredited providers, but no standard fees, drugs, etc. No direct performance incentive payment	40% in 2007 (may be higher now) Mostly exempt population	Primary and secondary care	No, only accreditation	Not known
Guyana HSR	MOH through Health Sector Development Unit	MOH allocation Regional allocations via Regional Development	Regional health authorities National hospital (GPHC)	Specify quantity, quality, and price (block allocation) for RHA and GPHC	First RHA covers 20%; 3 more will cover 80% GPHC	RHAs provide primary and secondary care	No, but contracts renewed annually	Yes, through evolving joint annual review process and quarterly reviews

		Councils External aid	Small private/mission providers		100%	GPHC provides specialist care		
Lebanon	MOH	MOH allocation User fees (15%)	Private hospitals	Standard terms negotiated for tariffs, budget, services eligibility and payment methods Fee-for-service reimbursement Not quality driven	MOH contracts for the uninsured	Hospital inpatient and outpatient care	All hospital contracted on standard terms Competition for patients	Medical auditor appointed to curb abuses Auditors checked by medical inspectors
Nigeria: Hygeia Community Health Plan	The Health Insurance Fund Foundation (HIF) contracts Hygeia, a private HMO	Dutch Government Nigerian Government Members contributions	Public and private clinics and hospitals	Not available	Target 115,000 25,000 enrolled by end 2007	Primary care Limited secondary care HIV	Not known	HIF monitors Hygeia Not known how Hygeia monitors providers

						treatment		
	Hygeia contracts public and private service providers							
Tanzania NHIF	NHIF for hospitals DMO's office for primary care	Government block grants Council basket funds User fees Contributions from salaries of public sector workers	All public health services —3,358 Non-state—600	Not specific in quantity, quality, or price No performance incentives	3% in 2005	Primary and secondary	No, all public services accredited	Not known

Appendix 2: International Examples of Purchasing: Listed

Afghanistan
- Ministry of Public Health contracting NGOs for Basic Package of Health Services covering 80 percent of population using donor funding and cost of about US$4.5 per capita

Albania
- NHI contracting for primary health care (PHC)

Anguilla
- Separating purchaser/provider, setting up autonomous agency, creating national purchaser fund, contracting with private providers overseas

Bangladesh
- Gonoshasthaya Kendra
- ADB urban NGO contracting
- Strengths and weaknesses of SWAp

Belize
- Autonomy for national hospital
- NHI as purchaser of PHC and hospital care
- Decentralization of public services, internal contracting

Brazil
- OSSE hospitals (São Paulo government built the hospitals, and then tendered for non-profit hospital organizations to run them)

Cambodia
- Contracting NGOs for PHC

Egypt
- Family Health Fund purchasing package of PHC services for registered families through contracts with private and NGO providers and public sector services using coverage, utilization and quality indicators for monitoring

Georgia
- State Medical Insurance Company contracting hospitals

Ghana
- NHIS purchasing from public and private providers

Guatemala
- Commissioning of NGOs on national scale after civil conflict

Guyana
- Autonomous regions under contract
- National hospital under contract
- Common fund as national purchaser (planned)

Haiti
- Performance-based contracting, also network example of a quality-driven network

India
- Gujarat maternity services contracted from private ob/gyns

Jordan
- Internal contracting of teaching hospital for specialty care

Kenya
- Decentralization program
- Autonomous national hospital

Lebanon
- Contracting private hospitals as main provider of care (90 percent)

Lesotho
- Tendering major public hospital to private sector

Nigeria
- Change agent program
- NHI contracting private providers
- HIF funding Hygeia, a private health maintenance organization, to purchase from private and public providers

Pakistan
- Contracting out of 100 PHC facilities in Rahim Yar Khan District (utilization, physical condition, and patient satisfaction improved, and OOP expenditure reduced, but no improvement in remote areas)

Romania
- Health authorities contracting doctors for PHC

Rwanda
- NHIS as purchaser
- About to contract out all PHC services to Partners in Health

South Africa
- Evolution from mission subventions to contracting

Swaziland
- Tendering major public hospital to private sector

Tanzania
- NHIS as purchaser
- Autonomous national hospital

Trinidad & Tobago
- Autonomous regional providers
- Government as purchaser
- Autonomous national hospital

Tunisia
- Contracting private providers for some specialist services

Uganda
- Evolution from subventions to contracting of major faith-based organizations

Zambia
- Evolution of HSR, creation of health boards, contracting mission providers.

Appendix 3: International Examples of Purchasing: Selected Summaries

A number of examples have been selected that illustrate relevant points made in the body of this report, and that have been summarized in matrix form in appendix 1:

Afghanistan
Bangladesh Urban Primary Health Care
Cambodia
Ghana National Health Insurance Scheme
Guyana
Lebanon
Nigeria—Health Insurance Fund / Hygeia
Tanzania National Health Insurance Fund

Afghanistan: Contracting with Nongovernmental Organizations

Summary

Purchaser/contractor
- Donors (World Bank, USAID, ADB, KfW, and EC) for most contracts.
- Ministry of Public Health (MOPH) is the contractor under the World Bank–funded strengthening mechanism for three provinces. The MOPH's Grant and Contract Management Unit administers all WB grants and is involved in the contracts for other donors.
- ADB and USAID have contracted NGOs to manage the contracting process (USAID now works through the WHO).
- The EC and KfW manage the contracting themselves.

Type of organization
- Government and donors

Sources of funding
- Donors fund the contracts with the NGOs with the World Bank supporting 11, EC 10, and USAID 13 provinces.

Provider/contractee
- NGOs: international (17) and national (10)

Type of organization
- International NGOs include two from Bangladesh (BRAC and Aga Khan)

Nature of contract
- Contracts vary according to the donor; some donors focus on inputs (e.g., number of trained staff), others on process indicators like level of use, and others on outputs, e.g., numbers immunized.
- Contracts are Performance-Based Partnership Agreements (PPAs).
- Bonuses are paid for good performance for WB grants.
- Contracts last from 12 to 36 months.
- Contracting process is transparent.

Extent of population coverage
- Estimates vary, but according to WB (2008), 82 percent of the population has access to PHC. However, the actual extent of service coverage is unclear.

Services covered
Basic Package of Health Services (BPHS), which aims to standardize services at all PHC facilities and provide equitable access, especially in underserved areas. Services:

- **Maternal and newborn health:** Antenatal Care, Delivery Care, Postpartum Care, Family Planning, Care of the Newborn
- **Child health and immunization:** EPI services (routine and outreach), Integrated Management of Childhood Illness
- **Public nutrition:** Micronutrient supplementation, Treatment of clinical malnutrition
- **Communicable diseases:** Control of Tuberculosis, Control of Malaria
- **Mental health:** Community management of mental problems, Health facility based treatment of outpatients and inpatients
- **Disability:** Physiotherapy integrated into PHC services, Orthopedic services expanded to hospital level
- **Supply of essential drugs**

Cost estimated at $4.5 per capita.

Routine immunization, HIV/AIDS, malaria, TB, and nutrition services are provided through vertical arrangements, supported (technically and financially) by UN agencies including WHO, UNICEF, UNFPA, and GFATM.

Secondary services remain the responsibility of the government.

Is it annually revised/negotiated?
Not known

Is there real competition for it?
In some districts, there is competition, but in others there is little. In one district, there was no competition (Palmer et al. 2007). More remote areas seemed to have less competition than other areas. It is questionable whether other NGOs would challenge existing contractors once the competitive process opens again.

What mechanisms are used for review, evaluation?
- Progress reports and site visits with a third party hired to undertake household surveys, facility inspections, and interviews (JHU)—balanced scorecard approach to monitoring. There is limited sampling so on the wider community level it is difficult to gauge (Palmer et al. 2007).
- Costs are high initially as external technical assistance is used to increase government capacity for monitoring. The USAID-funded program has over 20 expats in Afghanistan. Also costs associated with the third-party evaluation mentioned above.
- Performance is taken seriously.
- Problem of lack of adequate health information systems means that third parties are used, leading to public health managers feeling marginalized and disconnected from the contracting process (EMRO 2006).

Possible relevant lessons to date

Strengths

- Capacity in the MOPH has been expanded, including ability to manage contracts.
- NGOs have experience of working in Afghanistan and of contracting. They also understand how to deliver a basic package of health services.
- Some NGOs have good technical and managerial capability.
- Motivation is said to be higher in NGOs than in for-profit providers, and ideals closer to the government's.
- NGOs were working there already (constituting most of the public health expertise) and were aware of local problems.
- NGOs are more flexible in the ability to recruit staff and provide services quickly (MOPH is bureaucratic when trying to hire staff).
- Many NGOs have links to other organizations that can provide supplementary funds.

Weaknesses

- Services are fragmented with no consistency on standards, user fees, drug procurement systems, use of community health workers.
- Dependence on donor money raises issues of sustainability. An emergency withdrawal would lead to a collapse of the health system.
- NGOs are under short-term contracts and have no incentive to promote investment in facilities or equipment. This is problematic in terms of sustainability.
- Low capacity for health planning in the ministry with little initial experience of contracting, cost analysis, or monitoring. Stewardship is limited through weak political, bureaucratic, and legal capacity.
- With the predominance of international NGOs, national NGOs are not developing capacity.

Background

Following establishment of a new government, contracts with NGOs were used to quickly scale up health services. The MOPH did not have the funds to provide the staff or medicines required to run the public health system. Many of the NGOs were already providing health services in the country as the public provision had collapsed and doctors had either had left the country or gone to work for NGOs.

Legal/policy

The legal framework for health was largely irrelevant for the current health situation in Afghanistan (EMRO 2006). This situation, combined with the newly democratic government enabled the new legislation on contracting to be endorsed and built in to the 2004 constitution and the Public Investment Programme (2004). The government (MOPH) has had an explicit policy on contracting since 2002. Donors funded capacity building and the establishment of an elite unit for the management of grants and contracts. Funded by the World Bank, the unit can independently manage most aspects of contracting and can manage funds from other donors.

Services

The BPHS was developed in 2003 with WHO and includes the services likely to have the most impact on the population, be cost effective and equitable (deliverable to urban and rural areas equally). The BPHS will be expanded in 2010 to cover additional services including community care for the disabled and HIV prevention.

Contracts

Performance-based partnership agreements (PPA) were designed based on the experience of Cambodia. PPAs operate in 34 provinces with WB supporting 8, the EC 10, and USAID 14 as of 2007. Providers are expected to cover a defined population and provide specified services. They were selected based on previous knowledge of Afghanistan, experience in primary health care programs, and capacity for service delivery. These are "relational contracts" with obligations of the providers defined in general terms, and it is difficult to challenge non-performance except through non-renewal. MOPH retains responsibility for planning and monitoring, with the UN providing technical assistance to support program priorities.

Some contracts between NGOs and donors are vague with non-quantifiable indicators for access and use. Health facility use is quantified as one visit per capita per year. This is low considering the environment and need for prevention and aftercare.

Contractees

The NGOs vary in size and level of skill. Most do not have much management capacity. Many rely on donors to procure medicines. The issue of medicine quality has been raised as there is no inspection or regulation. NGOs can employ workers from the country or foreigners and can employ ex public sector workers, invariably paying them more. A salary policy was set up by the MOPH in 2005.

Three provinces are contracted through the MOPH Strengthening Mechanism. Management is contracted under the same conditions and targets as those set for NGOs. Recruitment of staff is carried out as part of the government's priority reform and reconstruction policy, which seeks to retain qualified and motivated health professionals and to provide them with competitive salaries.

Payments, costs, and incentives

Payment is based on capitation with a payment for each individual enrolled. Donors pay incentives for good performance with payment according to individual, NGO-devised budgets. Per capita costs vary. This could mean that quality varies, but it is also due to varying costs of delivery according to group. Funds from the World Bank are channeled to the finance ministry and then to the public health ministry's grants and contracts management unit, which is responsible for awarding and managing contracts to competing NGOs. User fees are operated but are nominal.

World Bank incentive payments are performance based (four NGOs have received a 1 percent bonus of contracting price). It would be useful to know how often these payments are made or withheld and with what impact on performance. One contract with a poorly performing international NGO has already been terminated.

Currently, the costs of contracting are high, with lots of international technical assistance to increase NGO and government capacity (USAID has over 20 in country), and expensive monitoring by third party.

Where quality has been poor and waiting times long, patients are visiting private facilities or public facilities out of hours, leading to high levels of out-of-pocket payments.

Monitoring

Progress reports and site visits are part of all contracts. A third party (JHU and Indian Institute of Health Management Research) has been hired to undertake household surveys, facility inspections, and interviews using a balanced scorecard; sampling is limited.

The report of the third round of sampling (2006) found that in most provinces, the health system had improved between 2004 and 2006. Improvements included the increased availability of essential drugs and family planning supplies, improved quality of patient care, increased provision of antenatal care, upgraded skills of health workers, increases in the number of female health workers providing care throughout the country, and relatively high levels of patient satisfaction. Performance had decreased in the areas of time spent with patients, facility infrastructure, presence of user fee guidelines, and the equity of patient satisfaction between the poor and the non-poor. Provincial results were more variable than national results.

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Bangladesh: Urban Primary Health Care Project (UPHCP) I and II

Summary

Purchaser/contractor
- Local Government Division (LGD) of the Ministry of Local Government Rural Development and Cooperatives (MLGRDC) is the executing agency.
- City corporations and municipalities are the implementing agencies.

Type of organization
- Local government

Sources of funding
- Government of Bangladesh, loan and grant from ADB and funding from DFID, SIDA, and UNFPA to support project activities
- User fees paid by the non-poor on a sliding scale

Provider/contractee
- NGOs provide the services and are contracted by the LGD.

Type of organization
- NGOs

Nature of contract
- Contract is formally agreed and performance based.

Extent of population coverage
- City corporations and five municipalities covered under 24 partnership agreements with each agreement defined geographically and covering 200,000–300,000 people, now totaling about 9.4 million people
- Thirty percent of services targeted to the poor, and women and children comprise 75 percent of the beneficiaries

Services covered
- PHC services in prevention, treatment, and promotion under essential service package plus (ESP+)
- VCT center in each partnership area
- STI and RTI control activities
- BCC and marketing

Is it annually revised/negotiated?
A contract can be negotiated or revised if contractee fails to perform or does not meet the terms of the contract; otherwise contracts run for six years

Is there real competition for it?

- Yes, NGOs bid under competitive tendering processes in line with ADB rules
- A national bid evaluation committee assessed bids from NGOs with representatives from co-financers and the Ministry of Health and Family Welfare (MOHFW)

What mechanisms are used for review, evaluation?

- Monitoring through monthly reports from the city corporations and municipalities to the project management unit (PMU)
- Project review: at least twice a year jointly by government, ADB, and co-financers with a mid-term review in the third year (this will reconsider ADB's involvement in urban PHC, depending on LGD reaching certain benchmarks)
- The LGD and PMU will establish a project performance monitoring and evaluation system (PPMES) to assess technical performance, delivery, impacts on target groups, and against the health-related Millennium Development Goals

Possible relevant lessons to date

- NGO providers have made considerable improvements in access, quality, awareness, and facilities, as shown by internal and external evaluations. But is this project inducing structural change in the sector or just adding new services with new money? There were very few public urban services, so the project has not replaced publicly funded and run services. Is it providing a demonstration effect?
- Targeting the poorest is difficult in practice, especially women as family circumstances may intervene. There is pressure from the non-poor for subsidized treatment.
- Communication to the poor that the services exist and are free or at reduced cost for them has not been effective.
- NGOs are seen as foreign, leading to distrust, a perception of them as not sustainable, and to a lack of ownership. It is not clear whether NGOs are to be involved in the long term or just until the government has learned from them.
- Record keeping is a problem, especially for the floating population (and with clients losing cards); there is pressure for providers to be more interested in the number of people treated and treatments provided than the histories of existing clients.
- Community participation exists only in the form of complaints. There is little involvement in design or implementation or in any follow-up discussions.
- Transaction costs may be too high for scaling up as accountability relationships are long and complex with multiple principles and multiple tasks: government of Bangladesh/MOHFW (policymaker) accountable to citizens; government of Bangladesh accountable to donors; LGD accountable to MOHFW; NGOs (provider organizations) accountable to LGD; facility-level health workers accountable to NGOs. The PMU and Project Implementation Unit involve lots of staff.
- Indicators are clear and understood by all involved (pasted on the notice board of each facility), but management performance indicators are thought to be efficient in only 50 percent cases.
- Overall, clients are satisfied, and targeting by most NGOs is effective.

- Regular disbursement has been evident.
- NGOs and the staff they employ may be more committed to project goals than public sector staff, but if the NGO has multiple goals that are not in line with the state, how are they held accountable? Can contracting do this? Selection of NGOs is important to make sure they are capable and have a similar mission, but this should not be a problem in Bangladesh where there are many motivated NGOs. Explicit criteria are needed for selection.
- Reporting is regular, but while input, output, and outcome indicators are requested, in reality facility-based outputs are reported.

Background

The first UPHCP finished in 2005, and UPHCP-II was approved in May 2005 to run till 2011. ADB offered $30 million in loans and $10 million in infectious disease control grants. Funding has also been agreed from DFID ($25 million grant), SIDA ($5 million grant) administered by the ADB, UNFPA ($2 million), and the government of Bangladesh ($18 million grant). UPHCP-II builds on the experience of UPHCP-I, targeting the poor (30 percent of the services have to be accessed by the poor), sexually transmitted infections (STIs), and reproductive track infections (RTIs). Within a year, contracts worth more than $30 million were finalized with NGOs that started delivering services in 2006. These consist of outreach services to the poor and those at high risk, awareness raising of high-risk behavior, treatment of STIs and RTIs, and HIV testing. The aim is to reduce child and maternal morbidity and mortality.

The services are managed by 12 partner NGOs in 22 partnership areas of 6 city corporations and 5 selected municipalities; 2 partnership areas in Chittagong City Corporation are managed by the city's Health Department (CCCHD). The 24 partnership areas cover a catchment population of 9.41 million, which is about 41 percent of the urban population of Bangladesh. An important aim of the project is to build the capacity of the government to plan, finance, contract, monitor, coordinate, review, and evaluate health care. The program is aligned with Bangladesh's Poverty Reduction Strategy.

A national urban PHC committee chaired by the LGD minister guides urban PHC, ensures local ownership by mayors or others, and improves links with ministries. For project implementation: the national project steering committee chaired by the LGD secretary will guide the PMU. The project director will be supervised by the project coordinator; levels of seniority are pre-determined. The PMU is housed in the LGD of the MOLGRDC. At the facility level, a ward PHC committee will help people to access services and ensure that the community is participating.

Capacity building in city corporations and municipalities, LGD and partner NGOs: An external organization is contracted to organize training, fellowships, and study tours.

Policy strengthening: The project aims to support the development of urban health strategies, better coordination between the LGD and MOHFW, better targeting and monitoring.

To support project implementation, long-term international consultants will be provided in the role of technical advisor, project implementation, and quality assurance, in addition to international (20 person/months) and local consultants (150 months) covering a variety of areas: poverty analysis, equity, quality assurance, nutrition, gender, procurement, contracting of NGOs, among others. A financial management and performance audit firm will help the PMU, the PIU, and partner NGOs with computer-based financial management. Eight operational research studies are also included in the project.

Monthly reporting to the PMU allows for tracking and evaluating inputs and outputs. Household surveys are to be carried out at inception, midterm, and end of project. Surveys of health facilities will also feed into monitoring and evaluation.

Baseline data on fiscal impact, improved use of resources, changes in access to services (particularly among the poor), improved service quality, cost savings from rationalization, client satisfaction, and Millennium Development Goal progress status are to be collected and evaluated. Participatory assessments and household and health facility surveys are to be used.

Some health facilities are to be built or renovated, and 12 buildings/apartments are to be purchased for PHC facilities in Dhaka. Community-run latrines and community-based solid waste disposal are to be trialed under the project. This is funded through the ADB loan.

Each partnership agreement area will have one comprehensive reproductive health center (CRHC) providing comprehensive emergency obstetric care, newborn care, and specialized ESP+ services, at least one PHC center per 20,000–30,000 people (providing the full range of essential services, including basic emergency obstetric care) and at least one satellite/mini-clinic per 10,000 people. UNFPA provides support to CRHCs by providing equipment, supplies, and training through parallel financing.

Field workers will be assigned to around 1,000 households in each area, which they will visit every two months and will advise on nutrition, refer severe cases and weigh children, support observed treatment like TB, inform about family planning, provide and advise on contraceptives, and help pregnant women prepare for delivery and care of newborns.

The poor are identified by participatory poverty assessments and household listings carried out by the NGOs, and given identification cards by field workers. The poor will be given free services, including medicines, and a performance bonus paid to NGOs that reach the poorest and identify their needs. Utilization, equity, cost-efficiency, quality, and health impact will also help determine the performance bonus. For the non-poor, user

fees will be charged on a sliding scale with drugs 10–20 percent cheaper than market prices.

Long contracts (six years) mean that continuity of provision is ensured, which benefits clients but means it is possible to be stuck with non-performers. To overcome this, there are provisions in place to discourage poor performance and revoke contracts if necessary.

A legal agreement is in place outlining the proportion of user fees to be retained by each party and other issues surrounding user fees, but financial sustainability is an issue. The project aims to assist the LGD in exploring financial options to sustain the program after 2011.

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Cambodia: Contracting under the Basic Health Services Project (BHSP) 1999–2003,

Extended under the Health Sector Support Project (HSSP) 2002–2009

Summary

Purchaser/contractor

- The project coordination unit (PCU) within the Ministry of Health (MOH), using local consultants; the Provincial Project Unit (PPU) maintains contact between provinces and the PCU

Sources of funding

- BHSP funding for pilot through ADB loan to the government
- Expanded project funded jointly by DFID, ADB, and the World Bank
- User fees also provide some income for the contracted district activities

Provider/contractee

- International NGOs with country experience

Nature of contract

- Contract is specific on the quality of services to be provided, and on incentive payments and salary supplements.
- Under the pilot there were two models:
  - Contracting out: NGOs were contracted to provide specified services in a specified district with full management control over employing staff directly, setting wages, and the like. There were two contracted-out districts.
  - Contracting in: NGOs were contracted to provide management services to public service health staff to strengthen the government system, with the government paying recurrent costs through the normal channels, but with loan funding of an extra $0.25 per capita expendable at the discretion of the provider within government rules and regulations. There were three contracted-in districts.
- Under the extended program, a hybrid model was used with NGOs contracting with MOH staff at supervisory and service delivery levels, and civil service rules applied to all MOH staff (but independent hiring can take place if the relevant staff is not available).
- The contractee has the obligation to build capacity.
- A minimum package of activities (MPA) is defined under the contract for health centers and a Complementary Package of Service (CPA) specified for hospitals.
- Performance incentives are funded through user fees and specified in contracts between the NGO and the MOH health facility.

Extent of population coverage

- Each of the districts covered under the pilot was between 100,000 and 200,000.
- The expanded program now covers 20 percent of the population.

Services covered

- The MPA covers basic curative and preventative services including immunization, birth spacing, antenatal care, provision of micronutrients, simple curative care for diarrhea, acute respiratory tract infections, and TB

Is it annually revised/negotiated?

Not known

Is there real competition for it?

Each contract goes out to tender in a competitive tender process, and tenders are two-envelope and judged on technical competence and price.

What mechanisms are used for review, evaluation?

- Monitoring teams from MOH staff (HSSP and planning unit)
- Monitoring visits seen as time consuming and became less frequent but picked up as contract monitoring specialist was employed under HSSP

Possible relevant lessons to date

- District-level contracting is attractive because it can strengthen incentives for government workers and reduces harmful incentives, for example, to over-prescribe antibiotics. Contracting can mean risks are shared without the need for private insurance schemes. Contracting at the district level allows "benchmark" competition between providers in a way that is not possible at the national level.
- Contracting in this way can improve services in a short period of time.
- An evaluation in 2002 found that contracting under these conditions is cost-effective and efficient, effectively targeting and benefiting the poor. It can provide interventions to reduce child and maternal mortality more quickly than usual government channels.
- Much time was spent on solving problems that arose between provincial and district authorities and NGOs.
- The ban on simultaneous private practice has been seen as needing strengthening as some practitioners are ignoring this.
- Comprehensive exit plans were not in place to allow smooth transition once contracts with NGOs ended.
- Management and ownership vary. Accountability and transparency were seen as improved under contracting. Capacity for planning also seems to have improved.
- Monitoring and supervision seem not to be integrated into the district systems. Complex and time-consuming tools are used for the monitoring and supervision which is undertaken by the referral hospital director, NGO, and the operational district.
- International NGOs have the potential to build capacity of MOH and local NGOs to undertake the contracting.

- The provincial health departments (PHD) should have been given more attention during contracting. By leaving them out, administration was easier for NGOs as they had more direct control and accountability, but this has led to problems. Non-performing staff at health facilities seem to have two bosses, the PHD director who is in charge of civil service salary administration and the contractor who is responsible for management and payment of incentives. Examples exist of poorly performing staff playing one off against another. In some cases, this has led to promotion. Relationships between the PHD and the contractor would be better if formalized in the contract.
- Some local NGOs were contracted to carry out small and specific elements of the contract. They were seen as good technically and managerially but only on a small scale.
- Different contracts contain details of different incentives: Contract have been drawn up between an NGO and MOH; the NGO then contracts with the operational district (OD), health facilities, and referral hospitals to outline incentives. Issues covered include maximum payments for incentives, the percentage of that which goes to the OD and to the health facility, determination of measuring targets, percentage of user fees to be spent on it, definition of penalties.
- Incentives are potentially sustainable as they are funded mainly through user fees.
- Review found that motivation and attendance of staff are higher than in non-contracted districts. Adequate job descriptions and incentives were also evident with training and support. But performance-based incentive systems were not clearly understood. It is a new concept in Cambodia, and incentive cuts are seen as a punishment. Delays in payment of overtime have reduced motivation. Variation in the level of user fees to pay for incentives has led to uneven incentive payments.
- Barriers to expansion of contracting: No new NGOs are bidding for new contracts, existing NGOs may not have the capacity to expand, and the learning curve is long for new ones that may be interested. It is not sustainable financially until the government can provide all of the necessary funds.
- Other benefits of contracting in Cambodia: A culture of performance is evident in the contracted districts; better access to health care in rural areas; better understanding of regulations and clearer lines of authority; improved technical training for staff; referral systems in place; restored trust and confidence in the health system.
- Main areas where contracting could be improved: problems of dealing with poor performance; delays in funding; few exit plans; supervision and monitoring possibly undertaken by different teams without being integrated; lack of trained staff available.
- It is possible that costs could come down as competition is increased among national and international NGOs.
- The relationship between the contract and national programs has not always been harmonious. Better alignment is needed.

Background

Results of the pilot: An evaluation at the end of the pilot found that contracting districts consistently outperformed the control districts with the contracting-out model being more

successful that the contracting-in model. The number of patient contacts with the health system per capita per year were 0.8 for the control districts, 1.2 for the contracting-in districts, and 1.7 for the contracting-out districts. Contracting out was also more cost effective. It seems that while more patient contacts were made in the contracting-out districts, this was more cost-effective as it reduced clinical complications requiring more expensive care. Other indicators of success include child immunization rates increasing by 156 percent in contracting out, 82 percent in contracting in, and 56 percent in control districts. Reproductive health coverage also increased by 400 percent in the contracting-out districts, 233 percent in the contracting-in districts, and 160 percent in the control districts. Annual expenditure was $3.88 per capita for contracted-out districts, $2.40 for contracting-in districts, and $1.65 for control districts. Contracted districts brought in technical assistance for management, which accounts for much of the difference in expenditure. Contracted-out districts had additional staff costs. Out-of-pocket expenditure was reduced in the contracted districts by more than the amount of the contract cost, thus reducing overall economic costs.

The MPA consists of immunization, birth spacing, antenatal care, provision of micronutrients, simple curative care for diarrhea, acute respiratory tract infections, and TB.

Pre-contract performance goals: child immunization and vitamin A, antenatal care, delivery by a trained birth attendant, delivery in a health facility, and knowledge and use of birth spacing in each district. An equity goal to target services to the poorest half of the population was mandated for all districts. The targets were shared with all of the districts' management.

Construction and renovation of health centers and referral hospitals, furniture and equipment, and district health offices were provided for all three types of district by the MOH.

A project coordination unit (PCU) was set up within the MOH to ensure timely and efficient implementation of projects and build capacity within the MOH in project administration, financial management, and procurement. The PCU implements policy and decisions of the steering committee; ensures proper record keeping of project activities; ensures that goods and services are procured in a timely manner; supervises monitoring and evaluation activities; accounts for project funds; tracks implementation and deals with delays; and coordinates with other funding agencies. The PCU is linked to the districts through the Provincial Project Unit (PPU).

Monitoring and evaluation are the responsibility of the PCU which are in charge of collecting, analyzing, and reporting data. Independently verifiable indicators were chosen with baseline data collected.

Extension of ADB funding for HSSP was approved for 2002–2008, of which contracting is one element. A further extension was approved until June 30, 2009. This second

incarnation of the contracting model is different in that all districts are of a hybrid model (see “nature of contract” in matrix summary above).

Ghana: National Health Insurance Scheme (NHIS)

Summary

Purchaser/contractor
- District mutual health insurance schemes (DMHISs)
- Private commercial health insurance schemes
- Private mutual health insurance schemes

Type of organization
- DMHISs established by NHI Act 2003, managed by core teams of technical staff, under the supervision of a Board of Directors drawn from the community. Ownership is vested in the registered members (AGM), with oversight from District Assemblies.
- Private commercial schemes established under Companies Code 1963 (Act 179)

Sources of funding
- Informal sector member contributions (minimum of 72,000 cedis a year)
- NHI Fund pays DMHISs for those exempt (young, old, and indigent)—Fund receives 2.5 percent of the 17.5 percent social security contributions paid by formally employed, and an NHI Levy of 2.5 percent of certain goods and services.

Provider/contractee
- Ghana Health Service (GHS) (public sector)
- Christian Health Association of Ghana (mission-run services)
- Other ministries
- Any other health services

In practice, almost all are GHS or the Christian Health Association of Ghana.

Type of organization
As above

Nature of contract
- Not specific in terms of volume, quality, or price
- Appears to be a memorandum of understanding between the National Health Insurance Council and accredited providers but no details available in literature accessed
- Reimbursement on a fee-for-service basis
- No standard fee scale yet
- No standard drugs list yet
- No performance incentives

Extent of population coverage

Thirty-eight percent of population registered (2007), mostly those exempt from contributions

Services covered
Primary and secondary

Is it annually revised/negotiated?
No formal specific contract

Is there real competition for it?
Apparently not much if any, just using existing services accredited by NHI Council at national level

What mechanisms are used for review, evaluation?
None known

Possible lessons to date

- Partial introduction of purchasing is causing problems about who is responsible for the indigent—the Ministry of Health retains responsibility for those exempt and uninsured—and some cost shifting.
- Lack of competition and fee-for-service reimbursement place financial risks on the purchasers, and providers have no performance or cost-containment incentives—alternatives are needed to fee-for-service for purchasing.
- Fee-for-service is also resulting in complicated and delayed billing, and high transaction costs.
- Weak specific contracting prevents its use to drive prevention and quality (big gains and savings possible from simple prevention, e.g., malaria).
- Purchasing was introduced without necessary contracting skills in purchaser bodies.
- No adequate gate-keeping function was built in (perhaps providers should be contracted for a wider spectrum of services to introduce incentives for cost containing behavior).
- Response from the private sector has been poor apart from the long-established missions (it is not known whether purchasing intentions were prepared and publicized, if there insufficient profit, real or anticipated, etc.
- Schemes are at the mercy of District Chief Executives of the respective District Assemblies. Interference by board persons. Management is not fully free to operate.
- Standard services package is not affordable by everyone, everywhere—maybe there should be more flexibility at the local level to determine package and premiums.

Background

In reaction to the negative effects of the user fee system, a voluntary mutual health insurance movement started in the early 1990s. By 2003, there were 168 Mutual Health Insurance Organizations in 67 districts, although less than 40 percent of these were functional, and the total coverage was only 1 percent of the population.

A National Health Insurance Act was passed in 2003 and officially launched in 2004, establishing mandatory district-level or district-wide mutual insurance organizations with the aim of covering the whole population.

A national regulatory body, the National Health Insurance Council, was established to guide and regulate the district schemes, including registering, licensing, setting the benefits package, and accrediting and monitoring service providers operating under the system. It also manages the NHI Fund.

Three types of schemes are permitted:

- District mutual health insurance schemes (DMHISs)
- Private commercial health insurance schemes
- Private mutual health insurance schemes

A DMHIS was established in each district. DMHISs are the only schemes receiving subsidy for the indigent under the NHIF (essential demand-side financing targeted on poorer), but it is doubtful that these subsidies have in fact been allocated exactly in this way. They establish a district administration, enroll and maintain members, collect contributions from those who can pay, apply a means test to determine the indigent and administer subsidies from the NHIF for the indigent, and pay the providers. There is a choice of joining a private commercial or mutual scheme instead of the local DMHIS, but in practice there was not always such a choice, and some mutual schemes are thought to have suffered from intimidation.

Finance is raised from:

- An NHI levy of 2.5 percent of specific goods and services (many exemptions)
- 2.5 percent of the 17.5 percent social security contributions paid by the formally employed (with contributors then automatically enrolled in their district scheme)
- Member premiums (a minimum of 72,000 cedis per adult—a typical two-parent family with three children paying 144,000 cedis, or about US$17)

It was anticipated that 80 percent of the NHIS would be financed by the two taxes.

In 2007 DMHISs operate in all districts, with 38 percent of the population registered, most of these exempt from contributions (<18, >70, or indigent). By the end of 2007, the government was claiming 45–50 percent coverage.

DMHISs are the purchasers, reimbursing providers on a fee-for-service basis.

Providers under the system are the Ghana Health Service, the teaching hospitals, the Christian Health Association of Ghana, health services provided by other ministries, and any other health service providers.

Information available suggests that the purchasing/contracting function is rudimentary as yet and weak. Providers are accredited, but it appears that there are no contracts that specify services volume, quality, or price. Weaknesses include:

- Tariff schedules are fragmented (different for different providers)—there is neither standardized prices nor competition.
- Drugs lists are not standardized, leading to lack of control over costs.
- Providers are under no performance incentives—huge cost reductions might be achievable by contracting for results in prevention, for example (many presentations are for malaria).
- DMHISs do not have the required contracting skills.
- The NHIS was designed to replace only about 20 percent of total public health spending, so the power of DMHISs to raise quality and value for money through purchasing is limited.
- Fee-for-service reimbursement to providers puts the risk on the insurance schemes and creates incentives for supply-driven consumption, cost inflation, and false claims.
- There is little or no competition between providers in specific locations.

Other problems include:

- The split of financing between NHIS and the Ministry of Health may result in some cost shifting.
- There are no disincentives for excess consumption (quite the reverse, apparently, since there appear to be no user charges) and the benefits package is quite comprehensive, leading to high expectations and costs.
- Lack of gate-keeping or incentives for efficient referral is causing excessive utilization.
- Income to purchasers may not be adequate and some schemes are running deficits (but some of this results from slow transfers of money from NHIF to DMHISs for subsidies).
- Fee-for-service reimbursement is likely to result in high transaction costs.

Observations regarding provider purchasing and contracting mechanisms:

Participation in the system by private providers (apart from the long-established mission faith-based organizations) appears minimal. Why is this?

If services and finance are not being packaged and offered competitively, the private sector cannot respond (e.g., in the way NGOs did in Cambodia when this was done).

Like national health insurance everywhere, more thought and planning appear to have gone into raising finance and "equity" in contributions than into how funds will be spent to drive results (contracting).

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Guyana: Health Sector Reform Program

Summary

Main components of reforms
- Autonomy for national referral hospital (Georgetown Public Hospital Corporation)
- Establishment of autonomous Regional Health Authorities (RHAs) under contractual arrangements
- Development of a national health fund as national purchasing organization

Purchaser/contractor
- Health Sector Development Unit for the Ministry of Health (MOH)

Type of organization
- A unit of the MOH also acting as Project Development Unit and handling external funding from the World Bank, IDB, and Global Fund

Sources of funding
- MOH budget
- Regional allocations via Regional Development Councils
- External aid

Provider/contractee
- Regional health authorities
- Georgetown Public Hospital Corporation
- Private, mainly mission, hospitals

Type of organization
- Autonomous bodies under act of parliament and state corporation act
- Private—mainly mission NGOs

Nature of contract
- Contracts specifying quantity, quality, and price
- Highlighting key targets
- Negotiated annually

Extent of population coverage
- GPHC—100 percent of population as national referral hospital
- Regions—first RHA fully operational covering 20 percent population; three more being introduced to cover remaining 80 percent

Services covered
- GPHC—specialist inpatient and outpatient care; secondary care for local population
- Regions—primary and hospital care

Is contract annually revised / negotiated?
Yes

Is there real competition for contracts?
No

What mechanisms are used for review, evaluation?
- Annual joint review process with feedback into national plan and budget
- Quarterly reviews on progress

Possible lessons to date

- The contracting process is improving the performance of GPHC and Region 6.
- Insufficient attention is paid to opportunities to contract with the private sector for primary and secondary care; purchasing is generally limited to use of external HIV funding for non-health projects.

Background

A reform program was started based on the experience that the "complex functions of funding, planning, regulating, and providing health services cannot be undertaken efficiently by a single public service agency like a ministry of health" that "lacks incentives to deliver high quality, consumer oriented services, and suffers from bureaucratic management unable to take dynamic and responsive decisions close to the point of services being delivered. Sensible policy is often not translated into actions, and services typically respond more to the demands of powerful middle classes and the interests of those providing the services, than to the health needs and preferences of the public" (National Health Sector Strategy 2008–12).

Guyana's policy to overcome these problems was to separate the functions of funding and regulation from those of providing services. Initially, the function of providing local health care services was devolved to local government, the Regional Democratic Councils (RDCs). But this was not able to overcome the lack of accountability for poor performance and lack of reward for good performance because the RDCs lack the degree of autonomy required to manage staff and services efficiently.

Currently, responsibility for health services is being assumed by Regional Health Authorities (RHAs) and Georgetown Public Hospital Corporation (GPHC). These are statutory authorities created under the RHA Act 2005 (and the Public Corporations Act in the case of GPHC). They operate under contracts with the MOH that specify the level and quality of services they should provide in return for the funding they receive. GPHC has operated like this for several years.

Four or five RHAs will cover health care delivery across the country, to justify full management teams and to achieve economies of scale in clinical services. The RHAs will be operationalized in phases over 2008–2010, covering one or more RDC geographic areas. The Berbice RHA has been established covering Region 6 and will later incorporate Region 5. It is already operational, with a Board and Executive Team. The authority has developed its RHA Strategic Plan 2006–10, its Business Plan 2007–9 and Annual Workplans. These are now part of the annual budgeting and workplan process led by the Ministry of Finance. Performance management systems are being introduced in which planning targets are converted into directorate and personal workplans that define roles and responsibilities down through the organization, and for the basis for staff achievement goals, performance incentives, and personal development.

The RHAs will employ their own staff, combining direct recruitment and transfer from traditional civil service employment. They will have full managerial control over staff and resources with which to meet their contractual obligations, avoiding the delays of the public service. They will be charged with managing the improvement of regional primary care services, regional hospital services, logistical systems including transportation, diagnostic and clinical monitoring. Their performance will be assessed on how well they meet their contractual targets based on national policy priorities. To optimize resources nationally, investment and development plans involving infrastructure and services development will be led and coordinated by the MOH but implemented by the RHAs and GPHC. A Package of Publicly Guaranteed Services (PPGS) has been produced to guide the development of services, subject to sector financing.

Combined with contracting, the increased local autonomy of the RHAs and GPHC is expected to improve the quality and cost effectiveness of services, and to ensure that they are more consumer oriented. Professional and allied staff will have a clearer work context and performance targets that will specifically include quality and consumer satisfaction measures.

Contracting will require the RHAs to make the best use of their resources, to rationalize services to achieve critical mass of skilled staff and raise quality, and to refer patients to the most appropriate facility. Combined with the development of a national single-payer mechanism through pooled funding of government and external sources, contracting will direct resources to priority health services. As contractor, the MOH will provide the targets for services linked to funding.

Weaknesses of the reforms include the following:

- Each RHA has to develop new management teams and skills more appropriate to independent organizations rather than the public service, skills that are in short supply.
- There is no competition for the roles of these major providers, and purchasing is more a process of gradual influence and persuasion by targeting funding, and by implied job insecurity for key managers for lack of performance.

- Board members are appointed by the government and are accountable to the government rather than a local constituency; consequently, there is still significant purchaser control over provider management.
- There is little allowance as yet for the possibilities for purchasing from private providers, but there are opportunities. One possibility with potential is that the RHA providers can start to make up their service packages (for which they are contracted by the government) by purchasing parts of it from private providers, including faith-based organizations and the commercial sector.

A second major component of the reform program is to create a national health fund. Currently, achievement of sector goals is hindered by the earmarking of much external funding for specific diseases and activities (mostly HIV) and by the stipulation of donors for separate reporting along lines that suit the their needs rather than conforming with and strengthening national systems. A process is needed to combine government and external funding and to direct this to the providers of services in ways that ensure their activities are aligned with and maximizing achievement of the overall sector strategy and priorities.

Government and donor funding for the sector is being consolidated into a single fund, a National Health Fund (NHF) that will combine finance from all sources into a single-purchaser mechanism to ensure that fund disbursement is aligned to the priorities of the National Health Sector Strategy 2008–12 and create a single forum for the government of Guyana and its development partners to ensure that they are harmonized in their support efforts. The NHF will help to smooth variations in donor (and domestic) financing so as to create more predictable sector funding and facilitate longer term planning. It will maximize the use of international disease-dedicated funding (for HIV particularly), to strengthen the health system and sustain the delivery of all health services.

A single-payer NHF will minimize the significant administrative burden of providing different reporting to different development partners. It will allow a single performance monitoring mechanism relating all support to achievement of an explicit national strategy and priorities. This is reflected in a new process of performance management for the health sector that guides annual planning, budgeting, and contracting arrangements. The process provides annual targets and financial estimates for the RHAs, GPHC, and other service providers or “implementing agencies” contracted. Based on these, the implementing agencies prepare their business plans covering the following two years, and their annual workplans, service targets, and budget requests for the following year.

Lebanon: MOH Contracting Private Hospitals

Background

Hospital care is dominated by the private sector. Even before the civil war (1975–91), less than 10 percent of hospital beds were provided by the Ministry of Health (MOH), and in small units with an average size of only 20 beds. A few private hospitals were contracted by the MOH to provide care to the very poor who could not receive the treatment they needed in public hospitals.

After the war, private hospitals maintained the 90 percent share of total beds, and the MOH began to contract with almost all of them for inpatient and outpatient care for public uninsured patients. Private care grew steadily to reach about 9,653 beds by 2004. But only 4 private hospitals have more than 200 beds, and only 14 have 100–200 beds. Occupancy rates are low.

Effectively, the MOH became little more than a funding agency, reimbursing private hospitals for care on a fee-for-service basis, with patients paying 15 percent of costs to the hospital (except the very needy). MOH receives 3–4 percent of the government budget, 75 percent of which is paid to private hospitals, but this is open-ended: all non-insured patients are eligible and are not enrolled but simply identified when they present. There was much misuse.

Individual hospitals are under contract to the MOH. Terms are negotiated with the syndicate of private hospitals covering tariffs, eligibility, services, priority of emergency cases, billing, and payment mechanisms. Although the MOH has good negotiating power at this point, it has little control over the behaviors of individual hospitals in terms of admissions, diagnosis, or treatment. Patient selection and shifting occurs, and many hospitals will avoid admitting expensive intensive care cases for fear that patients will not pay the co-payment component and because of the time lag in reimbursement from the MOH. There is certainly much over-provision of more routine care, and cost inflation.

The contracts are overseen by the MOH Director of Medical Services, assisted by the department of hospital care in the MOH, and supervised by the Director General of the MOH. They must be approved by the regulatory authorities and General Accounting Office of government, and signed by the minister and the hospitals. Contracts cover almost all personal health care services for outpatients and inpatients, and nothing of public health or primary care services, although many hospitals participate in MOH preventive initiatives including immunization, patient education, and screening (diabetes, various cancers, among others).

More recently, in an effort to curb excessive utilization and billing, the MOH assigns a medical auditor for a group of hospitals to manage daily patient requests and approve invoices. This role includes the following:

- Ensuring identity of patients
- Approving admissions
- Approving use of expensive diagnosis and treatment
- Receiving patient complaints and taking them up with the hospital
- Ensuring emergency cases are given priority
- Reviewing medical records to ensure proper billing

The work of these medical auditors is checked by MOH medical inspectors, and the MOH does a random 10 percent audit of invoices against medical summaries, correcting where required before sending on to the MOH finance department for payment. This can take 6–10 months. If a hospital bills over its budget, payment is stopped until the MOH gets a budget supplement from government or parliament, and the hospital may receive much less than invoiced. The government has a Directorate of Central Inspection that does regular unannounced audits on MOH and hospitals under contract.

Contracts specify budgets. These are allocated to each hospital by the MOH after approval of its annual budget. The MOH is stipulated to consider

- Size, specialty, and classification
- Budget utilization history
- History of abiding by earlier contract terms, including quality of care, acceptance of emergencies, sensible use of expensive procedures, not overcharging and the like.

In practice, allocations are much influenced by political and sectarian horse trading.

There is no coordination between the various hospitals. Each operates as an independent entity, and the MOH imposes no rational utilization or referral between them.

Purchasing occurs without much real competition between providers—almost all are included.

Fee-for-service reimbursement produces incentives to over-provide and creates high transaction costs including the attempts to police the system.

The purchaser, the MOH, is unable to coordinate the supply of services with the result that all providers decide what they do, whom they treat, and whether they refer a patient anywhere else.

Contracts are not driving quality or efficiency.

Nigeria: Hygeia Community Health Plan

Summary

Main components of reforms
- A private sector initiative but taking place within the context of the new National Health Insurance Scheme (NHIS)

Purchaser/contractor
- Hygeia contracts private and state service providers, and is itself contracted by the Health Insurance Fund Foundation, a Dutch NGO, with funding from the Dutch government.

Type of organization
- Hygeia is a private health maintenance organization.

Sources of funding
- Dutch government
- Nigerian federal government
- Members' contributions

Provider/contractee
- Private clinics and hospitals
- Public clinics and hospitals

Type of organization
- As above

Nature of contract
- Details of contracts or provider payment methods not available yet

Extent of population coverage
- Target of 115,000; 25,000 enrolled by the end of 2007

Services covered
- Primary care, limited secondary care and medication, including HIV/AIDS treatment

Is contract annually revised / negotiated?
Not known

Is there real competition for contracts?
Not known

What mechanisms are used for review, evaluation?

- Hygeia-providers not known
- HIF/PharmAccess—Hygeia: monitoring and evaluation

Possible lessons to date

- No public information is available on provider payment methods and on incentives to over- or under-provide services.
- It is not clear from published material how this fits into NHIS.
- No published information is available on income levels, and the like, of informal employed members.

Background

The Health Insurance Fund is a foundation that provides private health insurance to low-income groups in Sub-Saharan Africa, covering quality basic health care, including treatment for HIV/AIDS.

Beneficiaries of the Health Insurance Fund's programs are organized groups of previously uninsured, low-paid workers, such as women's associations, farmer organizations, or people with a micro-loan. Guaranteed access to good quality health care enables these beneficiaries to sustain and enhance their income and productivity.

The fund was established in 2005 and is based in the Netherlands. In October 2006, the Dutch Ministry of Foreign Affairs awarded the fund a € 100 million grant for the development and implementation of insurance schemes in four countries over a period of six years. The first schemes were launched in Nigeria in early 2007, targeting 115,000 market women and farmers and their families. The possibility to set up a second program in Tanzania is currently being investigated.

The Health Insurance Fund is an initiative of Kees Storm, former CEO of AEGON (one of the largest life insurance companies in the world), and PharmAccess Foundation. PharmAccess is a Dutch not-for-profit organization supporting AIDS treatment and general health care in developing countries.

Nigeria: The Community Health Plan

The first Health Insurance Fund program was started in Nigeria in early 2007 under the name Hygeia Community Health Plan (HCHP). The program targets potentially 115,000 persons—40,000 market women and their families in Lagos and 75,000 farmers and their families of the rural Shonga community in Kwara State, around 500 kilometers northeast of Lagos. Annual premiums are $60 per person per year in Lagos and $27 per person per

year in Kwara. The benefit package provides coverage for the most common medical problems that are found among the target groups and consists of primary care, limited secondary care, and medication, including HIV/AIDS treatment.

The local executing partner of the program is Hygeia, the largest health maintenance organization in Nigeria, which has a local network of over 200 clinics and hospitals throughout Nigeria and around 200,000 paying members. Hygeia has 20 years of experience in health care in Nigeria and is one of the eight health maintenance organizations executing Nigeria's National Health Insurance Scheme (NHIS), which started in June 2005. Due diligence was carried out by PricewaterhouseCoopers. As part of the program the Health Insurance Fund provides support to Hygeia to improve its administrative capacity.

Hygeia has contracted with 19 clinics and hospitals for the Health Insurance Fund program where the scheme beneficiaries can obtain their medical services. The clinics are selected on the basis of a medical due diligence of clinics carried out by PharmAccess and Hygeia. Of the selected clinics 13 are private and six are public. In Lagos 13 providers have been contracted and in Kwara State six providers. Eight of the clinics provide only primary health care, and eleven are referral centers providing primary and secondary care.

Thirteen of these providers, ten in Lagos and three in Kwara State, have been included in the fund's quality improvement program and are currently being upgraded. Of these facilities three are public and ten are private providers. In November 2006 Hygeia and the providers, with assistance from PharmAccess, developed upgrading plans for the clinics. These are currently being implemented. Within the program, funding is allocated for improvement of the physical infrastructure. In Kwara State, the governor has allocated funds from the state budget for two clinics, amounting to $75,000 per clinic, to rehabilitate them up to the required standards. In February 2007, PharmAccess and Hygeia organized the first medical and administrative training for the medical directors, nurses, pharmacists, laboratory technicians, and administrative staff of all health facilities involved in the program. The first monitoring and evaluation visit was carried out by PharmAccess in June 2007, and the second in January 2008.

Enrollment is voluntary; registration is done per family. Hygeia "marketing teams" go out into the field to enroll members from the target group. The teams use laptops to register beneficiaries of the program on the spot. After a person has paid, a photograph of him or her is taken, personal identification data are entered into the computer, and the insurance ID card printed. With this card, members can obtain access to health services in the designated health facilities nearby. By the end of 2007, more than 25,000 people had enrolled. Since the enrollment has started, clinics have already begun to notice an increase in the number of patients.

In the coming period, Hygeia aims to increase the numbers of enrolled persons in Lagos and in Kwara State. In the meantime, Hygeia is working closely with PharmAccess to further upgrade the health facilities and improve and expand the level of care.

Heineken, Celtel, Unilever, and Shell, all of whom have operations in Nigeria, provide local support by insuring their employees through Hygeia. In this way, Hygeia's risk pool is further increased, which contributes to the sustainability of the schemes.

Facilities upgrading and staff training are integral components, and are supported by PharmAccess.

Tanzania: National Health Insurance Fund

Summary

Main components of reforms
- Autonomy for Muhimbili national hospital 2000
- User fees introduced in 1993 incrementally
- Community Health Funds piloted in 1996 and encouraged with matching funds
- National Health Insurance Fund (NHIF) introduced in 2001 covering public sector employees

Purchaser/contractor
- NHIF for private and public hospitals
- District Medical Officer's office for public health centers and dispensaries

Type of organization
- Statutory authority—NHIF established by the NHIF Act in 1999 and commencing in 2001
- Local government

Sources of funding
- Main sources for providers are government block grants and council basket funds plus user fees—NHIF reimbursement is a very small amount.
- NHIF contributions from salary of public sector employees

Provider/contractee
- All public health services were accredited automatically—3,358.
- Mission, NGO, and private—up to 600 by the end of 2005

Type of organization
As above

Nature of contract
- No real purchasing occurs
- Not specific in terms of volume, quality or price
- Reimbursement on fee-for-service basis
- No performance incentives as bulk of budget guaranteed
- No competitive risk for public providers

Extent of population coverage
Three percent of population covered (2005)

Services covered
Primary and secondary

Is it annually revised/negotiated?
No formal specific contract

Is there real competition for it?
Very little because public services are guaranteed participation and private services are not yet much interested

What mechanisms are used for review, evaluation?
None known

Possible lessons to date

- Although compulsory, registration remains low because standards of public providers are perceived as low.
- Utilization remains low for similar reasons.
- Development of partial national health insurance in parallel with existing public system offers no leverage for purchasing or incentives for providers—lack of competition together with fee-for-service reimbursement places financial risks on the purchasers, and providers have no performance or cost-containment incentives. Alternatives to fee-for-service for purchasing are needed if national health insurance coverage grows.
- Reimbursement rates are not attractive to the private sector, but also the scheme has not been marketed or competitive tendering developed.
- Fee-for-service reimbursement creates high transaction costs (and confusion, complicated and delayed billing in the process).
- Weak specific contracting prevents its use to drive prevention and quality (big gains and savings possible from simple prevention).
- Purchasing skills are absent in purchaser bodies.
- Gate-keeping function of requiring referral letter appears not to work as lower levels are being by-passed—should providers be contracted for a wider spectrum of services to introduce incentives for cost-containing behavior?

Background

NHIF was a component of health sector reform started in the mid 1990s. It was brought in by the NHIF Act in 1999 and commenced in 2001. It aimed to cover all formal sector employees, who would then no longer have to pay the user fees at public services that had been introduced in 1993, but started with public sector employees for whom it is compulsory. It also aimed to stimulate a dormant private sector by allowing members choice of public or private services.

Contributions are 6 percent of salary (3 percent employer; 3 percent employee) collected by the Ministry of Finance and transferred to NHIF. Providers are paid through a fee-for-

service claims reimbursement system. Members are entitled to a quite full package of outpatient and inpatient services subject to actuarial assessment regularly. Access to higher level services requires a referral letter.

By 2004–2005, membership was about 248,343 (total beneficiaries 1,142,378 or about 3 percent of the population) out of a total of 445,000 government and para-statal workers. Non-members continue to pay user fees unless they are covered for PHC by a Community Health Fund (see below).

Total contributions were reported as:

- 10.53 billion Tanzanian shillings (US$9.6 million) in the first seven months of the year, which was about 6.1 percent of recurrent on-budget health expenditure
- 24 billion Tanzanian shillings for the whole year but with only 4.9 billion Tanzanian shillings of claims submitted, of which 86 percent were reimbursed.

Providers: At the start, all public health facilities were automatically accredited as NHIF providers, but by September 2005, over 594 mission/NGO providers and for-profit pharmacies were also accredited along with the 3,358 public providers. Only 68 percent of accredited providers appear to be claiming reimbursement.

Public providers submit claims to the DMO monthly, then to NHIF. NHIF reimburses private providers directly, and public providers via the DMO.

Purchasers: No real purchasing function appears to take place. Patients self-refer and providers either take user fees or claim from NHIF, but the bulk of the budget for public providers is guaranteed anyway (see below). The NHIF is the payer, via the DMO's office.

Weaknesses of the system include the following:

- Registration is low despite compulsory membership for public sector employees, many of whom are not filling in the forms because they perceive the standard of public providers as low.
- Use of services by NHIF members is low—resulting partially from problems with making ID cards available but, more importantly, because consumer concern with quality results in bypassing of lower level services and a preference for private providers including those outside NHIF.
- NHIF funds are a very small component of district and provider financing and offer very little leverage through a contracting process. The major sources of funding for districts are the government block grants and the council health basket funds, plus central allocations for drugs and supplies, any direct donor funding, and council's own funds. Providers also receive income from user fees at government hospitals (Health Services Fund), the Community Health Fund (a community based pre-payment scheme for PHC, see below), and possibly the Drug Revolving fund, as well as NHIF.

- Payment levels—unit or volume—are not enough to attract private sector providers including new entrants, and for missions, NHIF payments are often only replacing previous out-of-pocket payments and at lower unit prices.

There is no real purchasing because

- All public providers are accredited automatically.
- Councils (DMOs) have no say over which providers are "contracted" and what for.
- Providers are reimbursed fee for service, with the services provided decided by consumers and providers (mostly the latter).

There is much confusion in the process of reimbursement and retention of fees by providers, resulting in an absence of clear incentives to perform.

Community Health Funds

The CHF operates in parallel to NHIF. It is a voluntary prepayment scheme introduced after piloting in Igunga district in 1996, now covering 68 councils (2005).

Premiums are set by a community's ability and willingness to pay, and members are given a card entitling them to primary care services. As CHFs are established, user fees are introduced and charged to non-CHF members to encourage enrolment in CHF. Government provides a matching grant. Funds are held in a CHF account managed by the Council Health Board. Each CHF identifies those unable to pay, and the relevant council (district) pays those contributions.

Appendix 4: Contract Specification Example: GPHC Guyana

Republic of Guyana

Services Agreement for 2008

Between **Ministry of Health**

and **Georgetown Public Hospital Corporation**

January 2008

Contents

1.0 Preamble

This Contract is freely entered into by the parties concerned, namely:

- The Ministry of Health, the Contractor, and

- The Georgetown Public Hospital Corporation (GPHC), the Contractee.

It covers the period 1st January 2008 to 31st December 2008.

The authorised persons representing each party are identified below as signatures to this Contract and shall be the only persons empowered to act on behalf of each of the parties.

The Minister of Health:

..... date: .....

Ministry of Health
Brickdam
Georgetown
tel: 226-1560
fax:
email: ministerofhealth @gmail.com

The Chairperson of the Georgetown Public Hospital Corporation (GPHC):

..... date: .....

Georgetown Public Hospital Corporation
East Street
Georgetown
tel:
fax:
email:

2.0 Overall objectives

The MOH (the Contractor) wishes to secure the services of the GPHC (the Hospital), to provide hospital services and services in support of primary care as outlined in this Services Agreement.

In signing this Service Agreement, the two parties accept that GPHC serves as:

- Guyana's National Referral Hospital

- a Teaching Hospital, particularly for the training of health care providers
- a Regional Hospital for Region 4
- the Community Hospital for Georgetown.

Through this Services Agreement and financing mechanism, the MOH wishes to ensure that the Hospital is:

- providing those services that are needed, taking account of the role of the Hospital nationally and of national health priorities

- producing them cost effectively and to a high quality allowing for resource constraints

- engaged in a continuous process of improvement in which it will launch a fast-paced TQM initiative driven by (i) high quality, (ii) top management support, (iii) a steering group for implementation, (iv) balanced implementation across the Hospital.

This Services Agreement covers the period 01.01.08 to 31.12.08 but subject to satisfactory joint review by both parties and to any resulting adjustments to the Agreement, it is expected that this Agreement will continue over the following years.

3.0 Summary of Key Points

The context for this Services Agreement is provided by the National Health Sector Strategy 2008-12 and the various policy and technical documents referred to therein. In operating under this Services Agreement, the Hospital will take full account of this context and the implications for its role.

Key strategic actions to be achieved under this Services Agreement are:

3.1. The Board agrees to:

- meet at least ten (10) times per year

- conduct one public meeting and provide an annual report to the public no later than March 2009

- provide a comprehensive Annual Report to the Ministry of Health, no later than January 31st, 2009

- hold at least one media briefing to outline its achievements

- hold at least one call-in TV/radio presentation to engage the public on its work

- complete a performance appraisal of the CEO and all the Directors (Director of Medical and Professional Services, Director of Nursing Service, Director of Administration and

Human Resources, Director of Financial Services, Director of Facilities Management, and Director of Internal Audit) by July 15th 2008, covering January 1st to June 30th 2008, and by January 15th 2009, covering the period January 1st to December 31st 2008.

3.2. The Chief Executive Officer agrees to:

- ensure the smooth day-to-day functioning of the hospital
- monitor the activities of each Director in order to ensure that each Director is functioning in accordance with their responsibilities and duties on a daily basis
- put mechanisms in place so that GPHC meets all legal and regulatory requirements as the National Referral Hospital
- provide monthly financial, human resources, facilities and clinical service reports
- lead a team on a weekly inspection of the Hospital to ensure the physical and environmental infra-structure are in reasonable working conditions and prepare a written report on the result covering: general cleanliness, the functioning of all utilities including telephones, electricity, plumbing, water and sewer systems, air conditioning etc.
- maintain and regularly updated an asset register for GPHC on a departmental basis
- ensure the services of the GPHC are consumer-friendly, and responsive to consumer views.

3.3. Meeting the requirement of the Health Facilities Licensing Act and other laws and regulations

In addition to meeting the requirements of all health-related laws and regulations, the GPHC is specifically expected to do the following in 2008:

- apply for and obtain a license to operate under the Health Facilities Licensing Act 2007
- meet the requirement for the operation of a medical laboratory as outlined in the Regulations of the Health Facilities Licensing Act 2007l and the registration requirement under technical standards established by the Guyana Bureau of Standards.

3.4. Quality measures and patient safety

In addition to the continued implementation of its quality assurance programme and patient safety measures, GPHC is expected to implement the following specific activities addressing quality and patient safety:

- conduct at least two patient satisfaction surveys during the year, in March and November
- develop and implement three measurements of clinical performance, including one related to obstetrics and gynaecology
- develop and implement, by June, a programme to meet the goals of the Global Patient Safety Challenge.

3.5. Matching workload and bed use to needs

The Hospital will continue its efforts to attain workload and use of beds by speciality that is guided by projected needs and standards reflecting its role as the national referral hospital as outlined in this Services Agreement (Section 5.1.3 and discussed in the Health Sector Strategy 2008-2012, Annex 2), attaining an overall occupancy rate of 78%, with no department under 65%.

3.6. Obstetrics and gynaecology

In addition to the services normally provided by the Obstetric and Gynaecology Department of the GPHC, the hospital will:

- ensure that the PMTCT programme is fully implemented in accordance with the PMTCT manual published by the Ministry of Health, with 90% of women giving birth knowing their HIV status and 95% receiving anti-retroviral prophylaxis to reduce transmission to babies

- monitor the occupancy rate of the obstetric ward on a daily basis and take such actions as are necessary to avoid double occupancy of beds

- ensure that each new born baby is seen by the paediatric service

- report all maternal deaths to the Ministry of Health within 24 hours, start an investigation into each maternal death within 48 hours, identify weaknesses that might have contributed to the death and take all actions necessary to rectify these

- develop and implement a system whereby the staff on every shift identifies possible problems with pregnant women and alerts the staff on the following shift of problems they may confront.

3.7. Psychiatric services

GPHC will continue to strengthen its psychiatric services, and in 2008 will:

- support fully the implementation of the National Mental Health Plan
- strengthen its acute psychiatry service including acute in-patient beds
- revise its substance use dependency programme in order to develop a comprehensive treatment and rehabilitation programme and introduce group therapy support by February 2008

- support the MOH programme to deal with homeless persons in the Georgetown area.

3.8. Training programmes

GPHC will continue to expand its existing training programmes and introduce at least three new training programmes. Specifically, GPHC will:

- submit a proposal to formalize the Public Health Training Institute, which is to be managed by the GPHC, by September 2008
- conduct an intake of at least 5 students in the post-graduate surgery programme
- introduce the post-graduate Nurse Anaesthesia Programme before June 2008
- introduce the post-graduate Anaesthesiology Programme for doctors by September 2008.

3.9. Improved systems development and data generation

The Hospital will continue to improve management systems and the generation and use of reliable services indicator data, including its cost information capacity so as to establish realistic estimates of the costs of producing its services to an acceptable standard.

3.10. Human Resource Department

The GPHC Human Resource Department will:

- prepare a draft of the proposed Human Resource Establishment for GPHC and submit for Board approval by June 2008
- seek MOH approval for the establishment before the end of 2008
- ensure that Job Description profiles for all positions are completed and documented
- revise and seek Board approval for Rules for Employees.

3.11. Finance Department

The GPHC Finance Department will perform its functions according to the law, regulations, administrative edicts, established procedures, and standards of accounting generally accepted by the government. In particular, on a regular and timely basis, the Department will:

- compile and produce the annual budget by programme activity
- control and monitor expenditures in keeping with release of funds and budgetary provisions
- provide monthly financial reports on income and expenditures, including liabilities
- maintain adequate books and records
- ensure an adequate system of internal controls
- analyze and report overtime, particularly nurses overtime

- complete monthly reconciliation of bank accounts
- maintain a Fixed Assets Register
- ensure payment to vendors and staff are on time and in the correct amounts
- commence the process of designing and implementing an integrated computerized system of accounting based on cost centres.

3.12. Development of management information systems

The hospital has in place a number of computerised services and is in the process of expanding the computerisation of additional services. These services can be grouped in two categories: clinical services (Medical Records, Inpatient, Outpatient, Laboratory, Pharmacy, etc.) and administrative services (RMMS, Finance and Accounts, Human Resources, etc.). Much of the computer equipment used by the hospital is inadequate for today's applications and maintenance of its IT assets is currently outsourced, adversely impacting the work of the departments affected. The HSDU (MOH) will therefore support the strengthening of the Health Management Information Systems Unit in order for it to respond better to the existing and emerging IT services needs of the Hospital.

The hospital will therefore be required to:

- establish an approved department structure for the HMIS Unit
- identify work space for the positions of the HMIS Unit
- fill the positions of the department structure
- conduct an assessment of the IT requirements of the Medical Records Department and those of other priority Hospital departments
- devise an Action Plan for addressing the IT requirements of the Hospital, and Work Programmes for implementation for the Medical Records Department and other priority departments, seek HSDU approval and support, and begin to put these into effect during 2008.

4.0 Terms of the Agreement

Entitlement to services

The hospital will provide services to citizens of Guyana regardless of race, origin, gender or income. Services will be provided solely on a basis of need.

Reviews

The Hospital shall submit reports and information to the Ministry as specified in Annex 1. The Hospital and the Ministry shall participate in joint reviews of progress and problems as specified in Annex 1. In addition, the Hospital shall use its best endeavours to provide the Ministry with such information as may be required for the Ministry to meet its duties and obligations.

Variations to this agreement

Variations to this Agreement may only be made by agreement between the Authorised Representatives in writing and in numbered sequence.

Good Faith and Best Endeavours

The two parties enter into this Agreement in good faith to use their best endeavours to fulfil their obligations as specified. In the event of disagreement, both parties have a duty of care to resolve matters without resorting to arbitration arrangements. In particular, the Authorised Representatives must meet to try to resolve the issues(s) and there must be a written record of this meeting which must be jointly agreed. In the event of any dispute that cannot be resolved in this way, both parties will agree on the selection and appointment of an arbitrator, whose decision will be accepted by both parties

Payments

The Ministry of Health will recommend the Hospital's budget specified in this Agreement to Ministry of Finance for payment in 12 monthly payments.

Limitations of Liability / Indemnification

Individual members of the Hospital's Board of Directors shall not be personally or collectively liable for damages awarded to third parties as a result of the hospital's acts or omissions.

5.0 Schedules

Schedule 1: Services activity, costs and income data

5.1.1 Objectives

The Hospital will generate all data necessary to facilitate analysis of its activities and cost effectiveness, and evaluation of how well it is fulfilling its role in national health care delivery as this is defined over time.

In the period of this Services Agreement, the Hospital will continue to improve systems for generating, recording and reporting levels of services activity and costs in the main areas of care provided. Key indicators and target levels of performance will be identified by the MOH over the early months of this Agreement as part of the MoH/IADB Health Sector Programme, and these will form the basis of Quarterly Joint Reviews between the Contractor and the Hospital (see Annex 1).

5.1.2 Services activity indicators

Until further analysis under the MoH/IADB Health Sector Programme, the Hospital will record activity levels in each of the clinical specialties, sub-specialties and support services in which services are provided, including:

In-patients:

- number of active beds by specialty
- number of cases by specialty
- average lengths of stay by specialty
- number of deliveries, and number of Caesarean sections, HIV status of mothers delivering and number covered with PMTCT prophylaxis
- bed occupancy rates by specialty
- number of admissions from casualty/walk ins, and number referred from health services
- origin of all patients by region (1-10)

Outpatients:

- number of outpatients by specialty
- numbers of walk ins, and number referred from health services
- origin of all patients by region (1-10)

5.1.3 Services activity targets

The MOH recognizes the success of the GPHC in attaining 85% of its projected caseload for 2007. The Hospital will continue to develop its caseload capacity guided by the projected target caseloads by main department as follows.

GPHC target and actual caseload for 2006

Specialty	target caseload	actual caseload
surgery	10,789	5,410
medicine	4,950	5,289
paediatrics	3,724	8,570
psychiatry	1,860	387
maternity	9,854	7,937
gynaecology	3,183	2,703
ophthalmology	1,111	176
totals	**35,471**	**30,472**

Specifically, GPHC will note and give attention to the following:

- Surgical cases are to be increased by 15% over the 2007 actual surgical caseload.

- Medical admissions are a good match with the required caseload, but paediatric cases (excluding 5,875 special care baby cases, which may include many normal babies delivered at the hospital, not included in the projected figure) are still well below their projected level, although the gap is smaller than it was in 2001. This may be because the age boundary between paediatrics and adult medicine is lower in practice than that assumed in the projections of need, ie. 14-15 years. Taking paediatrics (excluding SCBU) and adult medicine as a whole, the recorded caseload is about 92% of that required, an improvement on the 2001 position.

- Psychiatric admissions are well below the expected level, reflecting staffing constraints and the limited bed complement. Psychiatric beds are not well distributed in Guyana, with a large concentration in Region 6 and only a small admissions unit at GPHC. Following finalisation of the National Mental Health Plan in 2008, the Hospital will work with MOH to plan the expansion of acute psychiatric services at GPHC.

- Maternity admissions are about 20 percent below the projected caseload, which includes an allowance for 20 percent of deliveries from the other regions to take place at GPH.

- Recorded admissions for gynaecology are also slightly below the expected level.

- Recorded admissions for ophthalmology are well below the projected level, which takes into account the relatively high incidence of cataracts in some regions, and the need to tackle a reported backlog of cases.

In terms of beds and their use by specialty, the Hospital will make progress in meeting the following targets.

GPHC target and actual bed use 2006

	target			actual		
Specialty	**ALOS**	**OR%**	**beds**	**ALOS**	**OR%**	**beds**
surgery	4.6	77.0	139	8.3	64.0	192
medicine	8.8	83.0	118	6.3	52.0	175
paediatrics	3.7	66.0	55	3.7	67.0	129
psychiatry	32.8	92.0	181	13.4	66.0	21
maternity	3.4	64.0	140	3.2	126.0	56
gynaecology	4.0	72.0	37	4.2	83.0	37
ophthalmology	2.7	70.0	9	8.6	90.0	5
totals	**6.3**	**78.0**	**679**	**5.0**	**68.0**	**616**
totals ex psychiatry	4.4	74.0	497	4.9	68.0	594

Note: The calculations of current average lengths of stay and bed occupancy are based on the reported occupied and available bed days in each specialty. For reasons not yet explained, the total available bed complement derived from these statistics exceeds the rated bed complement of the Hospital by 24 beds.

In working towards these targets, the Hospital will address the following:

- Average bed occupancy is below target at 68 percent, but there continues to be an unacceptable high occupancy level in maternity.

- In general, bed occupancy is now more satisfactory than it was in 2001, in part because there is now a better match between caseloads and bed allocations.

- Average lengths of stay are also generally closer to target than they were in 2001, although surgery and ophthalmology continue to have longer stays than appear necessary.

- In the surgery specialties, including ophthalmology, there are not only more beds than the current caseload requires, but also more than the projected load would require if lengths of stay were reduced.

- In medicine, the bed numbers are also more than are needed for the caseload.

- In paediatrics, a direct comparison is not possible because of the confusing factor of cots used for healthy babies in the maternity wards.

- In psychiatry there is a need for more beds, although it may not be necessary for all of the projected total of 181 beds to be located on the GPHC site. Nevertheless, as mentioned above, some redistribution of Guyana's psychiatric beds is needed for acute care and observation, and GPHC will provide some of these

- More maternity beds are also needed, even though the average length of stay has been reduced since 2001.

In general, the Hospital will endeavour to:

- reduce the number of non-essential admissions, and reduce average lengths of stay in specialties where this is possible

- ensure the continuous availability of all medications approved for GPHC at the point of dispensing, and improve the audited reconciliation of items paid for, items received and items dispensed.

- provide emergency psychiatric care, ie. the immediate care necessary to prevent death, severe or permanent disability or to alleviate severe pain, including medically necessary crisis intervention for patients suffering from acute episodes of mental illness, in accordance with the NMHP which is scheduled for full ratification and implementation in 2008.

5.1.4 Costs

The Hospital will continue to develop its capacity for cost centre reporting. reporting in line with the Government fiscal reporting policy guideline/protocol. GPHC will determine a suitable approved accounting software so as to improve in the quality of financial transaction processing with the intention of improving the Hospital financial operations. The requirements for having the complete financial system computerized will be outlined in the corporation's manual on financial administration.

5.1.5 Income

The Hospital will ensure that it collects full information on:

- income from user charges by main area of care /clinical activity
- any other income.

Schedule 2: Quality standards and operational efficiency

5.2.1 Objectives

The Hospital will ensure that its services are based on good practice inline with locally accepted standards/guidelines and taking account of international standards and protocols, the recommendations of professional advisory bodies and guidance that may be issued by the Contractor from time to time.

The Hospital will develop a practical programme for creating quality awareness and commitment at all levels and a culture of continuous improvement. The Hospital will make this programme known to all staff and will demonstrate implementation of the first steps of this programme during the period of this Agreement. In particular, by the end of 2008 the Ministry will wish to see a clearly stated plan for quality development covering objectives, responsibilities, training and incentives and created with wide participation of Hospital staff. This will include:

- quality improvement indicators and targets for major care activities, specialties and departments consistent with the National Health Sector Strategy 2008-12 and its revisions (these indicators and targets will form the basis of the Hospitals Annual Workplan for 2009)

- management structures for quality improvement including specific responsibilities, reporting and monitoring arrangements

- instituting a corporate governance code as part of the wider objective of transparency and accountability

- plans for ascertaining changes in consumer satisfaction, and for seeking and responding to consumer complaints and appreciations

- enhancing routine management and maintenance systems for infrastructure and equipment

- improving the materials management of pharmaceuticals and other medical related supplies.

5.2.2 Services quality indicators

The Hospital will aim to generate information on the following quality-related indicators:

- patient satisfaction: continuous assessment and at least two patient satisfaction surveys during the year, in March and November, covering key areas of patient care including waiting times, staff attitudes, and perceived quality of care

- actual waiting times: for outpatient appointments and consultations, for A&E triage and subsequent examination, elective admissions, and key diagnostics

- clinical quality of care: continuous assessment and external annual clinical audit including inpatient admissions practice and lengths of stay as well as clinical quality; development and implementation of three indicators of clinical performance, including one related to obstetrics and gynaecology; a service quality framework will be established in the clinical operations manual with links to Business Process Re-Engineering (BPR)

- human resources: continuous recording of staff compliment in all key categories.

5.2.3 Services quality targets

Until further analysis under the MoH/IADB Health Sector Programme, the Hospital will complete the following:

human resources:

- consolidation of all extant HR analyses and plans, and preparation of a practical and prioritised action plan for alleviating staff shortages in the short term (appointments from overseas, contracting private sector for specific areas of care, accelerated on-the-job training etc) and for the cost implications of attracting and retaining such staff or contracting out services

- development of advanced training (through an effective developed training curriculum) to harness requisite skill sets in areas of specialities, so as to ensure institutional strengthening and capacity building and applicable to all relevant skill sets in the various departments.

planned maintenance of facilities, plant and equipment:

- preparation of a costed practical plan based on maximising contracting out of services to the private sector where this is more cost effective (avoiding problems of in-house inflexibilities, training, theft etc)

- full computerization of the RMMS with a view of using the CMMS to enhance maintenance operations for physical infrastructure, equipment maintenance data tracking to improve systems reliability and availability indexes

- analysis of return on investment for the transition to the selected CMMS software package, recording:

  - ✓ increases in plant availability—by reducing down time (lower MTTR, higher MTBF)
  - ✓ reductions in operating costs—by reducing overtime, spares inventory and increases in asset life—by more effective maintenance

- ✓ reductions in spare parts inventory—by improved control over preventive maintenance schedule and documentation
- ✓ simplified access to maintenance data and statistics—through report generator.

drug supplies procurement, distribution and dispensing:

- preparation of an action plan for improving planning and control in the supply chain management systems for the Hospital and defining the roles in (i) purchasing and supplier management (ii) physical distribution management and (iii) materials management.

security:

- preparation of a short practical document specifying the requirements and costs of a simple system to secure the Hospital's assets and for the protection of staff and patients, and the achievements to date.

Schedule 3: Financial allocation

5.3.1 Recurrent:

The Contractor shall ensure that the Hospital receives a total of $ .... over the period of this Agreement, paid in 12 monthly instalments.

The approximate application of this funding is as follows:

- public sector salaries and emoluments
- other payments for staff
- contracted out services
- drugs
- supplies and minor equipment

5.3.2 Capital:

The Hospital may undertake capital projects subject to the written approval of the Ministry.

Annex 1: Performance reporting and evaluation

1. Reporting

Financial Reports

The Hospital will provide the MoH and MoF with Monthly Income and Expenditure Returns (MER) in the formats agreed with the Ministry of Finance. It should be submitted to the MOH within ten days from the end of the month. MERs should be signed by the GPH Director of Finance and the Accountant who prepared the returns.

Quarterly Progress Reports (QPR)

The Hospital will submit a QPR to the MOH within 14 days of the end of each quarter, to form the basis of the Quarterly Joint Review (QJR) which should be conducted within 30 days of the end of the quarter. . The hospital will develop reporting formats using "trending" with reports being generated statistically (highlighting actual and variances). Variance analysis gives a good reflection of the actual accomplishment when measured against the "financial or other base" set out in the overall operation.

The QPR should contain:

- a short Progress Report discussing progress against the Services Agreement, identifying the main achievements and problems encountered, and the proposals for dealing with them
- a financial statement of revenue and expenditure during the period including a review of performance against the targets set ; this will be set out in the financial projections and reviews.
- a statement of the workload dealt with during the quarter against targets any drafts of plans or proposals specified under the Agreement.

The QPR should be signed by the Hospital Director and the Director of Finance.

The QPR for the third quarter will contain a draft proposed budget for the Hospital for the following year, and an indicative budget for the following three years identifying any significant changes in the needs for funding.

Annual Reports

The Hospital will submit an Annual Report to the Contractor within one month of the end of each Financial Year. This should cover the same contents as the QPR but for the year as a whole.

2. Joint Reviews and audits

Quarterly Joint Review (QJR)

The Hospital and the Contractor will meet quarterly within 30 days of the month end to review the progress made and specifically to review the Quarterly Progress Reports. The Meeting should be attended by the authorised persons representing each party (section 1.0) and appropriate members of their teams.

Annual Joint Review (AJR)

Following the submission of the Annual Report, the two parties should hold a major joint review, the findings of which will refine the following Services Agreement period.

Internal/External Audit

The Hospital will commission an annual external audit to be completed within 45 days of the end of each Financial Year and submitted to the Contractor and to the Ministry of Finance. Audits will be done as a first level auditing verification exercise examining internal audit findings of the hospital operation and also to examine the financial transactions and other areas in the hospital operation referring specifically to the compliance of procedures/guidelines in areas of finance, procurement, facilities management operations (contracts and projects), etc.

The Hospital will continue to develop capacity in its in-house audit department; this department will provide guidance to the functional departments ensuring that all operating procedures/guidelines are followed and consulted with before committing funds or services to the public.

Appendix 5: Agenda and Participants at Small Meeting to Review Draft Report, July 18, 2008

Informal meeting, 10:00–12:00, July 18, 2008
HLSP Institute
5-23 Old Street
London EC1V 9HL
Tel.: +44 20 7253 5064

Agenda:

Comments and suggestions on document: Initial Program Scan, May 30, 2008
- Does it make a valid case?
- How to improve it

Ideas/contacts for opportunities for practical program support/action research
- Rockefeller Foundation wants to support some selected programs involving purchasing from the private sector
- Other possible outcomes

Participants:

Roger England, Health Systems Workshop (Convener)
Nel Druce, HLSP Institute (Chair)
Veronica Walford, Consultant
Mark Pearson, HLSP Institute
Bruce Mackay, HLSP
Jennifer Sancho, Guyana Health Sector Reform Programme
Elizabeth Gardiner, Options
Carmen Schickinger, KfW Asia
Valeria Oliveira-Cruz, LSHTM
Shaun Conway, Responsible Action, South Africa
Michael Holscher, Marie Stopes International
Philip Stevens, International Policy Network

Appendix 6: Individuals Invited to Review and Comment on Draft Report

Chris Atim, PATH
Katja Janovsky, WHO
Jim Tulloch, AusAID
Mary Mohan, GFATM/MOH Cambodia
Alice Levisay, UNDP Cambodia
Dominic Montagu, University of California San Francisco
April Harding, CGD/World Bank
Kara Hanson, London School of Hygiene and Tropical Medicine (LSHTM)
Tonia Marek, World Bank
Julian Lob-Levyt, GAVI
Guy Stallworthy, Bill and Melinda Gates Foundation
Klaus Hornetz, GTZ
Catherine Goodman, LSHTM/KEMRI/Wellcome Trust Collaborative Programme, Kenya
Henk Bekedam, WHO Philippines
Sara Bennett, WHO Geneva
Gill Walt, LSHTM
Dana Hovig, Marie Stopes International