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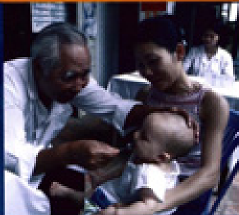

Performance-Based Contracting for Health Services in Developing Countries: A Toolkit

BY BENJAMIN LOEVINSOHN

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Summary for web of Section 3, pp. 19–66: "How to Contract: What Works and What Doesn't"*

This book was written to help bridge the yawning gap between many developing countries and the Development Goals for health. Right now, that gap looks daunting. But we can narrow the gap significantly by contracting, especially using non-state providers. The status quo, in which millions are denied basic health services, is not acceptable. Contracting is an effective way to improve the daily lives of the most vulnerable.

Contracting is the means by which a funder buys specific services from those non-state providers. This practical "how to" guide is aimed at staff of government agencies, insurance companies, social insurance funds, nongovernmental organizations, faith-based organizations, private health care providers, and international development partners.

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* This summary was written by Michael H.C. McDowell, an international public health communications consultant.

How to Contract: What Works and What Doesn't

SUMMARY BY MICHAEL H. C. MCDOWELL

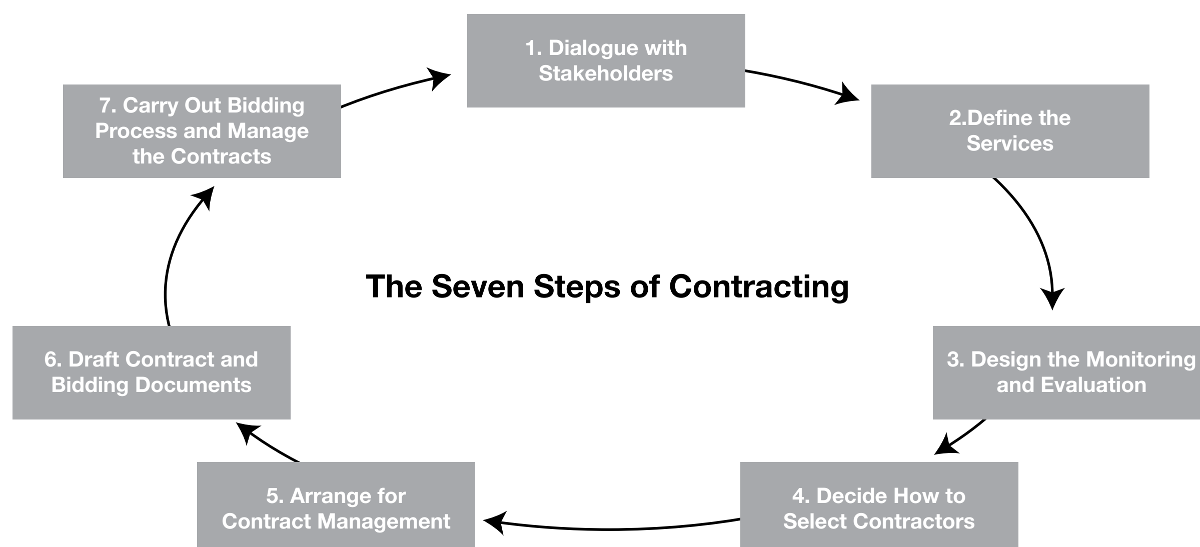
Contracting works best with a systematic approach, and with that in mind, we have devised a checklist, headlined below, and spelled out through specific "tasks". Don't feel overwhelmed by the detail, just aim for steady progress, not perfection, and focus on a few key issues:

- Define the contract's objectives; pick indicators of success; what results do you want to achieve?
- Make sure that both contractors and purchasers focus on the objectives and tangible results
- Define the size, and location of each contract "lot," who will be targeted, and where
- Define the scope of services to be delivered; what services do contractors need to provide to patients and communities ?
- Maximize the managerial autonomy of the contractors; hold them accountable but don't micromanage them
- Develop a plan which addresses how the contracts will be managed, and how monitoring and evaluation will be done

Contracting is more art than science, but approaching things systematically can avoid simple mistakes; ideally, you should only be making new and interesting mistakes, not repeating old ones. Importantly, be creative and adapt to what works *locally.* A "contracting cycle" involves speaking to stakeholders; defining the services; designing the monitoring and evaluation; deciding how to select the contractors and setting the price of the contract; arranging for contract management; drafting the contract and bid documents; organizing the bidding process and managing the contract.

Speaking To Stakeholders

TASK 1 • *How To Consult With Them:* aim to balance the interests of often competing and varied stakeholders; get this right at the beginning, and you prevent problems later, e.g., meet with each group to make them comfortable with contracting. Then get back to them with draft proposals and actual contracts.



TASK 2 • Identify "Champions," i.e., people who really "get" the value of contracting or at least are positively open to trying it. These "champions" may be businesspeople, community leaders, politicians, or their advisors.

TASK 3 • Directly Address the Legitimate Concerns of Stakeholders: e.g., government health officials are often deeply suspicious of contracting and can be "blockers". Give them evidence of contracting successes and suggest that better health services will show *them* in a good light, and free *them* to concentrate on the "big picture," including setting long-term strategy.

Reassure officials that the public sector will have the same level of resources and standards as non-state providers (NSPs). Introduce them to "champions" of contracting from other countries who illustrate the "win-win" side of contracting, e.g., the often time-consuming and exasperating hiring and managing of personnel can be passed on to contractors. Build in "ownership" among local politicians and government officials, having them not only sign or witness contracts but review quarterly performance reports.

On the other hand, let contractors see that the selection process is open and transparent, that payments will be made promptly, and that resources will be adequate to the task i.e. make it clear they are not being set up for failure but are real "partners" in a public-private endeavor.

Define the Services

TASK 4 • ***Defining the Objectives of the Contract:*** this is absolutely fundamental to success. From the very outset, make objectives explicit and measurable, focused on results. Limit indicators to no more than 10; emphasize independently measurable indicators—stress outputs and outcomes, rather than inputs or processes. For example, focus on immunization coverage, not on how many syringes were bought. Set targets broadly, e.g., if immunization stood at 50 per cent and the target is 80 per cent, then a 78 per cent score should be praised. Don't let perfection be the enemy of the good.

TASK 5 • ***Include Objectives Related to Equity and Quality:*** be explicit, e.g., on equity, emphasize use of services by the poorest, the geographically underserved, or those widely dispersed.

TASK 6 • ***Consider Pay for Performance (P4P):*** use bonuses linked to accomplishments or the number of services provided but make sure there is independent verification so that increasing quantity does not damage quality.

Paying for Performance in Haiti

In order to improve the performance of NGOs delivering primary health care in Haiti, USAID through Management Sciences for Health (MSH) started to pay them a bonus based on their performance on key indicators such as immunization coverage, skilled birth attendance, and prenatal care. These indicators were measured using the health management information system but were independently verified through a data audit. As the percentage of NGOs being paid on performance basis (i.e., offered performance bonuses if they achieved specified results) increased, the coverage of these services also increased.

Performance of NGOs in Haiti as Use of Bonuses Increases

Indicator	DHS 2000	2002	2003	2004	2005
% of children fully vaccinated	34	65	91	92	100
% of women receiving at least 3 prenatal visits	29	50	41	48	60
% of deliveries assisted by skilled attendant	58	64	57	63	77
% of NGOs paid on performance basis		35	37	44	93

Source: Based on R. Eichler et al., 2006.

TASK 7 • *Ensure that Purchasers and Contractors Focus on Objectives:* to repeat, read the contract carefully; neglect this and it can lead to mistakes later. Make sure contractors know they will be held to account for non-performance; have purchasers, contractors, and field monitors regularly review key indicators.

TASK 8 • Define the Size and Location of Each Contract "Lot": a "lot" or "package" being the size and location of an individual contract, which is usually defined by the purchaser.

Be clear about where you wish contractors to work and who the target populations are.

Choose a few large lots, rather than many small ones; this will create four economies of scale: i) financing economies of scale, due to fixed costs; ii) easier contract management; iii) more efficient monitoring and evaluation; iv) economies of scale in capacity building. Large lots, with their bigger budgets, encourage more organizations to bid; furthermore, it is easier to build capacity with larger lots, e.g., teaching 70 NGOs how to work with female sex workers is much harder than building the capacity of just 7 NGOs. But it's a balance: in general, experience suggests it makes sense to have between 7 and 20 lots.

TASK 9 • *Define the Scope of Services—Focus on "what" not "how":* avoid telling contractors "how" they should deliver services. What matters is meeting the goals, not the process e.g. prioritizing immunization coverage is common sense, but specifying that contractors must achieve this by going house-to-house or standing on street corners, is unnecessary.

Design the Monitoring and Evaluation

TASK 10 • *Decide How Data Will Be Collected:* for each indicator, it should be clear how data will be collected (see Table 1). It also makes sense to describe each data collection method, e.g., routinely collected data from the health management information system (HMIS); household surveys; health facility assessments; and supervisory checklists. (see Table 2)

TASK 11 • *Collect Baseline Data:* this can be tricky because collecting this information usually has to be done at the same time as services are being designed and service delivery is starting. Key, at the very beginning, is picking the organization which will collect the data.

TASK 12 • *Set a Clear Schedule for Data Collection:* household surveys should be once or twice a year; health facility assessments done annually; supervisory checklists used every two months; and HMIS data reviewed at least quarterly.

TASK 13 • *Look for Comparison/Control Groups:* "benchmark," i.e., compare performance of contractors to each other and other health service providers, especially using controlled "before and after" comparisons to show "lessons learned."

TASK 14 • *Assign Responsibility for Collection, Analysis, and Dissemination of Data:* make Monitoring and Evaluation (M&E) someone's full time job, possibly using a third-party firm.

Table 1: Partial List of Indicators

Indicator	Means of data collection	Baseline value	Approximate target
% of all women pregnant during the last year receiving at least one antenatal care visit from a skilled health care provider	1) HMIS 2) Household survey (HHS)	53% (HHS)	75%
Score out of 100 on an index of quality of care as judged by third party, which includes the adequacy of waste management, drug availability, provider knowledge, patient-provider interaction, etc.	1) Health facility survey (HFS) 2) Supervisory checklist	16 (HFS)	65

Table 2: Means of Data Collection

Means of data collection	Responsibility for data collection and analysis	Schedule and arrangements for baseline datacollection	Schedule for follow-on data collection	Budget requirement	Counterfactual or comparison group
Household survey	Third party with assistance from MOH primary health care department	July 200_, Firm will be recruited by March, 200_	Every two years after the baseline	US$250,000 per round of survey X 3 = US$750,000	Some non-contracted areas (5 districts) will also be surveyed
Health Facility Assessment	Third party with assistance from MOH contract management unit.	July 200_, Firm will be recruited by March, 200_	Every year	Total = US$400,000	Health facilities nation-wide will be included in sample. Sample size will allow comparison of contracted and in non contracted facilities

TASK 15 • *Budget Sufficient Funds for Monitoring and Evaluation:* a reasonable expectation is 4–7 per cent of the total value of the contracts.

Decide How to Select Contractors and Establish the Price

TASK 16 • *Use a Competitive Selection Process:* through open competition, clearly showing there is a "level playing field," emphasizing there are no "favorites" in the bidding process, no "fix," and inviting the best and the brightest to bid, thus reducing the chances for corruption which plagues so many no-bid contracts.

TASK 17 • *Develop Clear Selection Criteria before the beginning of the selection process:* pitch the criteria realistically, not too high or too low. Make sure organizations have the experience, skills-sets, minimum size, and track record; insist on three years of audited accounts, proof of reasonable turnover of funds; and good standing in the country involved.

TASK 18 • *Establish a Transparent and Independent Evaluation Process:* set up an independent, competent evaluation committee whose members individually rate proposals, e.g., to ensure transparency, it's useful to include staff from development partners and from international agencies such as UNICEF and WHO (excluding the World Bank) and the NGO community.

TASK 19 • *Maximize Interest of Possible Contractors:* drum up interest by consulting broadly with potential contractors, advertising widely, holding information or "pre-bid conferences", keep Request for Proposal (RFP) documents simple, ensure the selection process is transparent and understandable, allow smaller NGOs to form consortia, and avoid bid or performance bonds.

TASK 20 • *Select a Contractor:* ideally through competition, at least partly based on price; second-best, establish a fixed budget before the competition; and, least-preferred, through negotiation (since negotiations are often conducted behind closed doors, transparency can be compromised).

Arrange for Contract Management and Develop a Contracting Plan

TASK 21 • *Define Responsibility and Clarify the Contract Management Structure:* managing contracts requires a clearly defined, reasonably sized team with explicit responsibilities and authority. There are pros and cons to different models e.g. ministries of health (MOH) have limited experience or knowledge of managing contracts but they have technical knowledge of the sector and can feel real ownership. The local government level is obviously smaller and while it may be inefficient to build capacity, local officials can often better monitor contractor performance.

As regards specialized procurement units, these limit the stewardship function of the MOH and may be less motivated than organizations whose mandate is to improve health. Broadly speaking, the MOH or other line agency is probably the best approach, ensuring ownership and long term stewardship of the sector.

TASK 22 • *Ensure Proper Staffing of the Contract Management Unit:* pick a senior person to effectively manage relationships and communicate with stakeholders; select skilled people, with good experience in the field, troubleshoot and monitor performance; and include a competent financial manager.

TASK 23 • *Allow Sufficient Budget for Contract Management:* calculate realistically the cost of local staff or consultants; be accurate in pricing needed equipment, computers and software; include transport costs and per diems for field visits and monitoring; figure in positive incentives for contract management staff and link these to results achieved by contractors or timely payment of contractors.

TASK 24 • *Consider Computerization of Contract Tracking:* managing by hand will be difficult if there are more than 6 or 7 contracts, so it is critical to buy contract management software.

TASK 25 • *Develop a Written Contracting Plan:* pay close attention to this particular Task. The purchaser must develop a manual of procedures which addresses contract management and monitoring and evaluation. People focus on drafting contracts and bid documents and can easily forget about these crucial issues.

Draft the Contract and Bidding Documents

TASK 26 • *Maximize Managerial Autonomy:* a major benefit of contracting is cutting through "red tape" and political interference which bedevils so many government efforts to deliver services. By contracting, realistic decisions can be made by people on the ground who can solve problems quickly; in addition, purchasers can more easily hold contractors accountable for results, since contractors have made the decisions themselves and cannot pass the buck to others; managerial independence allows and indeed encourages innovations which can improve performance. How can managerial autonomy be strengthened?: make clear, and separate, what the purchaser does, and what the contractor does. When this is not clear, the purchaser usually tries to assert control; focus on "what" not "how"; and search for other ways to increase autonomy.

DECENTRALIZING DRUG PROCUREMENT IN AFGHANISTAN

In Afghanistan, the government signed contracts with NGOs which gave them responsibility for procurement of medicines and other supplies. At the same time, there were other contracts that stipulated that medicines would be procured centrally by an organization with long experience in drug procurement and distribution. In addition, in a few provinces drug procurement and distribution was handled by the central ministry of health. An independent assessment showed that the availability of drugs improved much more in the places where individual contractors were responsible for procurement and distribution.

Effects of Decentralized Procurement in Drug Availability Index in Afghanistan (Maximum score = 100)

Approach to drug procurement and distribution	Baseline	Endline	Change
Decentralized to individual NGOs	62.4	92.1	**29.7**
Centralized, non-state organization responsible for procurement and distribution	70.3	93.0	**12.7**
Centralized, public sector procurement and distribution	57.1	71.2	**14.1**

Source: Ministry of Public Health, Johns Hopkins University

TASK 27 • *Ensure That Contractors Can Manage Personnel Effectively:* so that they can hire, fire, place people, handle pay and benefits, set terms of employment (e.g., performance bonuses) and establish staffing levels.

TASK 28 • *Use Lump-Sum Contracts:* i.e. where contractors are paid an agreed-on sum on a regular basis which is NOT reimbursement for specific expenses incurred. Lump sums allow managers to flexibly move money where it is most needed, prevent "micromanagement" which stifles creativity, facilitate implementation (because permission is not needed for changes in line items), and ensure everyone focuses on outcomes and outputs, not just inputs like money.

TASK 29 • *Leave Procurement of Supplies, Equipment, and Services to Contractors:* decentralizing these almost always results in better delivery of supplies, when and where they are needed e.g. as regards quality of, say, drugs, there is little or no difference in the quality of drugs bought by the state or the nonstate sector.

TASK 30 • *Ensure That Duration of the Contract Is Sufficiently Long:* we recommend minimum 4-5 year terms because it takes time for both parties to understand and become comfortable with contractual arrangements and develop a solid working relationship; in addition, contractors need reasonable time to implement their plan; and finally, continuity, particularly in dealing with local communities, is a clear advantage.

TASK 32 • *Have Clear Procedures for Making Payments:* there are two types, mobilization payments, and regular payments. On mobilization payments, because contractors for health services are NGOs or CBOs, they have no "capital" and so it is important for them to be paid upon signing the contract, usually 10 per cent of the total. With regular payments, these should be done through quarterly or half-yearly lump-sums, after the contractor submits acceptable reports.

TASK 32 • *Establish a Clear Process for Termination and Imposing Other Sanctions:* spell out the procedures and rules governing termination of the contract but use a dispute resolution mechanism before terminating. If there is poor performance, first, have face-to-face meetings with key officials; then write letters to the project manager, next the board of directors of the organization (embarrassment seems to work quite well); demand replacement of key staff if other efforts have not produced the desired results; and limit the contractor's opportunities for more work.

TASK 33 • *Establish Dispute Resolution Mechanisms:* keep it simple; first, appoint a mediator acceptable to both parties; if that fails, use an arbitration panel of respected individuals.

TASK 34 • *Define Reporting Requirements of a Contract:* i.e. a description of progress made against the work plan; problems encountered and solutions undertaken; a summary of health management information system data; a financial statement; a bank account statement (and an annual external financial audit report).

TASK 35 • *Have an Explicit Policy on User Charges:* user charges or fees for health services are controversial, so be clear whether these are allowed. If allowed, they must not damage the goal of greater equity, their costs must be reasonable and publicly displayed, and exemptions must be made for the poorest. In addition, funds collected must be retained in the location where they are collected.

TASK 36 • *Ensure That Contractors Use Independent Private Sector Auditors:* some purchasers may want this at the end of a year.

TASK 37 • *Ensure That Contractors Build the Capacity of Health Workers:* stipulate the specific qualifications of the health workers to be hired but be realistic; be clear what obligations the contractor has for training and capacity-building for their staff; and ask how contractors will gain access for their staff to government-run or financed training courses.

TASK 38 • *Address the Capacity Needs of Contractors:* purchasers are sometimes reluctant to do this because they argue they would not hire the contractors without the necessary capacity. But it is in purchasers' best interests to build contractors' capacity e.g. when there are new and effective techniques and approaches which improve results and provide even greater value for money.

TASK 39 • ***Clarify Responsibilities for Physical Infrastructures:*** e.g. we recommend that equipment become the property of the purchaser after the contract, but until then the contractor should maintain it. Similarly, building maintenance, repair and rehabilitation should be the contractor's responsibility for the duration of the contract.

Carry Out the Bidding Process and Manage the Contract

TASK 40 • ***Formulate the Bidding Documents:*** the Request for Proposal (RFP) is the document given to interested bidders and contains the following: letter of invitation to bid; instructions to bidder on preparing bids, the process, and criteria for selection of contractors; form of the technical proposal; form of the financial proposal; terms of reference; draft contract.

TASK 41 • ***Track the Schedule of the Bidding Process:*** competitive bidding should be completed in six or seven months, so recruitment of contractors should begin ASAP, even before financing is fully secured. One way of diagnosing corruption is to carefully track how long the evaluation process takes and how long it takes to finalize the contract e.g. if it takes more than three weeks from the time of the final bid evaluation to the time the contract is ready for signing, then this is a likely early warning of corruption.

TASK 42 • ***Conduct Regular Monitoring Visits:*** a checklist for site visits should comprise an assessment of results from the routine recording system, data on medicines, equipment and vehicles, information on availability and morale of health workers, satisfaction of key stakeholders, and assessing quality of care of related processes. Importantly, visits are an opportunity to cement relationships among all stakeholders, identify issues and solve problems early on.

TASK 43 • ***Meet Frequently with Stakeholders:*** contract managers and contractors should meet every one to two months; set up a mechanism for contractors to share experiences and ideas, ideally without the purchaser present; and regularly report to major stakeholders – especially the purchaser and local governments – on progress.

TASK 44 • ***Review Contracting Plan and Contract:*** the contract management unit should make sure the contractors have fulfilled their obligations, and M&E tasks and that the purchaser is satisfied.

Checklist for Contracting

(Tasks shown in bold should receive particular attention.)

✔	Task	Comments
	Step 1: Dialogue with Stakeholders	
	1. **Establish a Consultative Process with Stakeholders:** (i) Hold a couple of discussions with each set of stakeholders; (ii) Get back to stakeholders with draft proposals and contracts	
	2. Identify Champions	
	3. Address Legitimate Concerns of Stakeholders: (i) government health officials; (ii) politicians and local governments; (iii) existing health workers; (iv) potential contractors; (v) the community; and (vi) development partners/donors	
	Step 2: Define the Services (Develop TORs)	
	4. **Define the objectives of the contract:** (i) limit the number of indicators; (ii) bias towards output/outcome indicators; (iii) ensure indicators are measurable; (iv) define indicators in detail; (v) set targets broadly.	
	5. **Include Objectives Related to Equity and Quality**	
	6. **Pay for Performance**–consider performance bonuses etc.	
	7. **Ensure Everyone Focuses on Objectives**	
	8. **Define the Size and Location of Each Contract "Lot"**	
	9. **Define the Scope of Services**—focus on "what" not "how"	
	10. **Decide How Data will be Collected**—(i) HMIS; (ii) household surveys; (iii) health facility assessments; (iv) supervisory checklist	
	11. **Collect Baseline Data**	
	12. Devise a Clear Schedule for Data Collection	
	13. Look for Comparison/Control Groups	
	14. Assign Responsibility for Collection, Analysis and Dissemination of Data	
	15. Budget Sufficient Funds for Monitoring and Evaluation	
	Step 4: Design How to Select Contractors and Establish Price	
	16. Use a Competitive Selection Process	
	17. Develop Clear Selection Criteria	
	18. Establish a Transparent and Independent Evaluation Process	
	19. Maximize Interest of Possible Contractors	
	20. Select the Method for Contractor Selection,	
	Step 5: Arrange for Contract Management	
	21. **Define Responsibility and Clarify the Contract Management Structure**	
	22. Ensure Proper Staffing of the Contract Management Unit	

✔	Task	Comments
	23. Allow Sufficient Budget for Contract Management	
	24. Consider Computerization of Contract Tracking	
	25. **Purchaser Develops a Written Contracting Plan** (or contracting manual)	
	Step 6: Draft Contract and Start Bidding Process	
	26. **Maximize Managerial Autonomy**—Clarify authority of both parties, etc.	
	27. Ensure Contractors Can Manage Personnel Effectively	
	28. Use Lump-Sum Contracts—rather than reimbursement based on line-items	
	29. Leave Procurement of Supplies, Equipment, and Services to Contractors	
	30. Ensure Duration of the Contract is Sufficiently Long	
	31. Have Clear Procedures for Making Payments: That covers (i) mobilization payments; and (ii) regular payments.	
	32. Establish a Clear Process for Termination and Imposing Other Sanctions	
	33. Establish Dispute Resolution Mechanisms	
	34. Define Reporting Requirements of the Contractor	
	35. Have an Explicit Policy on User Charges	
	36. Ensure Contractors Use Independent, Private Sector Auditors	
	37. Ensure Contractors Build the Capacity of Health Workers	
	38. Address the Capacity Needs of Contractors	
	39. Clarify Responsibilities for Physical Infrastructure	
	40. Formulate the Bidding Documents	
	Step 7: Carry Out Bidding Process and Manage Contracts	
	41. Track the Schedule of the Bidding Process	
	42. Conduct Regular Monitoring Visits	
	43. Meet with Stakeholders Frequently	
	44. Review the Contracting Plan and the Contract	