Introduction to Performance-Based Contracting for Health Services

*Health System Innovations Workshop*

*Abuja, Jan. 25-29, 2010*
Overview

1. Very Brief Definitions
2. Some specific examples of contracting (Cambodia, TB treatment, Pakistan)
3. Summary of main advantages and issues with contracting & some take home messages
What is Contracting?

1. Financing agency (government, insurance entity, development partner) – “purchaser”
2. Non-State Provider (NSP) such as NGO, CBO, private firm, or individual – “contractor”
3. “Contract” provides resources from the purchaser to the contractor for provision of a specified set of services, in a set location, for an agreed period
4. Voluntary
How “Performance-Based Contracting” from any contract?

1. A clear set of objectives and indicators by which to judge contractor performance
2. Collection of data on the performance indicators
3. Consequences for the contractor based on performance such as provision of rewards or imposition of sanctions
Overview

1. Very Brief Definitions
2. Some specific examples of contracting (Cambodia, TB treatment, Pakistan)
3. Summary of main advantages and issues with contracting & some take home messages
Cambodia Case Background

• 30 years of conflict left Cambodia with almost no health infrastructure, either physical or human
• Low morale among health staff (who earned about $15 per month)
• Poor quality district management
• Public expenditure of <$2 per capita, but private expenditure much higher
Results of National Health Survey in 1998

<table>
<thead>
<tr>
<th>Survey</th>
<th>NHS-1998</th>
</tr>
</thead>
<tbody>
<tr>
<td>EPI Coverage, 12-23 months fully immunized</td>
<td>38%</td>
</tr>
<tr>
<td>Ante-natal care, 2+ visits</td>
<td>23%</td>
</tr>
<tr>
<td>CPR, modern methods</td>
<td>16%</td>
</tr>
<tr>
<td>Delivery by qualified staff</td>
<td>31%</td>
</tr>
<tr>
<td>Infant Mortality Rate</td>
<td>82</td>
</tr>
<tr>
<td>Under-5 Mortality Rate</td>
<td>110</td>
</tr>
</tbody>
</table>
Response of the Government

- Devised a health coverage plan to increase physical infrastructure, HCs for each 10,000 population, fix district hospitals
- Developed a “minimum package of services” (MPA) including preventive, promotive, & basic curative services
- Using funds from the ADB, carried out an experiment of contracting with NGOs to manage district health services
How NGOs were Selected and Contracted

• Competitive process in which NGOs competed on the basis of their technical proposal and bid price
• MOH committee scored the technical proposals and then financial bids were opened publicly
• NGO selected that had the best “score” reflecting technical score at low cost
What was in the Contracts?

• Lump-sum contract, contractor paid a specific amount (in bid) every 3 months
• Specified 7 indicators of success and need to reach the poor
• Independent measurement of performance using household and health facility surveys
• Contracts could be terminated for poor performance
Cambodia - Different Approaches to Contracting

- **Contracting Out (CO):** Service delivery contract. NGO can hire & fire, transfer staff, set wages, procure drugs etc., organize & staff facilities

- **Contracting In (CI):** NGO manages district within MOH, cannot hire & fire, can request transfer, obtain drugs from MOH, $0.25 per capita budget supplement
Cambodia - Different Approaches to Contracting

• **Government with Support (GS):** Services run by DHMT, $0.25 per capita budget supplement, TA & DHMT training provided

• **Government without Support (G):** Those districts not successfully contracted, received no TA, training, or budget supplement
Methodology Used to Evaluate Contracting in Cambodia

• 12 districts (100,000-180,000 pop’n each) randomly assigned to CO, Cl, or GS.
• 3 districts were not contracted → G
• Baseline household surveys carried out by 3rd party in 1997
• Follow-on survey carried out in mid-2001, 2.5 years after start of the contracts and in 2003, 4 years into the contracts
% of Pregnant Women Receiving Antenatal Care
% of Deliveries Taking Place in Health Facility
Health Center Utilization in the Last Month (%)
Contracting was Pro-Poor: Change in Concentration Index

![Graph showing change in concentration index]
Change in QOC Index
Total Per Capita Health Expenditures - 2003

<table>
<thead>
<tr>
<th>Country</th>
<th>OOP</th>
<th>Public</th>
</tr>
</thead>
<tbody>
<tr>
<td>CO</td>
<td>19.12</td>
<td>4.83</td>
</tr>
<tr>
<td>CI</td>
<td>20.19</td>
<td>3.47</td>
</tr>
<tr>
<td>GS</td>
<td>21.60</td>
<td>1.74</td>
</tr>
<tr>
<td>G</td>
<td>21.69</td>
<td>1.7</td>
</tr>
</tbody>
</table>
Comments on Cambodia Experience

• Contracting was quite a bit more successful than business as usual
• Changes in service delivery were large and rapid at relatively low cost
• Services became more pro-poor
• Technical assistance and training (“capacity building”) were not effective
• Contracting was expanded
“Soft Contracts” for Improving TB Services

• 8 million new cases of TB each year globally
• Many patients go to private sector – 50%
• Grave concerns about the quality of care in the private sector
• Concerns about case-finding in public sector
• Many TB control programs now using soft contracts with for-profit private providers to improve case detection and treatment success
How TB Contracts Work

• National TB program provides drugs, forms, and training to private practitioners
• In exchange, private providers follow national TB guidelines, report regularly, and promise not to charge patients for the cost of the drugs
• Some programs use NGOs as intermediaries to work with the private providers
Experience in Hyderabad, India

- Mahavir Trust began TB DOTS in 1995 among 100,000 population with outreach to private providers
- Expanded in 1998 to 500,000 population not covered by public sector
- MOU – MOH provides drugs, lab supplies, training, Mahavir provides staff, overhead etc.
- Compared to Osmaina, similar sized area run by public sector working with private providers
- Independent assessment of records and costs
## Results in Hyderabad

<table>
<thead>
<tr>
<th>Parameter</th>
<th>NGO</th>
<th>MOH</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of TB cases detected per year</td>
<td>563</td>
<td>466</td>
</tr>
<tr>
<td>Treatment success rate (%)</td>
<td>94%</td>
<td>80%</td>
</tr>
<tr>
<td>Total cost per <em>successfully</em> treated patient ($US)</td>
<td>$118</td>
<td>$138</td>
</tr>
<tr>
<td>Total cost per patient treated</td>
<td>$88</td>
<td>$98</td>
</tr>
</tbody>
</table>
Results from 14 Different Examples Worldwide

![Bar chart showing Treatment Success Rate and Follow-up Rate for NGO and Government.]
Comments on TB Example

- In India (after only comparison) NGO did 21% better than MOH in case finding and 14% on treatment success rate
- Achieved these results at lower cost
- Part of success due to working with private providers
- This approach being successfully replicated in many other parts of the World
Pakistan: Contracting-in Management of Rural PHC

• Publicly provided PHC services in rural areas widely seen as poor quality
• Basic Health Units (BHUs) see very few patients (<20 per day)
• Prenatal care provided by public sector declining
• Large number of basic health units (BHUs) built in the 1980s and 1990s
Management Contract for BHUs in Pakistan

• R.Y. Khan district of Punjab = 3.3 million population with 104 BHUs

• With support from highly placed “champion” a quasi NGO (PRSP) given a contract to manage all the government’s BHUs

• PRSP given same budget as previously allocated to run BHUs

• PRSP given a single line budget and considerable autonomy
What the Contract Included

• Regular transfer of funds to NGO based on previous year’s budget
• Had to work with existing staff in government health facilities
• Did not specify indicators of success
• NGO had to provide audited accounts
• Could procure drugs but of “good quality”
Innovations Introduced by PRSP

• Recruited high quality managers at market salaries and held them accountable for results
• Used a “cluster” approach, 1 doctor covers 3 BHUs, 2 days per week in each
• MO-IC salaries increased 150%
• Invested in improving infrastructure
• Set up village committees
• Emphasized school health education
• Hired FMOs to visit BHUs once a week
Evaluation Methodology

• RYK was compared to the neighboring district Bawalpur (BWP)
• Household and health facility surveys conducted in both 2 years after experiment began
• HMIS data also used to examine trends
Outpatient visits per month in RYK and BWP – HMIS data

PRSP contract management begins
% of people sick in the last month who used a BHU – household survey results

- All: 34%
- Men: 31%
- Women: 37%

RYK
BWP

% of sick people using BHU

- All: 22%
- Men: 24%
- Women: 19%

34%
31%
37%
22%
24%
19%
Satisfaction with Care Compared to 2 years before survey – Bigger Improvements in RYK

![Bar chart showing improved and deteriorated satisfaction with care. RYK shows a significantly higher percentage of improved care compared to BWP.]

RYK vs BWP
BHUs in RYK in better physical condition (% of BHUs with...)

<table>
<thead>
<tr>
<th>Condition</th>
<th>RYK</th>
<th>BWP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intact boundary wall</td>
<td>50</td>
<td>40</td>
</tr>
<tr>
<td>Clean exterior</td>
<td>80</td>
<td>70</td>
</tr>
<tr>
<td>Waiting area with working fan</td>
<td>70</td>
<td>60</td>
</tr>
<tr>
<td><strong>Average</strong></td>
<td><strong>75</strong></td>
<td><strong>60</strong></td>
</tr>
</tbody>
</table>

RYK: Rorschach Yard Khairpur
BWP: Bonded Welfare Programme
OOPs for BHU services are lower in RYK, 70% pay Rs. 1

<table>
<thead>
<tr>
<th></th>
<th>RYK</th>
<th>BWP</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>Median</td>
</tr>
<tr>
<td>Basic Health Unit</td>
<td>28</td>
<td>1</td>
</tr>
<tr>
<td>Qualified private provider</td>
<td>673</td>
<td>150</td>
</tr>
<tr>
<td>All providers</td>
<td>419</td>
<td>60</td>
</tr>
</tbody>
</table>
OPDs Per Year in 3 BHUs in Pilot Area Run by NGO then by Government Again
Comments on Pakistan Example

- Controlled, retrospective before and after with data from HMIS, household & facility surveys.
- Now replicated in 40 other districts in the country covering more than 40 million population
- Achieved better results with the same resources
- Increased efficiency, i.e., Rs.40 per OPD visit compared to Rs. 60 in control district
- Going back to business as usual – not attractive
Overview

1. Very Brief Definitions

2. Some specific examples of contracting (Cambodia, TB treatment, Pakistan)

3. Summary of main advantages and issues with contracting & some take home messages
What Kinds of Services Can Be Contracted?

- Rural and urban PHC – Contracting In or Out
- HIV prevention and treatment
- Operating voucher or insurance scheme
- Intermediary to provide performance bonuses to government health workers
- Demand side financing
- Increasing ITN coverage and use
- Making BCC performance-based
## Different Types of Contracts

<table>
<thead>
<tr>
<th>Model</th>
<th>Design Services</th>
<th>Select Provider</th>
<th>Manage</th>
<th>Infra-structure</th>
<th>Finance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gov’t Services</td>
<td>Gov’t</td>
<td>Gov’t</td>
<td>Gov’t</td>
<td>Gov’t</td>
<td>Gov’t</td>
</tr>
<tr>
<td>Inter-Gov’t</td>
<td>Gov’t 1</td>
<td>Gov’t 1</td>
<td>Gov’t 2</td>
<td>Gov’t 2</td>
<td>Gov’t 1</td>
</tr>
<tr>
<td>C.I.</td>
<td>Gov’t</td>
<td>Gov’t</td>
<td>NGO</td>
<td>Gov’t</td>
<td>Gov’t</td>
</tr>
<tr>
<td>C.O.</td>
<td>Gov’t</td>
<td>Gov’t</td>
<td>NGO</td>
<td>NGO</td>
<td>Gov’t</td>
</tr>
<tr>
<td>Grants to NGO</td>
<td>NGO</td>
<td>Gov’t or donor</td>
<td>NGO</td>
<td>NGO</td>
<td>Gov’t or donor</td>
</tr>
</tbody>
</table>
Advantages – Why Contracting Seems to Work

1. Greater focus on results, more accountability
2. Private sector’s flexibility – less red tape more opportunity to innovate
3. Increases managerial autonomy & decentralizes decision making
4. Overcomes absorptive capacity constraints
5. Uses competition to increase effectiveness and efficiency
6. Allows governments to focus greater efforts on their unique stewardship roles
Posited Difficulties of Contracting

• Contracting can only be done on small scale
  – many examples with tens of millions of beneficiaries, one now covers 40 million people!!

• Contracting more expensive than government provision of services
  – Studies in Bangladesh, Pakistan, & India show NGOs can do better job at same or lower cost
Posited Difficulties of Contracting

• Contracting **worsens inequities**
  – NGOs willing to work anywhere if provided resources & direction
  – If designed properly contracting can reduce inequities, e.g. Cambodia, Bangladesh UPHCP

• Governments **can’t manage** contracts
  – Even if they can’t experience in Bangladesh & Guatemala shows it doesn’t matter much
  – Examples from Cambodia & Africa show that governments can manage contracts with help
Posited Difficulties of Contracting

• NGOs and Governments *weary* of each other
  – Contracting makes for more mature relationship, can work together

• Contracting will be a source of *corruption*
  – Needs constant vigilance, difficult to know how serious
  – Involvement of neutral parties important
  – May actually prevent corruption
Posited Difficulties of Contracting

• Contracting will not be sustainable
  – In all 10 examples where enough time (>3 years) elapsed and where information available, contracting sustained & expanded.
  – People likely mean different things around “sustainability”
    – financial sustainability
  – reliance on international NGOs
  – long-term role of government in health sector
Sustainability

• **Financial**: Contracting often lower cost. Even when not, reduces OOP by the poor
  – $3 to $6 per capita per year
  – sustainability a matter of political will!!

• **Reliance on International NGOs**
  – “If you build it they will come” local NGOs will develop
  – Bid process based at least partly on cost will lead to replacement by local NGOs & staff
Long-Term Role of Government

• Governments need to finance health services, but already some things (like drugs & supplies) they purchase from private sector
• In OECD countries very few health workers are civil servants, implicit or explicit contracts are the norm
• Experience in other sectors like public works indicates governments don’t have to deliver
• Less time spent on service delivery will allow MOH’s to do a better job on their other roles
Take Home Messages

• **Contracting has worked!!** Not just a far fetched idea. May make a real difference in achieving MDGs

• **Contracting can be used in many ways**

• **Evaluate** – debate on contracting should be decided by evidence not eminence
  – Evidence is good but not great. Better than other interventions though

• **Practical Issues will determine Success!!** – need to pay attention to contract design & management